

**Healthy Eating – Healthy Action:**

**Oranga Kai – Oranga Pumau**

**Implementation Plan: 2004–2010**

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MANATŪ HAUORA

# Foreword

Last year I launched the *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau* Strategy. Since then the Ministry of Health has worked closely with a number of groups to develop an implementation plan. The Strategy and this Plan address three of the 13 priority population objectives in the New Zealand Health Strategy.

Obesity, and the impact of diseases such as cardiovascular disease, cancer and type 2 diabetes, can be modified by the actions outlined in *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau Implementation Plan*. The burden of these diseases and the downstream health care costs of doing nothing to reduce illness and premature death due to poor nutrition, physical inactivity and obesity are unsupportable. We must act now in a co-ordinated way to reduce this impact.

The health sector alone cannot produce the outcomes this Strategy demands. A wide range of government, non-government and private sector agencies must be involved. Education, sport and recreation, local government, social development, transport, non-government agencies (such as the Cancer Society, National Heart Foundation and Diabetes New Zealand) and the food and physical activity industries (including advertising and the media) must all play a part.

This Implementation Plan is a companion document to both the *Strategic Framework* and *Background* documents for *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau* (Ministry of Health 2003d, 2003e). This third document brings the Strategy alive.

Sport and Recreation New Zealand (SPARC) has worked closely with us to develop the Plan, and I would like to acknowledge their energy and commitment to this work. I would also like to thank the members of each of the interagency, industry and external advisory groups who contributed to the development of the Plan. Their enthusiasm and commitment have been invaluable. They have shaped this document and have a stake in the actions it recommends.

I look forward to seeing the relationships built up during the development of the Plan continue and grow as it is implemented.

Kia kaha



Hon Annette King  
Minister of Health



# Acknowledgements

Developing this plan has been a year-long process. One of its strengths is the number of people who have contributed to its development. The groups involved are:

- the internal Ministry of Health and SPARC HEHA Steering Group
- the External HEHA Implementation Advisory Group including nutrition, physical activity and health promotion experts
- the Māori caucus
- the Government Interagency Group
- the Food and Physical Activity Industry Group
- international peer reviewers.

This work has been led by the Public Health Policy team at the Ministry of Health, in particular Megan Grant, with SPARC actively participating at all steps along the way, through Diana O'Neill, Senior Advisor (Health).

The people who have so enthusiastically contributed to this work also brought the views and expertise of their colleagues to the table. Thank you to everyone who has been involved.

The participants of the groups are listed in Appendix 1.

# Contents

Foreword .....	iii
Acknowledgements .....	iv
Executive Summary .....	vii
1 Introduction .....	1
The purpose of this Implementation Plan .....	1
Is this Plan for you? .....	1
The Implementation Plan and Māori health .....	3
Key population health messages underpinning the Strategy .....	4
2 Why Do We Need an Implementation Plan? .....	5
Comprehensive public health action .....	6
Reducing inequalities .....	7
Priority groups targeted by the Plan .....	7
3 Who Will Help Implement the Plan? .....	12
4 The Framework for the Implementation Plan .....	14
How the Strategy links with other Ministry of Health strategies .....	14
The structure of this Implementation Plan .....	15
Timelines and priorities for action .....	17
The Healthy Eating – Healthy Action <i>Start Here</i> list .....	17
The way forward .....	18
5 Healthy Eating – Healthy Action Implementation Plan: Outcomes and specific actions .....	19
Objective 1: Build healthy public policy .....	19
Objective 2: Create supportive environments .....	22
Objective 3: Strengthen community action .....	25
Objective 4: Develop personal skills (includes wider workforce involved in promoting nutrition and physical activity including industry and education) .....	26
Objective 5: Reorient health services .....	28

Objective 6: Monitor, research and evaluate .....	30
Objective 7: Communication .....	32
Objective 8: Workforce (health and physical activity workforces) .....	33
6 Evidence for the Effectiveness of the Proposed Actions .....	34
Objective 1: Build healthy public policy .....	35
Objective 2: Create supportive environments .....	36
Objective 3: Strengthen community action .....	38
Objective 4: Develop personal skills .....	39
Objective 5: Reorient health services .....	39
Objective 6: Monitor, research and evaluate .....	40
Objective 7: Communication .....	40
Objective 8: Workforce (health and physical activity workforces) .....	42
7 Resourcing, Evaluation and Monitoring .....	43
Resourcing .....	43
Evaluation and monitoring .....	43
Monitoring short-term outcomes .....	44
Monitoring long-term outcomes .....	44
Appendix 1: Groups involved in the development of the Implementation Plan .....	45
External HEHA Implementation Advisory Group membership .....	45
Healthy Eating – Healthy Action Food and Physical Activity Industry Group .....	46
Government Interagency Group .....	46
Internal Ministry of Health HEHA Steering Group .....	47
Appendix 2: The Healthy Action – Healthy Eating Framework .....	48
Appendix 3: Links to the Healthy Eating – Healthy Action Strategy .....	49
Appendix 4: Links between He Korowai Oranga and the HEHA implementation plan .....	55
Appendix 5: A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health (May 2004) .....	61
Appendix 6: Intervention framework to improve health and reduce inequalities .....	63
Glossary .....	64
Abbreviations .....	68
References .....	69

# Executive Summary

Our bodies are shaped by what we eat and what we do. The health problems resulting from poor nutrition, lack of physical activity and obesity include diabetes, cardiovascular disease and cancer. Delay in addressing these issues at a primary prevention level will lead to further demand for health services in the future.

Two out of every five deaths each year (approximately 11,000 annually) are due to nutrition-related risk factors such as high cholesterol (reflecting mainly saturated fat intake), high blood pressure (reflecting a range of factors most notably high sodium intake), overweight and obesity, and inadequate vegetable and fruit intake. Of these 11,000 deaths a year, 8000 to 9000 are likely to be due to dietary factors alone, and the remaining 2000 to 3000 due to sub-optimal physical activity levels (Ministry of Health 2003f). When looking at the top 20 causes of death, by risk factor, the joint effects of diet (includes cholesterol, blood pressure, BMI and vegetable and fruit consumption) rank first, with insufficient physical activity also in the top 10 (Ministry of Health 2004). Obesity is more of a problem for Māori and Pacific communities than other New Zealand groups.

The *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau: Strategy framework* (HEHA Strategy) provides an integrated policy framework to bring about changes in the environment in which New Zealanders live, work and play as this relates to nutrition, physical activity and obesity. It is the Ministry’s response to three of the 13 priority population health objectives in the New Zealand Health Strategy (Minister of Health 2000).

This Implementation Plan is based on, and is an extension of, the HEHA Strategy and associated background paper. Key points from the Strategy are provided in this document but the full text of the strategy and background paper should be referred to for a detailed analysis. The Implementation Plan has an outcome focus and provides a set of actions based on the HEHA Strategy. Evidence for action is presented. The reducing inequalities intervention framework has guided the development of this plan.

The work to improve nutrition, increase physical activity and reduce obesity requires multiple actions by multiple players to make it happen. The health and physical activity sectors will need to work alongside a wide range of other public and private sectors (eg, local government, transport, education, and industry).

There are 87 actions identified in the Plan. They cannot all be started at once. The Healthy Eating – Healthy Action ‘Start Here’ list gives an indication of where we think is the best place to start.

**Start Here list:**

- Develop and implement a comprehensive communication plan to ensure consistent nutrition and physical activity messages.
- Promote nutrition, physical activity and obesity issues in preschools and schools including Kohanga Reo and Kura Kaupapa Māori.
- Identify and develop activities for promoting nutrition and physical activity in primary health care settings.
- Investigate options for improving food security in low-income families with children.
- Initiate development and implementation of a range of social marketing strategies to facilitate behavioural changes supporting healthy eating, healthy action, and healthy weight.
- Develop and expand community action programmes for high-need groups.
- Develop and implement a strategy to increase capacity and capability of trained Māori and Pacific health professionals and community health workers.
- Encourage the food and physical activity industries to implement the HEHA Strategy.
- Develop a monitoring plan.

# 1 Introduction

## The purpose of this Implementation Plan

The Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau Strategy launched in 2003 is a high-level framework to improve nutrition, increase physical activity and reduce obesity. Over the past year the Ministry of Health has worked with various groups to develop this plan to enable the goals of the Strategy to be met.

The Plan provides a level of detail on how those goals can be met, and how they can be actioned by a wide range of individuals and organisations. The groups who will benefit from this work are similarly wide ranging. Actions have been included to enable the priorities of all population groups to be considered on the basis of need.

The Plan outlines the steps required to tackle the growing problem of poor nutrition, physical inactivity and obesity. A considerable amount of time and effort and increased investment of resources is needed to fully implement this Plan.

## Is this Plan for you?

The work to improve nutrition, increase physical activity and reduce obesity is wide-ranging and will require multiple actions by multiple players to make it happen. These actions will come from the health and physical activity sectors and a wide range of other sectors as detailed below.

### Health Sector

- Ministry of Health
- District Health Boards
  - hospitals, clinical and specialist services
  - Primary Health Organisations
  - primary health care providers
  - Public Health Units

- non-governmental organisations
- community-based providers and organisations (including Māori and Pacific)
- health professionals

### **Physical activity sector**

- SPARC (Sport and Recreation New Zealand)
- regional sports trusts
- physical activity providers
- community providers and organisations

### **Education sector**

- Ministry of Education
- academics and researchers
- tertiary institutions
- schools

### **Other sectors**

- central government agencies such as Social Development, Transport, Environment
- local government
- food and food service industry, including fast food, vegetable and fruit, grocery, restaurants
- physical activity industry, including gyms
- weight loss industry
- advertising and the media
- employers/the workplace

Actions can and must take place at a variety of levels, ranging from the Ministry of Health nationally to DHBs and their communities locally.

The Plan details a comprehensive public health programme. Not all stakeholders could or should consider every action. Some are suited to large organisations; others are much better done at a local level. You will see this in the Plan. Stakeholders should take this Plan, set it alongside their own plans, and determine where they can act to implement this Plan. We also encourage communication between agencies so that, ultimately, there are no gaps or duplications of the combined effort.

## The Implementation Plan and Māori health

Improving nutrition, increasing physical activity and reducing obesity are key issues for Māori health (see section 2 for specific data).

In addressing the goals of the HEHA Strategy in the Māori community it is important that consideration is given to the principles of the Treaty of Waitangi.

The Treaty of Waitangi acknowledges the special relationship between Māori and the Crown. In relation to the Implementation Plan, this relationship can be expressed by:

- partnership: working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services
- participation: involving Māori at all levels of the health and disability sector in the planning, development and delivery of health and disability services
- protection: working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices.

These principles continue to underpin that relationship and are threaded throughout He Korowai Oranga the Māori Health Strategy (Minister of Health and Associate Minister of Health 2002).

## Key population health messages underpinning the Strategy

The key population health messages that underpin the Strategy and this Implementation Plan are derived from the *Food and Nutrition Guidelines for Healthy Adults: A background paper* (Ministry of Health 2003c), *Breastfeeding: A guide to action* (Ministry of Health 2002a) and the *New Zealand physical activity guidelines* (Hillary Commission 2001).

### Key messages

- **Eat a variety of nutritious foods.**
- **Eat less fatty, salty, sugary foods.**
- **Eat more vegetables and fruits.**
- **Fully breastfeed infants for at least six months.**
- **Be active every day for at least 30 minutes in as many ways as possible.**
- **Add some vigorous exercise for extra benefit and fitness.**
- **Aim to maintain a healthy weight throughout life.**
- **Promote and foster the development of environments that support healthy lifestyles.**

The apparent simplicity of these key messages belies the fact that they are difficult changes for the whole population to embrace. If it were easy, there would be no need for the Implementation Plan. That is why the Plan has a whole section about how to communicate these key messages in such a way as to help bring about changes in behaviour as well as knowledge and attitudes.

## 2 Why Do We Need an Implementation Plan?

New Zealanders are becoming increasingly overweight and obese, and we know that some groups are more at risk of being overweight or obese than others. The latest national nutrition survey results show that adult New Zealanders have different rates of overweight and obesity depending on ethnicity. For example, 57 percent of adult Māori men and 60 percent of adult Māori women are either overweight or obese, and 76 percent of Pacific women and 85 percent of Pacific men surveyed were overweight or obese compared with 53 percent of New Zealand European men and 46 percent of New Zealand European women (Russell et al 1999).

This differential rate of overweight and obesity is also reflected in recent data collected from New Zealand children. The 2002 National Children’s Nutrition Survey collected data from 3275 children aged 5–14 years. Using the Cole et al (2000) cut-offs overweight and obesity levels were highest for Pacific males and females followed by Māori males and females and then New Zealand European males and females (Ministry of Health 2003g).

**Table 1: Percentage of overweight or obese children**

	NZ European and others		Māori		Pacific peoples	
	M	F	M	F	M	F
Overweight (%)	18.4	18.8	19.6	30.6	33.9	32.9
Obese (%)	4.7	6.0	15.7	16.7	26.1	31.0

There are also differences in rates of physical activity in different groups in New Zealand. Māori and New Zealand European adults are the most active (67 percent and 69 percent respectively) while 63 percent of Pacific adults are active and 54 percent of adults from other cultures (SPARC 2002). The 2002 National Children’s Nutrition Survey has shown that males were more likely than females to be more active. No weekend physical activity was reported by 12.5 percent of children overall, and 22.8 percent of females aged 11–14 years did no weekend physical activity (Ministry of Health 2003g).

Rates of non-communicable diseases such as diabetes and heart disease are higher in Māori and Pacific peoples than New Zealand Europeans. Type 2 diabetes reduces life expectancy by approximately seven years in New Zealand Europeans and 12 years in Māori and Pacific peoples (Ministry of Health 2002b).

Modelling using intervention scenarios has shown that it is possible to achieve substantial health gains relatively quickly. For example, a modest reduction in total cholesterol levels, a one-serving increase in fruit and vegetable intake, a gradual slowing in the rate of increase in body mass index (BMI) or a small reduction in systolic blood pressure, would each prevent an estimated 300 to 400 deaths per year by 2011, or over 1000 deaths per year if all or most of these changes in risk profile could be achieved simultaneously (Ministry of Health 2003f).

The 1997 National Nutrition Survey showed that those living in more deprived areas were more likely to have poor nutrition. Māori and Pacific peoples are significantly over-represented in lower socioeconomic populations. Approximately half of Pacific and a third of Māori households compared with only a tenth of New Zealand European and other households reported that food ran out sometimes or often (Russell et al 1999).

The statistics listed above indicate that there is great need for comprehensive actions to reduce obesity, particularly for Māori and Pacific populations. The culturally specific actions listed in the action tables later in this document (see section 5) include many that will try to address specific issues for Māori and Pacific peoples.

**The key message for energy balance is:**

- **Energy in minus Energy out equals Energy Balance.**

Positive energy balance results in weight gain. Negative energy balance results in weight loss. Achieving healthy weight requires attention to energy balance.

This energy balance also has to be achieved through eating healthy food. Food is not only a source of energy, it is also a source of essential nutrients. So, in the quest for healthy weight, nutrition and food choice also have to be considered.

## Comprehensive public health action

Changing what people do in order to produce certain health outcomes is very challenging. We only have to look back at the moves to change attitudes to smoking over the last 20 years to see how hard it is – and there are no perceived benefits to smoking! On the other hand, we all have to eat. Food is a necessity of life. The HEHA Strategy is therefore about getting a balance between energy in and energy out in a nutritious way to achieve a healthy life balance – a tall order. That is why the approach is a comprehensive public health approach, using a range of programmes and tactics.

