Healthy Action – Healthy Eating

Oranga Pumau – Oranga Kai

Towards an Integrated Approach to Physical Activity, Nutrition and Healthy Weight for New Zealand

A Draft for Consultation
2002
Foreword

The Ministry of Health has developed this consultation draft with input from key stakeholders involved in increasing physical activity, improving nutrition and reducing obesity. It is designed to open discussion on key issues, priorities and actions to improve nutrition, increase physical activity and reduce obesity. With your input, a final version of *Healthy Action – Healthy Eating* will be developed and, subject to agreement, will become Government policy in 2002.

Good nutrition, physical activity and maintaining a healthy body weight are fundamental to health and to the prevention of disease and disability. The rapid rise in health conditions where poor nutrition and inadequate physical activity are key risk factors, in particular the obesity epidemic, places significant urgency on the need to improve our approach now. In addition, socioeconomically disadvantaged groups are over-represented among obese populations, and their members are often unable to afford an adequate diet or to participate in physical activity. The health sector cannot therefore make these changes alone. *Healthy Action – Healthy Eating* is timely in its attempt to have an integrated approach to improving nutrition and physical activity across all sectors.

Contributions are now invited, and I urge you to have your say to ensure we have a strategy that reflects the needs, priorities and realities of New Zealanders and has the support of the key partners, like you, to make it happen.

Don Matheson (Dr)
Deputy Director-General
Public Health
How to Have Your Say

Please take this opportunity to have your say to help develop a national strategy to improve nutrition, increase physical activity and reduce obesity. We need your input to help us identify key approaches, priorities and partnerships that can help us to improve the health of all New Zealanders. You can provide comment by making a submission on your own behalf or as a member of an organisation.

There are some key questions that we would like you to think about and comment on as you read the document. These questions are found in the submissions booklet, which can be detached from the middle of this document or found on the website www.moh.govt.nz/healthyactionhealthyeating.

There are five different ways you can make a submission:

1. Complete the submission form on the Internet www.moh.govt.nz/healthyactionhealthyeating, which sends your comments directly to the Ministry of Health. This is the preferred method for the Ministry.

2. Complete the submission form as a Word document, which can be found at the above website and either email it to the Ministry of Health at hahe@moh.govt.nz or print it off and send it by post to the Ministry of Health (see below for postal address).

3. Write your comments directly on the submission booklet found in the centre of this document and send them to the Ministry of Health by post.

4. Write your comments on a piece of paper or as a letter or as an email and either send them to the Ministry of Health by post or by email hahe@moh.govt.nz.

5. Attend a consultation meeting, hui or fono where your comments will be recorded manually (see enclosed timetable of consultation meetings).

If you send your submission by post, the address is:

Healthy Action-Healthy Eating Submissions
Ministry of Health
PO Box 5013
Wellington.

All submissions are due by 5 pm, Friday 29 March 2002.

If you require additional copies of this document contact:

Wickliffe Press
PO Box 932
Dunedin.

Tel: 0800-226-440, Email: pubs@moh.govt.nz, Website: www.moh.govt.nz - look under publications.
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Glossary
Executive Summary

Far too many New Zealanders die prematurely or become ill from preventable diseases and conditions such as cardiovascular diseases, diabetes, cancers and obesity. Increasing physical activity levels, improving nutrition and achieving healthy weight across the population can reduce the risk of these diseases and conditions.

Physical activity, nutrition, and obesity reduction are priorities in the New Zealand Health Strategy. As these issues are inherently inter-related, this draft strategy aims to forge an integrated approach to improving population health in these three areas.

*Healthy Action – Healthy Eating* is a planning tool for action. It will help to define key priorities and strategies for physical activity, nutrition and obesity, to drive our efforts over the next five years. It aims to identify, promote, and co-ordinate culturally appropriate, effective and integrated programmes at national, regional, iwi and hapū, whānau and community levels. This strategy recognises that our objectives can best be achieved when are they co-ordinated in a systematic way.

*Healthy Action – Health Eating* is directed at a range of health service providers and sectors. It identifies key policy priorities for the Ministry of Health, and will guide funding of programmes and services by District Health Boards, and research priorities for the Health Research Council and other research funders. It emphasises the need for partnerships outside the health sector, and offers guidance for intersectoral action with other central and local government agencies, non-governmental organisations and industry.

The principles of the Treaty of Waitangi and directions for reducing inequalities in health are fundamental elements of this strategy. The *key principles* underpinning the strategy are:

- integration
- co-ordination and collaboration
- taking a life-course approach.

*Key priorities for action* identified by initial focus groups are:

- disadvantaged populations
- children, young people, and their families/whānau
- environments
- communication
- workforce.

In each priority area, the rationale is provided for its selection, along with objectives (linked to the approaches for action) and suggestions for specific actions that could be taken, and agencies that can take action.

The approaches for action in the strategy are framed by the Ottawa Charter: working to ensure healthy policy, creating supportive environments, strengthening community action, developing personal skills, reorienting services and programmes, and monitoring, research and evaluation.
While Healthy Action – Healthy Eating is intended to be a five-year strategy, annual implementation plans with agreed actions will be developed by the Ministry of Health in partnership with relevant agencies. An evaluation framework will be developed to measure progress over time. Once finalised, and subject to Government agreement, Healthy Action – Healthy Eating will become Government policy in 2002.

The key population health messages

To increase physical activity:

- follow the New Zealand Physical Activity Guidelines (Hillary Commission 2001)
- all New Zealanders should do at least 30 minutes of moderate intensity physical activity (equivalent to brisk walking) on most, if not all, days of the week to improve health
- all New Zealanders should be active in as many ways as possible as part of their daily routine (for example, active commuting to work or school, incidental and household activity)
- if possible, add some vigorous exercise for extra health and fitness.

To improve nutrition:

- follow the Food and Nutrition Guidelines series (Ministry of Health 1998a)
- increase the consumption of vegetables and fruit
- all infants should be breastfed until at least six months of age.

To achieve and maintain a healthy weight:

- promote overweight and obesity as major public health issues
- all New Zealanders should aim to maintain a healthy weight by eating a balanced diet and undertaking adequate physical activity
- New Zealanders who are overweight should aim to reduce their BMI (body mass index) by reducing energy intake and increasing energy expenditure
- in overweight people, any reduction in BMI reduces the risk of many obesity-related diseases and conditions.

1 These are the priority population messages. There are many more specific recommendations in each area and for specific groups, and these are referred to at different points in this document.
Part 1: Introduction

Outline

The development of this discussion document has been led by the Public Health Directorate of the Ministry of Health, with input from key stakeholders. It builds on existing work, national and international literature, and the experiences of people in the health and related sectors. The document provides a draft strategic framework to integrate physical activity, nutrition and healthy weight, identifies priorities and suggests actions. This draft is informed by research data, evidence of effectiveness, best practice, and focused consultation.

How was this discussion document developed?

This document has been developed with broad sector support and key stakeholder input. It is intended to build on existing work, international and national literature and the experiences of those working in the health, physical activity and food-related sectors in New Zealand. A range of activities have fed into this stage of development including:

- a review of relevant policy development in New Zealand
- a review of existing national services and programmes purchased by the Ministry of Health
- a descriptive epidemiological report (and a burden of disease project is underway)
- identification of relevant Health Research Council-funded research
- a review of key issues from the literature
- a review of national strategies from other countries
- a series of focus groups held around the county to seek input into the initial stage of the strategy development, which included Māori, Pacific peoples, researchers and academics, the public, primary and personal health providers, key interest groups, and food industry groups

The next stage in the development of Healthy Action – Healthy Eating is to seek feedback on this document, including international peer review, and to revise and reshape it accordingly into an agreed national plan.
Why do we need this strategy?

Sedentary lifestyles, poor nutrition and obesity are a growing international phenomenon. They are major and increasing causes of preventable disease, disability and death in New Zealand (King 2000). Some health consequences, such as diabetes and cardiovascular disease, cause major disability and illness, and require costly, long-term treatment and support. Projections suggest we are facing a steep increase in obesity in the future. This will have health impacts across the population, with a disproportionate burden on Māori and Pacific peoples (Diabetes New Zealand 2001). Physical inactivity has been directly associated with 8 percent of all deaths in New Zealand (Ministry of Health 1999a). Obesity has serious financial consequences both for the health sector and for New Zealand’s society and economy. Five years ago it was estimated that the direct costs of obesity were $135 million per year (Swinburn et al 1997a). As obesity has continued to rise, this figure is now likely to be much higher.

Sedentary lifestyles, poor nutrition and rising obesity are not easy problems to tackle. Improving health outcomes requires co-ordinating and integrating efforts across society, to change physical and social environments, target high-risk population groups, improve communication of key educational messages, and develop a comprehensive workforce. There is compelling evidence not only that we must do something now to address the increasing burden of disease, but also that there can be real benefits. For example, it has been predicted that universal adoption of a diet consistent with the Ministry of Health’s Food and Nutrition Guidelines could have an impact equivalent to the total elimination of smoking (Ministry of Health 1998a).

Food security\(^2\) is also a key issue addressed within this strategy. People on low incomes can struggle to afford high-quality food for a healthy diet.

The challenge is to make it easier for all New Zealanders to be more active and improve their diets. This requires a co-ordinated and integrated approach to the issues wherever possible, in research, training, prevention programmes and treatment.

The interaction between nutrition, physical activity and obesity

The New Zealand population trend for overall energy intake appears to be rebounding to late-1970s levels, after initially dropping through the 1980s. If we are not able to expend the energy we consume, then we put on excess weight, thereby putting our health at risk. New Zealand physical activity levels (the main contributor to energy expenditure) appear relatively high by international comparisons if we measure overall time spent weekly on physical activity (two-thirds of adults do 150 minutes of moderate-intensity activity per week). However, only 40 percent of adults are sufficiently physically active when regularity of activity is taken into account (number of days active per week), which aligns us with similar countries.

\(^2\) Food security: Reliable access, in economic and practical terms, to the food needed for a healthy life for all members of the household (adequate in quality, quantity, safety and cultural acceptability).
Currently we have very limited physical activity trend data. However, time series data on car ownership, pedestrian volumes, home computer ownership and passive recreational pursuits all suggest declining levels of physical activity over the past quarter century. The strong influence of these mainly environmental determinants is likely to have had a major effect on physical inactivity, and in combination with increasing energy intake leads to increasing prevalence of diseases and conditions like obesity, diabetes and cardiovascular diseases. Increasing physical activity, in combination with a healthy diet, are key elements to preventing and reducing overweight and obesity.

**Scope of Healthy Action – Healthy Eating**

The scope of *Healthy Action – Healthy Eating* is broad, with the focus on meeting the needs of all New Zealanders but with a special recognition of the particular needs of Māori and population groups at high risk, such as Pacific peoples. It aims to:

- look at action in the health arena across public primary, secondary and tertiary health care, and across public and personal health services
- identify appropriate areas for action at national, regional and local levels
- identify a range of key partnerships that could help to address each area for action, including government and non-government organisations, research and academic institutions, and industry and consumer groups.

While *Healthy Action – Healthy Eating* is not just focused on public or population health, the underlying principles used in developing the strategy are those of the Ottawa Charter. It is well recognised in the Ottawa Charter that a comprehensive approach to health requires action from a range of sectors and at a range of levels.

The approach taken is also mindful of the key determinants of health. Income, poverty, employment and occupation, education, housing, and culture, gender and ethnicity have all been shown to have an important impact on health (National Health Committee 1998). Improving physical activity and nutrition cannot be considered in isolation from these determinants.

While *Healthy Action – Healthy Eating* does not address issues of food quality and safety specifically, it does recognise that food quality is an important component of food security. Likewise, as reducing obesity is one of the key priorities of the New Zealand Health Strategy, obesity and overweight – rather than underweight – are the key issues of focus for this strategy.

Figure 2 (Section 2) illustrates the range of key partners that are important in the implementation of this strategy. It is not an exhaustive list, but provides an idea of the breadth of partnerships needed in this area.

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3 At this time government proposes a 1 July start date for the new Food Safety Authority subject to legislation being passed accordingly.
The Treaty of Waitangi

Central to the Treaty relationship and the implementation of the Treaty principles is a common understanding that Māori will have an important role in implementing health strategies for Māori, and that the Crown and Māori will relate to each other in good faith with mutual respect, co-operation and trust.

Given the high level of poor nutrition, diabetes, obesity and (to a lesser extent) physical inactivity among Māori, this relationship is crucial to improving overall health in New Zealand. Māori need to be able to define and provide for their own priorities for health, and develop the capacity to deliver services to their communities.

The relationship between Māori and the Crown in the health and disability sector is based on three principles: partnership, participation and protection (King 2000). The Waitangi Tribunal describes the principle of ‘active protection’ in health as requiring the Crown to act positively for Māori health, and as obliging the Crown to remedy past mistakes through measures that will give Māori opportunities to take advantage of the benefits of contemporary society (Durie 1998). In relation to the development and provision of health promotion programmes, participation and partnership imply that Māori should be able to determine their own health goals and have an active role in achieving them. It is clear from consultation with Māori on their health priorities (such as He Korowai Oranga, the Māori Health Strategy, and Omangia te Oma Roa (Te Puni Kōkiri 1995) that Māori consider improving nutrition (including food security) and increasing physical activity to be significant issues.

Reducing inequalities

One of the Government’s key goals is to reduce inequalities in health, education, employment and housing. The New Zealand Public Health and Disability Act 2000 requires DHBs to:

... reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders.

The results of sedentary lifestyles, poor nutrition, and obesity are not distributed evenly among New Zealanders, but particularly affect Māori and Pacific peoples.

Addressing the determinants of poor health is an essential element of population health policy. As many of the determinants of poor health are generated by social, economic, and environmental factors outside the direct influence of the health sector, it is critical that health providers form strategic partnerships with key sectors that impact on these wider determinants (for example, education, income support, local government, transport).

A challenge also exists to ensure that services and programmes do not inadvertently increase inequalities by only achieving better health outcomes for socioeconomically advantaged groups. An inequalities framework has been developed to aid policy development and implementation to reduce inequalities in health (in press).
Toolkits for District Health Boards (DHBs)

Toolkits for DHBs have been developed for the 13 priority health objectives in the New Zealand Health Strategy to guide DHBs’ planning and purchasing. These toolkits provide detail on health status and evidence of effective interventions. The toolkits are available on the Ministry of Health web site: www.moh.govt.nz/toolkits.

National Plan of Action for Nutrition

The Public Health Commission’s published National Plan of Action for Nutrition (NPAN) (Public Health Commission 1995) focused on policy, programmes and research issues that help to improve health through improving food and nutrition using population-based strategies. Significant progress has been made on nutritional issues raised in NPAN. A recent evaluation of NPAN recommended a need for a stronger focus on healthy weight and physical activity while maintaining recommendations for improved nutrition. Healthy Action – Healthy Eating builds on the directions and recommendations from NPAN that have already been achieved, while recognising the need for new issues to be addressed and a change in focus in some areas.

Ministerial Taskforce on Sport, Fitness and Leisure

The Hillary Commission has been the lead government agency for the delivery of physical activity promotion in New Zealand. From 2002 it will be replaced by the Sport and Recreation Agency. The new agency brings together the functions of the Hillary Commission, the Sports Foundation, and the sport and recreation policy functions of the Office of Tourism and Sport. This change was recommended in the Sports, Fitness and Leisure Taskforce report Getting Set for an Active Nation (Ministerial Taskforce on Sport, Fitness and Leisure 2001). To support an increase in physical activity participation, the Taskforce believed the recreation and sport sector required significant structural change to improve leadership, co-ordination, integration and delivery within the sector.

National targets

The Ministry of Health publishes annual national targets, and progress towards meeting these, in the series Progress on Health Outcome Targets (PHOT). Relevant targets for this strategy are food and nutrients, obesity, breastfeeding and physical activity. In addition, annual performance targets are set for DHBs in relation to the implementation of the New Zealand Health Strategy. Further discussions are required to decide on the most effective approach to measuring progress in the areas of physical activity, nutrition and healthy weight.
Implementation plan

Measuring improvement is critical to the success of the strategy. The Ministry of Health will identify an approach for measuring priority actions within clearly identified timeframes as part of the development of annual implementation plans for the strategy from the 2002/03 year. A process for selecting priority actions for each year of the implementation plan will also be developed, and will be informed by the consultation on the strategy.
Part 2: Key Issues in Physical Activity, Nutrition and Obesity

Moderate levels of physical activity, good nutrition and healthy weight have major implications for preventable disease, disability and death in New Zealand.

