

Examining Healthy Eating and Physical Activity Programmes in Māori and Pasifika Communities in Aotearoa

Prepared by
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“Ehara taku toa, he taki tahi, he toa taki tini”¹

My success should not be bestowed onto me alone, as it was not individual success but success of a collective

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¹ Māori Whakataukāki (Proverb), Author Unknown

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I tried to do my best, but if I didn’t get it right, blame no one else but me.

EXECUTIVE SUMMARY

This report provides observations, insights, learnings and recommendations based on my six-month examination of the New Zealand government's implementation of healthy eating and physical activity programmes in Māori and Pasifika communities. The viewpoints expressed come from a synthesis of literature review, site visits and key informant interviews, and establishes a context for later observations and recommendations.

According to the World Health Organization (WHO), unhealthy diets and physical inactivity are the leading causes of the major non-communicable diseases, including type 2 diabetes and heart disease.²

When I arrived in Aotearoa New Zealand in January 2010, I proposed to use my Ian Axford Public Policy Fellowship to examine the implementation of the Ministry of Health's Healthy Eating-Healthy Action national strategy (HEHA). HEHA was launched in 2003 to address the increasing prevalence of non-communicable diseases such as type 2 diabetes, heart disease and cancer in Aotearoa New Zealand (note: Aotearoa is also used to refer to New Zealand throughout this report). I was particularly interested in determining to what extent environmental change (i.e. local food systems and physical activity environments) rather than individual behaviour changes were emphasised, and how the implementation of HEHA differed in Māori and Pacific communities.

However, upon my arrival in Aotearoa, I discovered that HEHA had been significantly curtailed with the change in government following the 2008 elections. The HEHA Sector Steering Group was disbanded, much of the funding was shifted away from HEHA to primary care and sports programmes, and many HEHA staff and projects were disestablished. I found myself in the position of coming halfway around the world to examine a programme that no longer 'officially' existed. Yet, as is the case with large government bureaucracies, once a funding pipeline has opened it is difficult to immediately stop the flow of resources. Thus many HEHA projects were continuing in communities, and although government priorities had shifted there was significant funding still in the pipeline for nutrition and physical activity programmes.

Therefore, I decided to focus on projects that were still being implemented and try to determine what, if anything, would continue in Māori and Pacific communities once the HEHA funding pipeline closed. I discovered a lot of similarities in community contexts for the work happening in New Zealand and the US, and worked to understand how cultural differences shaped those contexts. In the process I came to appreciate the strengths inherent in, and challenges faced by, New Zealand indigenous and immigrant communities attempting to change their environments to support healthier lifestyles.

Throughout my time in New Zealand, I also presented my work to policy-makers, community members, and health officials through relevant meetings, presentations, and conferences. These presentations provided an important "reality check", and helped me interpret my experiences.

² World Health Organization (2003) no.E113/44 Add.1.

This report briefly describes the evolution and devolution of HEHA; provides current data on Māori and Pacific health; presents snapshots of contextual issues such as colonisation, immigration, and culture that affect eating and physical activity in indigenous and immigrant communities; discusses the role that a social determinants of health approach can play in reducing inequities, documents existing policy reports and strategies that address eliminating health inequities; and concludes with a series of observations and recommendations for improving policy implementation practice for healthy eating and physical activity community programmes.

My scan of community projects revealed that there were numerous projects engaging Māori and Pacific communities, but most were focused on individual behaviour change and promoting community education. Only a few Māori (and none of the Pacific) projects were working “to build healthy public policy”. Based on my analysis and past experience, I observed that:

- monitoring and evaluation systems need to include a component that annually assesses the alignment of governmental spending to priority populations; and tracks changes in measurements of health equity over time and place to help identify the impact of policies and practices
- policy implementation needs to more completely align with Māori and Pacific engagement and development principles
- environmental change approaches should expand to include social justice and food security
- Community Action Projects current funding levels are too low and not sustainable, oversight and governance are often driven by district health boards (DHBs) and government priorities rather than community wisdom
- Community Action Projects are too heavily focused on individual behaviour change
- Māori and Pacific nutrition and physical activity workforce levels need to increase
- Māori and Pacific youth and adolescents should be more engaged in programmes
- the level of cultural-specificity could improve (especially in Pacific projects)
- emphasis on obesity prevention and weight loss can lead people to engage in ineffective and potentially dangerous interventions to lose weight
- the concept of physical activity needs to broaden to include issues related to built environments and life-long physical activity skill-building
- physical activity programming (especially in Māori projects) focuses too heavily on competitive sports and games
- an opportunity is lost by not expanding New Zealand’s “clean and green” brand to include a health component (e.g. access to healthy foods and built environments).

Recommendations

The key audiences for these recommendations are community leaders, Ministry of Health (MoH) professionals, non-governmental organisations (NGOs), and government officials interested in practical suggestions and strategies for ensuring that current and future healthy eating and physical activity programmes in Aotearoa better serve Māori and Pacific communities. In addition to the general policy recommendations listed below, the report includes two annotated PowerPoint presentations tailored to Māori and Pacific community providers.

Realign Government's Role:

- “Just implement it!” Resist the urge to conduct more studies; instead work on the challenges involved in implementing quality, culturally relevant healthy eating and physical activity programmes in the Māori and Pacific communities that suffer disproportionately from health inequities.
- Set aside funding for Māori and Pacific providers in proportion to the level of health inequities.
- Allow Māori and Pacific communities to determine their own strategies for how to implement local healthy eating and physical activity programmes.
- Establish monitoring and evaluation systems that include a component which annually assesses the alignment of governmental spending to priority populations, and tracks changes in measurements of health equity over time and place.
- Allocate funding to support community organisations so that they can attend coordination and strategy development meetings.

Use Cultural Frameworks and Specificity:

- Utilise Whānau Ora-centred initiatives to improve healthy lifestyles by working with Māori (and Pasifika) providers and communities to develop healthy eating and physical activity whānau (family) outcomes.
- Develop materials in language rather than creating adaptations, and vary the messages and themes depending on the audience (e.g. Samoan, Tongan, Māori, and youth).
- Embrace oral and visual educational tools – storytelling, whakapapa, proverbs, Māori TV – using concrete examples to convey messages about the history and value of healthy eating and activity for Māori and Pacific peoples.

Adopt Health at Every Size:

- Adopt a Health at Every Size (HAES) approach to shift emphasis away from weight loss to chronic disease prevention and physical, mental well-being, and remove weight stigma.

Go Beyond Sports and Promote Physical Activity:

- Support creation, rehabilitation, and maintenance of parks, playgrounds, and recreation facilities in low-decile areas and offer quality programming to encourage and promote physical activity.

- Develop guidelines for implementing physical activity programmes (e.g. include non-competitive examples, movement by all).

View Healthy Lifestyles as a Vehicle for Māori and Pacific Workforce and Community Development:

- Create more pathways for Māori and Pacific youth and community members to enter the nutrition and physical activity workforce (e.g. remove barriers such as the only nutrition internship being in Dunedin at the University of Otago).
- Establish and support Māori and Pacific scholarship and internship programmes.
- Actively involve community members in monitoring and evaluation activities.
- Strengthen and ensure inclusion of the voice of Māori and Pacific peoples in social development policies and programmes that affect their lives at the national, regional and local levels.
- Empower Māori and Pacific peoples to develop their organisational and management capacity to operate community-based and faith-based programme delivery systems and services.
- Train and promote Māori and Pacific professionals in the areas of nutrition, physical activity, evaluation and culinary arts.

Get Youth Involved:

- Youth providers should be engaged to incorporate healthy eating and physical activity into existing youth programmes and projects (e.g. holiday and after school programmes, youth leadership, alcohol and drug prevention).

Work with the NGO Sector:

- Develop a strategy to obtain funding to support healthy lifestyle programmes by working with community and family trusts and foundations (e.g. J. R. McKenzie Trust focusing on Māori well-being, ASB Trust and Pacific and Māori educational achievement, Vodaphone Foundation and at-risk youth) .
- Use a community-based participatory research (CBPR) model to equitably involve Māori and Pacific NGOs as partners and research participants with a research topic of importance to the community.

Emphasise Environmental Change:

- Work in coalition with other Pacific countries and territories to develop a regional food and trade policy (e.g. WHO 2-1-22 Plan) that supports health.
- Work with district health boards (DHBs), local councils, and the Ministry of Tourism to create, support and promote healthy communities (e.g. access to healthy foods and built environments).

Strategies for Community Programmes:

- Develop interventions that work outside of church and marae settings,

especially for youth.

- Monitor government's role (i.e. funding, training, evaluation, community-based participatory research, workforce development) in providing resources to Māori and Pacific organisations.
- Share knowledge and collaborate and coordinate with other Māori and Pasifika organisations to optimise value and reduce duplication.
- Support the organisation of national and regional nutrition and physical activity networks and coalitions.
- Hold DHBs, primary health organisations (PHOs), and the MoH accountable for addressing the nutrition and physical activity needs of Māori and Pacific people.
- Advocate for healthy food and physical activity opportunities at church, in the workplace, and within whānau.

It is my hope that I have been able to provide some insight by comparing what I saw in New Zealand with my experiences providing training and technical assistance to communities in the US that are implementing similar projects. I believe that lessons learned from this project can inform community practice and policy implementation in and for Māori and Pasifika communities in New Zealand. I hope they will also help US government and philanthropic institutions develop policy strategies that can be adapted to eliminate health inequities between US American Indian, Latino, Black American and other ethnic communities.

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PREFACE

“Ko te pae tawhiti whaia kia tata”³

Seek out the distant horizons, and cherish those that you attain

Best Laid Plans...

Once sound public policies are developed, how can they be implemented in equitable ways that eliminate health inequities?

I have been trying to answer that question for the past 16 years by working at the heart of the movement to improve healthy eating and physical activity environments in low-income communities of colour. I come to this work as a Black American woman who grew up poor and working class in the heartland of the US. I was raised in a large extended family on a steady diet of soul food – greens, fruit, pork, chicken, and potatoes – a diet not unlike that found in many parts of the Pacific. After university I moved to a small island off the Eastern US and pursued work as a restaurant chef and organic farmer, learning to grow and cook all types of food. This love of food and community motivated me to go back to school to study nutrition and public health. From grassroots to government, I have worked with community-based and youth-serving organisations to raise-up local solutions and support the development of culturally competent nutrition and physical activity policies and practices.

According to the World Health Organization (WHO), unhealthy diets and physical inactivity are the leading causes of the major non-communicable diseases, including type 2 diabetes and heart disease.⁴ When I arrived in Aotearoa New Zealand in January 2010, I proposed to use the Ian Axford Public Policy Fellowship to examine the implementation of the New Zealand government’s Healthy Eating-Healthy Action national strategy (HEHA) in Māori and Pacific populations (with a particular focus on adolescents and their families). HEHA was launched in 2003 to address the increasing prevalence of non-communicable diseases such as type 2 diabetes, heart disease and cancer in Aotearoa New Zealand. I was particularly interested in determining to what extent environmental change (i.e. local food systems and physical activity environments) rather than individual behaviour changes were emphasised; and how the implementation of HEHA differed in Māori and Pacific communities. I wanted my project to focus on policy implementation issues, and assess: what worked, what did not work, and reasons why implementation succeeded, failed or faltered. My objectives were to determine the level of engagement of local indigenous communities, particularly low-decile communities, in the implementation of HEHA; and to assess the integration of HEHA strategies with the food systems and built environment of Māori and Pacific communities. I had hoped to share my experiences in implementing and evaluating community interventions in ethnic communities within the United States with New Zealand government officials, community providers, and with the HEHA Sector Steering Group that was established to advise the Ministry of Health (MoH).

However, upon my arrival in Aotearoa I discovered that the HEHA national strategy

³ Māori Proverb, Author Unknown

⁴ WHO (2003), no.E113/44 Add.1.

had been significantly curtailed with the change in government following the 2008 election. The HEHA Sector Steering Group was disbanded, much of the funding was shifted away from HEHA to primary care and sports programmes, and many HEHA staff and projects were disestablished. I found myself in the position of having come half-way around the world to examine a programme that no longer ‘officially’ existed. Yet, as is the case with large government bureaucracies, once a funding pipeline has opened it is difficult to immediately stop the flow of resources. Many HEHA projects were continuing in communities, and although government priorities had shifted, there was significant funding still in the pipeline for nutrition and physical activity programmes.

Therefore, I decided to focus on projects still being implemented and try to determine what, if anything, would continue in Māori and Pacific communities once the funding pipeline entirely closed. I discovered a lot of similarities in community contexts for the work happening in New Zealand and the US, and worked to understand how cultural differences shaped those contexts. In the process I came to appreciate the strengths inherent in, and challenges faced by New Zealand indigenous and immigrant communities attempting to change their environments to support healthier lifestyles.

It is my hope that I have been able to provide some insight by comparing what I saw in New Zealand with my experiences providing training and technical assistance to communities in the US that are implementing similar projects. I believe that lessons learned from this project can inform community practice and policy implementation in and for Māori and Pacific communities in New Zealand. I hope they can also help US government and philanthropic institutions develop policy strategies that can be adapted to eliminate health inequities between US American Indian and other ethnic communities.

INTRODUCTION

“Ko au ko koe, ko koe ko au”⁵

I am you, and you are me

⁵ Māori Proverb, Author Unknown

1. NUTRITION AND PHYSICAL ACTIVITY IN AOTEAROA

This report provides observations, insights, learnings and recommendations based upon my six-month examination of the New Zealand government's implementation of healthy eating and physical activity programmes in Māori and Pacific communities.

I engaged in the following process to develop my findings:

- reviewed current and archival documents and websites on HEHA, Māori health, and Pacific health
- conducted literature reviews on Pacific and Māori populations, culture, obesity prevention, eating, physical activity, and community development
- enrolled in 16 weeks of te reo Māori classes
- attended national, regional and local hui and fonoj
- interviewed over 100 people from government, district health boards (DHBs), non-governmental organisations (NGOs), Crown entities, primary care organisations, Māori and Pacific providers and policy-makers, academia, and local communities⁶
- visited Taranaki, Hutt Valley, Northland, the Hokianga, Rotorua, Tairāwhiti, Christchurch, and Auckland where I assessed the nutrition and physical activity environment, and met with representatives from community nutrition and physical activity projects
- met with my agency mentor (Dr Colin Tukuitonga) and academic advisors (Dr Sue Crengle and Dr Paparangi Reid) regularly to discuss issues, findings and community and political contexts.