Comprehensive public health action involves ‘the organised efforts of society’. It includes a range of initiatives, from individual actions through to legislation. There are many examples of such programmes. *Achieving Health for All People* (Ministry of Health 2003b) clearly sets out comprehensive public health action, and is a useful resource.

## Reducing inequalities

Reducing inequalities for different groups of New Zealanders has been identified as a key priority by the Government. Inequalities in health exist between socioeconomic groups, ethnic groups, people living in different geographic areas, and between males and females. People living in the most deprived circumstances have been shown to have greater exposure to health risks, poorer access to health and disability services and poorer health outcomes. Health inequalities in New Zealand are greatest between Māori and non-Māori, and also between Pacific peoples and non-Pacific non-Māori (see section above on need).

Effective action to address inequalities in health must take a balanced approach. It must both tackle the social and economic inequalities, and improve access to and the effectiveness of health and disability services.

There are several tools available for taking an equity approach. Two used commonly by the Ministry of Health are the Reducing Inequalities Intervention Framework (Ministry of Health 2002c) and the Health Equity Assessment Tool (Te Roopu Rangahau Hauora a Eru Pomare et al 2004). The Intervention Framework indicates the range of activities that can contribute to the outcomes desired. The Health Equity Assessment Tool is a series of 12 questions that help identify what the inequalities are, how they have arisen and how to ensure the proposed action does not inadvertently increase inequalities. Both these tools should be used when considering the outcomes and specific actions in this Plan. The tools are presented in Appendix 5.

## Priority groups targeted by the Plan

### Māori

He Korowai Oranga: The Māori Health Strategy (Minister of Health and Associate Minister of Health 2002) provides strong direction for funders and planners to ensure appropriate services are being purchased and delivered in a meaningful and sustainable way. Meaningful, in that Māori communities are able to participate and contribute to the development of any service, and sustainable in that Māori communities are given the opportunities to take ownership of the issue – doing it ‘with’ rather than doing it ‘to’.

The HEHA Strategy aims for whānau, hapū, and iwi wellbeing (whānau ora) and identifies pathways that need to be progressed in order to achieve those aims. These are:

Pathway 1 – Development of whānau, hapū, iwi and Māori communities

Pathway 2 – Māori participation

Pathway 3 – Effective health and disability services for Māori

Pathway 4 – Working across sectors.

Critical components for the above pathways to be carried out more effectively are:

- collating relevant information that will help with better planning
- understanding and relating effectively with Māori
- using better monitoring and evaluation procedures.

Approaches to nutrition, physical activity and obesity within Māori communities must recognise and include existing structures within Māoridom (eg, the Māori Women’s Welfare League). Māori provider services are known to increase Māori access to health and disability services. It is most important that we maintain and continue to improve on these developments to achieve the goals of the Strategy within Māori communities.

The following table shows how the pathways from He Korowai Oranga integrate with the objectives of the Implementation Plan.

**Table 2: How He Korowai Oranga pathways relate to the objectives of the Implementation Plan**

Objectives	He Korowai Oranga pathways			
	1	2	3	4
1. Build healthy public policy	x	x		x
2. Create supportive environments	x	x	x	x
3. Strengthen community action	x	x	x	
4. Develop personal skills	x		x	
5. Reorient the health sector	x	x	x	
6. Monitor, research and evaluate	x			
7. Communication	x			
8. Workforce		x	x	

The Māori caucus of the External Healthy Eating – Healthy Action Implementation Advisory Group created a table of Māori specific outcomes and actions consistent with the direction of He Korowai Oranga (see Appendix 4). The table identifies outcomes and actions that are important for HEHA to be implemented in a meaningful and sustainable way for Māori. The outcomes are based on He Korowai Oranga and differ slightly from those outlined in section 5. However, linkages work on various levels. For instance, there can be linkages through community action or at a personal level as indicated above, and in Appendix 4.

### Pacific peoples

Pacific populations in New Zealand are heterogeneous and culturally diverse. The migration of Pacific peoples to New Zealand, globalisation and urbanisation have all brought changes to the Pacific lifestyle. The impacts of migration include the ready availability and wider variety of foods, as well as changes in climate, language, housing and living arrangements (Harding et al 1986). Working in order to grow, gather and hunt for food is optional rather than necessary (Prior 1976). Lack of physical activity and a poor diet have contributed to increased levels of obesity and a

high prevalence of non-communicable diseases among Pacific peoples in New Zealand compared to New Zealand Europeans (Scragg et al 1991). Pacific peoples are over-represented in the lower socioeconomic groups and the National Nutrition Survey highlighted food security as an issue for Pacific peoples (Ministry of Health 1999; Russell et al 1999).

The Pacific Health and Disability Action Plan (Minister of Health 2002) identifies six priorities, all of which are of equal importance. They are child and youth health; promoting healthy lifestyles and wellbeing; primary health care and preventative services, provider and workforce development, promoting participation of disabled Pacific peoples and health and disability information and research.

Initiatives to encourage and improve nutrition, physical activity and healthy weight have had variable outcomes. Successful initiatives have been those that were community-based, incorporated multiple interventions and were specifically designed for and delivered by Pacific peoples for Pacific peoples within the context of the cultural values, beliefs and social environment (Finau 1996; Swinburn et al 1998). The escalating overweight and obesity levels among Pacific peoples need urgent action, requiring approaches designed and delivered by Pacific peoples and an appropriately trained workforce.

## **Children and families**

Obesity in adult life often has its origins in childhood, and childhood obesity is on the rise (Dawson et al 2001). It is important to recognise that children and young people are therefore one of the priority groups. Children are part of their wider environment, and are influenced by, and can influence, what adults do in regard to both nutrition and physical activity.

And it's never too late to start leading a healthier life; the benefits can still be gained well into adulthood. We are all living longer, and living healthier lives will make a difference to how much we are able to enjoy our old age. As a result, the Plan takes a life-course perspective, covering both men and women of all ages in the action tables.

## **Lower socioeconomic groups**

Access to nutritious food and the opportunity for physical activity are both more difficult for populations lacking in material resources. Paradoxically, obesity tends to be greater in lower socioeconomic groups. This is in part due to the type of food eaten, but it is complex to tease out the causes.

Food security (access to adequate food) is another issue for some people. Juggling a tight budget may mean that sometimes food is in short supply in some families. The cheapest food may also be ‘energy dense but nutrition poor’ – it fills you up but is not full of nutrients.

### **Other population groups**

The population can be considered by dividing it in many ways – young and old, men and women, geographical location and ethnicity. When considering what actions to take, you will need to focus on those groups with demonstrated needs.

The New Zealand population is becoming increasingly ethnically diverse through migration. Currently there is limited reliable data on physical activity status, eating patterns or obesity for the smaller ethnic groups. Barriers to providing information on good nutrition and access to physical activity may include income, language, education and cultural factors. In the future there may be other emerging high-need population groups such as the Asian population or older people that will be prioritised.

### 3 Who Will Help Implement the Plan?

The Plan is wide-ranging and should be looked at as a 'jigsaw' that, in its totality, will produce a comprehensive public health programme. But it will take time and lots of people's efforts to put the puzzle together.

The main action for the implementation will be undertaken in the wider sector. National co-ordination, and leadership, will be driven by the Ministry of Health and SPARC. Locally, District Health Boards will be key along with Primary Health Organisations (PHOs). The Ministry of Health funds public health services and will monitor progress. Many players will be involved, at national, regional and local levels. There have been many people involved in the development of the Plan, and all of these people will have a major role in its implementation.

The Plan will form the basis for purchasing in the health sector (including the physical activity sector), but it is much wider than that. It demonstrates the linkages with other sectors, and aims to foster collaboration and co-ordination.

One way the Plan can be used by all sectors and organisations is to take their own strategic plans, and sit this Implementation Plan alongside them to look for synergies. There is already a lot of action taken in other sectors that contributes to the overall goals of this Plan. Agencies can build on these synergies.

There is clearly a role for the food and nutrition industry and the physical activity industry to take action in line with this Plan. There will be areas of synergy, and areas where the Ministry and industry will take different lines. The strength will be in building on these synergies, and not letting the differences get in the way.

The table of specific actions identifies agencies that are involved in completing the actions. Although the Ministry of Health is co-ordinating the implementation many other agencies have a vital role to play. The NGO sector has a significant role, including influencing the environment. This sector includes Māori and Pacific providers and some primary health care providers. SPARC is the lead government agency for promotion of physical activity and has a network of sports trusts around New Zealand. Academic institutions are key for high-quality research as well as creating a high quality workforce.

District Health Boards fund primary health care services and will provide the link both to PHOs and public health activity as well as co-ordinating regionally across sectors. It is recognised that each DHB may implement the Strategy differently depending on the areas of activity they have been engaged in up until now.

The food and physical activity industries have been enthusiastic contributors to the plan to date and their commitment to implementing the plan will result in providing a more supportive environment for nutrition and physical activity in New Zealand in the future. Territorial Authorities are key to influencing the physical environment at a regional and local level.

The education sector is the gateway to the children of New Zealand and their families as well as being the sector responsible for training key professions. In New Zealand schools, *Health and Physical Education in the New Zealand Curriculum* (Ministry of Education 1999) is the instrument through which nutrition and physical activity are taught. In early childhood centres *Te Whāriki* (the early childhood curriculum) (Ministry of Education 1996) includes a strand titled 'Mana atua or wellbeing'.

The Ministry of Transport is committed to encouraging active transport (walking and cycling). The Ministry of Social Development co-ordinates a wide range of social programmes with a particular focus on children and young people.

The table of outcomes and specific actions in section 5 and Appendix 4 indicate where all of these players can become involved in implementing the Strategy. But we do not want to limit people, and if you can play a part anywhere in the action table, do not hold back.

Given the wide range of players it is important that everyone works co-operatively to prevent gaps and overlaps.

## 4 The Framework for the Implementation Plan

The framework for the Implementation Plan builds on the HEHA Strategy (See Appendix 2). The vision and goals of the strategy relevant to this implementation framework are presented here.

### The vision of the Strategy

The vision of Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau is:

An environment and society where individuals, families and whānau, and communities are supported to eat well, live physically active lives, and attain and maintain a healthy body weight.

### The goals of the Strategy

The three overarching goals of the Strategy reflect the priority population health objectives of the New Zealand Health Strategy:

- Goal 1 – Improve nutrition
- Goal 2 – Increase physical activity
- Goal 3 – Reduce obesity.

Ideal weight is achieved by a balance of ‘energy in and energy out’, achieved through nutritious food and adequate physical activity.

### How the Strategy links with other Ministry of Health strategies

The overarching strategies for the health and disability services are the New Zealand Health Strategy (Minister of Health 2000) and the New Zealand Disability Strategy (Minister for Disability Issues 2000). Nutrition, physical activity and obesity are also related to the development of several diseases. As a result, there are synergies with a number of other recently released Ministry of Health strategies including:

- He Korowai Oranga: Māori Health Strategy and Whakatātaka: Māori Health Action Plan (Minister of Health and Associate Minister of Health 2002)

- Pacific Health and Disability Action Plan (Minister of Health 2002)
- New Zealand Cancer Control Strategy (Minister of Health 2003)
- Reducing Inequalities in Health (Ministry of Health 2002c)
- Breastfeeding: A guide to action (Ministry of Health 202a)
- Child Health Strategy (Minister of Health 1998)
- Health of Older People Strategy (Associate Minister of Health and Associate Minister for Disability Issues 2002)
- Achieving Health for All People (Ministry of Health 2003b).

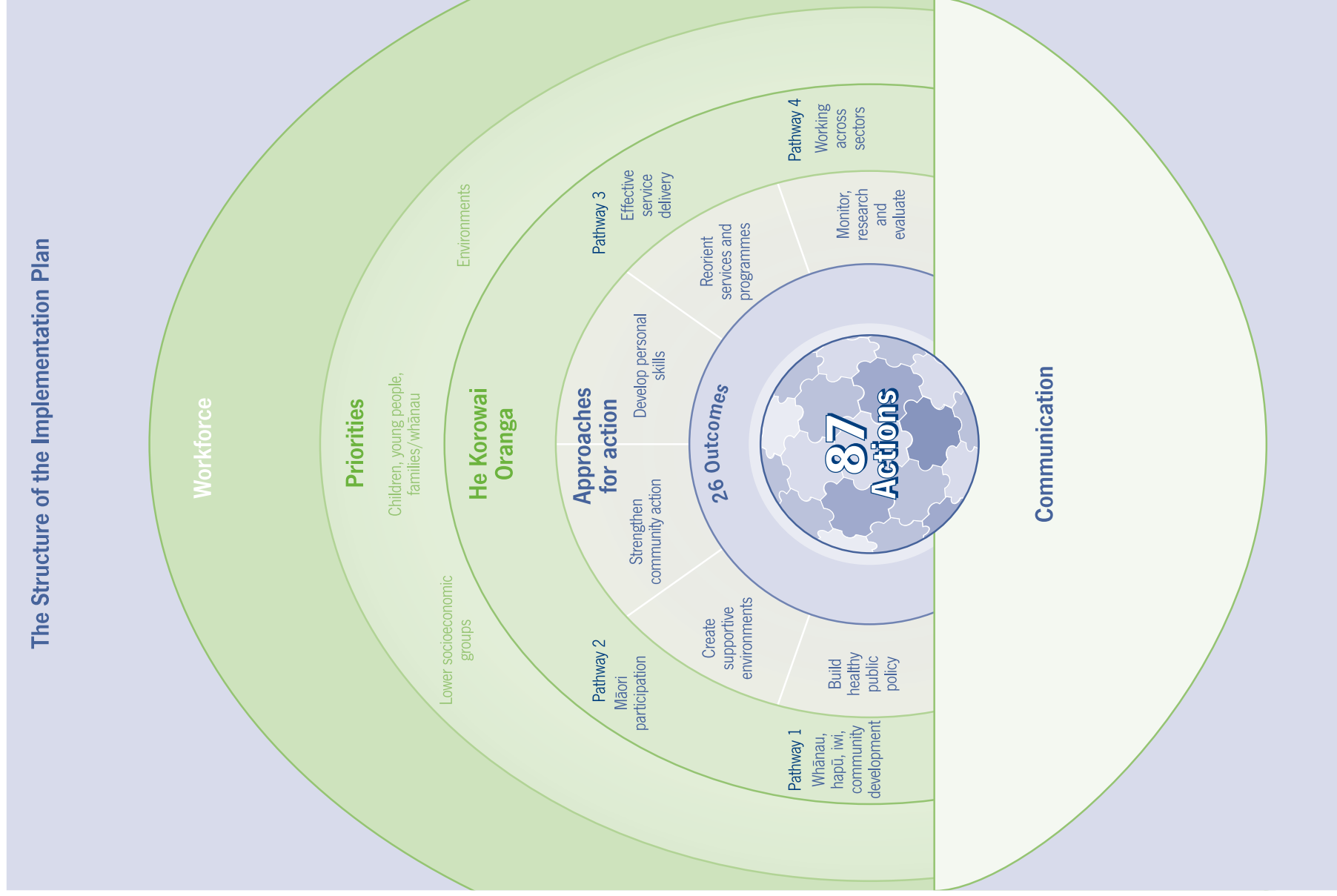
## The structure of this Implementation Plan

This Implementation Plan is outcomes focused and action oriented, so that all the stakeholders can work towards a common set of results. Its development has begun the process of intersectoral and interagency action, including the private sector. This will continue during the implementation phase.

The Plan is framed by three cross-cutting strands:

- the objectives based on the Ottawa Charter (WHO, et al 1986) and the approaches for action from HEHA
- the key priorities of HEHA
- He Korowai Oranga.