This section summarises the health status of New Zealanders, and the key issues underpinning the development of this draft strategy. More detailed information on each topic is provided in the District Health Board toolkits available on the Ministry of Health website [www.moh.govt.nz/toolkits](http://www.moh.govt.nz/toolkits). The toolkits cover health status, burden of disease, current programmes, evidence for effective interventions and best practice. Additional background on the Māori and Pacific peoples summaries is provided in Appendix 2.

**Physical activity**

About one-third of New Zealand adults are insufficiently physically active to benefit health. There is good evidence that 30 minutes of moderate-intensity physical activity on most, if not all, days of the week benefits health. Physical activity can reduce the risk, and modify the effects, of many major non-communicable diseases and conditions (cardiovascular diseases, cancers, diabetes, osteoporosis, obesity and depression).

Physical activity has several dimensions and is influenced by both environmental and individual factors. The dimensions of physical activity are: type, intensity, frequency, duration and context (for example, recreation, occupation, transport, incidental). The wider environment provides opportunities and presents barriers to physical activity (for example, urban design, safety, pollution, availability of parks and facilities). In addition to environmental factors, an individual’s physical activity level is influenced by preferences and constraints (such as perceived enjoyment, skill, income, social/cultural attitudes, family commitments, and health status). Approaches to increase physical activity must take account all of these elements, and bring together key players to collaborate and co-ordinate to support and encourage more people to be physically active.

**Key population health messages to increase physical activity**

- Follow the *New Zealand Physical Activity Guidelines* (Hillary Commission 2001).
- All New Zealanders should do at least 30 minutes of moderate intensity physical activity (equivalent to brisk walking) on most, if not all, days of the week to improve health.
- All New Zealanders should be active in as many ways as possible as part of their daily routine (for example, active commuting to work or school, incidental and household activity).
- If possible, add some vigorous exercise for extra health and fitness.
Health status

- Two-thirds of New Zealand adults are physically active, and one-third are inactive.
- Overall men and women appear equally physically active.
- New Zealand European, Māori and Pacific adults are almost equally likely to be physically active, although inactive Māori and those from ‘other’ ethnic groups are more likely to be sedentary (do no activity).
- The highest levels of physical activity are among 15–24-year-olds and 65–74-year-olds.
- Among school-aged children and young people, physical activity levels decline significantly after age 16–17, particularly among young women.
- Physical inactivity has not been associated with socioeconomic status in New Zealand. However, those who have no qualifications are more likely to be sedentary than those with school and post-school qualifications.

Physical activity levels (PALs), measured by both the Hillary Commission and the Ministry of Health in recent years, have used a four-category analysis of leisure-time physical activity (as presented in Table 1).

<table>
<thead>
<tr>
<th>Active/inactive</th>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically inactive</td>
<td>Sedentary</td>
<td>No sports/activities in the previous four weeks.*</td>
</tr>
<tr>
<td></td>
<td>Relatively inactive</td>
<td>Took part in some leisure-time physical activity in the previous seven days, but less than 2.5 hours in total.</td>
</tr>
<tr>
<td>Physically active</td>
<td>Relatively active</td>
<td>Took part in at least 2.5 hours, but less than five hours of leisure-time physical activity in the previous seven days.</td>
</tr>
<tr>
<td></td>
<td>Highly active</td>
<td>Took part in five hours or more of leisure-time physical activity in the previous seven days.</td>
</tr>
</tbody>
</table>

* The Ministry of Health survey asked about no activity (sedentary) in the past seven days.

Table 2: PALs of adults, 1997–99 as percentage of adult population

<table>
<thead>
<tr>
<th>Active/inactive</th>
<th>Category</th>
<th>Total</th>
<th>NZ European</th>
<th>Māori</th>
<th>Pacific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physically inactive</td>
<td>Sedentary</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Relatively inactive</td>
<td>22</td>
<td>22</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>Physically active</td>
<td>Relatively active</td>
<td>16</td>
<td>16</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Highly active</td>
<td>52</td>
<td>52</td>
<td>53</td>
<td>45</td>
</tr>
</tbody>
</table>

Note: Proportions standardised for age from 18+; genders pooled.

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When regularity was taken into account only 40 percent of the adult population was regularly active (on five or more days a week).

**Priority groups**

While all New Zealanders can benefit from participating in more physical activity, the greatest benefits will occur by focusing on the following groups:

- **People who are inactive**: physical inactivity is an independent risk factor for major non-communicable diseases, so it is important to encourage and support the 32 percent of inactive people to be more active (particularly those who are sedentary).

- **Older people**: the number of older people will grow substantially over the next 30 years. Physical activity in older age can help to reduce the risk of falls and chronic conditions common in older age, and help maintain independence and wellbeing (National Health Committee 1998).

- **Children and adolescents**: while, overall, children and young people are among the most active, there are indications that more children and young people are becoming inactive to the extent that their health is at risk (Dawson et al 2001).

- **People with a disability or at risk of chronic conditions and diseases**: it is important to ensure that those who are either already at higher risk or experiencing chronic diseases, and/or have a disability, are supported to be physically active to aid habilitation, rehabilitation and maintain health status.

- **Women with children, and pregnant women**: while further research is required, there are indications that some pregnant women and women with young children reduce activity levels, or find it difficult to be active (Clissold et al 1991; Genet 2000).

- **Māori**: although Māori are generally physically active, inactive Māori must be supported to become active to reduce the risk of ill health. Physical activity is also a key opportunity to promote other healthy behaviours (for example, Auahi Kore/Smokefree) in Māori communities to improve Māori health in relation to non-Māori.

- **Pacific peoples**: Pacific peoples appear to be slightly less active than Māori and New Zealand Europeans.

**Key opportunities for improvement**

- Target inactive people, children and young people and their families, underpinned by a life-course approach.

- Strengthen intersectoral collaboration within sectors and settings (particularly the interface with transport and regional/local councils to develop supportive environments).

- Research and monitor the impact of environments on children’s physical activity levels (for example, schools, leisure facilities, movie theatres, the influence of television, computers and computer games).
• Ensure social marketing of physical activity, communicating both the health benefits and the enjoyment of physical activity.
• Promote the additional benefits of more vigorous activity.
• Support workforce development in physical activity health promotion and primary care.
• Consider the benefits of promoting non-recreational physical activity (for example, transport–commuting, incidental and household activity).
• Monitor physical activity levels. Monitor, evaluate and research physical activity interventions.

**Nutrition**

There is an increasing recognition of the key role that diet and nutritional status plays in maintaining health and preventing disease (obesity, heart disease, hypertension, stroke, type 2 diabetes, some cancers, osteoporosis, anaemia, dental caries). Nutritional status is also a factor in determining survival and rate of recovery from sickness.\(^5\) Nutrient deficiencies, in pre-pregnant and pregnant women, can result in birth abnormalities (eg, folate).

Wider societal, cultural and environmental influences as well as individual behaviours have an impact on what and how much people eat. These factors include; food prices, food supply, food technology, the media, individual preferences, social and cultural attitudes and socioeconomic status.

Currently, there is an increasing trend towards eating food that has been prepared outside the home (restaurant meals, takeaways, snack foods, as well as pre-packaged convenience meals), a practice which may be increasing the energy content of the diet – especially from fat and refined sugar. The increase in consumption of beverages such as soft drinks and fruit juices among some sectors of the population may also be increasing the energy content of the diet. The food industry is now producing low fat/salt/sugar foods however these can be more expensive options and may not be an option for people on low incomes. Particular population groups consume inadequate amounts of nutritious food, especially those in socioeconomically deprived areas.

**Key population health messages to improve nutrition\(^6\)**

• Follow the *Food and Nutrition Guidelines* series (Ministry of Health 1998a).
• Increase the consumption of vegetables and fruit.
• All infants should be breastfed until at least six months of age.

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\(^5\) It has been demonstrated that people with compromised nutritional status are slower to recover than people with optimal nutritional status.

\(^6\) These key messages are the most general. More specific recommendations apply to particular population groups (eg, concerning folate and calcium).
Health status

- Two-thirds of all New Zealanders eat the recommended three servings of vegetables and half the recommended two servings of fruit. Māori and Pacific peoples are least likely to eat the recommended servings.
- Less than one-sixth of all New Zealanders eat the recommended servings of breads and cereals. Consumption is higher among Māori and Pacific peoples in more deprived areas.
- 35 percent of total energy comes from fat (30 percent recommended). Māori have higher fat intakes than non-Māori.
- The rate of full or partial breastfeeding at six months is 60 percent (62 percent New Zealand European, 53 percent Māori, 60 percent Pacific infants).
- 27 percent of New Zealanders report that the variety of food they eat is limited by lack of money; 14 percent report that food runs out sometimes or often because of lack of money.
- Although micronutrient intake is appropriate for the majority of the population, some groups are more at risk of inadequate intake. Those living in the most deprived areas are at greater risk from inadequate intakes of vitamin A, riboflavin and folate. Calcium intake is inadequate among young women and men (particularly Māori women).
- Overall 49 percent of women have folate intakes lower than those recommended for pregnancy.
- Other studies have suggested that some children may consume too much fat and sugar and that iron deficiency may be prevalent among some children.

Priority groups

While all New Zealanders can benefit from improved nutrition, the greatest benefits will occur by focusing on the following groups:

- **Infants**: full breastfeeding for six months is recommended by the WHO as being important for the health of infants.
- **Socioeconomically disadvantaged**: the 1997 National Nutrition Survey found that a significant proportion of the population was unable to afford nutritious food (27 percent stated variety was limited by lack of money).
- **Māori**: Māori are over-represented in areas of socioeconomic deprivation, and consequently are more likely to be unable to afford an adequate and nutritious diet.
- **Pacific peoples**: Pacific peoples are also over-represented in areas of socioeconomic deprivation.

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7 The data in this section comes mainly from the 1997 National Nutrition Survey, but is supplemented by data from non-national data on nutritional status from smaller studies undertaken in the last decade.
Key opportunities for improvement

- Strengthen the scientific basis for intervention by monitoring both the current nutritional status and the effectiveness of interventions
- Ensure ongoing evaluation of nutrition interventions
- Develop effective and consistent communication strategies across all sectors
- Develop and maintain an effective workforce
- Develop partnerships among key players at national, regional and local levels
- Ensure a focus on the needs of the most disadvantaged groups
- Provide simple messages based on the Food and Nutrition Guidelines, with a focus on positive messages such as increased consumption of vegetables and fruit
- Re-establish a monitoring system for the food supply (as the food supply changes and with the introduction of more dietary supplements).

Obesity

Obesity is a growing global public health problem. It is a major risk factor for many chronic, debilitating and life-threatening diseases. The cause of this growing trend is largely due to a changing social and physical environment, in which people are consuming excess energy through food and drink and not expending adequate energy through physical activity. Swinburn has described obesity as 'a normal response to an abnormal environment' (Swinburn 1997a). When tackling obesity, it is important to intervene to change the environment as well as to affect individual change.

Key population health messages to achieve and maintain a healthy weight

- Promote overweight and obesity as major public health issues.
- All New Zealanders should aim to maintain a healthy weight by eating a balanced diet and undertaking adequate physical activity.
- New Zealanders who are overweight should aim to reduce their BMI (body mass index) by reducing energy intake and increasing energy expenditure.
- In overweight people, any reduction in BMI reduces the risk of many obesity-related diseases and conditions.

Health status

- 37 percent of New Zealand adults are overweight and 17 percent are obese (see Table 5).

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8 Data from the 1997 National Nutrition Survey.
• New Zealand data indicates the prevalence of obesity (defined as a BMI of greater than 30 kg/m²) is increasing.\(^9\) Between 1989 and 1997 adult obesity increased by 55 percent\(^10\) and is projected to increase by a further 70 percent by 2011. It has also been estimated that by 2011 approximately 29 percent of the adult population may be obese (Ministry of Health 2002).

There are no nationally representative data on rates of obesity in New Zealand children. However, a study of 2273 Auckland school children, aged 5.0 – 10.9 years, found that, in all, 14.3 percent of children were obese using the recommended definition of obesity (Tyrrell et al 2001). There was no clinically significant difference in the relationship between BMI and body composition in different ethnic groups. Obesity rates varied with ethnicity and were higher in Pacific Island (24.1 percent) and Maori (15.8 percent) than in New Zealand European children (8.6 percent). Obesity rates also varied with age with the highest rates in older children. Percentage body fat levels were higher in females than males. Using a definition of obesity based on percentage body fat (PBF>30%), obesity rates were higher in all ethnic groups.

A further study (Dawson et al 2001) analysed secular trends in the body weight and fitness of 10–14-year-old Christchurch children over nine years. This study demonstrated that not only overweight and obesity increasing in this age group but also fitness levels are declining.

**Table 5:** Percentage of adults classified as obese\(^{11}\) or overweight\(^{12}\)

<table>
<thead>
<tr>
<th></th>
<th>NZ European and Others</th>
<th>Māori</th>
<th>Pacific peoples</th>
<th>Total population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Overweight (%)</td>
<td>41.0</td>
<td>29.8</td>
<td>30.0</td>
<td>32.7</td>
</tr>
<tr>
<td>Obese (%)</td>
<td>12.6</td>
<td>16.7</td>
<td>27.0</td>
<td>27.9</td>
</tr>
</tbody>
</table>

**Priority groups**

Most New Zealanders need to address the issue of energy balance to minimise the risk of obesity. However, some sectors of the population have a higher risk of developing obesity than others. If the population health burden of obesity is to be reduced, we need to pay special attention to directing prevention and treatment interventions to groups at high risk for obesity. These include:

- Overweight and obese people
- children (particularly already overweight or obese children and those with obese parents)
- Māori

\(^9\) BMI greater than 30 for NZ European and Other; BMI greater than 32 for Māori and Pacific peoples.

\(^{10}\) In 1989 10 percent of men and 13 percent of women were obese, compared with 1997 when 14.7 percent of men and 19.2 percent of women were obese.

\(^{11}\) BMI greater than 30 for NZ European and Other; BMI greater than 32 for Māori and Pacific peoples.

\(^{12}\) BMI 25–30 for NZ European and Other; BMI 26–32 for Māori and Pacific peoples.
• Pacific peoples
• people in lower socioeconomic groups
• people with disabilities
• ex-smokers
• women post-pregnancy
• physically inactive people
• post-obese people (people who have previously been obese).

Key opportunities for improvement

• Establish an integrated approach to nutrition and physical activity that focuses not only on individual behavioural change, but also on changing the obesogenic environment in a sustained way (ie, increased physical activity opportunities and greater availability of affordable nutritious food and less availability of high calorie food).
• Support co-ordination across health services and sectors to ensure approaches are accurate, consistent and complementary.
• Support further research on effective prevention and treatment interventions at population, family and individual levels.
• Develop ways to monitor changes in obesity rates in population groups.

Māori

Physical activity, nutrition and healthy weight are all important issues for Māori in terms of addressing the principles of the Treaty of Waitangi and reducing inequalities. The impacts of colonisation have led to major changes in the diet and physical activity patterns of Māori. Approaches to increasing physical activity, improving nutrition and achieving healthy weight must recognise the inter-relationship between the wider environment and the lives of the whānau and individual Māori, as encapsulated in Whare Tapa Wha model of health.

A useful health promotion framework to apply more specifically to the area of physical activity, nutrition and healthy weight is Te Pae Mahutonga (Durie 2001). Te Pae Mahutonga is composed of four stars, each of which represents a key component of health promotion relating to Māori health:
• access to te ao Māori – mauriora
• environmental protection – waiora
• healthy lifestyles – toiora
• participation in society – te oranga.

There are also two pointers – ngā manukura (leadership) and te mana whakahaere (autonomy). All these elements are essential to creating supportive environments, strengthening communities and supporting healthy lifestyle choices to improve Māori health and reduce inequalities.
Health status

Physical activity
- Māori and non-Māori are approximately equally active, and Māori children are much more likely than non-Māori or other ethnic groups to be regularly active; however, more Māori than non-Māori appear to be sedentary.