Throughout my time in Aotearoa I also presented my work to policy-makers, community members, and health officials through relevant meetings, presentations, and conferences (see Appendix 4). These presentations provided an important reality check, and helped me form reasonably accurate interpretations for what I was experiencing.

Significance of Project to New Zealand

As the New Zealand central government attempts to ameliorate health inequities, it may be helpful for New Zealand planners and health officials to learn how the implementation of a well-designed national strategy (HEHA) to address unhealthy eating and physical inactivity was carried out in Māori and Pacific communities. This information could lead to mid-course corrections, be useful for conducting outreach to other communities in New Zealand, and/or lead to shifts in policy implementation practice.

Significance of Project to US

New Zealand is a world leader in addressing the rights of its indigenous peoples through the Treaty of Waitangi, and in developing policies for culturally competent health services. Policy-makers in the US can learn a great deal from a racial analysis

⁶ In order to preserve confidentiality I promised all respondents that interview comments would be presented anonymously.

of New Zealand's approach to addressing health inequities and prevention of non-communicable diseases. New Zealand models of comprehensive, government-driven prevention activities in high-risk communities will be of tremendous interest to US planners, policy-makers and philanthropies, especially with the current focus of the Obama administration on childhood obesity prevention.

Comparisons and Contrasts

“New Zealand is a small society that can make change easily”⁷

Although it is more than 10,000 kilometres away from my home state, New Zealand and California share numerous similarities – climate, inspiring landscapes, a local film-making industry, wine-growing, progressive politics, and an agricultural economy. However, when looking at size and population, the similarities end, with New Zealand's 4.3 million residents living on a land mass roughly half the size of that supporting California's 43.4 million residents.⁸ Yet the state of California does share something else with the nation of New Zealand, and that is a social history based on original settlement by indigenous peoples who later had their land usurped, and current controversy with a distantly related transnational, immigrant population.

Although not entirely analogous, Māori in New Zealand can be compared with American Indians, and Pacific peoples can be compared with Latinos in the US. Both Māori and American Indians are indigenous peoples that are tribally organised, have a deep spiritual connection to the land, and have a strong history of resistance to cultural assimilation. While Latinos in the US, and Pacific peoples in New Zealand, share a history of being invited to immigrate to countries that needed a willing workforce, then being treated as though they had overstayed their welcome.

Figure 1: Demographic Comparison – American Indian – Māori

	CA (2007)	AZ (2008)	US (2007)	NZ (2006)
Population	285,162	318,509	2,419,895	565,329
% of total population	1.2%	4.9%	0.8%	15%

Source: US Census, NZ Census

Figure 2: Demographic Comparison – Pacific Peoples

	CA (2007)	HI (2007)	US (2007)	NZ (2006)
Population	262,000	269,000	1 million	266,000
% of total population	0.7%	21%	0.3%	6.9%

Source: US Census, NZ Census

⁷ Phillips (11 February 2010)

⁸ New Zealand has a land mass of 268,680 square kilometres; California's land mass is 423,970 kilometres.

Profound health inequities are common in the US. The complicated roots of such health inequities include many social factors (e.g. living environment, education, and employment) that disproportionately affect the health of poor and ethnic-minority populations. New Zealand is known throughout the world for its physical beauty, high environmental standards, and diverse, progressive society. Yet, even in ‘clean and green’ New Zealand, inequities in income, education, and health exist. As in the US, non-communicable diseases – heart disease, cancer, diabetes – are primary causes of death in New Zealand, and are the main determinants of inequities. However, in a comparison of New Zealand and US health indicators, inequities between indigenous and majority populations were more pronounced among Māori in New Zealand than among American Indian/Alaska Natives in the US.⁹

⁹ Bramley, D. et al (2005), p.850

2. WHAKAPAPA: HEHA EVOLUTION AND DEVOLUTION

“Sometimes our planning runs ahead of our ability to implement”

Chai Chuah, National Health Board – Liga Maopo Fono

New Zealand was one of the first countries in the world to develop a national, comprehensive strategy to decrease the risk factors associated with most non-communicable diseases. This strategy, which came to be known as Healthy Eating-Healthy Action (HEHA), was designed as a multi-sectoral framework to address New Zealanders at all levels of society. The HEHA strategy was conceptualised by the Ministry of Health (MoH) in 2003 and released in June 2004 with an implementation plan that covered 2004 to 2010. This section describes the evolution, structure, funding, and devolution of HEHA, and in the process illustrates features of the healthy eating and physical activity landscape for Māori and Pacific communities in New Zealand.

Evolution

HEHA was conceived under a Labour Party government with Ministers of Parliament Annette King (Health), Pete Hodgson (Health), Trevor Mallard (Sports and Recreation), and Steve Maharey (Education) taking leadership for ushering in the strategy. Other influential players included Don Matheson (Ministry of Health), Sue Kedgley (Green Party – responsible for establishment of Fruit in Schools), and Nanaia Mahuta (Minister of Youth Affairs). HEHA was one of the first MoH programmes to push public health to the district health board’s (DHB) planning and funding division, thus broadening the scope of DHBs to include primary prevention activities.¹⁰ Although there were healthy eating and physical activity programmes before HEHA, especially within Māori and Pacific communities (e.g. Let’s Beat Diabetes – Counties Manukau; Ngāti and Healthy – East Cape; Oranga Tu Tonu – Lakes DHB), HEHA served as a central government and MoH initiative that was meant to provide a framework to encompass new and existing programmes.¹¹ Refer to Table 1: HEHA Strategy Time Line for more information.

In attempting to address issues of health inequities, the *Māori Health Strategy: He Korowai Oranga* document was used by MoH to inform the design of the HEHA framework. However, there are differing opinions as to how effectively He Korowai Oranga principles have been incorporated into the HEHA Strategy’s Implementation Plan. Even though work was started on HEHA in 2002-2003, Pacific policy-makers at government departments were not consulted or involved with the development of the HEHA strategy until late 2006. Pacific engagement in HEHA was strengthened with the establishment of Community Action Projects (CAPs) in 2008. However, since CAPs were the first projects that specifically targeted funding towards the Pacific community, several DHBs struggled with effectively engaging these communities.¹²

¹⁰ Author interview, 27 March 2010

¹¹ Ibid.

¹² Author interview, 28 April 2010

Table 1: HEHA Strategy Time Line

Year	Month	Activities
2002	February	<i>Healthy Action – Healthy Eating Oranga Pumau-Oranga Kai: A Draft for Consultation</i> released by MoH
	December	Summary of feedback on draft strategy
2003	March	<i>Healthy Eating-Healthy Action Oranga Kai-Oranga Pumau: A Strategic Framework 2003</i> ; and <i>Healthy Eating-Healthy Action Oranga Kai-Oranga Pumau: A Background 2003</i> released by MoH
2004		Māori caucus convened to inform development of HEHA Implementation Plan (Caucus met three to four times, then disbanded in 2005)
	June	<i>Healthy Eating-Healthy Action Oranga Kai-Oranga Pumau: Implementation Plan: 2004-2010</i> released by MoH
	July	Tripartite Agreement signed between the MoH, Ministry of Education (MoE), and Sports and Recreation New Zealand (SPARC) (Agreement ended in 2007)
	September	Food Industry Accord signed
	October	External Coordination Group established
2004-05		Realignment of existing funding for nutrition and physical activity to meet actions outlined in the <i>HEHA Strategy for Implementation Plan</i>
2005	Term 4	Phase 1 of Fruit in Schools begins
2005-06		Allocation of the Cancer Control Action Plan funding for HEHA
2006	Term 2	Phase 2 of Fruit in Schools begins
	June	Permanent HEHA project team at MoH established
	September	Mission-On programme launched
	October	Crown Funding Agreements in place with DHBs for HEHA, including funding to support DHB project manager roles
	Term 4	Phase 3 of Fruit in Schools begins
2006-07		New ongoing funding allocated for HEHA
2007	January	DHB HEHA project manager positions established
	February	First meeting of Interagency Steering Group on HEHA
	March	<i>Healthy Eating-Healthy Action Oranga Kai-Oranga Pumau: Progress on implementing the HEHA Strategy 2007</i> released
	April	First DHB Ministry Approved Plans (MAPs) due with MoH for 2007-08 (first draft: final draft due in June following MoH feedback)
	May	<i>Feeding Our Futures</i> campaign launched by the Health Sponsorship Council (HSC) in partnership with Agencies for Nutrition Action (ANA)
	May	HEHA Community Action Plan funding announced in Budget (Māori and Pacific specific)
	May	Two clauses added to the National Administrative Guideline (NAG) 5 requiring boards of trustees to: “Promote healthy food and nutrition for all students; and where food and

		<i>beverages are sold on school premises, make only healthy options available.”</i>
	July	Breastfeeding campaign and Food and Beverage Classification launched
	August	Health Select Committee <i>Inquiry into Obesity and Type 2 Diabetes in New Zealand</i> released by Parliament
	November	<i>Government response to the Inquiry into Obesity and Type 2 Diabetes 2007</i> released
2007-08		Additional ongoing funding allocated to HEHA
2008	January	Establishment of DHB HEHA district coordinator positions
	April	Second DHB MAPs due with MoH for 2008-09
	May	Establishment of Sector Steering Group
	June	Development of HEHA network begins
	July	Launch of the first phase of the breastfeeding social marketing campaign
	November	<i>Healthy Eating-Healthy Action Oranga Kai-Oranga Pumau: Progress on implementing the HEHA Strategy 2008/09</i> released
	November	National Party-led government elected
2009	February	Removal of NAG 5 clause iii (“ <i>where food and beverages are sold on school premises, make only healthy options available</i> ”)
	June	Green Prescriptions to transfer from SPARC to MoH; other Mission-On programmes discontinued
		Funding for district coordinators, Mission-On and Feeding Our Futures ends
		Reductions in funding budgets for: Public Health Unit baseline nutrition and physical activity, DHB evaluation, Health Research Council (HRC) research partnerships
		Regional Child Nutrition fund (from Mission-On) merged with Community Action Initiative
		Budget savings from HEHA cuts transferred to Kiwisport Initiative

Adapted from HEHA Strategy Evaluation Interim Report, April 2009.¹³

Structure of HEHA

HEHA was driven nationally by the Ministry of Health (and by Sport and Recreation New Zealand (SPARC) for the physical activity-related actions) through internal and external HEHA coordination groups. Between 2004 and 2007 there was also a tripartite agreement between MoH, MoE, and SPARC to enhance coordination and alignment of initiatives and resources related to improving the health of students. Unfortunately, that coordination often didn’t trickle down to regional implementation.¹⁴

The original MoH HEHA project team included a Māori advisor and an analyst working on Pacific issues. The HEHA team also consulted with the Māori health and

¹³ HEHA Strategy Evaluation Interim Report (2009), p26

¹⁴ Author Interview, 27 April 2010

Pacific health policy units at MoH. The Sector Steering Group had representatives from Te Puni Kōkiri and the Ministry of Pacific Island Affairs, and implementation was guided by advice from Māori and Pacific caucuses and a youth advisory group. However, several informants commented that there was not a true partnership, stating: “It’s really difficult to be in partnership between the ministry and local communities...and we do rely on DHBs for that, and some DHBs are more successful than others.”¹⁵

HEHA stipulated six approaches for action:

1. build healthy public policy
2. create supportive environments (worked mainly in schools and early childhood education settings)
3. strengthen community action (focus of Māori and Pacific Community Action Projects)
4. develop personal skills
5. reorientate services and programmes
6. monitor, research and evaluate.

New Zealand’s 21 DHBs were funded through a mixture of DHB-controlled and direct MoH contracts to be regional coordinators and to mobilise community action around HEHA initiatives. The coordinating role for each DHB included establishing a project manager, a HEHA group to coordinate stakeholder agencies and an education sub-group; developing a ministry-approved district plan and communications plan; and providing a district coordinator to work with schools and early childhood centres. Within DHB control there were also many small projects funded through Nutrition and Community Action funds. However, of the 21 DHB HEHA project managers, only three identified as being Māori and none as Pacific, even though seven DHBs have a large Pacific population. Several interviewees mentioned that the understanding and commitment to the principles of He Korowai Oranga and Pacific engagement varied widely amongst HEHA project managers, who were the key drivers of implementation.¹⁶

MoH channelled most HEHA funding through DHBs’ Crown Funding Agreements, and established the new HEHA project manager and district coordinator positions in the planning and funding section of DHBs. This was a deliberate decision to ensure HEHA was incorporated within the planning and funding of every DHB, and was integrated across the whole continuum of health care from “primary prevention right through to secondary care”.¹⁷

There are also 12 regional public health units (PHUs) in New Zealand, each owned by and servicing one or more DHB areas. However, PHUs are funded directly by the MoH. Their work includes a nutrition and physical activity focus, which was realigned within their contracts to link with and support HEHA. For example, Fruit in Schools funding was channelled through PHUs. Thus DHBs were receiving two

¹⁵ HEHA Strategy Evaluation Interim Report (2009), p.51

¹⁶ Author interviews, 31 March 2010, 14 April, 2010

¹⁷ HEHA Strategy Evaluation Interim Report (2009), p.49

HEHA funding streams (through Crown Funding Agreements and to PHUs). Crown Funding Agreements require a return to Cabinet before reallocations of funding can be approved. This dual funding arrangement became an issue for many DHBs since it was hard to coordinate and to be responsive to community needs when budget modifications required Cabinet-level approval.