Figure 1: How the components of the Plan relate to each other



The first three key priority areas from the strategy (lower socioeconomic groups; children, young persons and their families and whānau, including older people; and environments) are considered under the six Ottawa Charter headings. The actions for these three key priorities are undertaken by the workforce and should occur in the context of the prevailing messages on nutrition, physical activity and obesity. Having a workforce ready to respond to the challenge and communicating clear and consistent messages are necessary for all other objectives. For this reason there are separate objectives for workforce and communications (see figure 1).

The result is a set of actions based on the Strategy, packaged in an outcome-focused way. The aim is to have all the key stakeholders able to identify where and how they can contribute to the overall goals of the Strategy. A table linking the outcomes identified in the Plan and the key actions from the Strategy is provided in Appendix 3.

## Timelines and priorities for action

The Plan is intended to have at least a six-year perspective, and to be reviewed after five years. The majority of the actions should have been implemented, or at least initiated, within that timeframe. Many will have become an integral part of 'business as usual' and some positive results should be apparent.

But we cannot move on all fronts at once. We need to make progress on the actions in a step-by-step fashion. This depends in part on the availability of resources, including the appropriate workforce. The 87 actions have been divided into three, two-year phases, but local needs, partnerships and resources may modify this phasing.

## The Healthy Eating – Healthy Action *Start Here* list

This list gives an indication of where we think is the best place to start. These actions are shown in bold in the table in section 5.

- Develop and implement a comprehensive communication plan to ensure consistent nutrition and physical activity messages.
- Promote nutrition, physical activity and obesity issues in preschools and schools including Kohanga Reo and Kura Kaupapa Māori.
- Identify and develop activities for promoting nutrition and physical activity in primary health care settings.
- Investigate options for improving food security in low-income families with children.

- Initiate development and implementation of a range of social marketing strategies to facilitate behavioural changes supporting healthy eating, healthy action and healthy weight.
- Develop and expand community action programmes for high-need groups.
- Develop and implement a strategy to increase capacity and capability of trained Māori and Pacific health professionals and community health workers.
- Encourage the food and physical activity industries to implement the HEHA Strategy.
- Develop a monitoring plan.

## The way forward

The next section is a table of specific actions based on the outcome results we are aiming for. This is where the Plan really comes alive. If we have done our job well, everyone will be able to see themselves taking some of the actions described in these tables.

The tables detail the desired outcomes and the specific actions identified to reach these outcomes. Agencies have been identified to take part in the actions specified as have milestones and measures of progress towards the outcomes. The final column identifies timelines and resources for the plan. The timelines use three two-year phases, giving the Plan a six-year timeline. Phase one indicates that action will be initiated in the first two years of implementation. Phase two actions will be initiated in years three and four and phase three actions in years five and six of the implementation.

The resources required are indicated by ‘existing’, ‘increased’ or ‘new’. ‘Existing’ indicates the action could be initiated within existing funding, ‘increased’ indicates that some activity can occur within existing resources but increased resourcing will be needed to expand activity. ‘New’ indicates that this action cannot be initiated without new resourcing.

An implementation steering group will be established to provide leadership and expert advice to the Ministry of Health during the implementation phase. Many of the people who have already contributed to the development of this plan will become part of this steering group.

Turn the page to find out where you become part of the action.

## 5 Healthy Eating – Healthy Action Implementation Plan: Outcomes and specific actions

### Objective 1: Build healthy public policy

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
1 Sectors work collaboratively and in a co-ordinated manner to improve nutrition, increase physical activity and reduce obesity, prioritising those with high need based on the wider determinants of health.	The Ministry of Health works with other government ministries/agencies to get commitment to adopt the WHO's Global Strategy on Nutrition and Physical Activity (WHO 2003b).	MOH	Global Strategy adopted by New Zealand Government.	Phase 1 Existing
	Co-ordinate implementation of the Global Strategy on nutrition and physical activity.	MOH	Work commenced on implementing the Global Strategy.	Phase 1 Existing
	Document the stakeholder groups that could have an influence on nutrition and physical activity for Māori eg, Māori Women's Welfare League, Te Kohanga Reo National Trust, iwi authorities, iwi media, Māori providers of health and social (and other) services.	DHB NGO	Database of stakeholders completed.	Phase 1 Existing
	Form interagency steering group for the cross-sectoral implementation of HEHA, with members from central and local government, agencies and NGOs. <ul style="list-style-type: none"> <li>Establish cross-sectoral processes that ensure appropriate Māori and Pacific involvement and identify how the groups can contribute to Māori and Pacific health gain.</li> </ul>	MOH DHB NGO SPARC TA Regional councils	Interagency groups (national, regional and local) established including appropriate Māori and Pacific participation.  A staged approach to joint work programmes is developed.	Phase 1 Existing

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
	Lead the development of new physical activity policies and strategies.	SPARC	New policies/strategies developed and implemented on an ongoing basis.	Phase 1–3
	<b>Encourage the food and physical activity industries to implement HEHA.</b>	MOH Industry	Industry participation in implementation of the Plan.	Phase 1
	Establish an Industry HEHA Implementation group.	Industry	Group established.	Phase 1–3 Existing
2 Increased information about and understanding of possible regulatory and policy options to improve the physical activity and nutrition environment (especially that for children and young people) by the health sector and other sectors.	Continue to monitor international regulatory and policy options for the nutrition and physical activity environment.	MOH	Ongoing surveillance of international regulations and policy options.	Phase 1–3 Existing
	Explore and implement policy options, as appropriate, to improve the physical activity and nutrition environments in schools.	MOH Education sector	Policy options explored. Most appropriate option adopted.	Phase 1–3 Existing
	Progress public health legislation that includes provision for influencing the social and physical environments in relation to the non-communicable disease, eg, by encouraging linkages between local authorities and health services and encouraging health impact assessments.	MOH	Public health legislation passed.	Phase 3 Existing
	Provide input into legislation and regulatory reviews where nutrition and physical activity considerations are appropriate, eg, Ministry of Education review of Early Childhood Centre Regulations 1997.	MOH MoE SPARC	Respond to review consultation documents as appropriate.	Phase 1–3 Existing
	Public health principles are considered in review of existing or development of new food-related legislation.	NZFSA FSANZ	Public health considerations included in legislation reviews.	Phase 1–3 Existing

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
3 Three-way strategic alignment of policies and priorities between Ministry of Health, MoE and SPARC in place to progress nutrition, physical activity and obesity issues.	Develop memoranda of understanding between Ministry of Health/Ministry of Education and the Ministry of Education / SPARC / Ministry of Health.	MOH MoE SPARC	Memoranda developed.	Phase 1 Existing
	Undertake collaborative planning between Ministry of Health / MoE / SPARC for nutrition and physical activity, making high-need groups a priority.	MOH MoE SPARC	Joint planning initiated.	Phase 1–3 Existing
4 Healthy public policy in the areas of nutrition and physical activity developed and supportive environments created.	Develop and implement nutrition and physical activity policies in settings such as schools, (including Kura Kaupapa Māori) preschools, (including Kōhanga Reo and Pacific Island early childhood centres), churches, hospitals and health services, tertiary institutions and marae. Prioritise settings with high-need groups.	MOH DHB SPARC NGO PHO	Nutrition and physical activity policy implemented in range of settings. Systematic audit processes specific policies developed and implemented.	Phase 1–3 Increased
	Investigate and analyse policy options regarding the advertising of foods to children.	MOH	Policy options developed.	Phase 1 Existing
5 Breastfeeding promoted to New Zealand women and their families, particularly Māori and Pacific women.	Develop a national health promotion campaign for the promotion of breastfeeding, with particular emphasis on high-need groups.	MOH DHB	Programme developed and implemented.	Phase 2 New
	Develop community-based breastfeeding promotion campaign by Māori providers specifically tailored for Māori women, whānau and communities.	MOH DHB NGO PHO	Programme developed and implemented.	Phase 2–3 New
	Develop community-based breastfeeding promotion campaign by Pacific providers specifically tailored for Pacific women, their whānau and communities.	MOH DHB NGO PHO	Programme developed and implemented.	Phase 3 New

## Objective 2: Create supportive environments

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
6 Increased profile of healthy food and physical activity through media, advertising and promotion.	Investigate options to increase the profile of healthy food choices and physical activity in media, advertising and promotions.	Industry MOH SPARC	Options considered, and agreed actions implemented.	Phase 2–3 Increased
7 Improved access to healthy food in preschools, Kohanga Reo, schools, and Kura Kaupapa Māori, with high numbers of high-need students.	Investigate feasibility of the Fruit in Schools programme as a model to improve student access to healthy food.	MOH	Feasibility study of Fruit in Schools completed and recommendations for rollout made based on evaluation.  Rollout undertaken as recommended.	Phase 1–2 New
	Expand other evaluated successful education setting initiatives, eg, breakfast programmes, gardening project).	MOH DHB	Number and coverage of programmes.	Phase 1–3 Increased
8 Reduced salt, sugar, fat content of commercially prepared foods.	Food service industry adopts best practice preparation, cooking and serving techniques consistent with the Ministry of Health’s food and nutrition guidelines.	MOH Industry	Best practice adopted.	Phase 2–3 Increased
	Food industry replaces saturated fats with unsaturated fats in foods and reduces fat, salt and sugar content of manufactured foods: <ul style="list-style-type: none"> <li>• explore the innovative methods to enable changed formulations of commercially prepared foods</li> <li>• investigate the monitoring of change through Manufactured Food Database.</li> </ul>	Industry MOH	Innovative methods identified and described.	Phase 1–3 Increased

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
9 Healthy food choices are affordable, available and accessible. Increased consumption of vegetables and fruits in the New Zealand population.	Undertake regional ecological scans regarding access to healthy food opportunities. Action taken to improve access.	MOH DHB	Scans completed at the regional level. Access improved.	Phase 1-3 Existing
	Industry to consider innovation to provide healthy nutritious choices to consumers at competitive prices.	Industry	Number and coverage of innovations identified.	Phase 3
	Promote consumption of vegetables and fruits in a variety of settings – schools, workplaces, rest homes, marae, community settings.	MOH DHB NGO PHO Industry	Consumption monitored in National Nutrition Survey and National Children’s Nutrition Survey.	Phase 1–3 Increased
	<b>Investigate options for improving food security in low-income families with children.</b>	MSD MOH	Number and range of options identified.	Phase
10 Environments promote and support physical activity and/or healthy eating.	Develop and implement a Walking and Cycling Strategy. Final plan addresses needs of priority groups and messages are consistent with HEHA.	MoT	Walking and Cycling Strategy developed and implemented.	Phase 1–3
	Develop regional physical activity plans.	SPARC	Number and coverage of plans.	Phase 1–3
	Develop district-level alliances and networks between health agencies and TAs to inform and influence district planning.	DHB TA NGO Regional councils	Networks developed.	Phase 1 Existing
	Run forums to foster identification of nutrition and physical activity and obesity as priorities for TAs.	DHB TA NGO Regional councils	Number of forums held. Participant evaluation indicates increased awareness of nutrition and physical activity as priority issues for TAs.	Phase 2–3 Increased
	Stocktake existing evaluated Māori and mainstream settings-based programmes.	MOH	Stocktake completed and results published and disseminated.	Phase 1 Existing

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
	Develop and expand existing settings-based programmes promoting healthy food and physical activity. Settings include: early childhood centres, schools, workplaces, health care facilities, church groups, marae, shopping centres, markets. Prioritise settings for high-need groups.	DHB NGO MOH	Successful programmes expanded (number and coverage) and new programmes developed.	Phase 1–3 Increased
	<b>Promote nutrition, physical activity and obesity issues to preschools and schools (including Kohanga Reo and Kura Kaupapa Māori) prioritising those with high-need populations.</b>	DHB MOH SPARC PHO	The monitoring process indicates success of promotion. (see outcome 22)	Phase 2–3 New
	Encourage schools to become Health Promoting Schools and to include nutrition, physical activity and obesity issues as a priority.	MOH DHB	Number of Health Promoting Schools identifying nutrition, physical activity and obesity as priorities.	Phase 1 Increased
11 Older people and people with disabilities are supported by an environment that encourages them to be physically active, eat healthy food and maintain a healthy weight.	Develop new and expand existing programmes promoting healthy food and physical activity for older people in the community, (eg, kaumātua programmes).	DHB MOH PHO	Number and coverage of programmes.	Phase 3 Increased
	Develop and expand programmes promoting healthy food and physical activity to people with disabilities.	DHB MOH PHO	Number and coverage of programmes.	Phase 3 Increased
	Apply food and nutrition and physical activity guidelines in residential care settings (link to guidelines and legislation).	DHB MOH PHO	Food, nutrition and physical activity guidelines consistently applied.	Phase 3 Increased

## Objective 3: Strengthen community action

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
12 Communities are actively involved and successful in influencing the availability and supporting the promotion of healthy food and physical activity in their communities.	<b>Develop and expand community action programmes for high-need groups.</b>	DHB SPARC MOH	Investment increased for high-need groups (number and coverage).	Phase 1 Increased
	Support community action by resourcing key community people (eg, kaiāwhina, kaimahi) to promote healthy food and physical activity, prioritising high-need communities.	DHB MOH	Investment increased for high-need groups (number and coverage).	Phase 2 Increased
	Support communities and whānau to develop nutrition and physical activity programmes in key settings of significance to Māori, Pacific peoples and high-need communities.  Support activities that foster whānaungatanga, āwhinatanga, wairuatanga and manaakitanga through sporting events, kapahaka, break-dancing competitions, etc	SPARC NGO DHB MOH	Research collated and disseminated about successful initiatives (number and coverage).	Phase 2 Increased
	Disseminate information about evaluated, successful community action initiatives especially those effective in achieving health gain in high-need groups.	DHB MOH	Mechanism to share information established within and between agencies.	Phase 2 Increased
	Māori-led community action/development programmes to use strengths-based approaches.	NGO MOH	Māori community actions are strengths-based.	Phase 2 Increased
	Support the home/school partnership programme with resources and information as appropriate.	MoE MOH	Number and coverage of programmes.	Phase 1–3 New
	Support community initiatives that promote healthy eating and physical activity (eg, community gardens).	SPARC NGO DHB MOH PHO	Number and coverage of programmes.	Phase 2 Increased

## Objective 4: Develop personal skills (includes wider workforce involved in promoting nutrition and physical activity including industry and education)

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
13 Increased knowledge and skills in whānau/families and communities about improving nutrition, increasing physical activity and reducing obesity.	Stocktake existing community-based education opportunities for Māori and Pacific peoples.	MOH	Stocktake completed.	Phase 1 Existing
	Expand existing access and develop new community-based education programmes aimed at increasing knowledge and skills of community members, about nutrition and physical activities.	DHB MOH PHO	Number and coverage of education programmes.	Phase 2–3 Increased
14 Increased knowledge of employers and other key stakeholders in settings such as workplaces and residential care about improving nutrition and increasing physical activity.	Train employers and other key stakeholders in workplaces to promote the key messages of food and nutrition guidelines and physical activity guidelines.	NGO DHB MOH PHO	Number and coverage of training programmes.	Phase 2 Increased
	Support key residential care staff, including kaumātua carers, in the key messages of food and nutrition guidelines and physical activity guidelines.	DHB NGO Industry	Number and coverage of training opportunities.	Phase 2 Increased
15 Increased knowledge and skills of teachers to deliver nutrition and physical activity in the curriculum.	Strengthen nutrition and physical activity training course content.	Education sector SPARC MOH	Nutrition and physical activity guidelines included in tertiary instruction course content.	Phase 2 Existing
	Make training available to early childhood centres (especially Kohanga Reo and Pacific early childhood centres) and schoolteachers on the key messages of the food and nutrition guidelines and physical activity guidelines.	MOH DHB NGO Education sector SPARC PHO	Number and coverage of professional development sessions conducted.	Phase 2 Increased