Nutrition
- Māori are more likely to meet the recommended intakes of breads and cereals than European and others.
- Māori have higher mean energy intakes from fat than non-Māori.
- Māori are over-represented among the most deprived groups in New Zealand. In general, people in such groups face problems providing the quantity and quality of food needed for a healthy diet.

Obesity
- Māori are more likely to be obese than other New Zealanders, except Pacific peoples. 27 percent of Māori men are obese and 27.9 percent of Māori women compared to 12.6 percent of other New Zealand men and 16.7 percent of other New Zealand women.
- Māori are over-represented among the most deprived groups in New Zealand, and there is a strong association between socioeconomic deprivation and obesity. This results in a greater prevalence of chronic and debilitating disease among Māori such as type 2 diabetes and stroke.

Key opportunities for improvement
- Support By Māori for Māori and kaupapa Māori approaches.
- Support community development approaches that involve and empower communities and provide a sense of local ‘ownership’.
- Ensure links between health promotion in physical activity, nutrition and healthy weight and other motivations such as whānau and hapū involvement and traditional cultural activities.
- Support workforce development: support the training of more community workers in nutrition and physical activity to help strengthen and develop their local communities; and establish clear pathways for career development for Māori working in the fields of nutrition and physical activity.

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14 There are two categories of inactivity (relatively inactive – some activity but less than 2½ hours moderate activity per week) and sedentary (do no physical activity).
For a more detailed discussion of issues for Māori, see Appendix 2.

**Pacific peoples**

Pacific populations in New Zealand are heterogeneous and culturally diverse. Each ethnic group has their own language, customs and traditions. Pacific peoples do, however, share a common migration and assimilation history in New Zealand (Ministry of Health 1997). For Pacific peoples, health is a holistic concept, which encompasses spiritual, emotional, mental, physical and social wellbeing. The emphasis is on the total wellbeing of the individual within the context of the family (Ministry of Health 1997).

The trends of poor health status, youthful population structure and high fertility rates of the Pacific population have significant implications for New Zealand’s health, education and social services, both now and in the future. Unemployment, low income, poor housing and overcrowding, low educational achievement, urbanisation and the breakdown of the traditional family structures serve to exacerbate the poor health status of Pacific peoples (Ministry of Health 1997).

The migration of Pacific peoples to New Zealand, globalisation and urbanisation has brought changes to the Pacific lifestyle. Lack of physical activity and unhealthy diet has precipitated an epidemic of obesity and a higher prevalence of non-communicable diseases among Pacific peoples compared to New Zealand Europeans (Ministry of Health 1997; Tukuitonga and Finau 1997; Ministry of Health 1999a; Public Health Commission 1994).

Food has a central role in the cultural life of Pacific peoples. Food plays an integral part in all major occasions, and this is a key consideration in developing approaches to address obesity and nutrition. Physical activity has also reduced significantly by migration into an urban environment (Simmons et al 1994b).

**Health status**

**Physical activity**

- Pacific peoples are slightly less physically active than Māori and non-Māori.

**Nutrition**

- Pacific peoples are least likely to meet the recommendations for fruit and vegetables consumption (compared to Māori and non-Māori).

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Obesity

- Pacific peoples are more likely to be obese than other New Zealanders (47 percent of Pacific women are obese, and 26 percent of men).

Pacific peoples are over-represented among the most deprived population groups. Fifty percent of Pacific people report running out of food or being unable to eat properly because of lack of money (Russell et al 1999). As noted earlier, risk for developing obesity is associated with socioeconomic deprivation.

Key opportunities for improvement

- Advocate and support significant investment to improve the socioeconomic status of Pacific peoples to the same level as that of New Zealand Europeans by intersectoral collaboration and coordination (government, NGOs, private agencies and Pacific communities).
- Improve the collection of Pacific health information (including ethnicity data, service utilisation), research, monitoring and evaluation.
- Support better co-ordination and investment in appropriate training and career pathways for Pacific peoples to develop the Pacific workforce.
- Ensure mainstream services are responsive to Pacific peoples’ needs and realities.

For a more detailed discussion of issues for Pacific peoples, see Appendix 2.

General population

While a number of particular population groups have been targeted in this draft strategy (for example, Māori, Pacific peoples, children, young people and their families), New Zealand Europeans and people from other ethnic groups will also benefit significantly from increasing physical activity, improved nutrition and maintaining a healthy weight.

Most adults need to address the quantity and quality of the food they consume. All inactive adults need to be encouraged to be physically active to reduce the risk of chronic conditions, diseases and disability, such as cardiovascular disease, diabetes, some cancers and obesity.

Although New Zealand Europeans tend to eat more fruit and vegetables and less fat than other ethnic groups, significant improvements can still be made in fruit and vegetable consumption and reductions in fat intake.

Many New Zealand Europeans and those from other minority ethnic groups are of lower socioeconomic status and must be a priority for increasing physical activity, improving nutrition and attaining a healthy weight.
Other ethnic groups

‘Other’ ethnic groups are increasingly contributing to the ethnic diversity of the New Zealand population. The broadly defined Asian population in New Zealand (major groupings include Chinese, Korean, and Indian) has increased by 71 percent from 1991 to 1996, mainly due to immigration. This broad population group is projected to increase to between 5 and 10 percent of the population by 2016 (Statistics New Zealand 2000). The Asian population group currently makes up 8 percent of the Auckland population.

There are also growing numbers of other ethnic groups represented in New Zealand. The number of immigrants from Africa more than doubled from 1991 to 1996 (the population from Africa, including South Africa is more than 20,000). Other newer groups include people from the Middle East, Eastern Europe, Somalia, Ethiopia, Iraq, Iran and Afghanistan. Currently there is little reliable data on physical activity status, nutritional patterns or obesity for other ethnic groups.

Barriers to information on good nutrition and access to physical activity for these groups may include income, language and cultural factors. One New Zealand survey on physical activity found that language and comprehension are the main barriers, hindering dissemination of information. Other barriers included cultural differences, embarrassment and image (Genet 2000).
Part 3: The Framework

The *Healthy Action - Healthy Eating* framework (Figure 1) has been developed by building on existing work, consideration of national and international literature and focused consultation with people in the health, physical activity and food related sectors in New Zealand.

Figure 1: The *Healthy Action – Healthy Eating* framework

The framework is explained in more detail in the following pages.
Treaty of Waitangi and reducing inequalities

The Treaty of Waitangi and reducing inequalities are fundamental to this strategy, and all activities directed at improving health, and therefore stand in an over-arching position above the strategy.

Vision

The overall vision for this strategy is:

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

The vision is purposely focused on the need for environmental and society-level support to lead physically active lives, eat well, and attain a healthy body weight. This recognises that there are many social, economic, cultural and environmental barriers that need to be eliminated or modified to support individual behaviour change.

Goals

Underpinning this vision are three goals derived from the priority population health objectives from the New Zealand Health Strategy:

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

Through the effective implementation of Healthy Action – Healthy Eating it is envisaged that, over time, these outcomes can be achieved.

Guiding principles

In addition to the fundamental importance of the Treaty of Waitangi and a focus on reducing inequalities, three key principles underpin this strategy:

- integration
- collaboration and co-ordination
- life-course approach.

Integration

This strategy requires integration across all levels of the health sector to ensure that physical activity, nutrition and obesity prevention and management are addressed as a package wherever possible.
Co-ordination and collaboration

Clearly the health sector alone cannot achieve the goals of this strategy, as the determinants of health often lie outside the direct control of the health sector. Co-ordination and collaboration are required across sectors and regions, between government and non-government, and involving both the public and private sectors. The health sector can encourage and support action in other sectors by offering support and advising on the health impact of policies and trends.

**Figure 2:** Key stakeholders with the potential to influence physical activity, nutrition, and obesity

Life-course approach

Health and the risk of premature death are affected by many socioeconomic influences that accumulate throughout life, as well as current influences. The life-course approach
suggests that there are ‘critical periods’ of life that can alter future health status. For example, maternal under-nutrition in pregnancy has been linked to the child having an increased susceptibility to cardiovascular disease and diabetes in adulthood (Perry 1997). The life-course approach also suggests that biological and social chains of risk can be broken at several stages of life through a range of targeted prevention and treatment interventions (Kuh and Ben-Shlomo 1997).

**Approaches for action**

Six key approaches have been identified to guide actions for each of the priority areas based upon the Ottawa Charter:

- build healthy public policy
- create supportive environments
- strengthen community action
- develop personal skills
- reorient services and programmes
- monitor, research and evaluate.

**Build healthy public policy**

Policies are essential at all levels and across all sectors to underpin and support actions and change. Policy makers need to be aware of the health consequences of any of their decisions, including both positive and negative impacts on physical activity and nutrition.

**Create supportive environments**

The links between people and their environment constitute the basis of a socio-ecological approach to health. Health cannot be separated from other goals. Changing patterns of life, work and recreation have a significant impact on health. The way society organises its social structures should help create a healthy society. In order to achieve change at the population and sub-population levels, co-ordinated efforts are required across key sectors and settings that can provide support to encourage physical activity, improve nutrition, and attain healthy weight (for example, transport, education, local government, education, income support, health care).

**Strengthen community action**

This approach involves strengthening communities to gain the capacity to set priorities and make decisions on issues that affect their health in a sustainable way. A fully functioning community will be able to assess its own community health needs in terms of physical activity, nutrition and healthy weight, take action to improve health outcomes in these areas. It will monitor performance, and evaluate the impact of initiatives on the local community.
Develop personal skills

This refers to enabling people to gain the knowledge and skills to meet life’s challenges and to participate and contribute to society. As applied to physical activity, nutrition and healthy weight it relates to understanding why these issues are important to health and how to overcome possible barriers, and to take opportunities to improve personal health by being more physically active, eating well and maintaining a healthy weight. Learning throughout the life course needs to be facilitated in the school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient services and programmes

The responsibility for health promotion in health (and related) services is shared among individuals, community groups, health professionals, health services, institutions and government. Promoting health also needs to extend beyond the health sector to other sectors that have an impact on the wider socio-ecological environment (including local government, education, transport, recreation, the sport and fitness sector, and the weight loss and food industries). Building on and integrating effective programmes and services and recognising where change in services may be more effective are essential.

Monitor, research and evaluate

Having up-to-date data on the health status of the population and evidence on those factors that influence it form the basis on which to build effective services and programmes. Evaluation of programmes to determine their effectiveness and measure progress must also be recognised as key aspects to all service delivery.

Key priorities for action

Five priorities have been identified to drive forward Healthy Action – Healthy Eating:

- disadvantaged groups
- children, young people, and their families/whānau
- environments
- communication
- workforce.

These five priorities have been selected, after initial consultation, as most likely to result in progress towards the overall goals of the strategy.

Priority 1: Disadvantaged groups

Some New Zealanders are unable to access the choices of physical activity and food and the services that support healthy choices because of inadequate money, disability or other
factors that disadvantage them. Ensuring that such groups can access healthy lifestyle choices will result in significant health gain for New Zealand.

**Priority 2: Children, young people, and their families/whānau**

Central to supporting children and young people to adopt lifelong habits of physical activity and good nutrition is the family/whānau. Parents and caregivers can also learn from their children, and the benefits will influence the wider community. Healthy habits begin before birth, and infancy and preschool years are key learning times. A focus on family/whānau can also encourage the adoption of healthy patterns among older people allowing them to be there to help their children/tamariki grow.

**Priority 3: Environments**

The wider physical, social and cultural environment has a major influence on physical activity, nutrition and healthy weight. Most of the levers to increase physical activity exist outside the health sector (for example, transport and local government). Nutrition is influenced by the availability and cost of food. Obesity is also strongly connected with the physical environment, urban design, the convenience of motorised transport, labour-saving technologies and inactive entertainment options.

**Priority 4: Communication**

Communication of consistent and reinforcing messages at all levels is a key element of promoting physical activity, nutrition and healthy weight. Clear messages on what physical activity benefits population and individual health, and what types of food and how much to eat, are essential. Accurate messages must be communicated across sectors and by health and other professionals in various settings. Open and clear communication is also a vehicle for intersectoral collaboration, for building trust, sharing ideas, and creating a supportive environment to improve health.

**Priority 5: Workforce**

All those involved in providing advice and support about physical activity, nutrition and healthy weight need to have a clear understanding of the key approaches, opportunities and barriers to improving health status in these areas. Key groups – particularly health professionals, community health workers, providers in other key sectors (such as recreation, sport and fitness sectors, food industry, education, transport and local government) – all need to have knowledge and understanding of how the wider environment impacts on health and how personal behaviours can be changed effectively.
Part 4: Key Priorities for Action

Outline of key priorities for action

For each priority area, the draft strategy sets out the underlying rationale for selecting the area, key issues, and actions based around the goals of increasing physical activity, improving nutrition, and reducing obesity. These actions are shaped by the approaches for action, guiding principles, goals and vision, and especially by the overarching Treaty of Waitangi and reducing inequalities.

Each priority area identifies actions directed at the whole population and/or specific sub-populations. All mainstream providers are required to ensure that the services they deliver are appropriate for Māori. In addition, specific priority actions targeting Māori are identified, as appropriate.

Under each of the proposed actions, one or more sectors or organisations has been identified as having the proposed responsibility for carrying out that task. Please note that these have not yet been agreed to and may carry financial implications that may not as yet be funded.

16 A key to the abbreviations used is provided at the end of the chapter.
**Priority 1: Disadvantaged groups**

Significant health gains can be achieved through increasing physical activity, improving nutrition and maintaining a healthy body weight among disadvantaged groups, who may have difficulty accessing physical activity and good nutrition.

**Rationale**

All New Zealanders should be supported to be physically active and to eat well. For some New Zealanders this is not easy. Many people on very low incomes – including an over-representation of Māori and Pacific peoples, new immigrants, people with disabilities, institutionalised people, and other marginalised groups – have difficulty accessing the resources, facilities, food and services that help them promote and maintain health.

Policies, programmes and services that assist in making the healthy choice an easy and accessible option for people in disadvantaged groups are key to improving the health and wellbeing of the nation.

Socioeconomic status is one of the key determinants of health. Socioeconomic disadvantage is associated with increased risk of obesity, diabetes and heart disease, and increased risk of micronutrient deficiencies resulting from inappropriate diet or insufficient food. Although in New Zealand socioeconomic status has not yet been clearly associated with physical inactivity, this contrasts with overseas experience, which may indicate that the issue is one of measurement rather than lack of association. Also, there is a strong association between educational status and sedentary behaviour (people with no qualifications are significantly more likely to be sedentary than people with school, or post-school qualifications). This indicator could be interpreted as a proxy for socioeconomic status.

People who are disadvantaged by socioeconomic status and/or by physical disability are often unable to access a wide range of services and facilities, such as health or recreation services (general practitioners, other health professionals, the weight loss industry, gyms, recreation and sports clubs, etc.). Disadvantage can also lead to poor housing, lack of cooking and storage facilities, lack of transport to recreational facilities and to supermarkets and fresh food markets.

Reducing socio-economic, ethnic and gender inequalities to improve physical activity, good nutrition and healthy weight cannot be achieved solely through the health sector. It requires broad commitment from government agencies, non-government organisations, industry and communities.

Pacific peoples are also significantly disadvantaged, generally having among the lowest incomes and a poorer health status than other non-Māori New Zealanders. In particular, the prevalence of overweight and obesity among Pacific peoples is high and increasing. Pacific communities, therefore, must be an important focus for approaches that aim to increase physical activity, improve nutrition and reduce obesity.
Māori

Māori are over-represented among disadvantaged New Zealanders. Inequalities in health must be addressed taking into account the principles of the Treaty, and the need both to support Māori development and to reduce inequalities. Physical activity levels among Māori compare favourably to non-Māori, and Māori tamariki and rangatahi are significantly more active than their non-Māori counterparts. This positive situation, and the important role that sport and recreational activities (such as kapa haka) play in Māori society, provide an opportunity to advance Māori health. Physical activity also provides an opportunity to promote other aspects of Māori health, such as good nutrition, smoking cessation and moderate alcohol consumption, which can in turn reduce the risk of poor health status.