Funding and Staffing

Significant funding for HEHA was not obtained until the 2005-06 financial year. Prior to this, in 2004-05, existing funding for nutrition and physical activity (about NZ\$10 million) was realigned to meet actions mentioned in the HEHA Implementation Plan. In 2005-06, NZ\$7.2 million of the Cancer Control Action Plan funding package was allocated to implement the HEHA Implementation Plan. The funding covered four main work areas: Fruit in Schools; DHB Innovation Fund; public awareness campaign; and evaluation and research.¹⁸

Conservative estimates are that between 2005 and 2010, high-level funding for HEHA-related activities was around NZ\$328 million. Besides funding specifically allocated for HEHA through the MoH, there were a number of other sources of funding for HEHA initiatives. For example, SPARC, the ministries of Education, Social Development and Youth Development, national NGOs (e.g. National Heart Foundation), local NGOs, PHARMAC (the Pharmaceutical Management Agency of New Zealand), and the HRC all funded or supported HEHA-related activities. In addition, some primary health organisations (PHOs) fund HEHA initiatives from their health promotion or services to improve access capitation subsidies.¹⁹

Table 2: Total HEHA Funding 2005-2010 (NZ\$ million GST exclusive)

Source	2005-06	2006-07	2007-08	2008-09	2009-10	Total (million)	% of Total
HEHA Budget		19.033	31.483	41.496	40.646	132.658	40%
Cancer Control	7.2	7.9	7.9	7.9	7.9	38.8	12%
General Nutrition and Physical Activity (PHU)	13.211	15.598	17.818	19.076	17.576	83.28	25%
SPARC (contribution to Mission-On)		3.466	3.217	2.047	2.05	10.78	3%
MoE (contribution to Mission-On)		4.643	6.629	4.621	4.425	20.318	6%
PHARMAC (Green Rx)	0.6	0.6	0.6	0.6	0.6	3	1%
HRC	0.126	1.055	1.055	0.989	1.704	4.929	2%
Other	8.722	7.740	7.740	7.740	1.949	33.892	10%
Total	29.859	60.035	76.442	84.47	76.849	327.657	

Source: HEHA Strategy Interim Report²⁰

¹⁸ Ibid. p.215

¹⁹ HEHA Strategy Evaluation Interim Report (2009), p199

²⁰ HEHA Strategy Evaluation Interim Report (2009), p.215

Funding streams of money going into HEHA and other nutrition and physical activity programmes (includes access and health promotion).²¹

In 2006-07, the HEHA budget allocation grew to NZ\$40.144 million. In the 2007-08 budget it grew to \$56.44 million and the HEHA work programme included:

- sector capability and innovation (collaboration)
- leadership (internal, external coordination groups, and DHB infrastructure)
- Community Action Projects
- school and early childhood education
- breastfeeding
- communications
- primary health care (e.g. developing and implementing national guidelines for the management of people who are overweight or obese)
- industry (e.g. food product reformulation, advertising, and Children's Food Classification system)
- departmental expenditure (MoH project team)
- research, monitoring and evaluation.

A total of 74.5 full-time employees (FTEs) were employed to implement and coordinate HEHA at the MoH and regional DHB levels.²²

Healthy Eating

The HEHA Strategy Evaluation Interim Report examined 1,249 HEHA initiatives from 2003 to March 2009. Of the 423 projects for which funding information was available, 23 per cent of funding went to nutrition, 46 per cent to physical activity and 31 per cent to initiatives that covered both nutrition and physical activity.

The majority of HEHA projects that focused on healthy eating emphasised increasing fruit and vegetable consumption. Very few initiatives focused on decreasing sugary drinks, energy dense foods, high-fat foods, obesity or sedentary behaviour. The Fruit in Schools programme provided for the delivery of fruit to low-decile schools (i.e. schools which draw children from low socioeconomic communities); and established MoE National Administrative Guidelines (NAGs) to serve only healthy food in school canteens and to teach healthy eating in schools. Unfortunately community engagement activities were not funded as a part of the school initiative.

A NZ\$3.7 million national social marketing campaign 'Feeding Our Futures' was created to support parents and caregivers to adopt healthy eating practices. Three research projects were commissioned to inform the campaign: *Healthy Eating in NZ Families and Whānau*; the *NZ Children's Food and Drinks Survey*; and the *Parents and Caregivers' Campaign Survey*. This formative research provides ethnic and

²¹ Ministry of Health (2007), p.10

²² HEHA Strategy Evaluation Interim Report (2009), p. 218

income specific data on attitudes, behaviours, beliefs, and knowledge about healthy eating.²³ During its implementation phase, the Feeding Our Futures campaign consisted of radio, print and television media advertising that targeted parents and whānau with messages for providing healthy food to their children.

Healthy Action

The “Healthy Action” portion of HEHA was coordinated by SPARC, a Crown entity charged under the Sport and Recreation New Zealand Act 2002 with promoting, encouraging, and supporting physical recreation and sport in New Zealand. SPARC was a core HEHA partner agency and co-signatory of the original tripartite agreement that created HEHA. SPARC was also the lead agency for Mission-On, a NZ\$67 million (over four years) initiative created by five ministers from the Labour government (Sports, Education, Youth Development, Health, and Youth Affairs). Mission-On was charged with improving food and nutrition in schools and early childhood centres, student health promotions, and control of television advertising.

Most SPARC programmes (such as the Green Prescription (GRx) and GRx Active Families programmes that link primary care and community based activity initiatives) predated HEHA. Besides Crown funding, SPARC receives revenue from contracts (e.g. MoH, MoE) and funding from the New Zealand Lottery Grants Board. SPARC used to contract with 17 regional sports trusts (RSTs) to deliver many community-based services. However, this oversight role is now provided by the New Zealand Recreation Society and SPARC serves primarily as a funding agency for RSTs and the newly formed Kiwisport. RSTs fulfil an important community need by using their population-based formula funding to increase regional levels of physical activity and strengthen regional sports and physical recreation infrastructures.

The physical activity landscape in New Zealand is heavily influenced by the population’s passion for sports. Rugby, football, and netball are huge spectator sports, and most Kiwis are avid followers of one or more local, regional or national sports teams. The role of the built environment in facilitating community physical activity opportunities was not well-integrated into HEHA, even though the HEHA goals were to improve nutrition, increase physical activity, and reduce obesity. Fortunately a recent local study found that most neighbourhoods in New Zealand have relatively good access to open space.²⁴

Community Projects

In 2007, two years after initial HEHA funding was allocated, NZ\$5 million was approved for HEHA Community Action Projects (CAPs) aimed at engaging and mobilising Māori and Pacific communities through DHBs. MoH worked with Māori and Pacific stakeholder groups to develop the service specifications. Within DHBs, CAPs are required by MoH to be jointly accountable between the HEHA programme manager and the Māori and Pacific general managers. An additional NZ\$5.05 million was allocated to CAPs in 2008-09.

²³ Health Sponsorship Council (2007)

²⁴ ENHANCE (2009), p.140

DHBs were required to consult with community members before implementing projects so that they could determine community-specific major issues and barriers related to healthy eating and physical activity. However, the MoH imposed constraints and targeted funding streams for HEHA funding, limiting DHBs' flexibility in addressing community issues.²⁵

Many HEHA CAPs have contracts through to 2012. A 2009 analysis of CAPs found that: 59.5 per cent went to Māori projects; 43.5 per cent went to Pacific projects; 47.4 per cent went to whānau/family projects.

Most projects were for young children (46 per cent); adolescent youth received the least focus (5.2 per cent). Overall, very few HEHA initiatives were implemented in churches (nine per cent) or on marae (14 per cent).²⁶

Devolution

The decision to end or reduce elements of HEHA funding was made by the National-led government, elected in November 2008. One of the National party's first acts upon taking control of Parliament was to cease the HEHA social marketing *Feeding Our Futures* campaign. Citing a desire for schools to stop being "food police", they also ended the National Administrative Guideline 5 (NAG 5) requirement to only serve healthy food in school canteens.^{27, 28} MoH reports indicate that much of the budget saved from the cuts was transferred to the Kiwisport initiative. The government also has prioritised elective surgery within the MoH budget portfolio.²⁹

Mission-On, the NZ\$67 million, four year initiative created by the Labour government and charged with improving food and nutrition in schools and early childhood centres, promoting student health, and controlling television advertising, was also disestablished in 2009. As result of the change in government priorities, the Green Prescription programme was shifted from Mission-On to primary care, and SPARC transferred their role of coordinating physical activity to the New Zealand Recreation Society.

The government shift in health priorities has also meant that HEHA has devolved from an over-arching national strategy with an external interagency coordinating group and 14-member project team, to an initiative under the oversight of the MoH public health operations section in the chronic conditions group (with five staff).³⁰

DHBs can continue with CAPs until June 2012. After that, removal of CAPs funding will have a significant impact on Māori and Pacific communities, especially since they may not have access to alternative funding to sustain such initiatives.

²⁵ HEHA Strategy Evaluation Interim Report (2009), p.54

²⁶ HEHA Strategy Evaluation Interim Report (April 2009), p.162-163

²⁷ Author interview, 24 February 2010

²⁸ Retrieved from: <http://www.national.org.nz/Article.aspx?articleId=29288>

²⁹ Author interview, 27 April 2010

³⁰ Author interview, 16 July 2010

3. HE TANGATA, HE TANGATA: NEW ZEALAND CONTEXTS

“He aha te mea nui o te au? He tangata, he tangata, he tangata”³¹

What is the most important thing in the world? It is people, it is people, it is people

This section examines some of the social, political and cultural issues that shape New Zealand society and the health of Māori and Pacific communities. They are by no means exhaustive. The viewpoints expressed come from a synthesis of literature review, site visits and key informant interviews, and establish a context for later observations and recommendations.

Health Inequities in Aotearoa

When people asked me why I was going to New Zealand, I told them that I wanted to see egalitarianism in action. I wanted to see how a country shares power and resources with its indigenous population, and I wanted to compare that with how immigrants (in this case, Pacific peoples) are treated. Being a public health professional, my proxy for equality is health status. If a society is truly equal, then there shouldn't be much difference in the health status of its citizens no matter what their ethnicity or income status. So in an equal society – Pākehā, Māori and Pacific peoples should have the same prevalence of chronic diseases, the same hospitalisation rates, and the same mortality rates. Unfortunately, that's not the case in Aotearoa.

Māori Data

The 2006 New Zealand Census estimates the Māori population of 565,329 is 15 per cent of the total New Zealand population. Māori youth less than 15 years are 35 per cent of the total Māori population (compared to only 19 per cent for non-Māori). The annual median income for Māori adults over 15 years is NZ\$20,900 (compared to NZ\$24,400 for New Zealand overall).³²

Māori suffer from more heart disease, diabetes, cancer, and hospitalisation than non-Māori populations in Aotearoa. Overall, in 2006, Māori life expectancy at birth was at least eight years less than that for non-Māori for both genders. Based on the SF-36, one of the most widely used questionnaires for measuring self-reported physical and mental health status, Māori adults generally rated their health lower than non-Māori adults. Among people with diabetes, Māori may be up to 8.8 times more likely than non-Māori to go on to develop renal failure, and up to 4.7 times more likely than non-Māori to have lower limb amputations (both are complications of diabetes).^{33, 34}

³¹ Māori Proverb, Author Unknown

³² Retrieved from: www.stats.govt.nz/.../2006CensusHomePage/.../maori/work-and-income-ko-nga-mahi-me-nga-whiwhinga-moni.aspx

³³ Ministry of Health (2010), Tatau Kahukura: Maori Health Chart Book

³⁴ Retrieved from: www.stats.govt.nz/.../2006CensusHomePage/.../maori/work-and-income-ko-nga-mahi-me-nga-whiwhinga-moni.aspx

Data on Pasifika Peoples

From a small immigrant community in the 1940s, New Zealand's Pacific population has grown through migration and a high rate of natural increase into a population of 266,000 (approximately seven per cent of the entire New Zealand population). Of this total, Samoans are the largest group at 131,100 (50 per cent); Cook Islanders 58,011 (20 per cent); Tongan 50,578 (18 per cent); Niuean 22,476 (eight per cent); Fijian 9,864 (four per cent); and Tokelauan 6,819 (two per cent).³⁵ Today's Pacific population is mostly New Zealand-born and predominately young. They are also highly urbanised, with 97 per cent residing in urban centres (66 per cent in the Auckland area). In 2006, the median income for Pacific adults (aged 15 years and over) was NZ\$20,500.³⁶

Data from the Diabetes Heart and Health Survey 2002-2003 shows that all Pacific groups have higher cardiovascular (CVD) and diabetes risk factors than Pākehā, Samoans have the highest estimated CVD risks and Niueans the lowest. Tongan men have more adverse lipid profiles. Diabetes is more prevalent in Samoan men (26 per cent) and Tongan women (36 per cent); undiagnosed diabetes is more prevalent in Cook Islanders, and Niueans have the lowest diabetes prevalence.³⁷ Pacific peoples in New Zealand are three times more likely to have diabetes than the general population.³⁸

The health needs of the majority of Pacific peoples (216,766 or 83 per cent) are served by 16 PHOs in seven DHB regions with the largest Pacific populations.³⁹ The K'aute Pasifika Trust estimates that 84 per cent of Pacific people are affiliated with a church or religious organisation, making churches an ideal setting for implementing health promotion interventions. It has been noted that within the New Zealand context "churches are proxies for the village".⁴⁰

For Pacific peoples, health is a holistic concept which encompasses spiritual, emotional, mental, physical and social well-being. The emphasis is on the total well-being of the individual within the context of the family. The family includes both the nuclear family and the extended family.⁴¹ This world view is very similar to that of the Māori.

³⁵ Statistics New Zealand and Ministry of Pacific Island Affairs (2010), pp.2-15

³⁶ Ibid.

³⁷ Sundborn, G. et al (2008), pp.28-39

³⁸ Medical Council of New Zealand (2010), p.7

³⁹ Author interview, 12 March 2010

⁴⁰ Author interview, 15 March 2010

⁴¹ Ministry of Health (1997)

Social Determinants of Health

“Social injustice is killing people on a grand scale”⁴²

Figure 3: The determinants of health and well-being in our neighbourhoods



Source: Public Health Advisory Committee (2010), *Healthy Places, Healthy Lives: Urban environments and wellbeing*. Wellington: Ministry of Health.

Like many travellers, I came to Aotearoa envisioning an environmental paradise and friendly, healthy people. I expected to find that the Treaty of Waitangi gave the indigenous Māori population an equal say in the government and the economy. I did find beautiful landscapes and friendly people, but when I looked closer I also saw polluted streams and attitudes that differed whether people thought that I was a Fijian immigrant or an American tourist.