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
16 Increase the knowledge and skills of workers in the food and physical activity industries about improving nutrition and increasing physical activity.	Train food industry employees in best practice food preparation, cooking and serving techniques consistent with the Ministry of Health's food and nutrition guidelines.	Food industry NGO MOH	Number and coverage of training opportunities.	Phase 1 Increased
	Train physical activity industry employees in the key nutrition messages in the Ministry of Health's food and nutrition guidelines and physical activity guidelines.	NGO MOH	Number and coverage of training opportunities.	Phase 2 Increased

## Objective 5: Reorient health services

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
17 Improved availability and access by high-need groups to affordable and appropriate programmes and services for weight loss (including maintenance).	Create a list of all evidence-based weight loss programmes / services.	MOH DHB Industry	List developed of evidence-based programmes.	Phase 1–2 Existing
	Identify gaps in availability of effective services programmes for high-need groups.	MOH Industry	Gaps in effective services for high-need groups identified.	Phase 2 Increased
	Expand existing or develop new programmes / services to meet consumer need.	MOH DHB Industry	Number and coverage of effective programmes.	Phase 2–3 Increased
	Develop service guidelines and training packages for providers on the treatment of overweight and obesity. Ensure guidelines are effective for Māori, Pacific peoples and other high-need groups including children and link to existing nutrition and physical activity guidelines.	MOH	Guidelines developed. Treatment guidelines consistent with food and nutrition guidelines.	Phase 1–2 Increased
	Maintain existing Green Prescription and expand services to meet the needs of Māori and Pacific groups.	SPARC MOH	Green Prescription services maintained and expanded.	Phase 1–2 Increased
	Consider inclusion of a nutrition component in Green Prescriptions.	SPARC MOH	Nutrition considered as a component of Green Prescriptions.	Phase 2 Increased
	Establish monitoring framework to measure number and coverage of Green Prescriptions.	SPARC	Green prescriptions monitoring in place.	Phase 2

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
18 HEHA Strategy and Māori models of health are integrated into health sector planning to improve nutrition, increase physical activity and reduce obesity.	Build nutrition and physical activity indicators into District Annual Planning processes and other health sector planning; incorporate Whakatātaka Māori Health Action Plan and Pacific Health and Disability Action Plan.	DHB MOH NGO	Changes in practice signalled in Annual Reports.	Phase 1–2 Existing
	Use HEHA and Māori models of health to prioritise and plan services and programmes to improve nutrition, increase physical activity and reduce obesity.	DHB NGO MOH	Changes in practice signalled in Annual Reports.	Phase 1–2 Increased
19 Increased promotion of nutrition and physical activity in primary health care settings.	<b>Identify and develop activities for improving nutrition and physical activity health promotion plans of PHOs and other primary health care providers and DHBs.</b>	DHB SPARC	Activities developed and implemented. Health promotion plans to include nutrition and physical activity.	Phase 1 Increased
	Strengthen and develop networks between primary health care and public health to promote nutrition and physical activity issues ensuring effective participation from high-need groups.	DHB MOH PHO	Effective networks in place.	Phase 1 Increased
	Pursue opportunities to support Māori provider service delivery.	DHB NGO	Number of Māori led services and programmes.	Phase 2 Increased
20 Improved mainstream responsiveness to Māori health needs.	Establish effective formalised mechanisms to facilitate meaningful Māori participation at all levels (governance, service development, service delivery).	MOH DHB NGO	Mechanisms established and implemented.	Phase 2 Existing

## Objective 6: Monitor, research and evaluate

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
21 Improved availability of research and information to support evidence-based approaches and interventions to improve nutrition, increase physical activity and reduce obesity.	Develop research agenda relevant to policy development and service delivery, including research for priority groups (Māori, Pacific, children).	MOH Academia	Research agenda developed.	Phase 1–2 Existing
	Work with Health Research Council to prioritise nutrition, physical activity and obesity-related research.	HRC MOH	Link with Health Research Council established.	Phase 2–3 Increased
	Undertake specific research on aspects of nutrition, physical activity and obesity including: <ul style="list-style-type: none"> <li>mechanisms for behavioural change with a population-based approach</li> <li>prevention of obesity</li> <li>interventions for Māori communities.</li> </ul>	Academia MOH	Research initiated.	Phase 2–3 New
22 Monitoring of New Zealanders' health includes information on nutrition and physical activity-related risk factors and diseases, behaviours and characteristics.  Environmental change measured through monitoring initiatives supporting nutrition and physical activity.	<b>Develop a monitoring process that monitors health status and environmental change related to nutrition, physical activity and obesity.</b>	MOH DHB NGO SPARC	Stocktake of existing monitoring of physical activity and nutrition related outputs completed. Monitoring process developed.  Specific activities/priorities are included in annual plans.	Phase 1 Increased
	Update key tools including: National Nutrition Survey, 2002 National Children's Nutrition Survey, Burden of Disease report, New Zealand Health Survey.	MOH	Updated New Zealand Health Monitor includes relevant information.	Phase 2–3 Increased
	Investigate other sources of monitoring information such as: Department of Statistics, Ministry of Transport and other transport agencies.	MOH Dept of Stats MoT	Other sources of data identified.	Phase 2–3 Increased

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
	Independently evaluate implementation of HEHA Strategy including Māori and Pacific perspectives.	MOH	Evaluation framework developed and evaluation completed. Results published and promoted widely.	Phase 2–3 New
23 Improve level of evaluation of nutrition and physical activity programmes particularly new and innovative programmes.	Build independent evaluation into all programmes funded by the health sector.	MOH DHB NGO	Number of independent evaluations published.	Phase 1–3 Increased

## Objective 7: Communication

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
24 New Zealanders aware of key messages of Healthy Eating Healthy Action Strategy.	<b>Develop and implement a communication plan to deliver clear, consistent messages about nutrition, physical activity and healthy weight for a variety of audiences and settings.</b>	MOH SPARC	Communication plan developed and implemented.	Phase 1 Increased
	Develop media guidelines for promotion of key messages from HEHA Strategy.	MOH Industry	Guidelines developed.	Phase 2 Existing
	Evaluate effectiveness of communication plan and modify if necessary according to results (pre- and post-evaluation required).	MOH	Communication plan evaluated.	Phase 3 Increased
	<b>Initiate the development and implementation of a range of social marketing strategies to facilitate behavioural changes supporting healthy eating, healthy action and healthy weight.</b>	MOH NGO DHB SPARC	Social marketing plan developed and implemented.	Phase 3 New
	Tracking survey to monitor reach, knowledge and awareness, uptake of messages and change of behaviour.	MOH	Impact of social marketing campaign documented.	Phase 2–3 New
	Develop the concept of a brand for HEHA that can be applied to healthier choices.	MOH	Scoping exercise completed. Recommendations made.	Phase 1–2 Increased

## Objective 8: Workforce (health and physical activity workforces)

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
25 New Zealand has a health and physical activity workforce with an understanding of nutrition and physical activity issues and guidelines, and able to implement effective approaches to support Māori and Pacific health gain.	Undertake needs assessment to identify training needs of health and physical activity workforce including Māori and Pacific workforce.	MOH	Needs assessment completed and existing training opportunities identified.  Database of workforce training opportunities developed and distributed.	Phase 1–2 Existing
	Extend existing and/or develop new training programmes that meet identified needs focusing particularly on the Māori and Pacific workforce.	MOH NGO DHB	Number and coverage of relevant training programmes.	Phase 2–3 Increased
	Develop and implement a strategy to encourage mainstream workforce capability to respond more effectively to the needs of Māori and to contribute to Māori health gain.	MOH DHB	Strategy developed and implemented.	Phase 1 Increased
	Work with tertiary institutions to include nutrition and physical activity in relevant health training curricula, eg, medical, nursing. Include physical activity components within nutrition training and nutrition components within physical activity training.	MOH Education sector	Consideration given to nutrition and physical activity training being included in relevant curricula.	Phase 3 Existing
26 Increased representation from high-need groups in health and physical activity workforce.	<b>Develop and implement a strategy to increase capacity and capability of trained Māori and Pacific health professionals and community health workers.</b>	MOH NGO Education sector	Strategy developed and implemented. Number and type of relevant positions established.	Phase 2–3 Increased
	Increase support of existing evaluated community training programmes that provide nutrition and physical activity training and support to community workers working with high-need groups.	MOH NGO	Number and coverage of training programmes supported.	Phase 2–3 Increased

## 6 Evidence for the Effectiveness of the Proposed Actions

This section summarises the evidence for the effectiveness of the actions outlined in this Plan. The analysis was limited to recent systematic reviews and key reports in the areas of nutrition, physical activity and reducing obesity. There are a number of limitations to this approach, including the exclusion of some qualitative analyses, and the fact that most systematic reviews are based on studies undertaken in the UK, Europe and North America. Some Australian and New Zealand studies have been included, where appropriate, to give local examples.

The term ‘effectiveness’ in this document refers to the action itself, not to the justification for targeting a particular group such as Māori, Pacific or children, nor the evidence surrounding the objectives in the Strategy. Evidence to support the objectives in the Strategy can be found in *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau – A background* (Ministry of Health 2003d).

Effectiveness may be defined as demonstrable intended effects on (usually quantitative) outcomes (NHS Health Development Agency 2003). Different outcomes may be measured such as change in weight, behaviour, or health status, so it is not always possible to directly compare the effectiveness of interventions or studies. It is also difficult to compare intervention strategies that differ in quality, scope, reach, dose, timing and specific target group between studies, even in the same setting.

The World Health Organization (WHO 2003) recommends that strategies need to be comprehensive, incorporating both policies and action, multisectoral, taking a long-term perspective and involving all aspects of society; multidisciplinary and participatory, consistent with the principles outlined in the Ottawa Charter for Health Promotion (WHO et al 1986); based on the best available scientific research and evidence; and transparent. The HEHA Strategy and Implementation Plan are based on the Ottawa Charter, reflecting best practice and expert opinion of the WHO.

While there is evidence supporting the important role that adequate nutrition and physical activity play in the prevention of obesity and chronic diseases, and the maintenance of health and wellbeing, there is a lack of good quality evidence on effective actions (ie, what works) to improve nutrition and physical activity, particularly at a population level. Lack of evidence does not imply that actions are ineffective, but it does support the need for good evaluation.

It is worth noting that the programmes and actions outlined in this Implementation Plan may differ from evidence-based actions reported in international literature but may cover the same area of influence (eg, schools). Generally, this Implementation Plan has more specific actions than those reported in the literature, and the Plan is intended to be seen as a whole, not as the parts in isolation.

The NHS Health Development Agency notes that ‘effective strategies to promote healthy eating are generally those which work at several levels (such as individuals, groups and communities) and which address the barriers to dietary change and the maintenance of a healthy diet’. The prerequisites for an effective strategy (WHO 2003b) have also been identified as leadership for effective action, effective communication, functioning alliances and partnerships, and enabling environments. Many of the actions in this Plan reflect the WHO prerequisites, and together provide a best-practice approach to improving nutrition, increasing physical activity and reducing obesity in the New Zealand population.

Areas where there is the strongest evidence to support the actions detailed in this Implementation Plan are outlined below.

## **Objective 1: Build healthy public policy**

Objective 1 centres on co-ordination, collaboration, policy development and intersectoral activity. These approaches are consistent with best practice and expert opinion as documented in the WHO draft global strategy (WHO 2003b).

The WHO (2003) also recommends making the best use of standards and legislation. Actions under outcome areas 2 and 4 relating to public health legislation, food-related legislation and policy options for food advertising reflect this.

There is evidence to support the use of school-based nutrition policies and tuck shop guidelines (actions under outcome areas 2 and 4) to prevent and treat childhood obesity (NHS Centre for Reviews and Dissemination 2002).

The US Taskforce on Community Preventive Services (2001) identified the use of environmental and policy approaches as effective interventions to increase physical activity. In addition the WHO (WHO/FIMS 1995) has recommended that all levels of government should be concerned with the needs of walkers and cyclists in terms of transport and environmental policies. Support for the Ministry of Transport’s Walking and Cycling Strategy *Getting There? On Foot, By Cycle* (Ministry of Transport 2003) is consistent with this approach (action for outcome area 10).

The WHO (2004) has identified support for, and promotion of, six months of exclusive breastfeeding as an area that needs to be addressed. The actions for outcome area 5 address ways to support breastfeeding and reflect a best practice approach.

## Objective 2: Create supportive environments

Objective 2 covers a number of settings including schools, preschools, community settings, and the physical environment. There is also best-practice evidence to support changes to the local environment in areas such as shops and catering outlets, to help people choose a healthy diet (NHS 2002).

### Children

A number of reviews have looked at interventions and actions to encourage healthy eating and activity for children and/or to reduce obesity. However, it is still difficult to find good-quality evidence for long-term behaviour change, as most evaluated initiatives have been short-term interventions, or involved a small number of participants. The current evidence supports interventions in the following settings.

#### Home and family settings

- Environments that support healthy food choices have a probable decreased risk of weight gain and obesity (associated evidence and expert opinion included) (WHO 2004).

#### School settings

- Health-promoting schools and health promotion in schools has led to improvements in healthy eating and fitness (Lister-Sharp et al 1999). A systematic review of 12 studies by Lister-Sharp et al found that a multi-faceted approach combining a classroom programme with a change in school ethos and/or environment, and/or with family/community involvement, was most likely to be effective.
- Multi-faceted school-based interventions to reduce obesity and overweight in schoolchildren, have been shown to be effective, particularly for girls. These interventions include nutrition education, physical activity promotion, reduction in sedentary behaviour, behavioural therapy, teacher training, curricular material, and modification of school meals and tuck shops (NHS Health Development Agency 2003; NHS Centre for Review and Dissemination 2002).

- School-based health promotion curriculum interventions alone (eg, classroom activities to reduce television, videotape and video game use) for the prevention of overweight and obesity in children are less supported by the available evidence (NHS Health Development Agency 2003).
- Multi-faceted physical education programmes including initiatives such as modified curricula and policies to increase physical activity are supported by a review of 13 studies, which used increase in activity levels as the outcome factor (US Taskforce for Community and Preventive Services 2001).
- The Fruit in Schools initiative in the UK (carried out by the Department of Health) found that 80 percent of the 80,000 children took the fruit provided, consumption levels in most of the 500 schools were maintained or increased, 99 percent of schools saw the scheme as a way of improving children's health, and 97 percent of schools regarded the scheme as a support to teaching and learning about healthy eating (Carahar 2002).
- In New Zealand, an evaluation found that the Heart Foundation School Food Programme is successful in achieving its aim of influencing the school environment by improving healthy food choices, and that improvements have continued over seven years in the programme (Carter and Swinburn 1999).

### Preschool and day-care centres

- Parental involvement may enhance the effectiveness of interventions (Tedstone et al 1998).

The above evidence lends support to the actions in outcome areas 7, 9 and 10 on in-school programmes such as fruit in schools and/or breakfast in schools, promoting nutrition and physical activity in kura kaupapa Māori and schools, and programmes encouraging supportive environments in school settings.

There has been little rigorous evaluation of the effectiveness of small-scale projects (NHS Health Development Agency 2002). Local community projects that appear to have been successful involve training for professionals and members of the community to enable them to acquire skills for a new way of working, striking a balance between local ownership and partnerships, involving local people, and ensuring equal respect, being flexible in responding to the needs of particular communities and having secure funding (McGlone et al 1999).

A review of 12 studies by the US Taskforce on Community and Preventive Services (2001) found sufficient evidence to support the creation of, or enhanced access to, places for physical activity. Interventions included providing access to relevant facilities, creating walking paths or reducing barriers to physical activity (eg, by reducing fees or providing time for use). Some programmes involved workplace programmes, training in using equipment and the use of incentives (eg, risk-factor screening or counselling).