Objective 1.1: Build healthy public policies for disadvantaged groups

Policies are developed that address the needs of disadvantaged groups.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Responsible Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.11 Establish strong links between the implementation of <em>Healthy Action – Healthy Eating</em> and the Inequalities in Health project, and develop joint approaches for increasing physical activity, and improving nutrition and healthy weight.</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>1.12 Support central government agencies, local government, schools, workplaces and community organisations to develop policies that promote and allow access to physical activity across special populations (eg, people with disabilities, women with young children, minority groups such as migrant and refugee groups, those on low incomes, the unemployed).</td>
<td>All</td>
</tr>
<tr>
<td>1.13 Support dialogue over developing income support policies for people on low incomes to purchase healthy food and access physical activity opportunities.</td>
<td>Ministry of Health, other government, LG</td>
</tr>
<tr>
<td>1.14 Explore international policy developments in food security for those most at risk.</td>
<td>Ministry of Health, other government</td>
</tr>
<tr>
<td>1.15 Support and encourage local government policies and initiatives that increase participation in physical activity for disadvantaged groups, including safe, accessible (design and low-cost) physical environments such as parks, footpaths and facilities.</td>
<td>Ministry of Health, other government, LG, RS&amp;F</td>
</tr>
</tbody>
</table>
Objective 1.2: Create supportive environments for disadvantaged groups

Environments are designed and modified to assist disadvantaged groups.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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</thead>
<tbody>
<tr>
<td>1.21 Ensure training of influential community members in physical activity, nutrition and healthy weight promotion for at-risk groups.</td>
<td>Ministry of Health, DHBs, Public health, NGOs</td>
</tr>
<tr>
<td>1.22 Support Māori communities, including iwi and hapū, to develop local initiatives, especially those aimed at improving nutrition and food security.</td>
<td>Public health, community</td>
</tr>
<tr>
<td>1.23 Work with the food industry to encourage the production and availability of affordable, healthy, ethnic food choices.</td>
<td>Food industry, NGOs</td>
</tr>
</tbody>
</table>

Objective 1.3: Strengthen community action for disadvantaged groups

Inequalities in health are reduced by working with disadvantaged communities and empowering them to develop their own solutions to increase physical activity, improve nutrition and attain a healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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<tbody>
<tr>
<td>1.31 Ensure communities most at risk are priorities for action for improving access to physical activity and good nutrition.</td>
<td>DHBs, Māori providers, Pacific providers, community</td>
</tr>
<tr>
<td>1.32 Ensure the needs of Māori communities, especially in the most deprived areas, are a priority for action.</td>
<td>DHBs, Māori providers, community</td>
</tr>
<tr>
<td>1.33 Continue to develop and support community-based physical activity and healthy eating programmes that target most at-risk groups.</td>
<td>DHBs, community, Māori providers, NGOs</td>
</tr>
<tr>
<td>1.34 Celebrate and support effective Māori health promotion programmes and circulate success stories to the wider community through hui and other public forums.</td>
<td>Māori providers, DHBs, Ministry of Health, NGOs</td>
</tr>
<tr>
<td>1.35 Work with community groups such as churches and food banks to develop ways to influence and support the health potential of charity services.</td>
<td>DHBs, community, NGOs</td>
</tr>
<tr>
<td>1.36 Support and foster community initiatives to address food security for disadvantaged groups.</td>
<td>Community, Ministry of Health, DHBs, Māori providers, Pacific providers</td>
</tr>
</tbody>
</table>
Objective 1.4: Develop personal skills among disadvantaged population groups

Inequalities in health are reduced through increased knowledge of the benefits of physical activity and good nutrition, and how to access services and programmes designed to meet the needs of disadvantaged groups.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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<tbody>
<tr>
<td>1.41 Ensure education resources that promote physical activity and healthy eating are</td>
<td>Ministry of Health,</td>
</tr>
<tr>
<td>appropriate and readily available for the most at-risk groups, including Māori, Pacific</td>
<td>DHBs, SRA, RS&amp;F,</td>
</tr>
<tr>
<td>peoples, new immigrants, people with disabilities, the unemployed and those on low</td>
<td>NGOs, Māori</td>
</tr>
<tr>
<td>incomes.</td>
<td>providers, Pacific</td>
</tr>
<tr>
<td>1.42 Ensure messages of the <em>Food and Nutrition Guidelines</em> are available and</td>
<td>DHBs, Public health,</td>
</tr>
<tr>
<td>appropriate for at-risk groups.</td>
<td>Personal health,</td>
</tr>
<tr>
<td></td>
<td>NGOs, Māori</td>
</tr>
<tr>
<td></td>
<td>providers, Pacific</td>
</tr>
</tbody>
</table>

Objective 1.5: Reorient services and programmes to focus on disadvantaged groups

All providers of physical activity and nutrition services and programmes tailor them to focus on the needs of disadvantaged groups.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1.51 Support the development of culturally appropriate weight-loss programmes and</td>
<td>Weight loss, DHBs,</td>
</tr>
<tr>
<td>services that are accessible to lower socioeconomic groups, including Māori, and to</td>
<td>NGOs, community</td>
</tr>
<tr>
<td>Pacific peoples and at-risk immigrant groups.</td>
<td></td>
</tr>
<tr>
<td>1.52 Expand the Green Prescription Scheme to a wider range and number of practitioners</td>
<td>Ministry of Health,</td>
</tr>
<tr>
<td>so it is more accessible to lower socioeconomic groups and includes appropriate nutrition</td>
<td>DHBs, SRA, RSTs,</td>
</tr>
<tr>
<td>components.</td>
<td>Public health,</td>
</tr>
<tr>
<td></td>
<td>Personal health</td>
</tr>
</tbody>
</table>
**Objective 1.6: Monitor, research and evaluate physical activity, nutrition and overweight and obesity status of the most disadvantaged groups**

Data and evidence is available to increase physical activity, improve nutrition and attain a healthy weight among disadvantaged groups.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Ministry of Health, SRA, A&amp;R, other government</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.61 Monitor the impact of price and spending power on food consumption and food choice, including the cost of a healthy diet, and the cost of physical activity opportunities particularly by lower socioeconomic groups.</td>
<td>Ministry of Health, SRA, A&amp;R, other government</td>
</tr>
<tr>
<td>1.62 Explore the potential, if any, for nationally and locally subsidised food programmes, such as milk-in-school programmes.</td>
<td>Ministry of Health, A&amp;R, food industry, education</td>
</tr>
<tr>
<td>1.63 Evaluate the effectiveness of existing mainstream nutrition and physical activity promotion programmes in reaching Māori.</td>
<td>Ministry of Health, A&amp;R, Māori providers</td>
</tr>
</tbody>
</table>
Priority 2: Children, young people, and their families/whānau

Services and programmes will have a focus on the nutritional and physical activity levels of infants, children, young people and their families, to build the foundation of health for a lifetime.

Rationale

It is well established that nutrition in-utero, and during infancy, childhood and adolescence is critical in determining adult health. Nutrition messages and issues differ according to age and the critical period of benefit. For example, nutritional status during pregnancy is linked to risk of birth defects and to later dental health. Breastfeeding can provide protection from a range of infectious diseases and adult chronic diseases, cardiovascular disease, cancer, Type 2 diabetes and asthma.

New Zealand children and young people appear to be following global trends of increasing overweight and obesity (Dawson et al 2001). There are indications that activity levels have dropped in the past 10 years, with children and young people occupying themselves with high levels of television watching, computer and video games. In addition children are consuming increasing levels of convenience energy-dense foods and drinks. The 1997 National Nutrition Survey revealed that in 15–24 year olds 18 percent of energy comes from non-alcoholic beverages (Russell et al 1999).

Because parents, caregivers and families provide some of the strongest influences in nutrition choices and physical activity patterns it is critical that approaches target the family/whānau where possible. Healthy food choices and physical activity patterns developed and reinforced at a young age can benefit the individual, but are likely also to impact on behaviours and choices of the wider family/whānau.

In addition to the family, the school, peer group, media, cultural, community and physical environments influence children and young people’s food and drink choices and activity patterns. Approaches need to be developed within a cultural context; for example, with Pacific families, taking account of the cultural significance of feasting and using relevant settings such as the church for nutrition education. For schools, the Health Promoting Schools programme provides a framework to address the curriculum, school policies, school health services, and the social and physical environment. It also provides a valuable connection with families and the wider community.

Food security is a major issue for many low-income families, particularly Māori and Pacific families.
Māori

Māori consulted for this project indicated that tamariki and rangatahi Māori must be a priority in Healthy Action – Healthy Eating. Tamariki and rangatahi make up a large proportion of the Māori population, so that improvements in nutrition, food security and physical activity for young people will lead to health gains for the Māori population as a whole now and into the future. As well, patterns of eating and activity in tamariki will be strongly influenced by members of the whānau, particularly parents but also grandparents and cousins. As such, interventions must support change in the whole whānau, and must not just be targeted at tamariki. Targeting nutrition and physical activity interventions to the whānau by utilising appropriate cultural approaches can also serve to strengthen the whānau and Māori communities more broadly.

Objective 2.1: Build healthy public policies for children, young people, and their families/whānau

Policies are developed that address the nutritional and physical activity needs of children, young people, and their families/whānau.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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</tr>
</thead>
<tbody>
<tr>
<td>2.11 Adopt policies ensuring that all food and drinks available on school campuses and at school events contribute towards eating patterns that are consistent with the Food and Nutrition Guidelines.</td>
<td>Education, Public health</td>
</tr>
<tr>
<td>2.12 Ensure daily physical education in primary schools, and regular physical activity in secondary schools and tertiary organisations, which is inclusive, safe and appealing to children and young people with diverse skills and from different backgrounds.</td>
<td>Education, SRA</td>
</tr>
<tr>
<td>2.13 Encourage schools to ensure that all children, regardless of gender, ethnicity or socioeconomic status, have access to a wide variety of appropriate physical activity opportunities.</td>
<td>Education, SRA, RS&amp;F</td>
</tr>
<tr>
<td>2.14 Promote the development of policies that support breastfeeding.</td>
<td>Ministry of Health, DHBs, other government, Employers</td>
</tr>
<tr>
<td>2.15 Support implementation of the principles of the Baby Friendly Hospital Initiative (BFHI) within healthcare/maternity settings and extend the initiative to include the antenatal services in the community.</td>
<td>Ministry of Health, DHBs, community, Personal health</td>
</tr>
<tr>
<td>2.16 Support the adoption of family-focused work policies, such as flexible and reasonable working hours, to allow more time for leisure activities with families, including participation in physical activity.</td>
<td>Other government, Employers</td>
</tr>
</tbody>
</table>
### Objective 2.2: Create supportive environments for children, young people, families/whānau

Environments are designed and modified to assist children, young people, and their families/whānau to be active, eat well and attain a healthy weight.

<table>
<thead>
<tr>
<th>Suggestion for action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.21 Continue to promote the key messages of the <em>Food and Nutrition Guidelines</em> for pregnant women, infants, children and adolescents.</td>
<td>Ministry of Health, DHBs, NGOs, Public health</td>
</tr>
<tr>
<td>2.22 Ensure pregnant women and women with young children are supported to be physically active and have access to physical activity opportunities.</td>
<td>SRA, RS&amp;F, Local govt, NGOs, Public health</td>
</tr>
<tr>
<td>2.23 Support the implementation of the Health and Physical Education Curriculum within New Zealand schools.</td>
<td>Ministry of Health, DHBs, education, SRA</td>
</tr>
<tr>
<td>2.24 Support Health Promoting Schools to provide school and community-based environments that increase physical activity, improve nutrition and achieve a healthy weight.</td>
<td>Education, DHBs, Public health, NGOs, SRA, RS&amp;F, Local govt</td>
</tr>
<tr>
<td>2.25 Support the provision of appropriate and enjoyable physical activities for girls and young women.</td>
<td>Education, Public health, NGOs, SRA</td>
</tr>
<tr>
<td>2.26 Ensure that healthy snacks and drinks are provided in vending machines and school tuckshops.</td>
<td>Education, food industry</td>
</tr>
<tr>
<td>2.27 Raise consumer awareness about reasonable food and beverage portion sizes.</td>
<td>Public, NGOs, food industry</td>
</tr>
</tbody>
</table>

### Objective 2.3: Strengthen community action for children, young people, and their families/whānau

Communities are supported to develop initiatives that encourage physical activity, good nutrition and healthy weight among children, young people, and their families/whānau.

<table>
<thead>
<tr>
<th>Suggestion for action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.31 Support and foster community development programmes that have a focus on infants, children, young people and their families/whānau.</td>
<td>DHBs, Māori providers, Pacific providers, NGOs</td>
</tr>
<tr>
<td>2.32 Ensure the needs of Māori communities, especially those in the most deprived areas, are a priority for action.</td>
<td>DHBs, Māori providers, community</td>
</tr>
<tr>
<td>2.33 Ensure communities have access to adequate information and resources on effective initiatives.</td>
<td>Ministry of Health, DHBs, NGOs, community</td>
</tr>
<tr>
<td>2.34 Identify programmes that increase participation in physical activity at school (eg, the ‘walking school bus’).</td>
<td>Community, education, Public health, NGOs, SRA, RS&amp;F, Local govt, transport</td>
</tr>
<tr>
<td>2.35 Encourage use of school facilities for physical activity programmes offered by the school and/or community-based organisations outside school hours.</td>
<td>Education, community</td>
</tr>
</tbody>
</table>
Objective 2.4: Develop personal skills among children, young people, and their families/whānau

Children and young people and their families/whānau are equipped with the knowledge and information to assist them to make healthy choices regarding food, and to be active.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.41 Continue to promote the benefits of breastfeeding, consistent with the <em>Food and Nutrition Guidelines</em>.</td>
</tr>
<tr>
<td>2.42 Ensure children and young people and their families/whānau receive healthy messages from childcare, schools and health professionals about physical activity, nutrition and healthy weight.</td>
</tr>
<tr>
<td>2.43 Educate girls and young women on the importance of physical activity to health.</td>
</tr>
<tr>
<td>2.44 Ensure messages for tamariki/rangatahi are appropriate and whānau centred.</td>
</tr>
<tr>
<td>2.45 Ensure messages for Pacific children and young people are appropriate and inclusive of families.</td>
</tr>
<tr>
<td>2.46 Ensure women of childbearing age are knowledgeable about folate intake.</td>
</tr>
</tbody>
</table>
Objective 2.5: Reorient services and programmes to focus on children, young people, families/whānau

Providers of physical activity and nutrition programmes incorporate an appropriate focus on children, young people, and their families/whānau.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.51 Support the involvement of appropriate health professionals in the delivery of the Health and Physical Education Curriculum in schools.</td>
<td>Personal health, Public health, education</td>
</tr>
<tr>
<td>2.52 Continue to support Push Play and other programmes to incorporate a focus on children, young people and families.</td>
<td>SRA, RSTs, RS&amp;F, Public health, NGOs, Ministry of Health, DHBs</td>
</tr>
<tr>
<td>2.53 Support appropriate prevention, maintenance and treatment initiatives for overweight and obese children and young people that also address the needs of Māori and Pacific children.</td>
<td>DHBs, Public health, Personal health, weight loss, education</td>
</tr>
<tr>
<td>2.54 Support appropriate whānau-based programmes and services for overweight children through school and community settings.</td>
<td>DHBs, Personal health, Māori providers, A&amp;R</td>
</tr>
<tr>
<td>2.55 Support development and continuation of appropriate programmes for poorly nourished children, such as free breakfasts in schools in areas of need.</td>
<td>DHBs, NGOs, education</td>
</tr>
<tr>
<td>2.56 Ensure delivery of appropriate physical activity programmes for children and young people, including those with disabilities</td>
<td>DHBs, RS&amp;F, education, NGOs</td>
</tr>
</tbody>
</table>
### Objective 2.6: Monitor, research and evaluate physical activity and nutrition status in children, young people, and their families/whānau

Physical activity, nutrition, weight status and interventions will be monitored, researched and evaluated for children, young people, and their families/whānau.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.61 Support appropriate applied research into effective interventions for children in nutrition, physical activity and obesity.</strong></td>
<td>DHBs, SRA, A&amp;R</td>
</tr>
<tr>
<td><strong>2.62 Support appropriate applied research into effective interventions for disadvantaged children in nutrition, physical activity and obesity.</strong></td>
<td>DHBs, SRA, A&amp;R</td>
</tr>
<tr>
<td><strong>2.63 Monitor international developments in the measurement and treatment of overweight and obesity in children.</strong></td>
<td>Ministry of Health, A&amp;R</td>
</tr>
<tr>
<td><strong>2.64 Support research into the development of healthy foods and drinks for children, especially snack foods.</strong></td>
<td>A&amp;R, Public health, food</td>
</tr>
<tr>
<td><strong>2.65 Continue to monitor the nutrition status of infants, and the nutrition and physical activity status of children and young people with a focus on the most vulnerable groups.</strong></td>
<td>Ministry of Health, A&amp;R, Public health, NGOs</td>
</tr>
<tr>
<td><strong>2.66 Evaluate the effectiveness of existing mainstream nutrition and physical activity promotion programmes in reaching Māori.</strong></td>
<td>Ministry of Health, DHBs, A&amp;R, NGOs, Māori providers</td>
</tr>
</tbody>
</table>
Priority 3: Environments

Environments will be developed and modified to support physical activity, good nutrition, and healthy weight across all key sectors and settings.