New Zealand prides itself on being an egalitarian society, and compared to the US, it is. There isn't the same stark contrast that you see in the US between rich and poor. However, even with a more humane society that has less social stratification than the US, there still are “haves” and “have nots” in New Zealand. And when you analyse the statistics and read the research, the “haves” tend to be Pākehā and the “have nots” tend to be Māori or Pacific Islanders. This is reflected in housing, in education, and in health. Fortunately, the New Zealand government acknowledges these inequities, and has officially pledged to support the 2008 World Health Organization (WHO) Commission on Social Determinants strategies to reduce health inequities.

⁴² World Health Organization (2008), p.26

The WHO report recommends that health inequities be addressed using a social determinants approach which involves improving daily living conditions; tackling the inequitable distribution of power, money, and resources; measuring the problem; and assessing the impact of action. The report calls on all governments to achieve health equity and close the health gap in a generation, specifically recommending that nations:

Ensure urban planning promotes healthy and safe behaviours equitably, through investment in active transport, retail planning to manage access to unhealthy foods, and through good environmental design and regulatory controls...⁴³

The social determinants approach is exemplified in the practice of community-based participatory research (CBPR). Meredith Minkler posits that CBPR is a strategy at the intersections of research, practice, and policy; and can be used as a vehicle for helping to promote and support healthy public policies, which in turn can help eliminate health inequities.⁴⁴

CBPR theory promotes two concepts relevant to eliminating health inequities – distributive justice and procedural justice:

...distributive justice also can relate to disproportionate lack of access to resources or assets, such as safe recreation areas and stores selling high quality and affordable fresh fruits and vegetables, while procedural justice is defined as equitable processes through which low-income communities of colour, rural residents, and other marginalised groups can gain a seat at the table-and stay at the table, having a real voice in decision-making affecting their lives.⁴⁵

CBPR in practice can help create policy environments that promote procedural as well as distributive justice and develop, enact, and enforce measures aimed at eliminating health inequities.⁴⁶

Colonisation

“When you travel and go from one sovereign house to another, you accept the rules (e.g. jurisdiction) of the house you travel to (e.g. going from England to France, you accept the rules of France). However, when people from Europe arrived they didn’t believe Māori had any jurisdiction – they came with the idea that they would ‘carry our laws with us’.”⁴⁷

History tells us that New Zealand was discovered in the 13th century by Kupe, a navigator from East Polynesia. When Kupe’s waka (canoe) arrived in the Hokianga region of the North Island one can only imagine the bounty that he found – seafood, cabbage trees, leafy ferns, abundant birdlife. He was soon followed by other explorers from Polynesia who came to settle in Aotearoa, “Land of the Long White Cloud”.⁴⁸

⁴³ World Health Organization, Commission on Social determinants of Health (2008), p.8

⁴⁴ Minkler, M. (2010), P. S81

⁴⁵ Ibid.

⁴⁶ Ibid, p.S86

⁴⁷ Author interview, 9 February 2010

⁴⁸ Retrieved from: <http://www.teara.govt.nz/en/history/1>

These original immigrants, now known as Māori, settled primarily on the North Island, and were a robust people, physically active and eating local, fresh seasonal food that they hunted, gathered or farmed. Over the next 300 years, the Māori developed a thriving culture based upon the land, sea, and inter-relationships amongst extended family (whānau).

This culture was thrown into turmoil after Europeans arrived in 1642 and later established colonies in New Zealand. Relations between Europeans and Māori ebbed and flowed between support and antagonism as land was usurped, disease spread, and economic power shifted. Finally in 1840 the Treaty of Waitangi was signed with Britain, recognising the sovereignty of Māori and establishing a formal, legal relationship between the Māori and the British who came to New Zealand. Māori sovereignty, and the rights inherent to it (i.e. the power to protect its citizens, power to define its culture, and power to decide its own affairs) have been under dispute since the Treaty was signed. The Waitangi Tribunal was established in 1975 to investigate grievances of Māori people in relation to the original treaty.

This Tribunal is still in effect today, resulting in numerous settlements between the Crown and iwi and hapū, and the return of land and resources to many Māori whānau. Although the international community lauds this reconciliation and redress process, Treaty claims annoy many Pākehā in New Zealand who question the historical accuracy and intent of the original Treaty document.⁴⁹ Some even claim that racism in New Zealand manifests as a disregard for the partnership between Māori and the Crown that was established by the Treaty of Waitangi, and that this disregard has led to contemporary structural factors which perpetuate historical injustices.⁵⁰

Māori have strong spiritual and cultural connections to the land, waterways and coastal areas of New Zealand. Māori regard land, soil and water as treasures which provide a source of unity and identity for the iwi and hapū. Soil was utilised to grow kumara, an important staple for Māori, and for other food production. Waterways and coastal areas also provided good sources of food and provided habitat and spawning grounds for native plants, birds and fish. However, through various forms of legislation, land confiscation, abuse of fisheries and pollution of waterways and coastal areas, many Māori no longer have access to these resources which provided a cheap, safe, healthy and readily available food supply.⁵¹

Changes in Māori health status are strongly affected by changing nutritional patterns, and nutritional patterns are also largely a product of lifestyle. One hundred and fifty years ago when hapū shifted from hilltop pa to low-lying kāinga, major dietary changes occurred. Fern roots, kumara, fish, birds and berries – all difficult to procure but nutritious and protein-rich gave way to flour, sugar, tea, salted pork, and potatoes. Bread and potatoes became the mainstay for many whānau and this often led to severe malnutrition.⁵²

⁴⁹ Author interview, 16 February 2010

⁵⁰ Jones, C. (1998), p.79

⁵¹ Te Hotu Manawa (2007), p.20

⁵² Durie, M. (1998), pp.33-34

Immigration

During the post war period (1940s) many Māori moved from rural areas to cities and towns to become part of the burgeoning industrial labour force. Even with the large rural to urban population shift there weren't enough workers to keep the factories operating smoothly. As a result, the government invited New Zealand's Pacific neighbours to come to Aotearoa and work in the canneries and on the assembly lines.⁵³ This rapid migration led to equally rapid changes in eating patterns and activity patterns for both Māori and Pacific peoples.

Today, the age structure of the New Zealand Pacific population reflects a dynamic trend in immigration status with 60 per cent of the current Pacific population being New Zealand born. However, in those under 15 years old, 81 per cent (46,126) were born in New Zealand, and of those 70 and older, 99 per cent (5,215) were born overseas. There are often marked cultural differences between Pacific New Zealand-born and Pacific-born people. The migration of Pacific peoples to New Zealand, globalisation and urbanisation has brought changes to the Pacific lifestyle. There are now more Pacific people from Niue, the Cook Islands, and Tokelau living in New Zealand than in their respective home countries.⁵⁴ The impacts of migration also include the ready availability and wider variety of foods, as well as changes in climate, language, housing and living arrangements.

Changes in eating and physical activity account for much of the decline in Pacific health. Pacific peoples in the US and New Zealand have often not had the educational opportunities or training to make the transition from a communal, agricultural non-competitive, and non-technological way of life to an independent, urban, competitive, and highly industrialised society.⁵⁵

Culture

“Ko taku reo taku ohoho, ko taku reo taku mapihi mauria”⁵⁶

My language is my awakening; my language is the window to my soul

Modern New Zealand culture is an amalgam of Māori, British and Pacific influences with a healthy dose of rugby and reggae thrown in. The official languages are Māori and English, yet walking down the streets of downtown Wellington or Auckland you are just as likely to hear Samoan spoken. I was intrigued during Waitangi Day celebrations to learn that because 6 February was also the anniversary of Bob Marley's birthday, reggae rather than waiata (Māori songs) were the music of choice.

Given this cultural mélange, Māori and Pacific eating, activity and general health behaviours are complex. Therefore it is difficult to make assumptions or generalisations. However, because both groups have retained so much of their language and many of their spiritual beliefs, it behooves health providers and policy-makers to consider culture at the beginning of any implementation planning. There are

⁵³ Author interview, 11 March 2010

⁵⁴ Statistics New Zealand (2010)

⁵⁵ Stafford, S. (May 2010) Caught between "The Rock" and a Hard Place: The Native Hawaiian and Pacific Islander Struggle for Identity in Public Health, *Am J of Public Health*, Vol 100, No 5, p.789

⁵⁶ Māori Proverb, Author Unknown

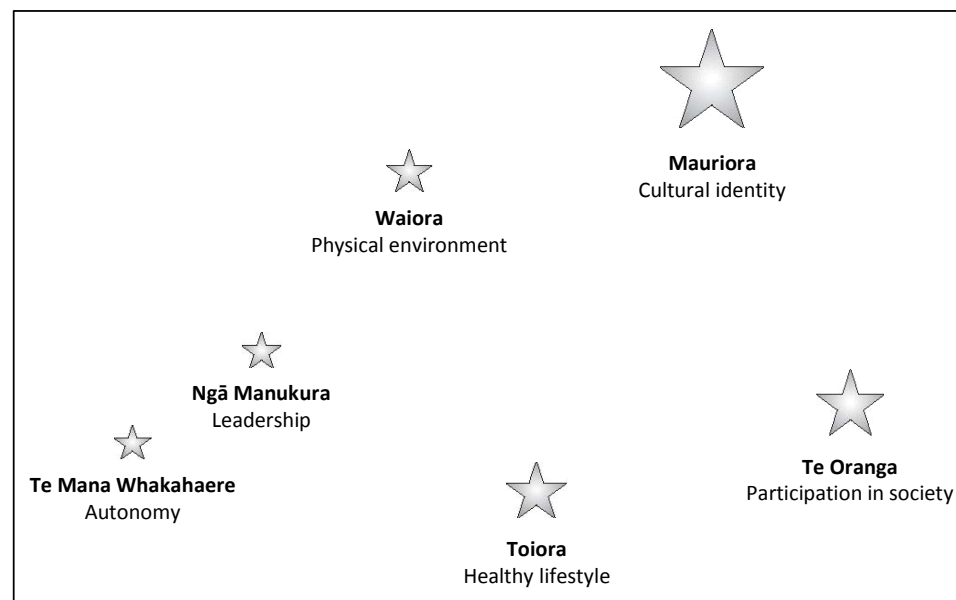
two common sayings amongst Māori and Pacific community members and providers: “For Māori, by Māori” and “For Pacific, by Pacific”:

Indigenous knowledge is local, unique to cultures, and focused on problem solving; it is the basis for community decision-making in health, education, resource allocation, etc. The recognition and systematic evaluation of culturally supported interventions confront the tradition of one-way translation of knowledge – from academia to the community – and assert the value of hybrid knowledge, or the intersection between Western and indigenous medical and public health knowledge.⁵⁷

Most public policy documents, plans and frameworks in Aotearoa contain a section on cultural tailoring and specificity, and there are numerous well-respected cultural models for health promotion practice (e.g. figure 3: Te Pae Mahutonga). Cultural models such as the Kakala Model (Helu-Thaman, 1992), Pacific Research Frameworks (Health Research Council), and Te Tuhono Oranga Evaluation Framework are commonly referenced and used when planning community health programmes. However, implementation in practice often lags behind theory. For example, some HEHA key informants commented on mixed messages about the true priority of Māori, for example with the lack of resources in Te Reo (Māori language) and their perceived low quality:

In many cases, the resources came out in English and two years later it might come out in Māori, and automatically that makes Māori feel they’re [far] back on the agenda, and they are supposed to be a priority group. I think that’s something that needs to be at the forefront of [Ministry of] Education’s and [Ministry of] Health’s minds when they’re publishing resources.⁵⁸

Figure 4: Te Pae Mahutonga



Source: Durie, M. 1999. Te Pae Mahutonga: A model for Māori health promotion. *Health Promotion Forum of New Zealand Newsletter* 49. 2–5 December 1999.

⁵⁷ Wallerstein, N. and B. Duran (2010), p.S46

⁵⁸ HEHA Strategy Evaluation Interim Report (2009), p.53

- Waiora promotes the idea that aspects of the physical environment important to Māori are protected.
- Toiora suggests that neighbourhoods where Māori live promote active and social living.
- Mauriora includes an urban cultural landscape that reflects cultural symbols, as well as the correct use of tribal names.
- Through Te Oranga, Māori are supported to participate in community engagement processes and design of urban features.
- The principles of Ngā Manukura and Te Mana Whakahaere are important for ensuring that Māori priorities are expressed and incorporated into urban planning, and that iwi have the autonomy to determine urban development priorities.

Consistent and thoughtful inclusion of cultural constructs about food, generosity, health and well-being can be powerful cues to action that resonate for Māori and Pasifika communities. For example, the ideas and concepts elucidated in the following quotes can serve as useful metaphors for designing culturally responsive programmes that resonate with the past, but also create relevant messages about the role of eating and physical activity in modern life:

Whereas in the past tapu and noa were often ways of rationing food resources and in the process ensuring exercise, as yet there are no comparable codes for coping with the environment of plenty and the hazards of being sedentary. If diabetes is to be conquered there is a need for indigenous peoples to adapt to modern environments just as earlier generations adapted to natural environments.⁵⁹

For indigenous peoples, dependency has been part of the post-colonisation experience and, all too often, it has been aggravated by poor health. The challenge is to create a climate within which self-management becomes the norm, and self-determination becomes the goal. Otherwise the effects of diabetes will be magnified several times over by a spirit of apology and a sense of incompetence. Self-management is a pre-requisite for self-determination, and self-determination is a precursor for wellness. The prevention of diabetes will not be possible on a wide scale until Māori and other indigenous peoples are able to exercise a greater measure of control over their own environments and their own destinies.⁶⁰

Current Political Economy

Most central governments around the world serve two core functions – to create wealth and protect health. The New Zealand government is no different, and in 2010 allocated a budget of NZ\$14 billion to tackle health issues in a country of 4.3 million people.⁶¹ Of this allocation, approximately NZ\$70 million per year (0.5 per cent of

⁵⁹ Durie, M. (2003), p.191

⁶⁰ Ibid. p.194

⁶¹ *Dominion Post*, 21 May 2010, p.A2

total health budget) is going towards nutrition and physical activity programmes.⁶² This figure represents a significant decrease in funding from previous years and is reflective of Health Minister Tony Ryall's decision last year to drop nutrition and physical activity from the government's health targets. This decision was made in spite of a 2009 Organization for Economic Co-operation and Development (OECD) report that ranked New Zealand as the third most obese country in the world, with an obesity rate of 26.5 per cent.⁶³

Ironically, the New Zealand government has endorsed the World Health Organization (WHO) Ottawa Charter for Health Promotion which explicitly commits its endorsers to "respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies".⁶⁴ The Ministry of Health has done an outstanding job documenting the extent of health inequities in Aotearoa, and there are numerous well-written policy reports and documents that outline policies and strategies needed to address healthy eating and physical activity (see Table 6: Selected Policy Documents). Yet, there seems to be "analysis paralysis" when it comes to implementing programmes. The onus rests with the New Zealand central government to protect the health of its citizens by implementing programmes that will reduce risk factors for the development of type 2 diabetes and heart disease, two major non-communicable diseases that significantly impact New Zealand's mortality rates.