A review of the evidence for physical activity and cancer (IARC 2002) also recommended transportation systems that encourage walking and the use of bicycles. This review provides support for actions such as the implementation of the Walking and Cycling Strategy (Ministry of Transport 2003), supporting and encouraging territorial authorities in creating nutrition and physical activity friendly environments, and supporting programmes in a range of settings (all part of actions for outcome area 10).

### **Objective 3: Strengthen community action**

Objective 3 covers community action programmes and local initiatives, particularly the evaluation and dissemination of information on successful programmes.

Social support interventions in community settings have been strongly recommended as a method of increasing physical activity levels based on a review of nine studies by the US Taskforce on Community and Preventive Services (2001). The programmes reviewed focused on building, strengthening and maintaining social networks. Components included setting up a buddy system, contracting with another person to complete specified levels of physical activity, and the use of walking groups.

Some of the community and local interventions identified as part of Objective 3 may involve these methods. It is, however, important that local interventions be evaluated to determine whether they are effective in the communities and populations they are designed for.

A review of the evidence (using studies undertaken in North America, Europe and Australia) on the efficacy of behavioural interventions to modify dietary fat and fruit and vegetable intake was undertaken by Ammerman et al (2002). Interventions appeared to be more successful at positively changing dietary behaviour among populations at risk of (or diagnosed with) disease than among general, healthy populations. Goal setting and small groups were identified as particularly promising intervention components. The findings of this review support providing a special focus on at-risk populations such as Māori and Pacific peoples, as identified in actions for outcome area 12.

There is also evidence from Australia that culturally appropriate, community-based nutrition programmes that address both supply and demand issues related to the food supply in indigenous communities can lead to marked and sustained improvements in chronic disease risk factors (Lee et al 1994, 1995; Rowley et al 2001). The implementation of community store nutrition policies has also demonstrated positive effects (Lee et al 1996; DATSIP 2001). These studies provide examples of how actions for outcome area 12 can be effective.

## Objective 4: Develop personal skills

Objective 4 includes the wider workforce becoming involved in promoting nutrition and physical activity such as teachers, employers, community leaders and community workers (particularly Māori and Pacific).

Areas where there is some evidence for effectiveness in the wider workforce are as follows.

- A review of healthy eating interventions in the workplace (NHS Health Development Agency 2002) identified the need for visible and enthusiastic support and involvement from management, and involvement by employees at all levels in the planning and implementation phases, to create a sense of ownership.
- McGlone et al (1999) reviewed small-scale community projects. The review identified training for professionals and members of the community, enabling them to acquire skills for a new way of working, as a key component of successful community projects.
- A review of interventions to promote healthy eating (NHS Health Development Agency 2002) identified training and support to those involved in delivering the intervention (eg, community workers, primary health care staff, and caterers) as a characteristic of successful interventions.

The above reviews provide evidence to support actions for outcome areas 14 (training for employers and other key stakeholders, and training for key residential care staff, kaumātua staff and whānau), 15 (focusing on trainee teachers and professional development), and 13 (community-based training programmes).

## Objective 5: Reorient health services

Objective 5 actions centre on process and structure (stocktakes, prioritisation of funding, networks, indicators, development of guidelines and reviews). Areas covered include access to weight-loss services for vulnerable groups, linkages between services, and development of service guidelines for the treatment of overweight and obesity, and Green Prescriptions.

The role of health services, particularly primary health care services, has been identified as important by the WHO (2004). The WHO recommends that health services counsel individuals on healthy diets and physical activity, taking a life-course approach and expanding the definition of health beyond overt disease to include the adoption of healthy practices and behaviours. The WHO recommendation based on expert opinion and current best practice, supports actions for outcome areas 18 and 19 (increasing nutrition and physical activity at primary health care and regional levels). Primary Health Organisations are well placed to support this activity.

Apart from the action on Green Prescriptions, the other actions in this section reflect a ‘best practice’ approach. A cluster-randomised controlled trial found that the Green Prescription programme was effective in increasing physical activity and improving quality of life over 12 months (Elley et al 2003). Based on this evidence, the action for outcome area 17 seeks to expand the programme to Māori, Pacific and low socioeconomic groups.

## Objective 6: Monitor, research and evaluate

Objective 6 includes the development of a research strategy, monitoring of indicators, supporting the evaluation of programmes, updating measurement tools, and evaluation of the HEHA Strategy implementation.

Nearly every review publication on healthy eating and activity highlights the need for evaluating programmes to determine what works. Programmes and interventions that have been properly evaluated and published tend to be from North America or Europe, so findings may not be directly transferable to the New Zealand environment. Evaluations also need to be of good methodological quality (NHS Centre for Reviews and Dissemination 2002; Campbell et al 2002). The WHO has identified monitoring, research and evaluation as critical to any nutrition and physical activity strategy (WHO 2004).

There is a lack of evidence in the systematic reviews and meta-analyses regarding the effectiveness of interventions targeting specific socioeconomic, ethnic and vulnerable groups (NHS Health Development Agency 2003). It is therefore important to evaluate interventions in these groups to ensure that what is being delivered is safe and effective. Dissemination of evaluations and research is also important to ensure that successes can be adopted, and that we can all learn from experiences.

## Objective 7: Communication

Objective 7 centres on the development of a comprehensive communication plan including social marketing, brand creation and guidelines for the media. This approach is consistent with the WHO’s global strategy on diet, physical activity and health (WHO 2004) where the provision of accurate and balanced information has been identified as an important area for action. It is also consistent with the *Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity* (US Department of Health and Human Services 2001), which identified media and communication as one of five key areas.

Measuring the effectiveness of large-scale population-type mass media and social marketing campaigns is difficult because there are often many confounding factors to consider, and outcome measures are often limited to awareness of the campaign rather than actual behaviour change.

The US Taskforce on Community Preventive Services (2001) strongly recommended large-scale high-intensity, community-wide campaigns with components such as support and self-help groups, counselling, risk factor screening, community events and the creation of places for physical activity (eg, walking trails) based on evidence from 10 studies that met their criteria. However, they found insufficient evidence to recommend mass media interventions (on their own) for physical activity. They did note, though, that this is not the same as evidence of ineffectiveness. The studies they reviewed covered a variety of media but excluded other components such as support groups and community events.

Evaluation of SPARC's (formerly the Hillary Commission's) Push Play campaign provides New Zealand evidence to support the use of media-led community-wide interventions (Bauman et al 2003). The campaign was designed to increase physical activity at a population level, and resulted in increases in message recognition and in the intention to be more active.

In the area of nutrition, 18 countries have adopted a 5+ A Day programme to encourage people to eat at least five servings of fruit and vegetables per day. Eighty-one percent of all New Zealanders are aware of the 5+ A Day message. Awareness increases to 90 percent of those who have children 15 years or under.<sup>1</sup> Evaluation of a similar campaign in Victoria, Australia called 2 Fruit 'n' 5 Veg Every Day, found that public awareness, reported consumption and comprehension of consumption levels paralleled changes in the level of mass media investment. Activities employed as part of the Victoria campaign were advertising on television, radio, and in print, and transit sports sponsorships and point of sale promotions (Dixon et al 1998).

A review of 27 social marketing campaigns found that the following approaches showed some promise: mass media and point of purchase promotions in conjunction with community coalitions and partnerships; multiple channels and sectors and consumer-driven research. The researchers also noted how difficult it is to appropriately assess the impact of population-wide campaigns (Carroll et al 2000).

The proposed approach for the development of a communications plan is much wider than just a mass media campaign, utilising a range of settings and audiences and delivery methods. This approach is consistent with the recommendations of the US Taskforce on Community Preventive Services (2001) discussed above.

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<sup>1</sup> <http://www.5aday.co.nz/5aday/index.html>

## Objective 8: Workforce (health and physical activity workforces)

Objective 8 focuses on the health and physical activity workforce and includes working with tertiary training institutions, identifying gaps in training, and co-ordinating and collaborating with the health and physical activity sectors. The workforce actions represent a best practice approach.

The WHO (2004) identified the need for national strategies to be culturally appropriate and capable of challenging cultural influences, and to respond to changes over time. Outcome area 26 (increasing the number of trained Māori and Pacific health workers) reflects this principle.

A working party in the UK (Royal College of Physicians et al 2004) that looked into overweight and obesity has recommended that appropriate training programmes for doctors, nurses and other health professionals should be established. They also stated that ‘all undergraduate and postgraduate training must include detailed instruction about the promotion of healthy eating and an active lifestyle’. Actions for outcome area 26 will help to ensure that the importance of healthy eating and an active lifestyle are part of relevant health training curricula.

The working party also noted that ‘... there remains a lack of co-ordination in terms of workforce planning. As more and more overweight patients are assessed as being at risk of cardiovascular disease or diabetes, so this will put a greater strain on local community dieticians and exercise referral services’. Actions for outcome area 25 will help to improve co-ordination across the relevant sectors.

# 7 Resourcing, Evaluation and Monitoring

## Resourcing

Resourcing covers the people, funding and information that are required to implement the Plan. There needs to be an increased investment in all of these areas over time. Financial resources are always at a premium and subject to prioritisation processes. The quality of the information available contributes to these prioritisation processes.

There is a considerable amount of work already going on to meet the goals of HEHA. The level of evidence for ‘what works’ has been detailed earlier. However, it is clear that more evaluation is needed to build up the evidence base, expertise and knowledge of what works. The information should be shared freely so that more and more programmes can be built on solid evidence.

The workforce will need support to expand to meet the challenges set out in this Plan. That is why workforce has a whole section to itself in the action tables.

One way the workforce will expand in numbers and acquire and increase the levels of the necessary skills, knowledge and abilities is by including players from other sectors. Other government and social sector agencies have a significant role to play in implementing this Plan. There is an extensive, influential food and physical activity industry, who work with the advertising industry and the media and who have demonstrated their willingness to be involved in this work. This expands the workforce capacity through an innovative route – a world first in the field.

## Evaluation and monitoring

Evaluation and monitoring have three basic elements:

- monitoring the overall rollout of the Plan (process monitoring)
- monitoring whether the actions made a difference – surveys (outcome monitoring)
- evaluation of individual initiatives (formative, process, impact and outcome evaluation).

There are many specific actions detailed in the Plan so it will be difficult to determine which discrete action will lead to any specific outcome. Behavioural change is complex, but the sum of all the actions should result in improved outcomes. This will be monitored over time by the regular survey monitoring programme, which includes the National Nutrition Survey and National Children's Nutrition Survey (Ministry of Health 2002d).

A mapping project will be undertaken initially so that details about initiatives, programmes and projects related to nutrition and physical activity can be recorded. This baseline information will allow further monitoring of the rollout of the Plan to be meaningful.

Any new programme should have a proportion of funding set aside for evaluation, and evaluation should be built into projects and programmes from the beginning.

The following list includes some of the basic measures that could be used to monitor the implementation of the Strategy. A detailed monitoring strategy will be developed under the guidance of the ongoing steering group.

## Monitoring short-term outcomes

This includes:

- fruit and vegetable consumption
- salt, fat and sugar content of manufactured foods
- blood pressure
- physical activity levels.

## Monitoring long-term outcomes

This includes:

- rates of diet-related cancers
- rates of type 2 diabetes
- rates of obesity.

# Appendix 1: Groups involved in the development of the Implementation Plan

## External HEHA Implementation Advisory Group membership

Eruera Maxted*	Dietitian	Te Tai Tokerau MAPO
Hine Martin*	Health Promoter	Public Health Information and Resource Management
Diana North	Former Medical Director	Heart Foundation
Paula Dudley	General Manager	United Fresh
Audrey Aumua	Chief Executive Officer	Ta Pasefika Health Trust
Stephanie McLennan	Exercise Advisor	Sport Waikato
Carolyn Watts	Health Promotion Manager	Cancer Society of New Zealand
Iain Potter	Director	Health Sponsorship Council
Cristina Van Dam	Road Safety Co-ordinator	Wellington City Council
Robyn Toomath	Medical Advisor	Capital and Coast DHB
Deborah Butt	Principal	Newlands Primary School
Dean Te Hae*	Health Promoter	Hauora Matakauraka
Jean O'Callaghan	Chief Executive	Canterbury District Health Board
Evon Currie	Public Health Manager	Canterbury District Health Board
Jim Mann	Professor in Human Nutrition	Otago University
Dave Gerrard	Associate Professor Sports Medicine	Otago University
Makuini Mckerchar*	Dietitian	Otago University
Aumea Herman	Public Health Registrar	Independent

\* Members of Māori Caucus

## Healthy Eating – Healthy Action Food and Physical Activity Industry Group

Bev Watson	NZ Milk
Frances Clement	NZ Pork Industry Board
Barry Hellberg	NZ Retailers Association
Mike Sim	Outdoors New Zealand
Jude Mannion	Robin Hood Foundation
Marcia Dunnett (1 meeting)	NZ Association of Bakers
Liam Jeory	McDonald's Restaurants (New Zealand)
Fiona Carruthers	NZ Beef and Lamb Marking Bureau
Richard Beddie	Fitness New Zealand
Alastair MacFarlane	Seafood Industry Council
Kate Ward / Glenda Gourley	NZ Vegefed and Fruitgrowers Federation
Brenda Cutress	New Zealand Grocery Marketers Association
Brian Fisher	NZ Recreation Association
Melissa Hodd	Foodstuffs New Zealand
Bronwen Hannay	New Zealand Nutrition Foundation
Jeremy Irwin	Association of New Zealand Advertisers
Bruce Wallace	Television Broadcasting Council
Paul Jefferys	Consultant

## Government Interagency Group

Ministry of Social Development  
SPARC (Sport and Recreation New Zealand)  
Local Government New Zealand  
Ministry of Transport  
Te Puni Kōkiri  
Ministry of Pacific Island Affairs