Rationale

Major changes in social and physical environments are likely to be largely responsible for the growth in sedentary lifestyles and obesity. It is critical, therefore, to take not just an individual approach to behaviour change, but an ecological approach that addresses the causes of poor nutrition, physical inactivity and obesity. Macro environmental influences include the food supply, availability and access to facilities, and values and expectations of the wider community. Micro environmental influences are closer to the individual and are often addressed through the development of personal skills or behaviour modification.

Changes in transportation, town planning, technological innovations and entertainment, issues around safety, availability and affordability all influence individual behaviour and choices about participation in physical activity and food consumption, yet are largely outside the sphere of an individual’s control. Many factors need to be addressed in order to improve the wider environment that impacts on physical activity, diet and weight. These factors include: technologies that require less activity (motor vehicles, TV, videos, DVDs, computer games), increases in the fat and sugar contents of foods produced outside the home, the cost of fruit and vegetables, increased portion sizes, sociocultural influences (for example, fashion and trends), family patterns and peer influences.

Patterns of work and recreation mean that much physical activity in daily life is not a result of planned exercise or sport, but occurs in the course of transport, occupational, incidental, domestic and leisure activities. Also, food patterns reflect a grazing pattern, with a higher reliance on take-away and convenience foods.

At the strategic policy level, policies should pursue shared objectives and intersectoral collaboration to create environments and infrastructures that support physical activity, healthy and safe food choices, and take into account the health impacts of decisions.

The role and inter-relationship between legislation and the interests of food industry in enabling or creating barriers to healthy eating is a key element of the wider environment.

Access to safe physical activity opportunities and healthy food choices is required across all relevant sectors and settings (for example, transport, workplaces, education, local government, food industry, recreation, sport and fitness, and the weight-loss industry, institutions such as hospitals and retirement homes).
Māori

Māori tend to view the world in a holistic way, in which the wider social, spiritual and physical environments are inextricably linked to individual, whānau, hapū and iwi experience. Improving the wider environmental context will improve the lives of all Māori. In doing so, values and concepts common to Māori, and the diversity of the Māori population, must be recognised. The Māori health promotion framework, Te Pae Mahutonga, is a useful model to assist in developing approaches that aim to improve the physical and social environment to improve outcomes for Māori. The framework helps to highlight the need to improve access to resources, to deliver services through culturally appropriate mechanisms (for example, kaupapa Māori approaches, the use of te reo), and to minimise the negative impacts of the constructed physical environment on the natural environment and communities, whānau and individuals.

Objective 3.1: Build healthy public policies for environments

Policies are developed that provide supportive environments for increasing physical activity, improving nutrition and attaining a healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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<tbody>
<tr>
<td>3.11 Develop integrated policies that support physical activity, nutrition, and healthy weight in key sectors and settings (eg, health care, education, workplaces, transport, local councils, food industry, weight-loss industry, recreation, sport and fitness, marae, wānanga, kōhanga, sports and social clubs).</td>
<td>All</td>
</tr>
<tr>
<td>3.12 Develop and implement health impact assessment tools that can be used to assess both negative and positive impacts of policies on physical activity, nutrition, and healthy weight.</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>3.13 Ensure appropriate input into any legislation, regulations and review that impact on physical activity, food and nutrition and healthy weight, both nationally and internationally.</td>
<td>Ministry of Health</td>
</tr>
</tbody>
</table>
Objective 3.2: Create supportive environments

Supportive environments are developed that encourage physical activity, improved nutrition, and healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Relevant Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.21 Deliver programmes and services that support physical activity, nutrition and healthy weight in a range of settings/areas including education, workplaces, transport and local government (particularly to encourage active commuting – cycling and walking), institutions, and the food and weight-loss industries.</td>
<td>All</td>
</tr>
<tr>
<td>3.22 Advocate for programmes and services that support physical activity, nutrition, and healthy weight in a range of settings/areas including education, workplaces, transport, institutions, regional / local councils, and the food and weight-loss industries.</td>
<td>All</td>
</tr>
<tr>
<td>3.23 Support culturally appropriate programmes and services that aim to improve environments for improved nutrition and increased physical activity.</td>
<td>All, Māori, education, DHBs</td>
</tr>
<tr>
<td>3.24 Work in settings such as restaurants, take-away food outlets, schools, workplaces, hospitals, retirement homes, prisons, sports clubs to increase the range of healthy food and beverage choices available.</td>
<td>DHBs, food industry, Employers, education, other government, Māori providers, Pacific providers, NGOs</td>
</tr>
</tbody>
</table>

Objective 3.3: Strengthen community action in local environments

Communities will be supported to address environmental factors that impact on physical activity, nutrition and healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Relevant Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.31 Support community development initiatives to identify local environmental priorities that can be modified to improve physical activity and nutrition.</td>
<td>DHBs, Public health, NGOs, Māori providers, Pacific providers</td>
</tr>
<tr>
<td>3.32 Support a community development approach to address Māori needs, which is based in Māori world views, and which recognises the holistic view of environmental influences.</td>
<td>Ministry of Health, DHBs, Māori providers</td>
</tr>
</tbody>
</table>
**Objective 3.4: Develop personal skills to improve environments**

Key personnel in stakeholder organisations have the knowledge to make decisions that improve environments to support physical activity, good nutrition and attaining a healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.41 Support the development of training courses for food handlers, retail outlets and caterers that promote healthy food environments in line with the <em>Food and Nutrition Guidelines</em>.</td>
<td>Ministry of Health, DHBs, NGOs, education</td>
</tr>
<tr>
<td>3.42 Provide education and training programmes that incorporate Māori knowledge and culture on ways to improve environments for increasing physical activity and improving nutrition.</td>
<td>Māori providers, A&amp;R, Public health, community, DHBs, NGOs. Other govt</td>
</tr>
<tr>
<td>3.43 Support delivery of By Pacific for Pacific education and training programmes that incorporate traditional and culturally appropriate knowledge and beliefs about ways to improve environments for physical activity, nutrition, and healthy weight.</td>
<td>Pacific providers, Public health, community, DHBs, NGOs, other govt</td>
</tr>
</tbody>
</table>

**Objective 3.5: Reorient services and programmes to modify environments**

Services and programmes are integrated and provided in a way that supports people to be physically active, eat well and achieve and attain a healthy weight.

<table>
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<tr>
<th>Suggestions for action</th>
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</thead>
<tbody>
<tr>
<td>3.51 Encourage and support relevant services and programmes to integrate nutrition, physical activity and healthy weight initiatives into each programme (across transport, local government, education, health).</td>
<td>DHBs, NGOs, SRA, education, transport</td>
</tr>
<tr>
<td>3.52 Support the development of appropriate programmes and services for treatment of overweight, including partnership with treatment and prevention services.</td>
<td>DHBs, Personal health, weight loss, Māori, Pacific</td>
</tr>
<tr>
<td>3.53 Fund and deliver mainstream physical activity and nutrition programmes only where there is evidence they are effective in reaching Māori.</td>
<td>Ministry of Health, DHBs, Māori providers, community, SRA, NGOs</td>
</tr>
<tr>
<td>3.54 Support the development of Māori providers to deliver programmes for Māori.</td>
<td>Ministry of Health, DHBs, Māori providers</td>
</tr>
<tr>
<td>3.55 Encourage recreation, sport and fitness sectors to provide appropriate programmes for Māori.</td>
<td>SRA, RS&amp;F, Māori providers, community</td>
</tr>
<tr>
<td>3.56 Support the delivery of mainstream physical activity and nutrition programmes with a specific focus on Pacific peoples, and, where possible, delivery of By Pacific for Pacific programmes.</td>
<td>Ministry of Health, DHBs, Pacific providers, community, SRA, RS&amp;F</td>
</tr>
</tbody>
</table>
**Objective 3.6: Monitor, research and evaluate environments**

Monitoring, research and evaluation provide evidence that helps to develop supportive environments for physical activity, nutrition, and healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.61 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 minority populations.</td>
<td>Ministry of Health, DHBs, SRA, A&amp;R</td>
</tr>
<tr>
<td>3.62 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 minority groups.</td>
<td>Ministry of Health, A&amp;R</td>
</tr>
<tr>
<td>3.63 Support research into maintenance of weight loss, particularly based in community, workplace, school and health care settings.</td>
<td>A&amp;R, Ministry of Health, DHBs, NGOs, community, Māori providers, Pacific providers</td>
</tr>
<tr>
<td>3.64 Ensure that all monitoring, research and evaluation into environments includes a focus on Māori needs.</td>
<td>A&amp;R, Ministry of Health, DHBs</td>
</tr>
<tr>
<td>3.65 Support and monitor evaluation of all physical activity and nutrition interventions that include measurable outcome indicators.</td>
<td>Ministry of Health, other government, A&amp;R</td>
</tr>
<tr>
<td>3.66 Support a trans-Tasman review of recommended dietary intakes (RDIs).</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>3.67 Re-establish monitoring of the food supply.</td>
<td>Ministry of Health, other government, A&amp;R</td>
</tr>
<tr>
<td>3.68 Ensure monitoring, research, and evaluation of nutrition, physical activity and healthy weight programmes. Include in the analysis the relevance of the programmes to Pacific peoples’ realities and settings.</td>
<td>Ministry of Health, DHBs, A&amp;R</td>
</tr>
</tbody>
</table>
Priority 4: Communication

Clear and consistent messages promoting the importance of physical activity, good nutrition and healthy weight will be understood by the general public and key stakeholders across relevant sectors and be effective in improving health outcomes.

Rationale

It is often stated that the general public are confused by conflicting and changing messages about nutrition, and physical activity. Health professionals (GPs, practice nurses, health promoters, dietitians, nutritionists, physiotherapists) must ensure that accurate and appropriate messages are portrayed to the public. Developing appropriate messages requires sound knowledge of the communities at which that message is targeted. National and local communication of key messages needs to be delivered consistently. Messages also must be adapted for different audiences (for example, Māori, Pacific peoples, those at high risk, children and young people, people with disabilities, older people, those with chronic conditions). It is also important to use different delivery mechanisms, such as television, hui, the school curriculum or messengers. Communication aimed exclusively at behaviour change, while not considering social, cultural, economic, and environmental influences, is likely to be less effective. An unbalanced focus on behaviour change can also reinforce attitudes of stigmatisation against people who are overweight and obese.

Māori

Mainstream health promotion and communication strategies can be ineffective in reaching Māori. To make changes, messages, messengers and the media used must reflect Māori realities and must be developed either by Māori or in partnership with Māori.

The key population health messages

To increase physical activity:
- follow the New Zealand Physical Activity Guidelines (Hillary Commission 2001)
- all New Zealanders should do at least 30 minutes of moderate intensity physical activity (equivalent to brisk walking) on most, if not all, days of the week can improve health
- all New Zealanders should be active in as many ways as possible as part of their daily routine (for example, active commuting to work or school, incidental and household activity)
- if possible, add some vigorous exercise for extra health and fitness.

To improve nutrition:
- follow the Food and Nutrition Guidelines series (Ministry of Health 1998a).
• increase the consumption of vegetables and fruit.
• all infants should be breastfed until at least six months of age.

To achieve and maintain a healthy weight:
• promote overweight and obesity as major public health issues
• all New Zealanders should aim to maintain a healthy weight by eating a balanced diet and undertaking adequate physical activity
• New Zealanders who are overweight should aim to reduce their BMI (body mass index) by reducing energy intake and increasing energy expenditure
• in overweight people, any reduction in BMI reduces the risk of many obesity-related diseases and conditions.

Objective 4.1: Build health public policy that supports effective communication

Policies are developed that support the effective development and dissemination of key health messages around physical activity, nutrition and healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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</thead>
<tbody>
<tr>
<td>4.11 Work on the development and ongoing review of communication to ensure appropriate messages and portrayals of physical activity, nutrition, and healthy weight/overweight and obesity, including for children and young people and Māori and Pacific peoples.</td>
</tr>
<tr>
<td>4.12 Work with relevant bodies to encourage accurate and appropriate advertising of the effectiveness of weight-loss programmes and products.</td>
</tr>
</tbody>
</table>

Objective 4.2: Create supportive environments that are reinforced through health-promoting communication

New Zealanders are encouraged to be physically active, eat well and attain a healthy weight through an environment supported by comprehensive communication strategies.

| Suggestions for action | |
|-------------------------|
| 4.21 Develop social marketing and health education programmes that reach Māori populations and improve knowledge of how they can improve nutrition and increase physical activity. | Ministry of Health, DHBs, Māori, NGOs |
| 4.22 Develop a national social marketing strategy that supports initiatives to promote physical activity, good nutrition and healthy weight (including positive body images) for all population groups. | Ministry of Health, DHBs, Public health, SRA, NGOs |
| 4.23 Encourage television media to minimise the amount of food advertising during prime-time viewing for children and adolescents. | Ministry of Health, media, NGOs |
| 4.24 Foster the dissemination of accurate and appropriate information for the media (eg, develop a media kit). | Ministry of Health, media, NGOs, SRA |
| 4.25 Provide education and training to health professionals on consistent messages regarding physical activity, nutrition and weight loss. | Public health, NGOs, A&R, SRA |
**Objective 4.3: Strengthen community action communication strategies**

Local communities are supported to develop and deliver customised messages on physical activity, nutrition and healthy weight.

<table>
<thead>
<tr>
<th>Suggested for action</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.31 Support the development of local community communication strategies that support and encourage physical activity, good nutrition and healthy weight.</td>
<td>Public health, NGOs, SRA, community</td>
</tr>
<tr>
<td>4.32 Convey messages using appropriate communication methods and language for Māori and Pacific communities.</td>
<td>Public health, Māori providers, Pacific providers, NGOs</td>
</tr>
</tbody>
</table>

**Objective 4.4: Develop personal skills through effective communication**

Health-promoting messages are effective in assisting individuals to make healthy decisions regarding physical activity, nutrition and healthy weight.