Philanthropic Sector

"Philanthropy is the act of giving financial resources to a cause that is intended to improve general human well-being, and where the giver expects no direct reciprocation or financial gain in return."⁶⁵

Unlike the US, the New Zealand government takes care of basic needs for its population. The Prime Minister John Key highlighted this cultural trait in a 30 January 2007 speech entitled "The Kiwi Way: A Fair Go for All". During the campaign speech at the Burnside Rugby Club in Christchurch, Key proclaimed, "We should be proud to be a country that supports people when they can't find work, are ill, or aren't able to work".

As a result of a strong national commitment to public sector spending for basic needs, the New Zealand philanthropic sector is able to give the majority of its support to culture, sport and recreation. By contrast, in the US, philanthropy has to fill the void left by a lack of government spending, thus the amount spent on social services and health by the US philanthropic sector is much greater.

⁶² *Dominion Post*, 12 July 2010, p.A5

⁶³ OECD Health Data (2009) accessed 12 July 2010

⁶⁴ World Health Organization (1986)

⁶⁵ Business and Economic Research Ltd (BERL) (2007)

Table 3: Total Giving by Source

Source of Giving	Estimated Giving		
	\$	%	%GDP
Trusts and foundations - voluntary	\$124,712,000	9.8%	0.08%
- statutory	\$617,433,000	48.5%	0.39%
Personal giving	\$442,799,000	34.8%	0.28%
Business and corporate giving	\$89,180,000	7.0%	0.06%
TOTAL	\$1,274,124,000	100.0%	0.81%

source: BERL

New Zealand's philanthropic sector consists of family trusts and foundations, community and energy trusts, business and corporate foundations, and gaming machine societies. A relatively new potential source of philanthropic dollars stems from Treaty of Waitangi settlement claims with Māori iwi and rūnanga (tribal authority).⁶⁶ Total philanthropic giving in New Zealand in 2006 is estimated to have been NZ\$1.27 billion. The total giving figure of \$1.27 billion corresponds to approximately 0.81 per cent of New Zealand Gross Domestic Product (GDP).⁶⁷

The four activities that received the greatest amount of funding accounted for over three quarters of grant funding. These activities were culture, sport and recreation (27 per cent), education and research (24 per cent), social services (16 per cent) and health (10 per cent). BERL estimates that gaming machine societies provided just over 45 per cent of the funding in the first category to sports.⁶⁸

As the wealth of the New Zealand grows, there will be more funding available for philanthropic trusts and foundations.

Table 4: Activities That Grants Support

Activity	Number	Value (\$)	% of Total Grants Made
Culture and Recreation	52	56,617,000	26.58
Education and Research	59	51,641,000	24.24
Health	37	21,827,000	10.25
Social services	41	33,594,000	15.77
Environment	15	14,127,000	6.63
Development and Housing	11	16,580,000	7.78
Law, Advocacy and Politics	3	132,000	0.06
Philanthropic Intermediaries and Voluntarism Promotion	7	264,000	0.12
International	5	226,000	0.11
Religion	15	1,818,000	0.85
Buisness and Professional Associations, Unions	2	14,000	0.01
Other (not elsewhere specified)	22	16,159,000	7.59
TOTAL	87	212,997,000	100.00

[Source BERL]

⁶⁶ Ibid. p.10

⁶⁷ Ibid.

⁶⁸ BERL (2007), p.2

In the US, the National Convergence Partnership serves as an innovative model for philanthropic collaboration. The Convergence Partnership consists of six of the largest health foundations in the US, pooling their resources to address Healthy People, Healthy Places.⁶⁹ This voluntary collaborative controls approximately US\$2 billion in annual giving that is solely targeted to community efforts to improve eating and physical activity.⁷⁰

Current Events

During much of my time in New Zealand, the news was filled with media stories that made reference to New Zealand's "clean and green" brand. Stories as diverse as controversies about mining on public land, dairy farm expansion, river and stream reclamation, and foreign nations potential purchase of New Zealand land all mentioned the value of the "clean and green" brand for the country's continued economic growth and ability to attract tourists. Protecting the 'clean and green' brand seems to be as iconic a Kiwi value as the oft-quoted references to egalitarianism, No 8 fencing wire, and tall poppy syndrome.

Selected Policy Documents

There are numerous well-written policy reports and documents that outline policies and strategies needed to address healthy eating and physical activity in New Zealand. Yet there seems to be "analysis paralysis" when it comes to implementing the cultural concepts and theories put forward in policy documents. Instead of conducting more studies and writing new reports (including this one), communities would be better served if providers worked on the challenges involved in the implementation of quality, culturally relevant programmes in Māori and Pasifika communities.

Table 5: Selected Policy Documents

Policy Document	Author/Publisher	Year	Sample Recommendations Addressing Health Inequities
Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives	Office for the Community and Voluntary Sector, Ministry of Social Development	2010	Māori families supported to achieve their maximum health and well-being. Success evident when whānau are self-managing, living healthy lifestyles.
Best health outcomes for Pacific Peoples: Practice Implications	Medical Council of New Zealand	2010	The booklet offers guidance on the cultural diversity of and cultural preferences for Pacific peoples in New Zealand. p.4
'Ala Mo'ui: Pathways to Pacific Health and Well-being 2010-2014	Minister of Health, Minister of Pacific Island Affairs	2010	MoH will continue to work with DHBs to roll-out community action projects to increase physical activity and improve nutrition in Pacific communities, providing tangible support for Pacific communities. p.16 MPIA will help to build NGO and Pacific provider capacity. p.14

⁶⁹ The California Endowment (2008)

⁷⁰ Retrieved from: www.convergence.org

			MoH will work with DHBs, training institutions, service providers and national (professional) organisations to improve the recruitment, training and ongoing professional development of Pacific health workers. p.8
Healthy Places, Healthy Lives: Urban environments and wellbeing.	Public Health Advisory Committee, Ministry of Health	2010	Te Pae Mahutonga (a Māori model of health promotion developed by Professor Mason Durie) can be used to outline elements of Māori engagement in urban environments.
HEHA Strategy Evaluation Interim Report	Evaluation Consortium, Ministry of Health	2009	<p>Ensure ring-fenced funding is maintained and strengthened to assist targeting of HEHA interventions for Māori. p.99</p> <p>Strengthen the whole-of-government approach and HEHA Strategy support for wider environmental change. This will assist in ensuring that approaches are likely to align well with Māori health frameworks. p.100</p> <p>Funding is crucial for ongoing commitment to Pacific communities to see some differences in Pacific peoples health outcomes in the future. p. 115</p>
Enhancing Food Security and Physical Activity for Māori, Pacific and Low-Income Peoples (ENHANCE)	Clinical Trials Research Unit, University of Auckland; GeoHealth Laboratory, University of Canterbury; Health Promotion and Policy Research Unit, University of Otago; Te Hotu Manawa Māori	2009	<p>-There appear to be many nutrition and physical activity initiatives underway that could be built on, including programmes run by Pacific Islands Heartbeat and Te Hotu Manawa Māori. p.201</p> <p>-Provide sustainable government funding to maintain and develop effective programmes promoting food security and physical activity for Māori, Pacific and low-income communities. p.202</p> <p>-Ensure that the ongoing process of developing a National Policy Statement on Urban Design incorporates an evaluation of the health implications of its recommendations, and specifically targets the improvement of physical activity in Māori, Pacific and low-income communities. p.219</p>
Healthy Eating-Healthy Action Oranga Kai-Oranga Pūmau: Progress on implementing the HEHA Strategy 2008/09	Ministry of Health	2008	<p>To ensure that HEHA maintains a focus on Māori and Pacific peoples, the HEHA Strategy and Implementation Plan recognise and make linkages to key Ministry of Health publications such as</p> <p>He Korowai Oranga: Māori Health Strategy (Minister of Health and Associate Minister of Health 2002) and the Pacific Health and Disability Action Plan (Minister of Health 2002). p. 5</p>
Inquiry into Obesity and Type 2 Diabetes in New Zealand	Health Committee, Parliament	2007	Narrow the ethnic gaps in childhood obesity rates so that by 2015 the rates are equally low in Māori, Pacific, and other New Zealand children. p.4
Government response to the Inquiry into Obesity and Type 2 Diabetes	Parliament	2007	Invest in workforce to build Māori and Pacific capability and capacity and to enhance the diabetes workforce. p.6

Whakatātaka Tuarua: Māori Health Action Plan 2006–2011	Minister of Health, Associate Minister of Health	2006	Describes the actions to be implemented in order to achieve the aim of He Korowai Oranga: Māori Health Strategy.
Healthy Eating- Healthy Action Oranga Kai-Oranga Pumau: Implementation Plan: 2004-2010	Ministry of Health	2004	HEHA strategy and implementation plan clearly identify priority groups, including Māori, Pacific peoples, lower socioeconomic groups, children and their families, because focusing on these groups will give the greatest health gains.
Healthy Eating- Healthy Action Oranga Kai-Oranga Pumau: A Background	Ministry of Health	2003	Effective interventions for Māori need to recognise the interdependence of people, that the ‘collective’ and individual well-being of Māori are equally important and the need to work with people in their social context beyond the treatment of physical symptoms. p.58 Successful initiatives have been those that were 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. p.64
Healthy Eating- Healthy Action Oranga Kai-Oranga Pumau: A Strategic Framework	Ministry of Health	2003	There is an issue of limited resources that are appropriate for Māori, which requires attention along with development of appropriate programmes and training. p.57
He Korowai Oranga: Māori Health Strategy		2002	National strategy that outlines what is needed to achieve the goal of supporting Māori families to achieve maximum health and well-being.

Whānau Ora

On 8 April 2010, the Minister for the Community and Voluntary Sector released the long-awaited *Whānau Ora: Report of the Taskforce on Whānau-Centred Initiatives*. This report laid out principles, outcome goals, and recommendations for “improving social, education and other support services for families across New Zealand”. Based upon *He Korowai Oranga: the Māori Health Strategy*, the Whānau Ora approach was conceived by the Māori Party and posits that “Māori families will be supported to achieve their maximum health and well-being”.⁷¹ The taskforce report states that Whānau Ora outcome goals will be met when whānau are: “self-managing; living healthy lifestyles; participating fully in society; confidently participating in te ao Māori; economically secure and successfully involved in wealth creation; cohesive, resilient and nurturing”.⁷²

The government allocated NZ\$134 million over four years in the 2010-11 Budget to get Whānau Ora off the ground and to set up a monitoring and evaluation system for the strategy. An inaugural 20 health and social providers are expected to begin the implementation process in October 2010. The initial whānau selected for the programme will each be assigned a “champion” or “navigator” who will assist the families in identifying their issues, seeking effective solutions and navigating the

⁷¹ Office for the Community and Voluntary Sector (2010), p.7

⁷² Ibid.

government systems needed to meet the outcome goals.⁷³ With one of its outcome goals being “living healthy lifestyles”, Whānau Ora presents a unique opportunity for enabling Māori and Pasifika whānau to access healthy eating and physical activity programmes in their communities.

⁷³ Trevett, C. (2010)

4 AKO: MY OBSERVATIONS AND TEACHINGS

“Ko te kai o nga Rangatira, He Korero” – The food of Chiefs is talk⁷⁴

“From talk comes understanding. From understanding comes the knowledge and wisdom that will enable iwi to continue the journey that their tipuna (ancestors) began, and that their mokopuna (grandchildren) will continue into the future.”⁷⁵

In order to analyse what I observed and heard in communities, I applied a model that has been used in many US prevention initiatives targeting traffic safety, violence prevention, injury prevention, nutrition, and fitness. The Spectrum of Prevention helps expand prevention efforts beyond education models by promoting a multifaceted range of activities for effective prevention. Originally developed by Larry Cohen while he was director of the Contra Costa County, California Health Services Prevention Program, the spectrum is based on the work of Dr Marshall Swift in treating developmental disabilities. The spectrum identifies multiple levels of intervention and encourages people to move beyond the perception that prevention is about teaching healthy behaviours. The spectrum is not sequential; all levels need to be happening concurrently. See Figure 5: The Spectrum of Prevention.

Figure 5: Spectrum of Prevention



Source: Cohen, Larry. Contra Costa County Prevention Program, California, US, 1986

After a stock-take of HEHA and HEHA-related documents and materials I discovered that:

1. There are many substantial and well-written policy reports, strategies, planning documents, and pilot programmes that address how to apply cultural frameworks to implement programmes in Māori and Pacific communities. (See Table 5: Selected Policy Documents).
2. Principles for engaging Māori and Pacific communities are well-defined and articulated (i.e. Treaty of Waitangi, He Korowai Oranga, ‘Ala Mo’ui, Pathways to Pacific Health and Well-being 2010-2014, Mason Durie – Launching Māori Futures, social determinants approach).
3. Funding is still available (until 2012) for Community Action Projects in Māori and Pasifika communities.