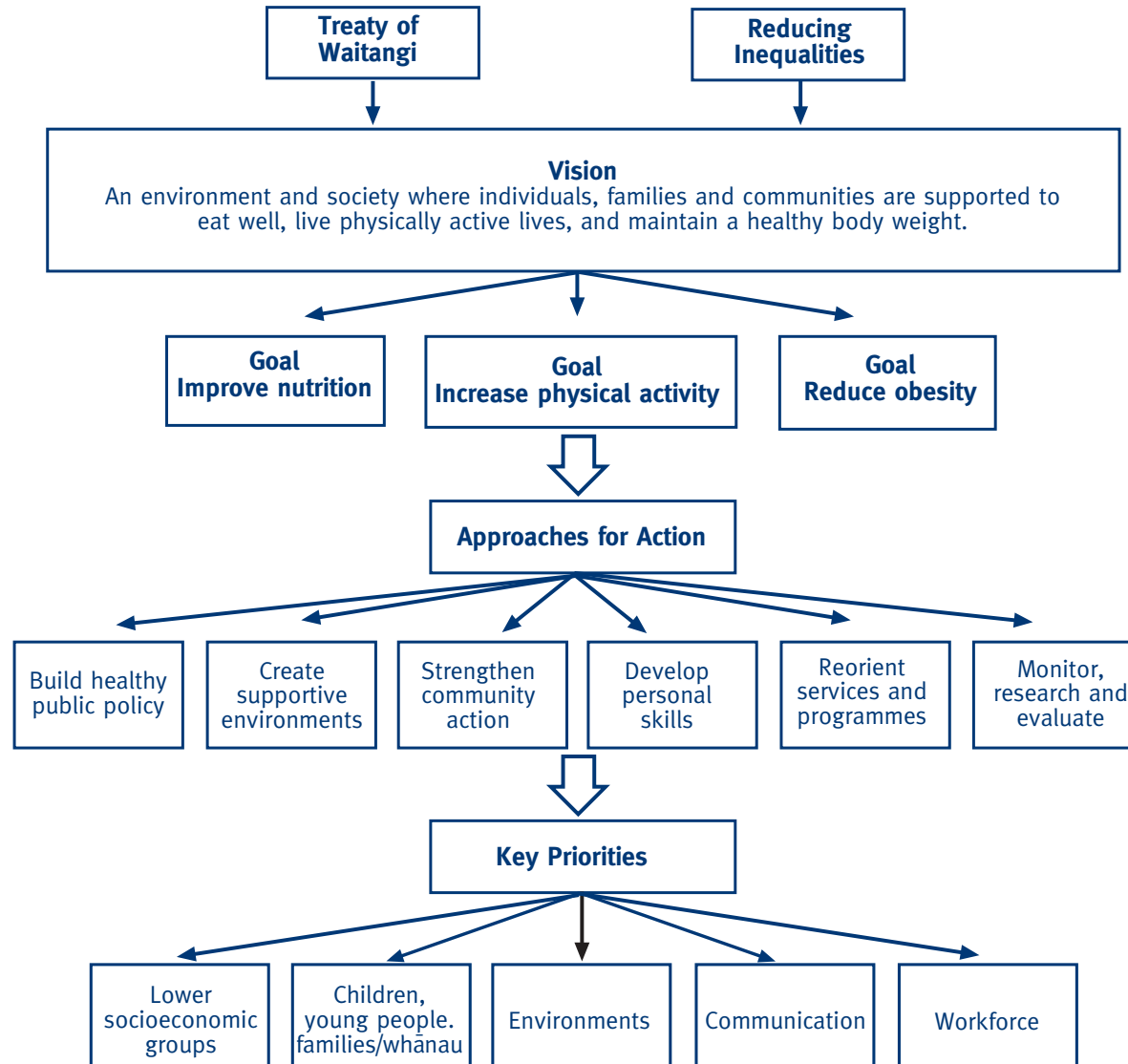
Ministry of Women's Affairs  
Ministry of Education  
Energy Efficiency Conservation Authority  
Food Standards Australia New Zealand  
NZ Food Safety Authority

## Internal Ministry of Health HEHA Steering Group

Cynthia Maling	Public Health Policy
Megan Grant	Public Health Policy
Ruth Richards	Public Health Policy
Michelle Mako*	Public Health Policy
Jon Royal*	Public Health Policy
Cheryl Billett	Public Health Localities
Barbara Lusk	Public Health Localities
Harriette Carr	Public Health Policy
Maraea Craft*	Public Health Policy
Christine Stewart	Public Health Policy
Laura Lambie	Clinical Services Directorate
Sandy Dawson	Clinical Services Directorate
Christine Andrews	Clinical Services Directorate
Harvey Steffans	Sector Policy Directorate
Diana O'Neill	SPARC
Dallas Seymour*	SPARC
Nicola Nelson	Clinical Services Directorate
Debbie Ryan	Clinical Services Directorate

\* Members of Māori Caucus

## Appendix 2: The Healthy Action – Healthy Eating Framework



## Appendix 3: Links to the Healthy Eating – Healthy Action Strategy

Key actions from the HEHA Strategy		Implementation Plan outcome/result
1.1.1	Initiate and foster dialogue and action, at all levels and across all sectors, to develop and support policies for people on low incomes to improve their ability to purchase healthy food and access physical activity opportunities.	1
1.1.2	Explore international policy developments in food security and opportunities to increase physical activity for those most at risk.	8
1.2.1	Work with the food industry, local government and non-government organisations to encourage the increased availability of affordable, healthy food choices and physical activity opportunities.	9
1.2.2	Create safe environments for physical activity, such as footpaths, access to public transport, lighting parks.	9
1.2.3	Create a range of environments that support healthy eating, which are accessible and appropriate for lower socioeconomic groups.	9
1.3.1	Ensure communities most at risk are priorities for action (for improving) access to good nutrition and physical activity opportunities, through community development approaches.	11
1.3.2	Ensure the needs of Māori and Pacific communities are a priority for action, especially in areas of high deprivation.	11
1.4.1	Ensure education and health promotion resources and programmes that promote healthy eating and physical activity are appropriate and readily available for the most at-risk groups, including Māori, Pacific peoples, new immigrants/ refugees, people with disabilities, people who are unemployed and those on low incomes.	23
1.4.2	Extend health promotion programmes that are effective for people on low incomes or for people in lower socioeconomic groups.	13
1.4.3	Ensure messages of the Food and Nutrition Guidelines are available and appropriate for low-income groups.	23
1.5.1	Support the development of culturally appropriate weight-loss programmes and support and expand services and programmes that are acceptable and effective for Māori and Pacific peoples.	15

Key actions from Strategy		Implementation Plan outcome/result
1.5.2	Support and expand services and programmes that are acceptable and effective for Māori and Pacific peoples.	9
1.5.3	Expand effective services such as the Green Prescription Scheme to ensure access for people in lower socioeconomic groups.	19
1.6.1	Support research that identifies, monitors and evaluates issues and interventions for nutrition, physical activity and healthy weight that is relevant for lower socioeconomic groups.	20
2.1.1	Promote the development of policies at all levels (national, regional and local) across all relevant sectors and in key settings that support healthy food choices and participation in physical activity for children, young people and their families and whānau including older people.	1
2.1.2	Promote ongoing support and further development of policies that support breastfeeding.	5
2.1.3	Investigate policy options to reduce adverse health outcomes related to nutrition and physical activity.	2
2.2.1	Promote the development of environments, including infrastructure, that support healthy eating and physical activity for infants, children and young people and their families and whānau, including older people.	9
2.2.2	Promote the development of environments that are particularly mindful of the needs of older people and people with disabilities (including safety).	10
2.3.1	Support and foster well-evaluated programmes that have a whole of community and whole-of-family approach to improving nutrition and physical activity.	11
2.4.1	Ensure children, young people and their family and whānau receive and are responsive to consistent healthy messages from child care, schools and health professionals about nutrition, physical activity and healthy weight New Zealanders.	14
2.5.1	Support the involvement of appropriate health professionals in the delivery of the health and physical activity curriculum in schools.	Not included as not in line with Plan direction

Key actions from Strategy		Implementation Plan outcome/result
2.5.2	Support, evaluate and resource appropriate prevention, maintenance and treatment initiatives for overweight and obese children and young people that also address the needs of Māori and Pacific children.	15
2.5.3	Support and develop programmes to encourage healthy eating and active lifestyles for older people.	10
2.6.1	Support appropriate applied research into effective interventions for children and young people in nutrition, physical activity and obesity.	20
2.6.2	Monitor nutrition status of infants, and the nutrition, physical activity and weight status of children, young people and their families and whānau including older people, with a focus on the most vulnerable groups.	21
3.1.1	Develop integrated policies that support nutrition, physical activity and healthy weight in key sectors and settings (eg, health care, education, schools, residential homes, workplaces, transport, local councils, food industry, weight loss industry, recreation, sport and fitness, marae, wānanga, Kohanga Reo, sports and social clubs).	1
3.1.2	Investigate regulatory and policy options to improve nutrition and increase physical activity.	2
3.1.3	Ensure appropriate input into any legislation, regulations and reviews that impact on food and nutrition, physical activity and healthy weight, both nationally and internationally.	2,4
3.2.1	Ensure that impacts on nutrition and physical activity are considered in the development and redevelopment of towns, suburbs and communities so that infrastructure becomes more supportive of good nutrition and physical activity.	9
3.2.2	Support culturally appropriate programmes and services that aim to improve environments that demonstrably improve nutrition and increase physical activity for target groups.	9
3.3.1	Support community development initiatives to identify and modify local environments to improve physical activity and nutrition.	11
3.3.2	Support community development approaches to address Māori needs, which are based in Māori world views, and which recognise the holistic view of environmental influences.	11
3.3.3	Support community development approaches to address the needs of Pacific peoples, which are based on a Pacific framework, and recognises the holistic view of environmental influences.	11

Key actions from Strategy		Implementation Plan outcome/result
3.4.1	Provide education and training programmes, incorporating Māori knowledge and culture that promote ways to improve environments for improving nutrition and physical activity.	12
3.4.2	Encourage and educate key leaders in influential positions to understand the potential implications of environmental change that can impact on the health status of New Zealanders.	13
3.4.3	Provide education and training programmes that reflect Pacific knowledge and culture on ways to improve environments for improving nutrition and increasing physical activity.	12
3.5.1	Encourage and support services and programmes with demonstrated effectiveness to integrate nutrition, physical activity and healthy weight initiatives into each programme (eg, transport, local government, education and health).	10, 11, 12, 13, 14
3.5.2	Support the development of appropriate programmes and services for the treatment of overweight, and obesity, including partnership with treatment and prevention.	18
3.6.1	Continue to monitor the health of New Zealanders (including physical activity, nutrition and healthy weight) through a periodic survey programme, including appropriate sampling of Māori, Pacific and other population groups.	21
3.6.2	Encourage, support and monitor research (both national and international) into environmental interventions to increase physical activity, improve nutrition and achieve healthy weight, including a focus on Māori and Pacific peoples and other priority population groups.	20
3.6.3	Support the ongoing development and upgrading of key tools for measuring and monitoring nutrition, physical activity and body weight.	20
3.6.4	Monitor the impact of environmental policies and societal developments that impact on nutrition, physical activity and weight (eg, transport policies, urban design etc).	21
4.1.1	Work on the development and ongoing review of communication messages at a national policy level to ensure approaches and communication tools are effective and appropriate in relation to nutrition, physical activity and healthy weight/ overweight and obesity, including for children, young people and Māori and Pacific peoples.	24
4.1.2	Investigate options that would minimise the adverse health impact of inappropriate advertising or communication about nutrition, physical activity and healthy weight.	24

Key actions from Strategy		Implementation Plan outcome/result
4.2.1	Develop appropriate communication strategies that support initiatives to promote good nutrition, physical activity and healthy weight (including positive body images) for all population groups but ensuring they are appropriate for Māori and Pacific peoples.	24
4.2.2	Work with national and local media to develop appropriate messages and campaigns.	24
4.3.1	Support the development of local community communication strategies that encourage good nutrition, physical activity and healthy weight.	24
4.3.2	Convey messages using appropriate communication methods and language for Māori, Pacific communities and other target populations.	24
4.4.1	Promote the messages of the Food and Nutrition Guidelines for all population groups, including infants, children, adolescents, pregnant and breastfeeding women, adults and older people using a range of proven strategies, ensuring communication is appropriate for Māori and Pacific peoples.	24
4.4.2	Promote the messages in the <i>New Zealand Physical Activity Guidelines</i> , with specific messages for individuals at risk of different conditions/diseases based on current evidence.	24
4.4.3	Ensure that messages aimed at those who are overweight and obese do not further stigmatise or foster an environment conducive to the development of eating disorders.	24
4.5.1	Foster collaboration across the health sector and between appropriate industry groups (eg, food, recreation, sport and fitness, weight loss industry) to ensure consistent and appropriate messages on nutrition, physical activity and healthy weight are disseminated.	24
4.6.1	Research and evaluate communication strategies, including media campaigns, on nutrition (including the Food and Nutrition Guidelines), physical activity and healthy weight for at-risk population groups, eg, children and young people, Māori and Pacific peoples and older people.	24
4.6.2	Facilitate the collection and dissemination of research information regarding effective programmes for physical activity and nutrition, including for Māori and Pacific peoples.	20
5.1.1	Develop a national strategic plan to address the workforce development needs required to improve nutrition, increase physical activity and reduce obesity, including developing a stronger Māori and Pacific workforce.	25

Key actions from Strategy		Implementation Plan outcome/result
5.1.2	Work with appropriate bodies to investigate the potential to include physical activity and nutrition as areas of learning in the training of health and education professionals.	25
5.2.1	Establish mechanisms to increase effective communication and collaboration across the nutrition, physical activity and weight-loss sectors.	24
5.2.2	Support training organisations to expand training opportunities for Māori and Pacific peoples in nutrition, physical activity and weight loss.	26
5.3.1	Support the identification of key and appropriate community workers to upskill in nutrition and physical activity, particularly in Māori and Pacific communities.	26
5.3.2	Develop local networks to increase co-ordination and collaboration across nutrition, physical activity and weight-loss sectors.	18
5.4.1	Support training opportunities in nutrition, physical activity and obesity prevention and management among relevant health and education professionals.	25
5.4.2	Support workforce development opportunities to increase the effectiveness of non-Māori personnel who work with Māori.	25
5.4.3	Support the development of best practice guidelines, which provide a consistent approach for health professionals to implement Healthy Eating – Healthy Action (eg, guidelines for weight-loss).	19
5.5.1	Encourage partnerships between health care providers, schools, workplaces and community organisations in prevention efforts targeted at the social and environmental causes of overweight and obesity.	18
5.5.2	Implement initiatives to increase collaboration of those working across prevention and treatment settings.	18
5.6.1	Monitor, review and quantify existing and projected workforce needs to improve health outcomes for physical activity, nutrition and obesity, including a particular focus on Māori and Pacific peoples.	25
5.6.2	Evaluate workforce development initiatives and disseminate findings.	25

## Appendix 4: Links between He Korowai Oranga and the HEHA Implementation Plan

The table details outcomes and actions that are important for HEHA to be implemented in a meaningful and sustainable way for Māori.