<table>
<thead>
<tr>
<th>Suggested for action</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.41 Promote the messages of the <em>Food and Nutrition Guidelines</em> for all population groups, including infants, children, teenagers, pregnant and breastfeeding women, adults and older people.</td>
<td>Ministry of Health, DHBs, SRA, food NGOs, Public health, media</td>
</tr>
<tr>
<td>4.42 Promote the messages in the <em>New Zealand Physical Activity Guidelines</em>.</td>
<td>SRA, Public health, NGOs, media</td>
</tr>
<tr>
<td>4.43 Raise consumer awareness about the effect of being overweight on overall health and the benefits of a healthy weight and physical activity.</td>
<td>Public health, Personal health, NGOs</td>
</tr>
<tr>
<td>4.44 Educate parents about the need to serve as good role models by practising healthy eating habits and regular physical activity to instil lifelong healthy habits in their children.</td>
<td>Public health, NGOs</td>
</tr>
<tr>
<td>4.45 Raise policy makers’ awareness of the need to develop social and environmental policy that will help communities and their families/whānau to be more physically active and consume a healthier diet.</td>
<td>Ministry of Health, DHBs, NGOs, other government, SRA</td>
</tr>
<tr>
<td>4.46 Raise health professionals’ awareness of the importance and integrated nature of physical activity, nutrition and healthy weight to improved overall health.</td>
<td>Ministry of Health, DHBs, SRA, NGOs</td>
</tr>
<tr>
<td>4.47 Ensure information, advice and support is readily available to the general public on safe and effective ways of losing weight.</td>
<td>DHBs, media, weight loss</td>
</tr>
</tbody>
</table>
Objective 4.5: Reorient services and programmes to communicate effectively

All relevant service providers work collaboratively to communicate clear and consistent messages about the importance of physical activity, good nutrition and healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.51 Inform health care providers, policy planners and administrators of the burden of overweight and obesity on the health care system in terms of mortality, morbidity, and cost.</td>
<td>Ministry of Health, DHBs</td>
</tr>
<tr>
<td>4.52 Foster collaboration between the health sector and appropriate industry groups (eg, recreation, sport and fitness, food, weight-loss industry) to ensure consistent and appropriate messages on physical activity, nutrition and healthy diet are disseminated.</td>
<td>Ministry of Health, DHBs, SRA, RS&amp;F, food, weight loss, NGOs</td>
</tr>
<tr>
<td>4.53 Support a dialogue to consider whether obesity should be classified as a disability to be eligible for disability support services.</td>
<td>Ministry of Health, DHBs, NGOs, other government</td>
</tr>
</tbody>
</table>

Objective 4.6: Monitor, research and evaluate communication strategies

Monitoring, research, and evaluation provide evidence to support effective communication of key messages on physical activity, nutrition, and healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Responsible Parties</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.61 Evaluate media campaigns and programmes.</td>
<td>Ministry of Health, DHBs, NGOs, SRA, A&amp;R</td>
</tr>
<tr>
<td>4.62 Monitor advertising of weight-loss, physical activity and nutrition programmes to ensure accuracy of messages.</td>
<td>A&amp;R, SRA, media</td>
</tr>
<tr>
<td>4.63 Research messages on physical activity, nutrition (including Food and Nutrition Guidelines) and healthy weight messages for at-risk population groups (eg, children and young people, Māori, Pacific peoples, other ethnic groups).</td>
<td>Ministry of Health, A&amp;R, SRA</td>
</tr>
<tr>
<td>4.64 Facilitate and regularly update documentation and dissemination of information regarding effective programmes for physical activity and nutrition, including for Māori (eg, a clearing house).</td>
<td>Ministry of Health, DHBs, NGOs</td>
</tr>
</tbody>
</table>
Priority 5: Workforce

A skilled and knowledgeable workforce will be in place to support increasing physical activity, improving nutrition and reducing obesity.

Rationale

Improving population health relies on having the right health personnel with appropriate skills and experience to deliver quality health services across public, primary and secondary health care. Key health personnel include: primary health care providers, specialists, nutritionists, dietitians, midwives and early childhood health professionals, health promoters, weight-loss specialists, community health workers, physiotherapists, and dental professionals. At some levels of the health workforce, particularly the tertiary level, there is a lack of people with adequate skills in nutrition and physical activity. In some areas there appears to be a lack of opportunities for those who have received training, and there are few opportunities for career development.

Improved integration across the health services is also required to improve collective efforts to increase population physical activity levels, improve nutrition and reduce obesity. There are opportunities to improve partnerships between schools, workplaces and community settings so that primary and secondary health providers serve to reinforce the adoption and maintenance of healthy lifestyles.

Due to the large body of often contradictory messages about nutrition and weight loss, it is vital that all those who are involved in providing services and programmes are delivering consistent and accurate messages. In some areas this may require the development of training and/or best practice material and additional training opportunities.

Improvements are also needed to ensure that service providers have the appropriate skills and knowledge to develop and provide effective programmes and services, particularly to those at high risk, such as Māori and Pacific peoples.

There is a need to ensure that the research and academic community have suitable expertise and the resources to provide high-quality data and research in areas that can make a difference to improving health outcomes.

In particular, Māori and Pacific peoples have identified workforce as a key barrier to change. Not only is there a need to train new people in nutrition and physical activity at the tertiary level, but there is also a need to maintain and strengthen the current workforce and to offer clear career development. There needs to be an emphasis on training at all levels, from community health worker to postgraduate levels.
Māori

Māori have identified the need for a stronger Māori workforce as a key factor to be addressed. Training and developments also need to recognise the value of Māori knowledge and the skills that many ‘unqualified’ Māori bring to promoting good nutrition and increasing physical activity.

Objective 5.1: Build healthy public policies to support workforce development

Policies are developed that help develop a workforce to support the importance of physical activity, good nutrition and healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Ministry of Health, education</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.11 Work with appropriate bodies to investigate the potential to include physical activity and nutrition as areas of learning in the training of preschool, primary school and post-primary school teachers.</td>
<td></td>
</tr>
<tr>
<td>5.12 Work with training schools for health professionals to include appropriate physical activity, nutrition and healthy weight modules in their training.</td>
<td>Ministry of Health, education, A&amp;R</td>
</tr>
<tr>
<td>5.13 Support academic and training institutions to consider scholarships for minority groups to study physical activity and health-related courses.</td>
<td>Ministry of Health, A&amp;R, education</td>
</tr>
<tr>
<td>5.14 Support more academic and training institutions to provide studies in nutrition (including a postgraduate medical specialty in obesity), physical recreation and physical activity and health.</td>
<td>Ministry of Health, education, A&amp;R</td>
</tr>
<tr>
<td>5.15 Ensure that development of physical activity and health and nutrition skills are linked into career development schemes, including appropriate career pathways for Māori and Pacific peoples consistent with their level of training and appropriate to the needs of their communities.</td>
<td>Ministry of Health, A&amp;R, education, Public health, Māori providers, Pacific providers, community, NGOs</td>
</tr>
</tbody>
</table>

Objective 5.2: Create supportive environments for an expanding workforce

A wide range of people are encouraged and supported to undertake careers in the health, recreation, sport and fitness and related sectors.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Ministry of Health, DHBs, Māori, Pacific, NGOs, community, RS&amp;F, SRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.21 Work with commercial ‘train the trainer’ providers in the recreation, sport and fitness, and health sectors to access lower socioeconomic groups, including Māori and Pacific communities, in order to recruit appropriate community members for training.</td>
<td></td>
</tr>
<tr>
<td>5.22 Support training organisations to train more Māori and Pacific community members in physical activity, nutrition and obesity management.</td>
<td>Ministry of Health, DHBs, Māori providers, Pacific providers, NGOs, community, RS&amp;F</td>
</tr>
</tbody>
</table>
Objective 5.3: Strengthen community action to develop a local workforce

Communities are supported to identify and train local community members to educate their communities in physical activity, nutrition and healthy weight issues.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5.31 Support the identification of key and appropriate community health workers to upskill in physical activity and nutrition, particularly in Māori and Pacific communities.</td>
<td>Public health, Māori providers, Pacific providers, NGOs, community</td>
</tr>
</tbody>
</table>

Objective 5.4: Develop personal skills to improve the workforce

Health professionals and community health workers are supported to gain knowledge of approaches to increase physical activity, improve nutrition and attain healthy weight.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
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</tr>
</thead>
<tbody>
<tr>
<td>5.41 Support training opportunities in physical activity, nutrition and obesity prevention, and management among relevant health professionals.</td>
<td>DHBs, A&amp;R, NGOs, SRA, Public health, Personal providers</td>
</tr>
<tr>
<td>5.42 Educate health care providers, funders and planners to identify and reduce environmental barriers that affect individuals’ lack of access to effective nutrition and physical activity interventions.</td>
<td>Education, NGOs, DHBs, community, Public health, Personal health, other government</td>
</tr>
<tr>
<td>5.43 Ensure health care providers are trained in, and have access to, best practice material on effective prevention and treatment techniques for overweight and obesity.</td>
<td>Ministry of Health, DHBs, Public health, Personal health, A&amp;R, weight loss</td>
</tr>
<tr>
<td>5.44 Encourage private weight-loss providers to promote healthy and effective weight-loss programmes and products.</td>
<td>Weight loss, NGOs, Public health, Personal health</td>
</tr>
</tbody>
</table>
Objective 5.5: Reorient services and programmes to expand and improve the workforce

Services and programmes are reoriented to support a workforce knowledgeable in physical activity, nutrition and healthy weight issues.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Entity(ies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.51 Support, and expand where appropriate, current integrated training programmes for community health workers in nutrition and physical activity.</td>
<td>Ministry of Health, DHBs, Public health, Māori providers, Pacific providers, NGOs, community</td>
</tr>
<tr>
<td>5.52 Develop evidence-based guidelines on weight loss for primary health care providers.</td>
<td>Ministry of Health, DHBs, Public health, Personal health, A&amp;R, weight loss</td>
</tr>
<tr>
<td>5.53 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.</td>
<td>All</td>
</tr>
<tr>
<td>5.54 Ensure service planners and providers are equipped with the knowledge and skills and partnerships to deliver services that are effective for Māori.</td>
<td>All</td>
</tr>
<tr>
<td>5.55 Ensure service planners and providers are equipped with the knowledge, skills and partnerships to deliver services that are effective for high-risk groups, including Pacific peoples, socioeconomically disadvantaged groups and ethnic minorities.</td>
<td>All</td>
</tr>
</tbody>
</table>

Objective 5.6: Monitor, research and evaluate the workforce

Monitoring, research and evaluation provide evidence to develop and support a knowledgeable workforce to increase physical activity, improve nutrition and reduce obesity.

<table>
<thead>
<tr>
<th>Suggestions for action</th>
<th>Entity(ies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.61 Monitor, review and quantify the existing and projected required health workforce to improve health outcomes regarding physical activity, nutrition and obesity, including a particular focus on Māori and Pacific peoples.</td>
<td>Ministry of Health, DHBs, A&amp;R, education, RS&amp;F, SRA, Public health, Personal health, Māori providers, Pacific providers, NGOs, community</td>
</tr>
<tr>
<td>5.62 Ensure that new training programmes and best practice resources are evaluated for their effectiveness.</td>
<td>All</td>
</tr>
</tbody>
</table>
### Abbreviations for key agencies

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>All organisations can be involved</td>
</tr>
<tr>
<td>A&amp;R</td>
<td>Academic and research</td>
</tr>
<tr>
<td>ANZFA</td>
<td>Australian New Zealand Food Authority</td>
</tr>
<tr>
<td>Community</td>
<td>Community groups</td>
</tr>
<tr>
<td>DHBs</td>
<td>District Health Boards (funders, planners)</td>
</tr>
<tr>
<td>Education</td>
<td>Education</td>
</tr>
<tr>
<td>Employers</td>
<td>Employers</td>
</tr>
<tr>
<td>Food industry</td>
<td>Food industry</td>
</tr>
<tr>
<td>Local govt</td>
<td>Local government</td>
</tr>
<tr>
<td>Māori providers</td>
<td>Māori providers (health and other services and programmes)</td>
</tr>
<tr>
<td>Media</td>
<td>Media</td>
</tr>
<tr>
<td>Ministry of Health</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-governmental organisations</td>
</tr>
<tr>
<td>Other government</td>
<td>Other government departments/Ministries</td>
</tr>
<tr>
<td>Pacific providers</td>
<td>Pacific providers (health and other services and programmes)</td>
</tr>
<tr>
<td>Personal health</td>
<td>Primary care providers, private practitioners (eg, physiotherapists, dietitians, osteopaths, podiatrists etc), specialists</td>
</tr>
<tr>
<td>Public health</td>
<td>Public health units, non-governmental public health providers, Māori providers, Pacific providers</td>
</tr>
<tr>
<td>RSTs</td>
<td>Regional sports trusts</td>
</tr>
<tr>
<td>RS&amp;F</td>
<td>Recreation, sport and fitness sectors</td>
</tr>
<tr>
<td>SRA</td>
<td>Sport and Recreation Agency (formerly the Hillary Commission)</td>
</tr>
<tr>
<td>Transport</td>
<td>Transport</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Weight-loss sector</td>
</tr>
</tbody>
</table>
Appendix 1: Strategies Informing this Document

A1.1 Key strategies

The New Zealand Health Strategy and the New Zealand Disability Strategy together set the overarching guide for planning, developing and funding health and disability services in New Zealand.

The New Zealand Health Strategy

The New Zealand Health Strategy was released in December 2000. It provides the framework within which DHBs and other organisations across the health sector operate. It highlights the priorities the Government considers to be most important, and identifies a way forward with a high focus on prevention and population health approaches. The New Zealand Health Strategy identifies 13 priority population health objectives.

Underpinning the implementation of the New Zealand Health Strategy is the development of ‘toolkits’ for DHBs for each of the 13 priority population health objectives. The Ministry of Health has developed toolkits to provide DHBs with advice on the most effective interventions to address the priority health objectives.

The New Zealand Disability Strategy

Twenty percent of the total New Zealand population has a long-term disability or health condition. The Statistics New Zealand report *Disability Counts* (1998) defines disability as ‘any self-perceived limitation in activity resulting from a long-term condition or health condition, lasting or expected to last 6 months or more and not completely eliminated by an assistive device’ (Statistics New Zealand 1998). It is important to look for interventions that assist this group to be physically active, either as part of habilitation or rehabilitation programmes, or to prevent a worsening health condition or disability. There is also recognition that morbid obesity can be a disability in its own right and hinders people’s ability to participate fully in society.

*Healthy Action – Healthy Eating* needs to link with the New Zealand Disability Strategy (Ministry of Health 2001b). An important approach is to pursue improvements in access to different environments to allow people with disabilities to participate in physical activity. This involves ensuring recreational and sports facilities in communities (for example, swimming pools, parks, fitness centres) are designed to be accessible to, and to protect the rights and dignity of, people with disabilities (Ministry of Health 2001b). Objective 9 of the New Zealand Disability Strategy, ‘Support lifestyle choices, recreation and culture for disabled people’, is particularly relevant to *Healthy Action – Healthy Eating*. 

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*Healthy Action – Healthy Eating: Towards an Integrated Approach to Physical Activity, Nutrition and Healthy Weight for New Zealand*
A general principle (or rule) for planners of recreational facilities and public spaces is to consider the access requirements of those with disabilities first (accessibility standards developed by Standards New Zealand will assist this approach). This approach in turn will ensure that the whole community can have access to the facility or space.

**He Korowai Oranga (Māori Health Strategy)**

The He Korowai Oranga Māori Health Strategy Discussion Document (King 2001) sets two broad directions that reflect the important roles both Māori and the Crown have in implementing health and disability strategies for Māori. These recognise that both Māori and the Crown have aspirations and roles in improving Māori health. The final strategy is due to be published in April 2002.

The overall aim of Te Korowai Oranga is whānau ora: Māori families supported to achieve maximum health and wellbeing. The strategy proposes four pathways to achieve the aim of whānau health:

- the Crown working collaboratively with whānau, hāpu and iwi to identify what is needed to encourage health as well as prevent and treat disease
- active participation by Māori communities at all levels of the health and disability sector
- ensuring that whānau receive timely, high quality, effective and culturally appropriate health and disability services
- the health and disability sector taking a leadership role across the whole of government and its agencies to address the broad determinants of health.

The overall focus on whānau and the four pathways are consistent with the *Healthy Action – Healthy Eating* framework and particularly with priority action area 2: children, young people, their families/whānau.

**A1.2 Other strategies**

A number of more detailed health and related strategies for services, health issues or population groups already exist or are being developed. These strategies provide more detailed guidance for the health and disability sector, particularly DHBs, on how to achieve the goals of the New Zealand Health Strategy and the New Zealand Disability Strategy.

Health-related strategies include:

- Primary Health Care Strategy
- Health of Older People Strategy
- Roadside to Bedside
- Pacific Health and Disability Action Plan
- Youth Health Strategy

17 Accessibility standards have been developed by Standards New Zealand (see NZ Standard 4121: Design for Access and Mobility—Buildings and Associated Facilities), which include standards for accessibility to recreation facilities (eg, playgrounds, swimming pools, etc).
• Reducing inequalities in health framework (in press).

Related strategies include:
• Positive Ageing Strategy (Ministry of Social Development)
• Agenda for Children (Ministry of Social Development)
• Youth Development Strategy (Ministry of Youth Affairs)
• New Zealand Transport Strategy (Ministry of Transport)
• Road Safety Strategy (Land Transport Safety Authority).

A1.3 International policy context

Addressing physical activity, nutrition and obesity is also a key international priority of the World Health Organization (WHO) and related international organisations. Information on WHO initiatives in physical activity, nutrition and obesity include the following.