⁷⁴ Māori Proverb, Author Unknown

⁷⁵ Pihema, H. (1997), p.36

The spectrum model offered a useful framework for assessing whether the projects that I encountered were addressing the full range of activities that can lead to changes in community eating and physical activity environments. My scan of community projects revealed that there were numerous projects engaging Māori and Pacific communities, but only a few Māori (and none of the Pacific) projects were working at the “influencing policy” level of the spectrum – this level also correlates with the “building healthy public policies” objective found in both the HEHA Implementation Plan and the WHO Social Determinants report. Most community projects that I encountered were focused on individual behaviour change and promoting community education. Based on my analysis and past experience, I observed that:

- monitoring and evaluation systems need to include a component that annually assesses the alignment of governmental spending to priority populations, and tracks changes in measurements of health equity over time and place to help identify the impact of policies and practices
- policy implementation needs to more completely align with Māori/Pacific engagement and development principles outlined above
- environmental change approaches should expand to include social justice and food security
- Community Action Projects current funding levels are too low and not sustainable, oversight and governance are often driven by DHB and government priorities rather than community wisdom
- Community Action Projects are too heavily focused on individual behaviour change, and should expand to adopt a complete Spectrum of Prevention approach
- Māori and Pacific nutrition and physical activity workforce levels need to increase
- Māori and Pacific youth and adolescents should be more engaged in programmes
- the level of cultural-specificity could improve (especially in Pacific projects)
- emphasis on obesity prevention and weight loss can lead people to engage in ineffective and potentially dangerous interventions to lose weight
- the concept of physical activity needs to broaden to include issues related to built environments and life-long physical activity skill-building
- physical activity programming (especially in Māori projects) focuses too heavily on competitive sports/games
- an opportunity is lost by not expanding New Zealand’s “clean green” brand to include a health component (e.g. access to healthy foods and built environments).

In addition, there are many exemplary programmes (not all HEHA-funded) that highlight community strengths and assets in culturally appropriate ways. The following are just a few that I encountered which adhere to Māori or Pacific cultural frameworks and best practices (See Table 6 and 7 below for examples of such frameworks).

Table 6: Strategies for Addressing Diabetes in Indigenous Peoples

Strategy	Focus
Macro-political interventions	Elimination of socioeconomic disadvantage, recognition of indigenous peoples and indigenous rights
Adaption to modern environments	Changes to lifestyle through the use of codes for living, improved nutrition
Treatment	Early detection, effective screening; providing services that are clinically and culturally relevant
Empowerment	Increased access to education, research, self-management and self-determination

Source: Durie, M. *Ngā Kāhui Pou: Launching Māori Futures*, Huia Publishers, Wellington: 2003

Table 7: He Korowai Oranga Evaluation Framework⁷⁶

Principles	Components
Māori Development	<ul style="list-style-type: none"> • Development of whānau, iwi, hapū • Promotion of healthy lifestyles for Māori • Access to the Māori world • Enhanced participation in society by Māori
Māori Autonomy	<ul style="list-style-type: none"> • Māori control and self-determination in the delivery of services and initiatives • Active Māori involvement in priority setting and planning process
Māori Delivery	<ul style="list-style-type: none"> • Active Māori involvement in the delivery of services and initiatives
Māori Leadership	<ul style="list-style-type: none"> • Māori leadership in developing, implementing and evaluating initiatives and research
Māori Integration	<ul style="list-style-type: none"> • Active and positive links with aligned sectors to promote the health of Māori
Māori Environmental Perspectives	<ul style="list-style-type: none"> • Developmental goals and aspirations should not impede environmental sustainability and the broader Māori desire to connect with nature
Māori Responsiveness	<ul style="list-style-type: none"> • Mainstream is responsive to the needs of Māori

Māori Exemplary Programmes

- Te Puni Kokiri's Mara Kai Fund for community garden and orchard programmes
- Marae Healthy Kai and Kaupapa programmes run by marae (e.g. Ngāti Tuhoe, Whakatane) – especially given there are approximately 978 marae in New Zealand⁷⁷
- Kai Tootika me Whakapakari Tinana – Te Hotu Manawa Māori programme (train-the-trainer community nutrition course)
- Te Whānau o Waipareira Trust (Wai Health) – (Auckland)

⁷⁶ HEHA Strategy Evaluation Interim Report (2009), p.A13

⁷⁷ Retrieved from: www.naumaipalace.com

- “Tamaiti” Whangai Whānau Māori Family Advocate programme (Central Hutt, Naenae, Pomare)
- Hapai te Hauora Tapui – Whai Ao Nutrition and Fitness programmes (Auckland)
- He Oranga Poutama (a national network of kaiwhakahaere, established in 1998) – the primary role of kaiwhakahaere is to assist and facilitate physical activity initiatives out in the regions; the kaiwhakahaere network includes key stakeholders such as regional sports trusts and iwi organisations.

Pasifika Exemplary Programmes

Successful initiatives have been those that were 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:⁷⁸

- church-based programmes: Enea Ola (Waitemata DHB), Lotu Moui (Counties Manukau DHB), Healthy Village Action (Auckland DHB)
- Pacific Provider Development Fund (through MoH)
- Certificate in Pacific Nutrition two-day and nine-day courses (Pacific Island Heartbeat, National Heart Foundation)
- Tongan Community Action (Christchurch).

⁷⁸ Thaman (2003), p.17

5 RECOMMENDATIONS

The key audiences for these recommendations are community leaders, Ministry of Health professionals, non-governmental agencies and government officials interested in practical suggestions and strategies for ensuring that current and future healthy eating and physical activity programmes in Aotearoa better serve Māori and Pacific communities.

In addition to the general policy recommendations listed below, see:

Appendix 1: Māori Community Presentation for more information

Appendix 2: Pasifika Community Presentation for more information

Re-align Government's Role

“The fact is we are already spending millions of dollars for Wellington bureaucrats to write strategies and to dream up and run their own schemes. I want more of those dollars spent on programmes that work, regardless of who thinks them up and who runs them.”⁷⁹

- Just implement it! Resist the urge to conduct more studies, and instead work on the challenges involved in implementing quality, culturally relevant healthy eating and physical activity programmes in the Māori and Pacific communities that suffer disproportionately from health inequities.
- Set aside funding for Māori and Pacific providers in proportion to the level of health inequities.
- Allow Māori and Pacific communities to determine their own strategies for how to implement local healthy eating and physical activity programmes.
- Establish monitoring and evaluation systems that include a component which annually assesses the alignment of governmental spending to priority populations, and tracks changes in measurements of health equity over time and place to help identify the impact of policies and practices.
- Allocate funding (based on State Services Commission regulations) to support community organisations so that they can attend coordination and strategy development meetings.

Use Cultural Frameworks and Specificity

“Nga tipuna ki mua, Ko tatou kei muri”⁸⁰

The ancestors in front, We are behind

- Utilise Whānau Ora-centred initiatives to improve healthy lifestyles by working with Māori (and Pasifika) providers and communities to develop healthy eating and physical activity Whānau outcomes.

⁷⁹ Key (2007), p.7

⁸⁰ Māori Proverb, Author Unknown

- Develop materials in language rather than creating adaptations, and vary the messages and themes depending on the audience (e.g. Samoan, Tongan, Māori, and youth).
- Embrace oral and visual educational tools – storytelling, whakapapa, proverbs, Māori TV – using concrete examples to convey messages about the history and value of healthy eating and activity for Māori and Pacific peoples.

Adopt Health at Every Size

“Pacific people felt a stigma with being overweight which prevented them from exercising in public...a lot of our people in churches go for walks at 3 o’clock in the morning, 4 o’clock in the morning, 5 o’clock in the morning because it’s dark, because they know they’re not going to be looked at and laughed at when people see them walking on the road in the morning and the afternoon.”⁸¹

- Adopt a Health At Every Size (HAES) approach to shift emphasis to chronic disease prevention and physical, mental well-being, and remove weight stigma.^{82, 83, 84}

Go Beyond Sports and Promote Physical Activity

“Where services are limited, there are innovative ways of increasing access to physical activity programming and facilities and creating positive health outcomes. The establishment of ‘public-private partnerships’ between schools and swimming clubs in Auckland is one example.”⁸⁵

- Support creation, rehabilitation, and maintenance of parks, playgrounds, and recreation facilities in low-decile areas and offer quality programming to encourage and support physical activity.
- Develop guidelines for implementing physical activity programmes (e.g. include non-competitive examples, movement by all).⁸⁶

View Healthy Lifestyles as a Vehicle for Māori and Pacific Workforce and Community Development

“Ko te amoranga ki mua, Ko te hapai o ki muri”⁸⁷

Strong leaders require continuous support

- Create more pathways for Māori and Pacific youth and community members to enter the nutrition and physical activity workforce (e.g. remove barriers

⁸¹ HEHA (2009), p.110

⁸² Robison (2005), p.13

⁸³ Bacon (2008)

⁸⁴ Gaesser (2006), p.18

⁸⁵ PHAC (2010), p.24

⁸⁶ CANFIT (2009)

⁸⁷ Māori Proverb, Author Unknown

such as the only nutrition internship being in Dunedin at the University of Otago).

- Establish and support Māori and Pacific scholarship and internship programmes.
- Actively involve community members in monitoring and evaluation activities.
- Strengthen and ensure inclusion of the voice of Māori and Pacific peoples in social development policies and programmes that affect their lives at the national, regional and local levels.
- Empower Māori and Pacific peoples to develop their organisational and management capacity to operate community-based and faith-based programme delivery systems and services.
- Train and promote Māori and Pacific professionals in the areas of nutrition, physical activity, evaluation and culinary arts (expand the role of internships).

Get Youth Involved

“A’oa’i le tamaitiiti ina aua ne’i alo ese mai ona ala”⁸⁸

Instruct a child so he/she will not stray from his/her path

- Youth providers should be engaged to incorporate healthy eating and physical activity into existing youth programmes and projects (e.g. holiday and after school programmes, youth leadership, alcohol and drug prevention).

“I want to turbo-charge the efforts of private and community groups making a difference. I want to change the balance of spending between government and privately run groups.”⁸⁹

- Develop a strategy to obtain funding to support healthy lifestyle programmes by working with community and family trusts and foundations (e.g. J. R. McKenzie Trust focusing on Māori well-being, ASB Trust and Pacific and Māori educational achievement, Vodaphone Foundation and at-risk youth, US Convergence Partnership).
- Use a community-based participatory research (CBPR) model to equitably involve Māori and Pacific NGOs as partners and research participants with a research topic of importance to the community.

Emphasise Environmental Change

“The health system has an obvious role to play in other urban planning issues as well: for example, access to healthy food outlets, access to green spaces and Māori engagement.”⁹⁰

- Work in coalition with other Pacific countries and territories to develop a regional food and trade policy (e.g. *WHO 2-1-22 Plan*) that supports health.⁹¹

⁸⁸ Samoan Proverb, Author Unknown

⁸⁹ Key (2007), p.7

⁹⁰ PHAC (2010)

⁹¹ World Health Organization (2009), p.2

- Work with DHBs, local councils, and the Ministry of Tourism to create, support and promote healthy communities (e.g. access to healthy foods and built environments).

Strategies for Community Programmes

- Develop interventions that work outside of church and marae settings, especially for youth.
- Monitor government's role (i.e. funding, training, evaluation, community-based participatory research with Pacific governance rather than relevance framework, workforce development) in providing resources to Māori and Pasifika organisations.
- Share knowledge and collaborate and coordinate with other Māori and Pasifika organisations to optimise value and reduce duplication.
- Support the organisation of national and regional nutrition and physical activity networks and coalitions.
- Hold district health boards (DHBs), primary health organisations (PHOs), and the Ministry of Health (MoH) accountable for addressing the nutrition and physical activity needs of Māori and Pacific people.
- Advocate for healthy food and physical activity opportunities at church, in the workplace, and within whānau.

CONCLUSION

“Mehemea karekau ana he whakakitenga ka mate te iwi”⁹²

Where there is no vision, the people will perish

I have had over 20 years of experience implementing community nutrition and physical activity projects in low-income, ethnic communities in the US. For the past six years, I have been working through non-governmental channels on environmental and public policy changes in this area. I can't, however, presume to be an expert in healthy eating and physical activity in Māori and Pasifika communities after my brief seven months in New Zealand. Therefore, I offer the observations and recommendations in this report in the spirit of koha:

“E iti noa ana na te aroha”⁹³ – A small gift, given in love

I believe that it is not for lack of reports and plans and strategies that there are health inequities in Aotearoa – I think that it is a lack of political and social will to truly share power and resources with Māori and Pacific peoples. The loss of the “HEHA brand” is unfortunate, however I do not think that the devolution of HEHA has to mean the end of effective healthy eating and physical activity programmes in Aotearoa. However, I firmly believe that if New Zealand chooses to implement a healthy eating and physical activity strategy that focuses solely on individual education and behaviour change it runs the risk of increasing health inequities.

The New Zealand government must make a long-term commitment to support healthy eating and physical activity programmes in Aotearoa. At least 10 years of funding, along with constant CBPR evaluation and monitoring, are needed to reverse the tide of increasing health inequities associated with unhealthy eating and physical inactivity. The strategy needs to be apolitical, culturally based, grounded in indigenous wisdom, and focused on the social determinants of health in order to be effective. If there is true collaboration and power-sharing with Māori and Pacific communities, I have no doubt that effective solutions can be implemented.

My final month in Aotearoa will be spent participating in many meetings, hui and fonoj where I will share what I have learned during my Ian Axford Fellowship. I also look forward to sharing New Zealand models of comprehensive, government-driven non-communicable disease prevention strategies for high-risk communities with US planners, policy-makers, philanthropies, and social justice advocates upon my return to the US.

Clear and concise examples of New Zealand strategies to reduce health inequities in Māori and Pacific communities through healthy eating and physical activity programming, will be useful to US congressional members who are already crafting legislation in response to First Lady Michelle Obama's childhood obesity prevention initiative. For example, regional sports trusts that receive population-based formula funding to increase regional levels of physical activity and strengthen regional sports and physical recreation infrastructures is a model that the US could easily adopt. In the rush to become a “melting pot” the US neglects to spend sufficient time examining the cultural values and nuances that help define how different ethnic

⁹² Māori Proverb, Author Unknown

⁹³ Ibid.

populations in the US view eating and physical activity. I also believe that the US would benefit from adapting NZ's practice of documenting more explicit cultural frameworks and models for working in ethnic communities.

Existing federal health and nutrition programmes could be re-tooled by congress to be more responsive to US multi-ethnic populations, or re-aligned by state legislatures to achieve closer collaboration. I plan to distribute this report, briefs and presentations that I develop to interested members and staffs of relevant congressional committees, to colleagues at the National Alliance for Nutrition and Activity (NANA), and with my fellow policy advocates in the food and nutrition policy arena.