### Te Ara Tuatahi: Pathway 1: Development of whānau, hapū, iwi and Māori communities

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
<p>Communities supported to identify and implement their own priorities and solutions as they relate to improving nutrition, increasing physical activity and reducing obesity.</p> <p><i>(Link to section 5 outcomes 1, 4, 5, 7, 10, 11, 12, 13, 18, 23, 24)</i></p>	<p>Identify the stakeholder groups who could have an influence on nutrition and physical activity for Māori eg, Māori Women’s Welfare League, Kohanga Reo, Kura Kaupapa Māori, Iwi authorities, Māori wardens, iwi media, Māori providers of health, social (and other) services etc. Includes voluntary and community action activities in the broadest sense, including those that foster whānaungatanga, āwhinatanga, wairuatanga, manaakitanga, through sporting events, kapa haka, break-dancing competitions etc.</p>	<p>DHB NGO</p>	<p>Stakeholder groups identified.</p>	<p>Phase 1 Existing</p>
	<p>Formal mechanisms established to engage whānau, hapū iwi and Māori communities and agree on priorities. (Stakeholder groups would be key links with whānau, hapū, iwi and Māori communities.)</p> <p>Keep Māori communities informed and engaged.</p>	<p>DHB in partnership with Māori communities</p>	<p>Formalised mechanisms established (eg, MOUs, forums).</p>	<p>Phase 1 Existing</p>
	<p>Reach agreement on the resources (eg, people, materials, financial) required to implement the agreed priorities.</p>	<p>DHB in partnership with Māori communities</p>	<p>Agreement reached. Programmes implemented. Number and coverage of programmes. Programmes are strengths based.</p>	<p>Phase 1–3 Increased</p>

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
	Evaluate programmes implemented for sustainability.	DHB in partnership with Māori communities	Programmes evaluated.	Phase 1–3 Increased
<p>Communities have the information they need to make informed decisions about improving nutrition, increasing physical activity and reducing obesity.</p> <p><i>(Link to section 5 outcomes: 9, 10, 12, 17, 21, 22, 24)</i></p>	<p>Compile a comprehensive local database. Could comprise the following:</p> <ul style="list-style-type: none"> <li>• Stakeholder groups.</li> <li>• Māori networks.</li> <li>• Nutrition and physical activity services and programmes available.</li> <li>• Identification of key settings for reaching Māori, eg, preschools and schools, including Kōhanga Reo and Kura Kaupapa Māori.</li> <li>• Knowledge sources and skill base.</li> <li>• Identification of ways to improve nutrition and Increase physical activity with Māori.</li> <li>• Identification of existing community-based nutrition and physical activity education and training opportunities.</li> <li>• Identification of existing evaluated Māori and mainstream settings based nutrition and physical activity programmes.</li> <li>• Other relevant information.</li> </ul>	MOH DHB in partnership with Māori communities	Comprehensive local database created.	Phase 1 existing
	Ministry of Health to make available national information in relation to the previous action.	MOH	National information made available.	Phase 1 Existing
	Initiate evidence-based Māori-led research to strengthen interventions for Māori communities.	DHB in partnership with Māori communities Academia MOH	Research priorities identified with relevant Māori communities and proposals prepared for funding bodies, in particular research bodies.	Phase 1–2 New

## Te Ara Tuarua: Pathway 2: Māori participation in the health and disability sector

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
Decision-making incorporates Māori priorities, values and approaches to health. <i>(Link to section 5 outcomes:1, 4, 7, 10, 11, 12, 18, 19)</i>	Identify local, regional and national nutrition, physical activity and obesity networks. Identify and address gaps in Māori representation.	MOH DHB	Networks identified and gaps filled with appropriate Māori representation.	Phase 1 Existing
	Support development of Māori-led services and programmes.	MOH DHBs and NGOs in partnership with Māori communities	Carry out a stock take of existing services. Identify resources needed and prioritise investment to meet priority for Māori service development.  Number of Māori-led programmes.	Phase 1–2  Increased
An appropriately trained Māori workforce. <i>(Link to section 5 outcome: 25)</i>	Undertake a needs assessment to identify the workforce development needs of the Māori health and physical activity workforce (eg, in the technical aspects of nutrition and physical activity, health promotion, community development etc).	MOH DHB NGO	Needs assessment completed and training implemented as indicated.	Phase 1–2 Increased
Increase of Māori in the nutrition and physical activity workforce. <i>(Link to section 5 outcome:26)</i>	Develop a workforce strategy to increase number of Māori health workers, ie, educators, kaiāwhina, kaimahi, health promoters, dietitians, nutritionists, eg, investigate increased provision of scholarships for Māori students for tertiary study in nutrition and physical activity.	MOH DHB	Workforce strategy developed and implemented.	Phase 2–3 Increased

## Te Ara Tuatoru: Pathway 3: Effective health and disability services

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
<p>Mainstream workforce has capability to respond effectively to the needs of Māori.</p> <p><i>(Link to section 5 outcomes: 17, 18, 20, 25)</i></p>	<p>Introduce a robust quality improvement programme to monitor the effectiveness (and efficiency) of health service provision to Māori.</p> <p>Gather baseline data to inform planning, for example:</p> <ul style="list-style-type: none"> <li>· nutrition and physical activity services and programmes Māori are accessing</li> <li>· how nutrition and physical activity services and programmes are provided</li> <li>· gaps in services for Māori</li> <li>· how effective the services and programmes for Māori are</li> <li>· what mainstream services need in order to improve eg, professional development</li> <li>· other information identified as relevant.</li> </ul>	MOH DHB	<p>Mechanism in place to identify and address mainstream service development needs and measure effective service delivery.</p> <p>Best practice models identified and shared across DHBs.</p>	Phase 1–2 Existing
	<p>Undertake a needs assessment to identify the workforce development needs of the mainstream health and physical activity workforce, eg, Māori models of health and wellbeing, working with Māori communities, Tikanga Māori, Te Reo, community development, processes of engagement with Māori etc.</p>	MOH DHB	Needs assessment completed and training implemented as indicated.	Phase 1 Increased
<p>Nutrition and physical activity related inequalities between Māori and other New Zealanders are reduced.</p> <p><i>(Link to section 5 outcome: 18)</i></p>	<p>Use the reducing inequalities framework and the equity lens to further inform prioritisation, resource allocation and service development.</p>	MOH DHB	DHBs and Ministry of Health demonstrate the use of the frameworks in planning documents.	Phase 1–3 Existing

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
<p>Funding allocation supports services, which incorporate Māori models of health and wellbeing and reduce inequalities.</p> <p><i>(Link to section 5 outcome:7, 10, 11, 12, 13, 17, 18)</i></p>	<p>Establish criteria for prioritising all new funding for new or existing nutrition and physical activity community action/ development programmes to ensure Māori needs are met and inequalities are reduced, and strengths-based approaches are supported.</p>	<p>MOH DHB</p>	<p>Criteria established and applied.</p>	<p>Phase 1 Increased</p>
<p>Improved mainstream responsiveness to Māori health needs.</p> <p><i>(Link to section 5 outcome: 17, 20)</i></p>	<p>Establish effective formalised mechanisms to facilitate Māori participation.</p> <p>A monitoring process is developed to ensure meaningful input and participation by Māori at all levels, from governance, service development, service delivery for mainstream and Māori.</p>	<p>MOH DHB NGO</p>	<p>Mechanisms established and implemented.</p> <p>Monitoring process established Service integration initiatives which are led by Māori.</p>	<p>Phase 1–2 Existing</p>

## Te Ara Tuawha: Pathway 4: Working across sectors

Outcome	Specific Actions	Agencies	Milestones/Progress Measures	Timeframe/resourcing
Improved collaboration and co-ordination across sectors. <i>(Link to section 5 outcome: 1, 2, 10)</i>	Identify the key groups / stakeholders / community organisations eg, health and physical activity sector agencies, education sector, social and welfare services, TPK, TAs, sporting agencies, Māori stakeholder groups etc.	DHB NGO Central Government Agencies TA Regional councils	Interagency groups formed nationally and locally with appropriate Māori stakeholder representation.	Phase 1 Existing
	Establish cross sector integration processes: <ul style="list-style-type: none"> <li>· Ensure appropriate Māori involvement.</li> <li>· Develop terms of references, establish clear roles and responsibilities between groups.</li> <li>· Investigate options for joint activities</li> <li>· Develop a communication plan to inform agencies for sectoral activities.</li> <li>· Key groups investigate and identify how they can contribute to Māori health gain in the areas of nutrition, physical activity and obesity.</li> </ul>	DHB NGO Central Government Agencies	Terms of references developed. Investigation completed. Joint activities implemented. Communication plan developed and implemented.	Phase 1–2 Existing
Other sectors have increased awareness of how their activities impact on health and specifically on nutrition, physical activity and obesity. <i>(Link to section 5 outcome: 1)</i>	Develop and implement a plan to assist and inform other sectors on how to assess their activities.	DHB NGO Central Government Agencies	Plan developed and implemented.	Phase 1–2 Existing

## Appendix 5: A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health (May 2004)

There is considerable evidence, both internationally and in New Zealand, of significant inequalities in health between socio-economic groups, ethnic groups, people living in different geographical regions and males and females (Acheson 1998; Howden-Chapman and Tobias 2000). Research indicates that the poorer you are the worse your health. In countries with a colonial history, indigenous people have poorer health than others. Reducing inequalities is a priority for government. The New Zealand Health Strategy acknowledges the need to address health inequalities as ‘a major priority requiring ongoing commitment across the sector’ (Minister of Health 2000).

Inequalities in health are unfair and unjust. They are also not natural; they are the result of social and economic policy and practices. Therefore, inequalities in health are avoidable (Woodward and Kawachi 2000).

The following set of questions have been developed to assist you to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them. They should be used in conjunction with the Ministry of Health’s Intervention Framework (Ministry of Health 2002).

1. What health issue is the policy/programme trying to address?
2. What inequalities exist in this health area?
3. Who is most advantaged and how?
4. How did the inequality occur? (What are the mechanisms by which this inequality was created, is maintained or increased?)
5. What are the determinants of this inequality?
6. How will you address the Treaty of Waitangi in the context of the New Zealand Public Health and Disability Act 2000?
7. Where/how will you intervene to tackle this issue? Use the Ministry of Health Intervention Framework to guide your thinking.

8. How could this intervention affect health inequalities?
9. Who will benefit most?
10. What might the unintended consequences be?
11. What will you do to make sure it does reduce/eliminate inequalities?
12. How will you know if inequalities have been reduced/eliminated?

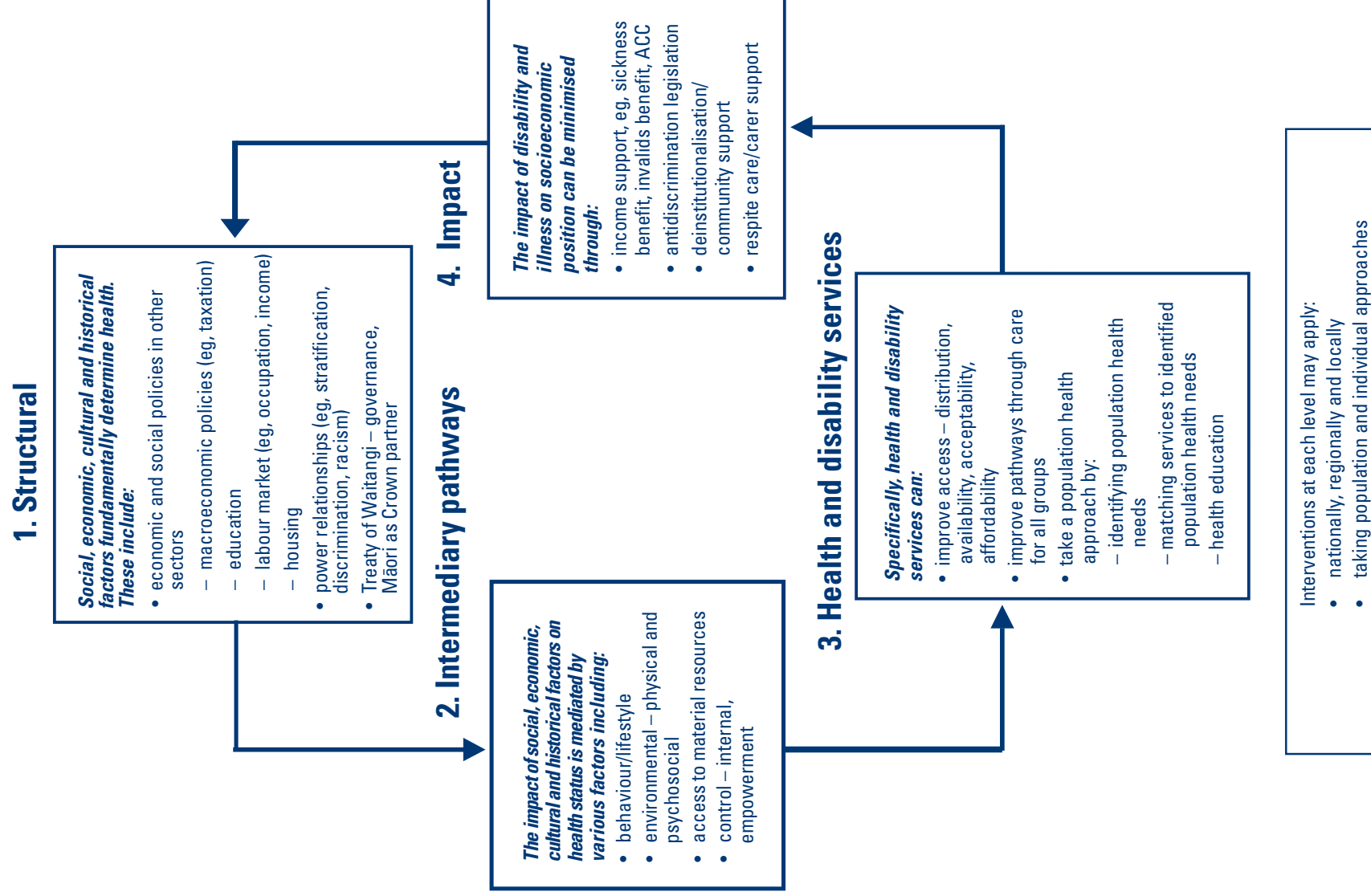
[Based on Bro Taf Authority, 2000 *Planning for Positive Impact: Health Inequalities Impact Assessment Tool*]

Source: Te Ropu Rangahau Hauora a Eru Pomare, Ministry of Health and Public Health Consultancy 2003. *A Health Equity Assessment Tool*. Wellington: Public Health Consultancy, Wellington School of Medicine and Health Sciences.

#### References

- Acheson D. 1998. *Independent Inquiry into Inequalities in Health*. London, The Stationery Office.
- Howden-Chapman P and Tobias M. (Eds). 2000. *Social Inequalities in Health: New Zealand 1999*. Wellington, Ministry of Health.
- Minister of Health. 2000. *The New Zealand Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health (2002). *Reducing Inequalities in Health*. Wellington: Ministry of Health.
- Woodward A. and Kawachi I. 2000. Why reduce health inequalities. *Journal of Epidemiology and Community Health* 54 (12):923.

# Appendix 6: Intervention framework to improve health and reduce inequalities



Source: Ministry of Health 2002c.

# Glossary

academia	Tertiary institutions and other academic bodies with the resources to undertake research
āwhinatanga	To embrace and support a concept or material or person.
Breastfeeding: A Guide to Action	Plan published by the Ministry of Health in November 2002. This document sets out the Ministry of Health's plan of action for improving the initiation and maintenance of breastfeeding throughout New Zealand during 2002–03.
Burden of Disease Report	A report entitled <i>Nutrition and the Burden of Disease New Zealand 1997–2011</i> and published by the Ministry of Health in August 2003. It assesses how many premature deaths and years of life lost are attributable to nutrition-related factors in this country.
2002 National Children's Nutrition Survey	A survey published by the Ministry of Health in November 2003 as <i>NZ Food NZ Children: Key results of the 2002 National Children's Nutrition Survey</i> . This is the first national survey of the nutritional status of New Zealand children.
District Annual Plan	An operational plan written by DHB covering a 12-month period.
District Health Boards (DHB)	Organisations established to protect, promote and improve the health and independence of a geographically defined population. Each District Health Board will fund, provide or ensure the provision of services for its population.
ecological scan	An investigation of the total supply environment.
External Expert Group	Nutrition, physical activity and health promotion experts who do not work for the Ministry of Health but have provided advice for the development of the plan through this group.
Food and Nutrition Guidelines	A set of six positive, food-orientated statements that give health professionals and teachers simple, understandable guidance on healthy eating for the adult population of New Zealand. There are also additional guideline statements for specific population groups.
food security	Access to adequate, safe, affordable and acceptable food.
Fruit in Schools Programme	A pilot programme which provides a daily piece of free fruit to primary school children.
Government Interagency Group	A group formed to ensure all appropriate policies are taken into account, and links established to achieve co-operation and synergy. It includes representatives from a range of government departments, ministries and organisations.

Green Prescription	Written advice for physical activity delivered in a primary health care setting. The initiative is designed to address a range of diseases resulting from inactivity. Currently a range of Primary Health Organisations, DHB, Māori health providers and physical activity providers are engaged in the programme and support for patients is serviced by the regional sports trusts.
hapū	Sub-tribe.
Health Research Council (HRC)	The major government-funded agency responsible for purchasing and co-ordinating health research and fostering the health research workforce in New Zealand.
health workforce	Includes any providers that contract for health services including DHBs and PHOs.
He Korowai Oranga	The Māori Health Strategy. The overall aim is whānau ora: Māori families supported to achieve their maximum health and wellbeing.
High needs group	A group that has a high level of health inequality relative to the local community or wider society to which the group belongs. Ethnic identity (Māori, Pacific peoples) and poverty are associated with high levels of health inequality.
iwi	Tribe.
Kaiawhina / kaimahi	People who work within and amongst whānau, hapū and iwi to deliver services that are based around and support rather than clinical objectives.
kaumātua	Elder.
key stakeholders	Key organisations/groups with a direct interest and involvement in aspects of the Plan.
Kohanga Reo	Māori-medium preschool.
Kura Kaupapa Māori	School.
Kura kaupapa Māori kaupapa manaakitanga	Teaching of Māori values, traditions and aspirations within an education programme.
Māori models of health and wellbeing	Responsibility and care of whānau members.
marae	Holistic approaches that incorporate Māori concepts for health and wellbeing eg, Te Whare, Tapa Wha, Te Wheke.
National Nutrition Survey (NNS97)	Enclosed space in front of a Māori meeting house.
	A cross-sectional survey of adult New Zealanders aged 15 years and older, published by the Ministry of Health in 1997.