The WHO Global Initiative on Active Living / Physical Activity for Health

Launched in 1997, the global initiative of the World Health Organization brought together various international partners – such as UNESCO, the International Olympic Committee, non-governmental organisations, collaborating centres and interested countries – to co-operate and participate actively in its implementation. The aim is to integrate physical activity practices into everyday life and promote them among population groups of all ages and conditions, both men and women, including people with disabilities, especially in the family, at school, in the workplace and in the community within supportive environments.

Nutrition

The WHO and the Food and Agriculture Organization of the United Nations (FAO) have continued to focus international efforts on supporting countries in the development of national plans of action for improving nutrition, including reducing food insecurity. The approaches outlined in Healthy Action – Healthy Eating are consistent with international recommendations.

The 1997 WHO Consultation on Obesity

The WHO Consultation on Obesity met in Geneva in 1997. This was the culmination of a two-year preparatory process, involving more than 100 experts worldwide with close collaboration from the International Obesity Task Force. The overall aim of the Consultation was to review current epidemiological information on obesity, and to draw up recommendations for developing public health policies and programmes for improving the prevention and management of obesity.
WHO – Pacific Region Workshop on Obesity Prevention and Control

In April 2000 a workshop on obesity prevention and control strategies was held in Samoa. This was organised by WHO, in partnership with the Secretariat of the Pacific Community, the International Obesity Taskforce, the FAO and the International Life Sciences Institute. An operational framework was constructed and country representatives undertook to promote country-specific and regional strategies.
Appendix 2: Context for action (Māori, Pacific peoples)

A.2.1 Māori

Māori generally do not separate ‘public’ and ‘personal’ health. One commonly used conceptualisation of the Māori view is the ‘four cornerposts’ Whare Tapa Wha model, which involves:

- te taha wairua, spiritual health, including the practise of tikanga Māori in general, and the health of land, air and water
- te taha hinengaro, the emotional and psychic wellbeing of the whānau and of each individual within it
- te taha tinana, the physical aspects of health
- te taha whānau, the social environment in which individuals live – the whānau unit, and the communities in which whānau live and act (Durie 1985).

At the Te Ara Ahu Whakamua Māori Health Decade Hui (March 1994), ‘healthy Māori’ were defined as people having a strong sense of identity; self-esteem, confidence and pride; control of their own destiny; leadership; intellectual, physical, spiritual and whānau awareness; personal responsibility; respect for others; knowledge of te reo and tikanga; economic security; and solid whānau support (Te Puni Kokiri 1994).

Professor Mason Durie has developed a framework for Māori health promotion, Te Pae Mahutonga (the Southern Cross) (Durie 2001), which can usefully be applied to physical activity, nutrition and obesity. In keeping with the Māori cornerstone of health (Te Whare Tapa Wha), Te Pae Mahutonga comprises four stars, each of which represents a key component of health promotion relating to Māori health:

- access to te ao Māori – mauriora
- environmental protection – wairora
- healthy lifestyles – toiora
- participation in society – te oranga.

There are also two pointers – ngā manukura (leadership) and te mana whakahaere (autonomy).

Activities to improve the health status of Māori include:

- improved access to culture, language and knowledge
- economic resources such as land, forests and fisheries
- social resources such as whānau
- active participation in the economy and education, and access to real employment
- acknowledging the link between environment and wellbeing
- working to improve the physical environment.
The need to reduce the exposure to risk factors, to encourage Māori capacity for self-governance and to support community and tribal leadership are also highlighted in this model.

Changes in Māori diet and activity over time

Māori in pre-European Māori society ate a diet of mainly low-fat food, with little sugar and relatively little meat. In addition people needed to work hard to gather and prepare food, and there were times when food supplies were scarce.

The impacts of early colonisation on Māori included the change to eating lots of fatty and salty meats (for example, mutton, salt pork) and the addition of sugar, tea and potatoes, as well as the introduction and promotion of tobacco and alcohol consumption. Māori society was also affected by the loss of mahinga kai (traditional food-gathering areas), especially the destruction of forest, and the pollution of coasts, rivers and lakes.

It is generally recognised that as a result of land and asset loss, and the destruction of traditional social structures and the public health system they supported, Māori are over-represented among the most deprived groups in New Zealand. In general, people in such groups face problems in providing the quantity and quality of food needed.

As Māori moved to urban centres after World War II, there was more reliance on prepared foods, and changes from high-activity work to less strenuous jobs. At the same time, Māori continued to participate in sports and physical activity. Over recent decades, work has gone into improving nutrition for Māori and sustaining and increasing physical activity, such as changing the types of food offered on marae and developing culturally appropriate activity programmes.

Nutrition

Key findings of the 1997 National Nutrition Survey included:

- Māori were more likely to meet the recommended intakes of breads and cereals than Europeans and others
- Māori had higher mean energy intakes from fat than non-Māori
- Māori women had higher saturated fat intakes than non-Māori women
- Māori women had higher total sugar and sucrose intakes than non-Māori women
- Māori men had a slightly lower total sugar and sucrose intake than non-Māori men
- a high proportion of young Māori and Māori women had inadequate intakes of calcium: the majority of Māori and Pacific people chose standard milk, which has a lower calcium content than trim milk; and fewer Māori ate cheese than non-Māori (Russell et al 1999).

According to this survey, Māori (37 percent) were more likely to be trying to change their diet than New Zealand Europeans and others (26 percent).

There are particular issues for children, both in infant and childhood nutrition. Māori rates of ‘full’ breastfeeding are lower than those for European or Pacific New Zealanders. The
validation phase of the Child Nutrition Survey also supports concerns that poor nutrition and obesity are significant problems for Māori children (Chal 2001).

The 1997 National Nutrition Survey also showed that people living in more deprived areas, in particular Māori, were most likely to:

- have poor nutrition
- not be meeting the Ministry of Health’s Food and Nutrition Guidelines
- report running out of food, or being unable to eat properly because of lack of money.

**Physical activity**

National surveys have found that Māori and non-Māori are about equally active, and Māori children are much more likely than non-Māori or other ethnic groups to be regularly active; however, more Māori than non-Māori appear to be sedentary (Ministry of Health 1999a).

Te Puni Kōkiri has found a number of barriers for Māori wanting to increase activity levels. In addition to cost, transport difficulties, work and whānau commitments, and lack of childcare, a number of other distinctive issues were raised:

- lack of whānau support for Māori women taking time out of childcare for active leisure
- lack of appropriate programmes for Māori
- whakamā (sense of shame or embarrassment)
- low self-esteem
- communication difficulties
- transience due to seasonal work
- perception of cost
- low awareness of the impact on their own lives, the facilities and opportunities available (Te Puni Kōkiri 1995).

It has been suggested that the desire for physically inactive Māori to become active can be strengthened when linked to other, stronger motivations such as whānau and hapū involvement.

**Obesity and overweight**

Obesity and overweight are strongly associated with low socioeconomic status and deprivation, which is likely to be the major reason why Māori are much more likely to be obese than European and other New Zealanders. The 1997 National Nutrition Survey found high rates of obesity among Māori, with 27 percent of Māori men and 27.9 percent of Māori women being obese (and a further 30 percent overweight), compared with 12.6 percent of New Zealand European and other New Zealand men and 16.7 percent of women (Russell et al 1999).
**Burden of disease**

Health problems related to poor nutrition, obesity and lack of physical activity include cardiovascular disease, diabetes, and some cancers (such as colorectal). Māori men and women die from coronary heart disease at more than twice the rate of their non-Māori peers.

Obesity is of greatest significance in relation to Type 2 diabetes: at least one third of all diabetes-related deaths are attributable to obesity, and this proportion is much higher for young Māori. Māori also suffer higher rates of diabetes than the general population. For all-cause mortality, approximately 11 percent of all Māori deaths in the 45–64 years age group are attributable to obesity, compared with 6–7 percent for non-Māori (Swinburn et al 1997a).

**Nutrition initiatives**

Between 1994 and the present, four Māori community nutrition initiatives were set up by Māori organisations in collaboration with health agencies, aimed at improving nutrition at a community level by training community workers in basic food and nutrition (Moewaka Barnes et al 1998a&b; Pipi et al 1994; Tunks et al 1998). All the initiatives were based on strong community development perspectives.

Evaluations found that all the initiatives achieved a great deal of Māori community involvement, empowerment and sense of local ‘ownership’. There was significant change in each community’s awareness of nutrition issues, and some changes in eating habits and in the kind of food provided. In the Tarāwhiti pilot, for instance, there were significant changes in food offered at participating marae, with more wholemeal bread, fruit, vegetables, lean meat, cereals and water being available (Maskill and Hodges 2001). There were also spin-off benefits, such as the extension of smokefree initiatives and safer food-handling practices.

**Physical activity initiatives**

The following initiatives are being undertaken.

- **He Oranga Poutama** is a By Māori, for Māori initiative developed by the Hillary Commission in conjunction with communities. It supports kaiwhakahaere, who work with iwi in developing programmes and events, mostly carried out on the marae. It is also intended as a vehicle for other health messages, such as Auahi Kore/Smokefree (Cram et al 1999).

- **Te Hotu Manawa Māori** delivers a range of physical activity and nutrition programmes and training. A number of public health units, Māori providers and NGOs provide Māori-specific physical activity and nutrition services.

- A number of hikoi (walking) programmes have been established in different regions. The Hikoi 2000 programme run in conjunction with Hutt Valley Health has been evaluated and showed that a significant proportion of formerly inactive Māori became physically active and, what is more, maintained activity levels for more than three months (Wehipeihana and Burr 2001).
A2.2 Pacific peoples

The term ‘Pacific peoples’ refers to populations of Pacific Islands ethnic origin (Samoan, Cook Island Māori, Tongan, Niuean, Fijian and Tokelauan make up the six main ethnic groups). It incorporates Pacific people born in New Zealand as well as in the Pacific Islands (Statistics New Zealand 1998a). ‘Pacific Islander’ or ‘Pacific people’ is a blanket term, and its use undermines the historical, social, and cultural uniqueness of each Pacific Island society (Mara et al 1994). As a result, the plural ‘Pacific peoples’ is used by the Ministry of Health where appropriate to reflect this diversity.

Pacific populations in New Zealand are heterogeneous and culturally diverse. Different ethnic groups have their own language, customs and traditions. Pacific peoples do, however, share a common migration and assimilation history in New Zealand (Ministry of Health 1997).

In the 1996 census Pacific peoples made up 6 percent of the total New Zealand population. Pacific children under 15 years of age made up 39 percent of the Pacific population, compared with children comprising only 23 percent in the total population. The Pacific population growth is 11 times faster than that of other New Zealand population groups. It is estimated that the number of Pacific children will double to 12 percent of all children by 2031 (Statistics New Zealand 1998a).

The Pacific concept of health

For Pacific peoples, health is a holistic concept, which encompasses spiritual, emotional, mental, physical and social wellbeing. The emphasis is on the total wellbeing of the individual within the context of the family (Ministry of Health 1997).

The Pacific family

‘Family’ to Pacific peoples means ‘extended family’, regardless of locality, living arrangements and the number of households. The family provides its members with a material, emotional, spiritual and cultural environment. It has also been the only support structure for older people. Although the closeness of mutual family obligations may be weakening due to socioeconomic factors, urbanisation or assimilation, the extended family structures are still at the centre of Pacific cultures, behaviours and beliefs (Ministry of Health 1997; Finau 1982). Pacific peoples have a strong sense of belonging and individual identity through their families, the church and the community.

The trends of poor health status, youthful population structure and high fertility rates of the Pacific population have significant implications for New Zealand’s health, education and social services, both now and in the future. Unemployment, low income, poor housing and over-crowding, low educational achievement, urbanisation and the breakdown of the traditional family structures serve to exacerbate the poor health status of Pacific peoples (Ministry of Health 1997).
Impact of migration and globalisation

The migration of Pacific peoples to New Zealand, globalisation and urbanisation have brought changes to their lifestyle and diet that have precipitated an epidemic of obesity and a higher prevalence of non-communicable diseases among Pacific peoples compared to New Zealand Europeans (Ministry of Health 1997; Tukuitonga and Finau 1997; Ministry of Health 1999a; Public Health Commission 1994).

The importation to the Pacific of high-fat-content and poor-quality meats, especially corned beef, *povi masima*, mutton flaps, chicken parts and refined carbohydrates, has significantly contributed to the high rates of non-communicable diseases among Pacific peoples. The increased reliance on imported foods has meant that a Western diet with fast food of poor nutritional value has replaced the healthier traditional diet (WHO 2001b; Zimmet 2000). These dietary changes include an increase in the proportion of energy supplied by fats, animal proteins and refined carbohydrates; a higher intake of sodium and cholesterol; a decrease in energy provided by unrefined carbohydrates; and lower intake of dietary fibre in New Zealand than in the Islands (Ministry of Health 1997; Simmons, 1996; Tukuitonga and Finau, 1997; Public Health Commission 1994). A sedentary lifestyle and factory work in the new environment have replaced the more physically strenuous agricultural jobs in the Islands (Simmons et al 1994a).

Burden of disease

Pacific peoples are over-represented in the non-communicable-disease morbidity and mortality data in New Zealand. Pacific peoples are more than twice as likely to have been diagnosed with type 2 diabetes, and are diagnosed at a younger age than European New Zealanders (Ministry of Health 1999b). Pacific peoples have multiple cardiovascular risk factors compared to European New Zealanders (Bullen et al 1996). This is consistent with New Zealand Health survey findings that people in lower socioeconomic groups are more likely to have two or more cardiovascular risk factors (Ministry of Health 1999b).

Food and culture

Food has a central role in the life of Pacific peoples, and plays an integral part in all major occasions. Pacific peoples tend to see food as something to enjoy rather than as a source of nutrients needed to stay healthy. Certain traditional foods may lack nutritional value but have significant cultural value. Food is a vehicle to show love and respect, to express hospitality and to bring people together. Feasting is an important cultural ritual in Pacific communities: it serves as a venue for family, community and social exchange. It is considered hospitable to offer ample food to guests. In return the guests demonstrate their appreciation by consuming as much food as possible (Ministry of Health 1997; Hodge et al 1996; Moata’ané 1999).
Nutrition

The 1997 National Nutrition Survey found that compared to New Zealand Europeans and other ethnic groups, Pacific peoples were the least likely to meet the recommendations for fruit and vegetables consumption. High cost was the main barrier to increased consumption of fruit and vegetables (Russell et al 1999).

Food security

The survey showed that Pacific peoples and those living in more deprived areas were more likely to have poor nutrition, and to not be meeting the Food and Nutrition Guidelines. Fifty percent of Pacific people report running out of food or being unable to eat properly because of lack of money (Russell et al 1999). Food demand is income-sensitive among low socioeconomic groups. They struggle to obtain adequate good-quality food and their diet tends to be energy dense with a high saturated fat intake. Vegetables, fruit and whole-grain cereals are eaten more sparingly because they are perceived to be more expensive.

Obesity

In the recent past, obesity among Pacific populations was traditionally regarded as a symbol of high social status and prosperity. Among Pacific peoples obesity has been shown to be positively and independently associated with age, urban residence, high occupational status and higher educational attainment (Hodge et al 1996). The 1997 Survey found that Pacific peoples were likely to be more overweight or obese than New Zealand Europeans. The risk for developing obesity was also associated with deprivation, and obesity is more prevalent in Pacific women (47 percent) than in men (26 percent) (Russell et al 1999).

Physical activity

Thirty-seven percent of Pacific people were considered physically inactive compared to 32 percent of New Zealand Europeans and Māori (Tobias and Hogden 2002).

Physical activity among Pacific peoples has declined dramatically with urbanisation. The marked reduction in the number of people involved in manual farming and fishing has led to a more sedentary lifestyle. Factory work in the new environment has replaced the more physically strenuous agricultural and manual jobs in the Islands (Simmons et al 1994).

Effective interventions

Initiatives to encourage improved nutrition, increased physical activity and weight control among Pacific communities have had variable outcomes. The programmes targeting Pacific peoples have been largely unco-ordinated and ad hoc.