In the US, the administration of large-scale nutrition and health service programmes is driven by a confusing array of categorical funding sources and is often duplicative and scattershot. New Zealand's more centralised approach to health and nutrition planning and service delivery provides some excellent models for US administrators. Examples of these approaches, if offered with skill and creativity, can catalyse programme reforms and incremental systems change.

US Health Foundations and Health Endowments, including Robert Wood Johnson, The Kellogg Foundation, Kaiser Family Foundation and The California Endowment, are often catalysts for innovation and systems change in emerging public health problems. Several of these foundations are currently implementing large obesity prevention funding initiatives, and are eager to avoid reinventing the wheel. A New Zealand model of a comprehensive nutrition and physical activity national strategy that provides clear guidelines for addressing health inequities in indigenous (e.g. Māori) and immigrant (i.e. Pacific) populations may help shape the discourse on healthy lifestyle programmes and be a guide for successful implementation.

The Ian Axford Public Policy Fellowship has allowed me to work within a government context and learn how public policy is implemented. I have also had a uniquely rich cultural experience working in and learning from Māori and Pasifika communities. I have learned many things about myself and my place in the world as a result of my time in Aotearoa, and have come to realise that:

- Black American, Māori and Pacific communities share a culture of generosity, deep spirituality, and resistance to colonisation and oppression
- a well-written policy report that includes recommendations for addressing health inequities does not necessarily result in effective implementation
- “He aha te mea nui o te au? He tangata, he tangata, he tangata” – what is the most important thing in the world? It is people, it is people, it is people (our greatest resource).

Being able to live and work in New Zealand has been a privilege and an honour. I came as manuwhiri, but am leaving with the wairua of tangata whenua. Kia ora.

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APPENDIX 1: POWERPOINT WITH NOTES – MĀORI

Slide 1

The slide features a dark olive green background with a white, rounded rectangular area on the left containing the title in red text. To the right of this area, the name and title of the speaker are listed. Below the title, there is a red horizontal bar. At the bottom left, there is a logo for 'IAN AXFORD (NEW ZEALAND) FELLOWSHIPS in PUBLIC POLICY' with decorative borders. At the bottom right, there is the CANFIT logo with the tagline 'Communities • Adolescents • Nutrition • Fitness'.

**Policy Implementation for Health Equity:
Examining Healthy Eating and Physical Activity
Programmes in Māori Communities in Aotearoa**

Arnell Hinkle, RD, MPH
Executive Director, CANFIT
Ministry of Pacific Island Affairs

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Tēnā koutou katoa
Ko Arnell taku ingoa
Nō Amerika ahau
Ko Boeing 747 tōku waka
Ko Ngati Mangumangu tōku iwi
Ko Hinkle tōku hapū
Ko Tamalpais tōku maunga
Ko Sacramento tōku awa
Ko Mildred tōku tīpuna
Tēnā koutou katoa

Today's Agenda

- Whakapapa
- What I do in the US
- Why I am here in New Zealand
- My initial findings and recommendations
- How you can help
- Q & A



Blind-folded people and elephant analogy

Whakapapa

“Ngā tīpuna ki mua, Ko tātou kei muri” - The ancestors in front, We are behind



Once sound public policies are developed, how can they be implemented in equitable ways that eliminate health disparities?

For the past sixteen years, I have been trying to answer that question by working at the heart of the movement to improve healthy eating and physical activity environments in low-income communities of color.

I come to this work as a Black American woman who grew up poor and working class in the heartland of the US. I was raised in a large extended family on a steady diet of soul food – greens, fruit, pork, chicken, and potatoes. A diet not unlike that found in many parts of the Aotearoa. After study at university I moved to a small island off the Eastern US and pursued work as a restaurant chef and organic farmer, learning to grow and cook all types of food. This love of food and community led me to go back to school to study nutrition and public health.

From grassroots to government, I have worked with community-based and youth serving organizations to raise-up local solutions and support the development of culturally competent nutrition and physical activity policies and practices.

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CANFIT Mission



To work with communities and policymakers to develop culturally resonant policies and practices that improve food and physical activity environments for adolescents in low income communities and communities of color.



Work with US Foundations providing training and technical assistance to communities across US on how to implement community nutrition and physical activity programs in low-income communities of color

Resources

- *Roadmap to Improving Food and Physical Activity Environments and Promoting Healthier After School Environments: Opportunities & Challenges*
www.healthyeatingactivecommunities.org

- Also from CANFIT: www.canfit.org
 - Healthy Snack Guide for Your After School Program
 - Physical Activity Policy Brief
 - Lesson plans, media kits, trainings
 - MO Project



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AXFORD FELLOWSHIP:



Established in 1995 to:

- reinforce New Zealand-United States links by enabling Americans to come to New Zealand to gain experience and build contacts in the field of public policy development;
- help improve the practice of public policy in New Zealand and the United States by the cross-fertilization of ideas and experience in the two countries; and
- build a network of public policy experts on both sides of the Pacific, and encourage ongoing policy exchange between New Zealand and the United States.

[See <http://www.fulbright.org.nz/awards/am-ian-axford.html> for more information about this and other Fulbright awards]

Demographic Comparisons: American Indian-Māori

	CA (2007)	AZ (2008)	US (2007)	NZ (2006)
Pop.	285,162	318,509	2,419,895	565,329
% of total pop.	1.2%	4.9%	0.8%	15%

AXFORD PROJECT



Determine the level of engagement of local indigenous communities, particularly low-income communities, in the implementation of the HEHA campaign

Assess the integration of HEHA strategies with the food systems and built environment of Māori and Pacific communities

Disseminate findings and recommendations in NZ and US via appropriate policy, public health and ethnic media channels

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AXFORD PROJECT PROCESS

- Reviewed current and archival documents and web sites on HEHA, Māori Health, Pacific Health
- Literature review on Pacific/Māori populations and obesity prevention, eating, physical activity, community development
- 16 weeks of Māori classes
- Attended national, regional and local hui and fonos

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AXFORD PROJECT PROCESS

- Interviewed over 100 people from government, DHBs, non-governmental organisations, crown entities, primary care organisations, Māori and Pacific providers, and community members.
- Visited Taranaki, Hutt Valley, Northland, the Hokianga, Rotorua, Tairāwhiti, Christchurch, and Auckland where I assessed the nutrition and physical activity environment, and met with representatives from community nutrition and physical activity projects

WHAT'S WORKING:

- There are many substantial and well-written policy reports, strategies, planning documents, and pilot programs [Ex: ENHANCE, HEHA Strategy, HEHA: Oranga Kai-Oranga Pumau Strategy Evaluation Interim Report]
- Principles for engaging Māori and Pacific communities are well-defined and articulated (i.e., Treaty of Waitangi, He Korowai Oranga, 'Ala Mo'ui, Pathways to Pacific Health and Well-being 2010-2014, Mason Durie - *Launching Māori Futures*, social determinants approach)
- Funding is going to Community Action Projects in Māori/Pasifika communities, including successful projects to change environments of maraes and churches

The Spectrum of Prevention



In attempting to analyse what I was seeing and hearing in communities, I applied a model that I have used in the past.

The Spectrum of Prevention helps expand prevention efforts beyond education models by promoting a multifaceted range of activities for effective prevention. Originally developed by Larry Cohen while he was director of the Contra Costa Health Services Prevention Program, the Spectrum is based on the work of Dr. Marshall Swift in treating developmental disabilities. It has been used nationally in prevention initiatives targeting traffic safety, violence prevention, injury prevention, nutrition, and fitness.

The Spectrum identifies multiple levels of intervention and encourages people to move beyond the perception that prevention is about teaching healthy behaviors.

The Spectrum is not sequential, all levels need to be happening concurrently

Individual Knowledge & Skills

• What's Working:

- ~ 60% of HEHA Community Action Projects going to Māori
- "Aru i te ara o te ra"
(Follow the pathway of the sun)
e.g., pursue the positive elements in your culture
Cook Islands Proverb

• What Could Change:

- A. Community Action Projects could expand to adopt a complete Spectrum of Prevention approach
- B. Rangatahi should be more engaged in programmes
- C. Emphasis on obesity prevention and weight loss can lead people to engage in ineffective and potentially dangerous ways to lose weight.

Community Education

• What's Working:

- He Haurora Kai
- TPK's Mara Kai Fund

• What Could Change:

- Materials and other visual media should be developed in language rather than being adapted (e.g., consider youth as a culture)
- Utilise oral culture - storytelling, whakapapa, proverbs, concrete examples - to convey messages about the history and value of healthy eating and activity for Māori

Educating Providers

Ko te amoranga ki mua Ko te hapai o ki muri - Strong leaders require continuous support

What's Working:

- Te Hotu Manawa Training in Māori Nutrition
- Hapai Te Hauora Tapui

What Could Change:

- A. Create more pathways for Māori youth and community members to enter nutrition and physical activity workforce
- B. Create/support scholarships and internships (e.g., remove barriers such as only Nutrition internship being at Otago)
- C. Actively involve community members in monitoring and evaluation activities
- D. Engage youth providers to incorporate healthy eating and physical activity into existing youth projects

- A. If 40% of diseases faced by Māori are nutrition/activity related, why doesn't 40% of workforce development go towards Māori health workers that can address these issues?
- B. Hiki Pihema, "Training - What's in it for Māori" editorial, Journal of NZ Dietetics Association, 1998, vol 52, no 1, pp3-4

It's been over 10 years, and there still are few Māori nutritionists!

To increase number of Māori students studying nutrition:

- address barrier of doing internship/course at Otago (Dunedin), it's a hardship for most Māori youth (distance, expense, climate, away from family)
- potential solutions: develop internship/course opportunities in NZ; explore developing a joint agreement with nutrition internship program in Samoa and/or Tonga (working with your Pacific cousins)

Fostering Coalitions and Networks

Na taku rourou, Na taku rourou, Ka ora te iwi - Our people will survive through unity

- **What's Working:**
 - Te Hotu Manawa Annual National Nutrition & Physical Activity Hui
 - Māori Health Managers (DHB)
- **What Could Change:**
 - Develop a strategy to obtain funding to support healthy lifestyle programs by working with community trusts and foundations (e.g., JR McKenzie Trust focusing on Māori well-being, Vodaphone Foundation and at-risk youth, National Convergence Partnership in US)

[Business and Economic Research Ltd (2007): Giving New Zealand, Philanthropic Funding 2006 Wellington: Philanthropy New Zealand]

Annual distributions by family trusts and foundations was estimated at \$353.7 million NZD recorded by BERL in 2006.

The four activities that received the greatest amount of funding accounted for over three quarters of grant funding. These activities were culture, sport and recreation (27 percent), education and research (24 percent), social services (16 percent) and health (10 percent). BERL estimates that gaming machine societies provided just over 45 percent of the funding in the first category to sports. p.2

US Example: National Convergence Partnership consists of all of the largest health foundations in the US, pooling their resources to address Healthy People, Healthy Places

Changing Organisational Practices

- **What's Working:**

- Māori Community leaders are stepping up and becoming role models for healthy eating and physical activity

- **What Could Change:**

- Strengthen governance, leadership, accountability, and fundraising capabilities of Māori organisations
- More kōrero on cultural beliefs and attitudes that support and hinder Māori attainment of healthy lifestyles

Example: Cultural beliefs and attitudes such as generosity, portion size, meal components

Influencing Policy and Legislation

- **What's Working:**

- The past experience of Kaupapa Māori programs
- MoH funding (via HEHA) is going to Community Action Projects in Māori communities

- **What Could Change:**

- A. Policy implementation needs to more completely align with principles of Māori engagement and community development
- B. Community Action Projects - current funding levels are too low, oversight and governance are often driven by DHB and Government priorities rather than community wisdom, funding is not sustainable

Hike Pihema

Whai Ao – Hapai Te Hauora Tapui

Many Community organisations are attending coordination and strategy development meetings, often without remuneration, especially an issue in Māori and Pacific communities.

Recommend the allocation of funding (perhaps based on State Services Commission regulations) to support organisations where appropriate.

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POLICY RECOMMENDATIONS:

1. Just implement it!
2. Utilise Whānau Ora to improve healthy lifestyles by working with Māori (and Pacific) communities to develop eating and physical activity whānau outcomes
3. Develop strategies that work outside of marae settings, especially for youth
4. Adopt a Health At Every Size (HAES) approach to shift emphasis to chronic disease prevention and physical, mental well-being, and remove weight stigma

1. There are numerous well-written policy reports and documents that outline policies and strategies needed to address healthy eating and physical activity. Yet, there seems to be “analysis paralysis” when it comes to implementing programmes. Resist the urge to conduct more studies, and instead work on the challenges involved in implementing quality, culturally-relevant programs in Māori communities.
3. In comparison with non- Māori, Māori constituted a very youthful population. 35 percent of Māori were aged less than 15 years, compared with only 19 percent of non-Māori
4. Health at Every Size is based on the simple premise that the best way to improve health is to honor your body. It supports people in adopting good health habits for the sake of health and well-being (rather than weight control). Health at Every Size encourages:
 - Accepting and respecting the natural diversity of body sizes and shapes.
 - Eating in a flexible manner that values pleasure and honors internal cues of hunger, satiety and appetite.
 - Finding the joy in moving one’s body and becoming more physically active.

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POLICY RECOMMENDATIONS:

5. Monitor Government's role (i.e., funding, training, evaluation, community based participatory research) in providing resources to Māori organisations
6. Share knowledge and collaborate/coordinate with other Māori organisations to optimize value and reduce duplication
7. Support the organisation of National and Regional Māori Nutrition and Physical Activity networks and coalitions

5. Government role: funding, training, evaluation, community based participatory research, workforce development mechanisms

Community-based Participatory Research (CBPR) is a strategy at the intersections of research, practice, and policy; and as such, can be used as a vehicle for helping to promote and support healthy public policies, which in turn can help eliminate health disparities. Inherent in CBPR are two concepts relevant to eliminating health disparities: distributive justice and procedural justice.