New Zealand Health Strategy	A strategy published by the Ministry of Health in December 2000. It provides the framework within which District Health Boards and other organisations across the health sector will operate and highlights the priorities the Government considers to be most important.
New Zealand Health Survey	A survey published as <i>A Snapshot of Health: Provisional results of the 2002/03 New Zealand Health Survey</i> published by the Ministry of Health in December 2003. This was the third national health survey of New Zealand adults aged 15 years and over and was conducted between August 2002 and September 2003.
obesity	Having a body mass index (BMI) greater than or equal to 32 for Māori and Pacific peoples, and a BMI greater than or equal to 30 for all other new Zealanders.
Ottawa Charter	A document produced by the World Health Organization in 1986 which describes the process of enabling people to increase control over and improve their health status.
outcomes	The anticipated overall effects of an intervention or programme, especially in relation to whether the overall programme goal has been achieved.
overweight	Having a BMI greater than or equal to 27 for Māori and Pacific peoples and a BMI of greater than or equal to 25 for all other New Zealanders.
Pacific Health and Disability Action Plan	A plan published by the Ministry of Health in February 2002. It sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples.
Pacific peoples	Encompasses a diverse range of peoples from the South Pacific region (eg, Tongan, Niuean, Fijian, Cook Island Maori, Samoan and Tokelauan) living in New Zealand, who have migrated from those island nations or identify with them because of ancestry or heritage.
physical activity	Movement, produced by the contraction of skeletal muscles, which people need to do on a daily basis, and at recommended levels of intensity and duration to sustain a healthy life.
physical activity workforce	Workers who are employed by organisations that promote physical activity such as Regional Sports Trusts, YMCA, YWCA, local authorities community providers and gyms.
Primary Health Organisation (PHO)	A group of health providers whose job it is to provide primary health care to all people enrolled with them. The group will always include a GP and may also include some or all of nurses, Māori providers, Pacific providers, health promotion and public health workers, pharmacists, dietitians, mental health workers, community health workers and dentists – often working in teams. PHO are the local provider organisations through which District Health Boards (DHB) will implement the Primary Health Care Strategy.

Public Health Services Handbook	A manual produced by the Ministry of Health to describe the range of public health services purchased by the Ministry.
regional sports trusts	Independent charitable trusts, governed by boards of trustees, based in 17 regions of New Zealand. They are contracted by SPARC to promote sport and physical activity, to deliver targeted interventions, and to support the other sport and physical activity providers in their region.
resourcing	The material required to action a project which include workforce and finance.
social marketing plan	A plan that applies commercial marketing technologies to the planning, execution and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of their society.
strengths-based approaches	Approaches that build on the positive capabilities of Māori whānau, individuals and communities. It requires a shift of focus from what doesn't work to what does, and the potential in an individual, whānau or community.
tikanga	Customary practice, rule.
wairuatanga	Spirituality of all things.
Walking and Cycling Strategy	A strategy called <i>Getting there – On Foot, by Cycle</i> which is a draft strategy to increase walking and cycling in New Zealand transport being developed in 2004 by the Ministry of Transport.
Whakatātaka	The Māori Health Action Plan 2002–2005, published by the Ministry of Health in November 2002. It outlines the process to weave together both existing and innovative activities, under the direction of He Korowai Oranga: The Māori Health Strategy.
whānau	Family.
Whānau ora	Healthy family.
whānaungatanga	Having a shared vision and connectedness.
WHO Global Strategy	The WHO Global Strategy on Diet, Physical Activity and Health is a strategy under development by the WHO in recognition of the heavy and growing burden of non-communicable diseases.

# Abbreviations

BMI	Body Mass Index
DHB	District Health Board
FSANZ	Food Standards Australia New Zealand
GP	General Practitioner
HEHA	Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau
MoE	Ministry of Education
MAPO	Māori Purchasing Organization
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSD	Ministry of Social Development
MWWL	Māori Women’s Welfare League
NGO	Non-governmental Organisations
NHS	National Health Service (England)
NZFSA	New Zealand Food Safety Authority
PIECC	Pacific Island Early Childhood Centre
PHO	Primary Health Organisation
RST	Regional Sports Trust
SPARC	Sport and Recreation New Zealand
TA	Territorial Local Authority
WHO	World Health Organization
YMCA	Young Men’s Christian Association
YWCA	Young Women’s Christian Association

# References

- Ammerman AS, Lindquist CH, Lohr KN, et al. 2002. The efficacy of behavioural interventions to modify dietary fat and fruit and vegetable intake: a review of the evidence. *Preventive Medicine* 35:25–41.
- Associate Minister of Health and Minister for Disability Issues. 2002. *Health of Older People Strategy*. Wellington: Ministry of Health.
- Bauman A, McLean G, Hurdle D, et al. 2003. Evaluation of the national ‘Push Play’ campaign in New Zealand – creating population awareness of physical activity. *New Zealand Medical Journal* 116 (1179): 535–46.
- Campbell K, Waters E, O’Meara S, et al. 2002. Interventions for preventing obesity in children (Cochrane Review). In: *The Cochrane Library*, issue 1, 2004. Chichester, UK: John Wiley & Sons Ltd.
- Carahar M. 2002. An apple a day...*Health Matters* 46: Winter URL: <http://www.healthmatters.org.uk/stories/caraher.html>
- Carroll A, Craypo L, Samuels S. 2000. *Evaluating Nutrition and Social Marketing Campaigns: A Review of the Literature for use in Community Campaigns*. University of California, Davis, CA: Samuels & Associates and the Centre for Advanced Studies in Nutrition and Social Marketing. URL: <http://socialmarketing-nutrition.ucdavis.edu/Downloads/SamuelsSMC.pdf>
- Carter M-A, Swinburn B. 1999. Measuring the impact of a school food programme on food sales in New Zealand. *Health Promotion International* 14(4): 307–16.
- Cole TJ, Bellizzi MC, Flegal KM, et al. 2000 Establishing a standard definition for child overweight and obesity worldwide: international survey. *British Medical Journal* 320: 1240–3.
- DATSIP. 2001. *Nutrition Policy for Remote Retail Stores*. Brisbane, Queensland: Department of Aboriginal and Torres Strait Islander Policy.
- Dawson K, Hamlin M, Ross J. 2001. Trends in health-related physical fitness of 10-14 years old New Zealand children. *Journal of Physical Education New Zealand* 34: 26–39.
- Dixon H, Borland R, Segan C, et al. 1998. Public reaction to Victoria’s ‘2 Fruit ‘n’ 5 Veg Every Day’ campaign and reported consumption of fruit and vegetables. *Preventive Medicine* 27: 572–82.
- Elley CR, Kerse N, Arroll B, et al. 2003. Effectiveness of counselling patients on physical activity in general practice: cluster randomised controlled trial. *British Medical Journal* 326:793.
- Finau S. 1996. Health, environment and development: towards a Pacific paradigm. *Pacific Health Dialog* 3(2): 266–78.
- Hillary Commission 2001 *Movement = Health: Guidelines for promoting physical activity*. Wellington: Hillary Commission.
- IARC (International Agency for Research on Cancer). 2002. *Weight Control and Physical Activity*. IARC Handbooks of Cancer Prevention. Lyon: IARC Press.
- Lee A, Bailey A, Yarmirr D, et al. 1994. Survival tucker: improved diet and health indicators in an Aboriginal community. *Australian Journal of Public Health* 18: 277–85.
- Lee A, Bonson AP and Powers JR. 1996. The effect of retail store managers on aboriginal diet in remote communities. *Australian and NZ Journal of Public Health* 20(2): 212–14.
- Lee A, Bonson (Bailey) A, Yarmirr D, et al. 1995. Sustainability of a successful Aboriginal community-based nutrition project. *Medical Journal of Australia* 162: 632–5.
- Lister-Sharp D, Chapman S, Stewart-Brown S, et al. 1999. Health promoting schools and health promotion in schools: two systematic reviews. *Health Technology Assessment* 3: 22. URL: <http://www.nchta.org/fullmono/mon322.pdf>

- McGlone P, Dobson B, Dowler E, et al. 1999. Food projects and how they work. London: Joseph Rowntree Foundation. In: NHS Health Development Agency. 2002. *Cancer Prevention – A resource to support local action in delivering the NHS Cancer Plan*. UK: Health Development Agency.
- Minister for Disability Issues. 2001. *The New Zealand Disability Strategy: Making a world of difference/Whakanui Oranga*. Wellington:Ministry of Health.
- Ministry of Education 1996. *Te Whāiki. Early Childhood Curriculum*. Wellington: Learning Media.
- Ministry of Education 1999. *Health and Physical Education in the New Zealand Curriculum*. Wellington: Learning Media.
- Minister of Health. 2000. *The New Zealand Health Strategy*. Wellington: Ministry of Health.
- Minister of Health. 2002. *The Pacific Health and Disability Action Plan*. Wellington: Ministry of Health.
- Minister of Health. 2003. *The New Zealand Cancer Control Strategy*. Wellington: Ministry of Health and the New Zealand Cancer Control Trust.
- Minister of Health and Associate Minister of Health. 2002. *He Korowai Oranga: The Māori Health Strategy*. Wellington: Ministry of Health.
- Minster of Health. 1998. *Child Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health 1999. *Taking the Pulse: The 1996/1997 NZ Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2002a. *Breastfeeding: A guide to action*. Wellington: Ministry of Health.
- Ministry of Health. 2002b. *Modelling Diabetes: A summary*. Wellington: Ministry of Health.
- Ministry of Health. 2002c. *Reducing Inequalities in Health*. Wellington: Ministry of Health.
- Ministry of Health. 2002d. *The New Zealand Health Monitor. 2002*. Wellington: Ministry of Health.
- Ministry of Health. 2003a. *A Snapshot of Health: Provisional results of the 2002/03 New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2003b. *Achieving Health For All People*. Wellington: Ministry of Health.
- Ministry of Health. 2003c. *Food and Nutrition Guidelines for Healthy Adults: A background paper*. Wellington: Ministry of Health.
- Ministry of Health. 2003d. *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau – A background*. Wellington: Ministry of Health.
- Ministry of Health. 2003e. *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau: A strategic framework*. Wellington: Ministry of Health.
- Ministry of Health. 2003f. *Nutrition and the Burden of Disease: New Zealand 1997-2011*. Wellington: Ministry of Health.
- Ministry of Health. 2003g. *NZ Food NZ Children: Key results of the 2002 National Children’s Nutrition Survey*. Wellington: Ministry of Health.
- Ministry of Health. 2004. *Looking Upstream: Causes of death cross-classified by risk and condition New Zealand 1997*. Wellington: Ministry of Health.
- Ministry of Transport. 2003. *Getting There – On Foot, by Cycle: A draft strategy to increase walking and cycling in New Zealand transport*. Wellington: Ministry of Transport.  
URL: <http://www.transport.govt.nz/business/land/getting-there/index.shtml>
- NHS Centre for Reviews and Dissemination. 2002. The prevention and treatment of childhood obesity. *Effective Healthcare Bulletins* 7(6).

- NHS Health Development Agency. 2002. *Cancer Prevention – A resource to support local action in delivering the NHS Cancer Plan*. UK: Health Development Agency.
- NHS Health Development Agency. 2003. *The Management of Obesity and Overweight: An analysis of diet, physical activity and behavioural approaches*. Evidence briefing. 1<sup>st</sup> edition, October 2003. UK: Health Development Agency.
- Prior IPM. 1976. Nutritional problems in Pacific Islanders. *Proceedings of the Nutrition Society of New Zealand 1*: 1–44.
- Rowley KG, Su Q, Cincotta M, et al. 2001. ‘Improvements in circulating cholesterol, antioxidants and homocysteine after dietary intervention in an Australian Aboriginal community. *American Journal of Clinical Nutrition 74*(4): 442–8.
- Royal College of Physicians, Royal College of Paediatrics & Child Health, and Faculty of Public Health. 2004. *Storing up Problems – The medical case for a slimmer nation. Report of a working party 2004*. Salisbury, Wiltshire: Sarum ColourView Group. URL: [http://www.rcplondon.ac.uk/pubs/brochures/pub\\_print\\_SUP.htm](http://www.rcplondon.ac.uk/pubs/brochures/pub_print_SUP.htm)
- Royal Commission on social Policy. 1988. The April Report. *New Zealand Today*. Vol 1. Wellington: Royal Commission on Social Policy.
- Russell D, Parnell W, Wilson N, et al. 1999. *NZ Food, NZ People: Key results of the 1997 National Nutrition Survey*. Wellington: Ministry of Health.
- Scragg R, Baker J, Metcalf P, et al. 1991. Prevalence of diabetes mellitus and impaired glucose tolerance in New Zealand multi-racial workforce. *New Zealand Medical Journal 104*:395–7.
- SPARC. 2002. *SPARC Facts. Results of the 1997-2001 Sport and Physical Activity Survey*. Wellington: Sport and Recreation New Zealand.
- SPARC. 2003. *Statement of Intent*. Wellington: Sport and Recreation New Zealand.
- Swinburn B, Amosa H, Bell C. 1998. The Ola Fa’autauta Project: the process of developing a church based health programme. *Pacific Health Dialog 4*(2): 20–5.
- Tedstone AE, Aviles M, Shetty P, et al. 1998. *Effectiveness of Interventions to Promote Healthy Eating in Pre-school Children Aged 1–5 Years: A review*. London: Health Education Authority.
- Te Ropu Rangahau Hauora a Eru Pomare. 2004. *Ministry of Health, Public Health Consultancy*. Wellington: Wellington School of Medicine and Health Sciences.
- US Department of Health and Human Services. 2001. *The Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity*. Rockville, MD: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General. URL: <http://www.surgeongeneral.gov/topics/obesity/calltoaction/toc.html>
- US Task Force on Community and Preventive Services. 1996. *Guide to Clinical Preventive Services (2nd ed): Report of the US Preventive Services Task Force*. Baltimore: Williams and Wilkins. URL: <http://www.ahcpr.gov/clinic/uspstfix.htm>
- US Task Force on Community and Preventive Services. 2001. Increasing physical activity: a report on recommendations of the Task Force on Community Preventive Services. *Morbidity and Mortality Weekly Report 50* (RR-18): 1–14
- WHO. 2003. *Diet, Nutrition and the Prevention of Chronic Diseases. Report of a joint WHO/FAO Expert Consultation*. WHO Technical Report Series 916. Geneva: World Health Organization.
- WHO. 2004. *Global Strategy on Diet, Physical Activity and Health*. WHA 57.17. Geneva: World Health Organization.
- WHO/FIMS Committee on Physical Activity for Health. 1995. Exercise for Health. *Bulletin of the World Health Organization 73*: 135–6.
- WHO, Health and Welfare Canada, Canadian Public Health Association. 1986. *Ottawa Charter for Health Promotion*. Ottawa: World Health Organization, Health and Welfare Canada, Canadian Public Health Association.