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18 Overweight is defined as a body mass index (BMI) between 25 and 30 for New Zealand European and Others; between 26 and 32 for Māori and Pacific peoples.
The most successful initiatives have been community-based, incorporated multiple interventions and were specifically designed for, and delivered by, Pacific people for Pacific peoples within the context of their cultural values, beliefs and social environment (Swinburn et al 1997b; Finau 1995; 1996).

The key to successful and sustainable Pacific initiatives was the recognition that community groups play a key role in the success of the programmes. As a result, strong links were established early between the programme and community structures such as Pacific churches and community leaders (Swinburn et al 1997b; Finau 1996). The Ola Fa’autauta Project (Samoan Lifewise Project) is an example of such collaboration, where the important role and place of the church in Pacific peoples’ lives were acknowledged and utilised for maximum community benefit (Swinburn et al 1997b). The church has become a ‘substitute Pacific village’ for Pacific migrants (90 percent belong to a church), and it provides an effective avenue whereby Pacific communities can be engaged in the planning and delivery of health promotion and health services (Finau 1996). Key church ministers have been instrumental in influencing Pacific peoples’ behaviour and practice regarding food and feasting. Some churches have effectively adopted salads and healthier food alternatives, replacing the regular feasts laden with roast pigs and high-fat foods. Health providers and community groups have partnered to introduce church-based aerobics and walking programmes, which have been successfully taken up by adults and older people. Similar community-based initiatives need to be promoted and tailored to meet the needs of Pacific youth.
References


Ministerial Taskforce on Sport, Fitness and Leisure. 2001. *Getting set for an active nation.*


## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal obesity</strong></td>
<td>Accumulation of fat around the abdomen. This form of obesity is most associated with adverse health outcomes.</td>
</tr>
<tr>
<td><strong>(ANA) Agencies for Nutrition Action</strong></td>
<td>A non-governmental organisation, with members comprising the National Heart Foundation, the Cancer Society of New Zealand, the Nutrition Foundation, New Zealand Dietetic Association, Diabetes New Zealand, and Te Hotu Manawa Māori. The Ministry of Health and the Sport and Recreation Agency are observers. The mandate of ANA is to serve as a body that has a united voice on key nutrition and physical activity issues in New Zealand, with a key focus on the importance of maintaining a healthy body weight.</td>
</tr>
<tr>
<td><strong>ANZFA (Australia New Zealand Food Authority)</strong></td>
<td>The joint Australian – New Zealand regulatory body with the key function of developing and maintaining joint food standards for Australia and New Zealand.</td>
</tr>
<tr>
<td><strong>Adult</strong></td>
<td>A person aged 18 to 65 years.</td>
</tr>
<tr>
<td><strong>(BMI) Body mass index</strong></td>
<td>An indicator of body fatness. It is calculated from the formula: weight/height, where weight is in kilograms and height is in metres.</td>
</tr>
<tr>
<td><strong>By Pacific for Pacific</strong></td>
<td>Programmes delivered by Pacific providers specifically targeting Pacific communities.</td>
</tr>
<tr>
<td><strong>Calcium</strong></td>
<td>A mineral that is essential for building strong bones and teeth. The most common dietary source is milk and milk products.</td>
</tr>
<tr>
<td><strong>Cardiovascular disease</strong></td>
<td>Diseases of the heart and blood vessels.</td>
</tr>
<tr>
<td><strong>Child</strong></td>
<td>A person aged between 3 and 14 years of age.</td>
</tr>
<tr>
<td><strong>Cholesterol</strong></td>
<td>A fat-like steroid found in animal fats, oils, bile, brain tissue, milk, egg yolk, nerve myelin, liver, kidneys and adrenals. Mostly synthesised in the liver, it is important in the synthesis of steroid hormones and bile acids.</td>
</tr>
<tr>
<td><strong>Cohort study</strong></td>
<td>A study of a population group who are followed over a period of time to ascertain incidence of a particular disease or condition.</td>
</tr>
<tr>
<td><strong>Community action</strong></td>
<td>Action focused on the implementation of initiatives and programmes within a community to address specific health and other outcomes identified by a community, related to particular health topic(s); for example, physical activity, nutrition and healthy weight.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Community development</td>
<td>‘The process of organising and/or supporting community groups in identifying their health issues, planning and acting upon their strategies for social action/social change and gaining increased self-reliance and decision-making power as a result of their activities’ (Labonte 1993).</td>
</tr>
<tr>
<td>Confounding</td>
<td>The situation where the measure of the effect of an exposure on risk is distorted because of an association of the exposure with other factors (confounders) that influence the outcome of interest.</td>
</tr>
<tr>
<td>Contaminants</td>
<td>Substances either naturally occurring in foods or purposely or inadvertently added to foods at any stage along the food chain.</td>
</tr>
<tr>
<td>Convenience foods</td>
<td>These include takeaways and pre-prepared foods.</td>
</tr>
<tr>
<td>DHBs (District Health Boards)</td>
<td>Organisations established to protect, promote and improve the health and independence of geographically defined populations. Each DHB will fund, provide (or ensure) the provisions of health and disability services for its population.</td>
</tr>
<tr>
<td>Diabetes Type 1 (also referred to as IDDM – insulin-dependent diabetes mellitus)</td>
<td>caused by the destruction of insulin-producing cells, resulting in insulin deficiency.</td>
</tr>
<tr>
<td>Diabetes Type 2 (also referred to as NIDDM – non-insulin-dependent diabetes mellitus)</td>
<td>of unknown cause but associated with a combination of insulin resistance and a relative insulin deficit. The major risk factors for type 2 diabetes are obesity, increasing age, physical inactivity, and nutritional factors such as high intake of saturated fats. Type 2 diabetes makes up about 85–90 percent of all diabetes in developed countries.</td>
</tr>
<tr>
<td>Dietary supplements</td>
<td>Food supplements in the form of tablets/liquids or powders that may be consumed in addition to the diet to supplement intakes of vitamins, minerals, herbs or other substances.</td>
</tr>
<tr>
<td>Disability</td>
<td>Any self-perceived limitation in activity resulting from a long-term condition or health condition, lasting or expected to last six months or more and not completely eliminated by an assistive device.</td>
</tr>
<tr>
<td>Exclusive breastfeeding</td>
<td>Feeding of breast milk only, without water, medications or any other substances.</td>
</tr>
<tr>
<td>Exercise</td>
<td>A subset of physical activity that is distinguished by being done to improve or maintain physical fitness or health. Exercise can be done at a variety of intensities but often means vigorous activity. It can include moderate-intensity (brisk) walking.</td>
</tr>
<tr>
<td>Folate/folic acid</td>
<td>A vitamin of the B group essential for cell division, growth and red blood cell formation. The term ‘folate’ is a generic name for folic acid (pteroyl monoglutamic acid) and related polyglutamate compounds which exhibit the biological activity of folic acid.</td>
</tr>
<tr>
<td>Fono</td>
<td>A gathering.</td>
</tr>
</tbody>
</table>
Food Balance Sheets  National accounts of the annual production of food, changes in stocks, imports, exports and distribution of food within the country (prepared by Statistics NZ).

Food banks  Collections of food that are distributed to those who are unable to purchase enough food for themselves and their families. Most food banks are run by volunteer groups.

Food security  Reliable access, in economic and practical terms, to the food needed for a healthy life for all members of the household (adequate in quality, quantity, safety and cultural acceptability).

Fortified foods  Foods that have had nutrients added, usually vitamins and minerals, during manufacture. The types and amounts of these are specified in food legislation.

Full breastfeeding  Feeding of breast milk, water and medication, but not other substances.

Functional foods  Foods similar in appearance to conventional foods but which have been modified to have benefits beyond the provision of simple nutrient requirements.

Glycaemic index (GI)  ‘the incremental area under the blood glucose response curve of a 50 g carbohydrate portion of a test food, expressed as a percent of the response to the same amount of carbohydrate from a standard food (either white bread or glucose), taken by the same subject’.

Hapū  social and political unit made up of several whānau sharing common descent

Health impact assessment  Any combination of procedures or methods by which a proposed policy or programme may be judged on the effects it may have on the health of a population.

Hillary Commission (Sport and Recreation Agency)  The government body responsible for sport and recreation in New Zealand; to be disestablished and reconstituted as part of the Sport and Recreation Agency in 2002.

Host responsibility  A broad set of strategies designed to create safer drinking environments. The concept originated in the United States, where it is known as server intervention.

Hyperlipidaemia  Raised levels of fat in the blood.

Hypertension  Raised blood pressure.

Hui  A gathering.

IDDM  See diabetes type 1.
**Inactive**
In the context of physical activity, refers to two categories of inactivity of those surveyed over a seven-day period. Participants stated either that they did no activity (sedentary) or some activity (relatively inactive) but less than the recommendation of 30 minutes’ moderate-intensity physical activity contained in the *New Zealand Physical Activity Guidelines* on most, if not all, days of the week (Hillary Commission 2001).

**Infants**
Children aged less than 12 months.

**Iodine**
An essential micronutrient, where deficiency may result in an enlarged thyroid gland (goitre).

**Iwi**
A social and political unit made up of several hapū sharing common descent; Māori tribe or nation.

**Kai**
Food.

**Kai moana**
Sea food (fish and shellfish).

**Kaumātua**
Wise and experienced older members of the whānau, usually over 55.

**Kohanga reo**
Māori-language ‘nests’ – a movement established by Māori to teach the Māori language to Māori children.

**Micronutrients**
The essential nutrients, which include vitamins and minerals and are usually required in small quantities.

**Moderate-intensity physical activity**
The main physical activity population health message recommends 30 minutes of moderate-intensity physical activity on most, if not all, days of the week to benefit health, as recommended in the *New Zealand Physical Activity Guidelines*.

**New Look Health Clinics**
Health clinics offering services to improve general wellbeing, appearance and energy. Services offered include a range of counselling, diet therapy and physical activity recommendations. These clinics may also use dietary supplements, herbs and alternative therapies.

**New Zealand Food and Nutrition Guidelines**
The Ministry of Health’s guidelines on nutrition for key population groups in New Zealand. They include recommendations for: infants and toddlers; children; teenagers; adults; pregnant and breastfeeding women; and older people.

**NGOs (non-governmental organisations)**
Organisations that do not receive direct funding from government but are not solely industry funded either.

**NIDDM**
See diabetes type 2.

**Non-communicable diseases**
Those diseases that cannot be transmitted from one person to another. They can be referred to as lifestyle diseases, and include obesity, hypertension, diabetes, cardiovascular disease and gout.
Non-recreational physical activity | Includes active commuting (physical activity as a form of transport), and incidental activity (such as climbing stairs at work, household domestic activity such as washing windows, the car)
---|---
Nutrients | Food components essential to support human life.
NZDep96 | This is an index of deprivation based on the residential address of the individual used by the National Nutrition Survey 1997. The index is based on eight dimensions of deprivation: income, access to a car, living space, home ownership, employment, qualifications, support, and access to a telephone. Quartile I is defined as individuals living in the least deprived areas and quartile IV as individuals living in the most deprived.
Obesity | This has been defined as a BMI ≥ 32 for Māori and Pacific peoples and a BMI ≥ 30 for all other New Zealanders.
Osteoporosis | A reduction in bone mass, resulting in risk of fracture.
Ottawa Charter | The Charter developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986. This Charter defines health promotion as the process of enabling people to increase control over, and to improve, their health.
Overweight | This has been defined as a BMI ≥ 26 and < 32 for Māori and Pacific peoples and a BMI ≥ 25 and < 30 for all other New Zealanders.
Partial breastfeeding | Continuation of breastfeeding along with either infant formula and/or solids.
Personal health services | Services offered on an individual basis. Includes most treatment services, and one-on-one visits to GPs and other health professionals.
Physical activity | Any bodily movement produced by skeletal muscles that results in energy expenditure. It can be analysed in terms of duration, frequency, intensity, type and context.
Povi masima | Salted meat. The meat is usually chunks of mainly fat, bone and gristle with very little red meat. The meat is put into brine in plastic buckets. *Povi or puli masima* is high in fat. Salted beef originated from England and was introduced by European missionaries and settlers.
Pre-prepared foods | Foods that have been manufactured to be partially prepared to enable easy and quick preparation of the final product. They may require the addition of some other ingredients, or just particular heating and serving steps.
Prevalence | The number of instances of a given disease or other condition in a population at a designated time. Prevalence includes both new (incidence) and existing instances of disease.
Primary health care  Usually the health services of first point of contact, based around key health practitioners or providers such as GPs, and generally community-based, but can include hospitals and other health services. Can also refer to essential health care made universally attainable to individuals and families in the community, by means acceptable to them.

Public health services  Services offered on a population basis. These include all programmes, interventions, policies and activities that improve and protect the health of individuals and the community. Public health services intervene at the population or group level, as distinct from the individual personal health services.

Push Play  A Hillary Commission national social marketing campaign encouraging New Zealanders to do at least 30 minutes of moderate-intensity physical activity on most, if not all, days of the week. Supported regionally and locally by regional sports trusts and community partners.

Rangatahi  Young Māori, usually between 13 and 24 years.

Recommended dietary intakes (RDIs)  Recommended levels of nutrient intake based on basal, average or low-risk requirements.

Riboflavin  An essential B-group vitamin (B₂), required for the growth and repair of tissues, including skin and eyes.

Risk factor  An aspect of personal behaviour or lifestyle, an environmental exposure, or an inherited characteristic that is associated with an increased risk of a person developing a disease.

Saturated fat / fatty acids  Fatty acids with no double bonds. Many saturated fats / fatty acids tend to raise levels of blood cholesterol. They are common in animal fats, coconut and palm oil.

Secondary health care  Specialist care that is typically provided in a hospital setting.

Sedentary  No physical activity in the past seven days.

Selenium  An essential trace element for humans and animals which is in short supply in the New Zealand environment.

Smokefree  Government-funded initiatives to reduce the incidence of smoking in New Zealand. A number of key strategies have been undertaken, including legislative measures to ensure that public places are ‘smokefree’.

Social marketing  A multi-media approach to the marketing of key social issues.

Takeaways  Foods that are purchased in a ready-to-eat form. They tend to be high in fat and salt. Examples include fish and chips, hamburgers, fried chicken and chips, pizzas, Chinese takeaways.
<table>
<thead>
<tr>
<th>Term</th>
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<tbody>
<tr>
<td>Tamariki</td>
<td>Māori children 0 to 12 years.</td>
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<tr>
<td>Tertiary health care</td>
<td>Very specialised care, often only provided in a small number of locations.</td>
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<tr>
<td>Te reo</td>
<td>Language (usually used for the Māori language).</td>
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<tr>
<td>Treaty of Waitangi</td>
<td>New Zealand’s founding document, which establishes the relationship between</td>
</tr>
<tr>
<td></td>
<td>the Crown and Māori as tangata whenua, and requires both the Crown and</td>
</tr>
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<td></td>
<td>Māori to act reasonably towards each other and with utmost good faith.</td>
</tr>
<tr>
<td>Toddlers</td>
<td>Infants aged from 1 to 2 years of age.</td>
</tr>
<tr>
<td>Total Diet Survey</td>
<td>A periodic survey undertaken in New Zealand which assesses the potential</td>
</tr>
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<td></td>
<td>exposure to contaminants and some nutrients in the food supply.</td>
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<tr>
<td>Vigorous activity</td>
<td>The <em>New Zealand Physical Activity Guidelines</em> define vigorous exercise as</td>
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<td></td>
<td>activity that makes people breathe hard or 'puff'.  For young adults, it is</td>
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<td></td>
<td>activity requiring seven times as much energy as rest, or greater;</td>
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<tr>
<td></td>
<td>equivalent to jogging.</td>
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<tr>
<td>Vitamin A (retinol)</td>
<td>An essential fat-soluble vitamin that helps the body fight infections.</td>
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<tr>
<td>Wānanga</td>
<td>Māori tertiary institution.</td>
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<tr>
<td>Walking school bus</td>
<td>A concept to encourage children to walk to school, whereby a parent or</td>
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<td></td>
<td>adult is the ‘bus driver’ and collects children from designated points on</td>
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<tr>
<td></td>
<td>the way to school and walks with them to school, or home from school.</td>
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<tr>
<td>Whānau</td>
<td>Relationships that have blood links to a common ancestor; extended family.</td>
</tr>
<tr>
<td>Young people</td>
<td>People aged 15 to 24 years (see also rangatahi).</td>
</tr>
</tbody>
</table>