“...distributive justice also can relate to disproportionate lack of access to resources or assets, such as safe recreation areas and stores selling high quality and affordable fresh fruits and vegetables.” while procedural justice is defined as “equitable processes through which low-income communities of color, rural residents, and other marginalized groups can gain a seat at the table-and stay at the table, having a real voice in decision making affecting their lives.” pS81

“CBPR can help create policy environments that promote procedural as well as distributive justice and develop, enact, and enforce measures aimed at eliminating health disparities.” pS86

[Minkler, Meredith. “Linking Science and Policy Through Community-Based Participatory Research to Study and Address Health Disparities”. American Journal of Public Health. 2010; 100: S81-S87]

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POLICY RECOMMENDATIONS:

8. Support creation, rehabilitation, and maintenance of parks, playgrounds, and recreation facilities in low decile areas and offer quality programming to encourage and support physical activity

9. Hold District Health Boards (DHBs), Primary Health Organisations (PHOs), and the Ministry of Health (MoH) accountable for addressing the nutrition and physical activity needs of Māori


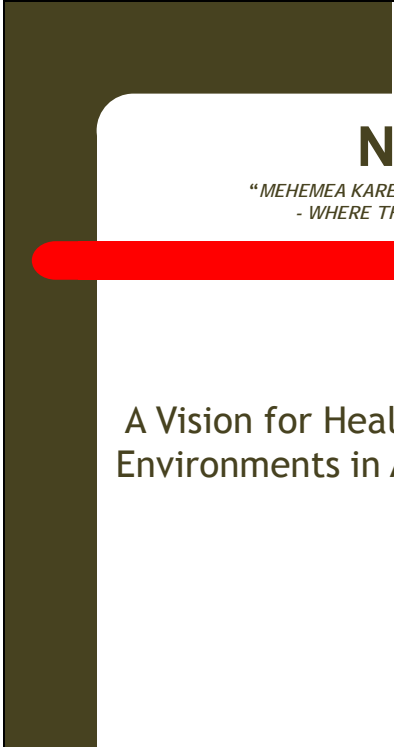
10. Advocate for healthy food and physical activity opportunities at your marae, workplace, and within your whānau

8. Broaden physical activity to include issues related to built environments and life-long physical activity skill-building. Develop guidelines for implementing physical activity programs (e.g., include non competitive examples, movement by all) – see CANFIT policy briefs
9. Monitoring and evaluation systems need to include a component that annually assesses the alignment of governmental spending to priority populations, and tracks changes in measurements of health equity over time and place to help identify the impact of policies and practices
10. Environmental change approach should expand to include social justice and food security

New Zealand's "Clean Green" brand could be expanded to include a health component (e.g., access to healthy foods and built environments)


Work with DHBs, local councils, and Department of Tourism to create, support and promote healthy communities.

One suggestion is to add questions to the visitor satisfaction survey on visitors' ability to obtain healthy food and participate in daily physical activity.



NEXT STEPS:

*“MEHEMEA KAREKAU ANA HE WHAKAKITENGA, KA MATE TE IWI “
- WHERE THERE IS NO VISION, THE PEOPLE WILL PERISH*



A Vision for Healthy Food and Physical Activity
Environments in Aotearoa....”What’s Yours?”

KIA ORA!



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Ian Axford (NZ) Fellowship in Public Policy
Fulbright NZ
Dr. Sue Crengle
Dr. Paparangi Reid

Community members and health providers that shared their time and insights with me.

APPENDIX 2: POWERPOINT WITH NOTES – PASIFIKA

Slide 1

The slide features a dark blue background on the left and a white background on the right. The title is in orange text within a white rounded rectangle. The speaker's name and affiliation are in black text. A logo for Ian Axford (New Zealand) Fellowships is on the left, and the CANFIT logo is on the right.

**Policy Implementation for Health Equity:
Examining Healthy Eating and Physical
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Ministry of Pacific Island Affairs

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“Talofa lava, Malo e lelei, Kia orana, Ni sa bula, Halo lo lufala, Fakaalofa lahi atu. Warm Pacific greetings!”

Acknowledgements:

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Blind-folded people and elephant analogy

Whakapapa



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From grassroots to government, I have worked with community-based and youth serving organizations to raise-up local solutions and support the development of culturally competent nutrition and physical activity policies and practices.

***A'oa'l le tamaitiiti ina aua ne'l alo ese
mai ona ala —*** *Instruct a child so he/she will not stray from his/her path*



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- Also from CANFIT: www.canfit.org
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 - Physical Activity Policy Brief
 - Lesson plans, media kits, trainings
 - Youth Media Online (MO Project)



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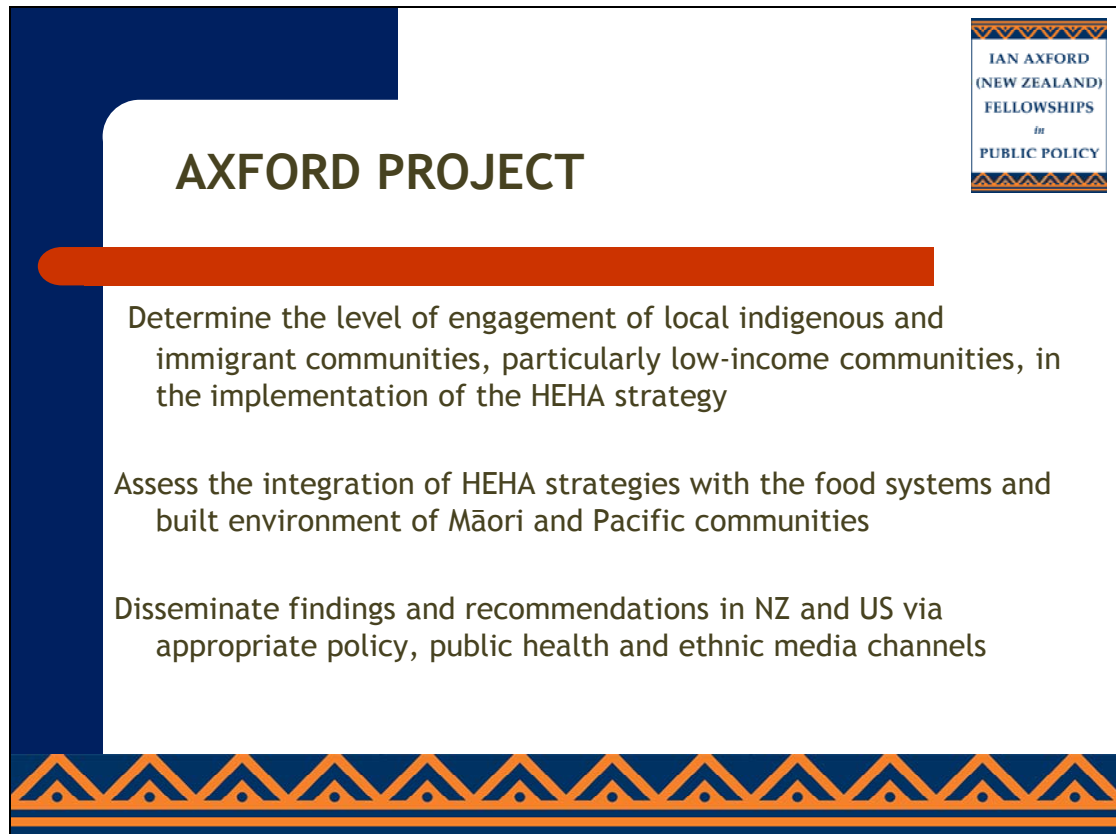
AXFORD FELLOWSHIP:



Established in 1995 to:

- reinforce New Zealand-United States links by enabling Americans to come to New Zealand to gain experience and build contacts in the field of public policy development;
- help improve the practice of public policy in New Zealand and the United States by the cross-fertilization of ideas and experience in the two countries; and
- build a network of public policy experts on both sides of the Pacific, and encourage ongoing policy exchange between New Zealand and the United States.

[See <http://www.fulbright.org.nz/awards/am-ian-axford.html> for more information about this and other Fulbright awards]



AXFORD PROJECT

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- Determine the level of engagement of local indigenous and immigrant communities, particularly low-income communities, in the implementation of the HEHA strategy
- Assess the integration of HEHA strategies with the food systems and built environment of Māori and Pacific communities
- Disseminate findings and recommendations in NZ and US via appropriate policy, public health and ethnic media channels

Practicing healthy eating and regular physical activity can help avoid diseases like diabetes, high blood pressure, kidney failure, heart problems and breast cancer.

Demographic Comparisons: Pacific Peoples in US and NZ

	CA (2007)	HI (2007)	US (2007)	NZ (2006)
Pop.	262,000	269,000	1 million	266,000
% of total pop.	0.7%	21%	0.3%	6.9%

AXFORD PROJECT PROCESS

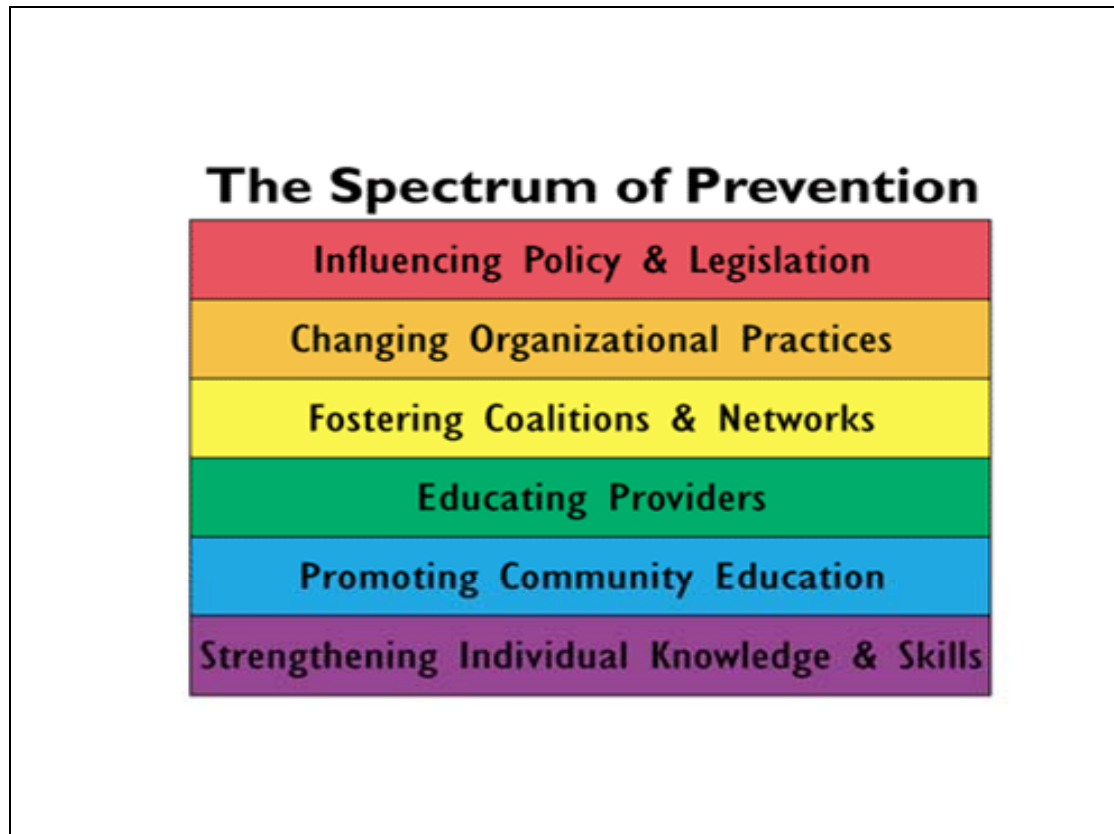


- Reviewed current and archival documents and web sites on HEHA, Māori Health, Pacific Health
- Literature review on Pacific/Māori populations and obesity prevention, eating, physical activity, community development
- 16 weeks of Māori classes
- Attended national, regional and local hui and fonos



AXFORD PROJECT PROCESS

- Interviewed over 100 people from government, DHBs, non-governmental organisations, crown entities, primary care organisations, Māori and Pacific providers, academia, and community members.
- Visited Taranaki, Hutt Valley, Northland, the Hokianga, Rotorua, Tairāwhiti, Christchurch, and Auckland where I assessed the nutrition and physical activity environment, and met with representatives from community nutrition and physical activity projects



In attempting to analyse what I was seeing and hearing in communities, I applied a model that I have used in the past.

The Spectrum of Prevention helps expand prevention efforts beyond education models by promoting a multifaceted range of activities for effective prevention. Originally developed by Larry Cohen while he was director of the Contra Costa Health Services Prevention Program, the Spectrum is based on the work of Dr. Marshall Swift in treating developmental disabilities. It has been used nationally in prevention initiatives targeting traffic safety, violence prevention, injury prevention, nutrition, and fitness.

The Spectrum identifies multiple levels of intervention and encourages people to move beyond the perception that prevention is about teaching healthy behaviors.

The Spectrum is not sequential, all levels need to be happening concurrently

Individual Knowledge & Skills

What's Working:

- ~ 44% of HEHA Community Action Projects going to Pasifika
- "Aru i te ara o te ra"
(Follow the pathway of the sun)
e.g., pursue the positive elements in your culture
Cook Islands Proverb

What Could Change:

- A. Community Action Projects could expand to adopt a complete Spectrum of Prevention approach
- B. Pacific youth and adolescents should be more engaged in programmes
- C. Emphasis on obesity prevention and weight loss can lead people to engage in ineffective and potentially dangerous ways to lose weight.

The Ministry of Pacific Island Affairs conducted a Pacific Youth Leadership and Transformation (PYLAT) parliamentary simulation in Christchurch from 12 to 16 April 2010. Attended by 50 Pacific youth from numerous schools, tertiary institutions and community groups, these youth acted as members of parliament, listening to submissions by lobbyists and community members, and then drafting a communiqué based upon parliamentary debate and discussion. The communiqué stated:

1. "The parliamentarians recognise that obesity and obesity-related health problems are serious issues for Aotearoa/New Zealand's Pacific Island community, because Pacific islanders are at a higher risk than the rest of the population."
2. The PYLAT parliamentarians recognise the usefulness of government initiatives such as the healthy Eating Healthy Action (HEHA) and advocate for the continuation of such programmes that provide for:

Community-based classes focused on healthy cooking and eating habits. And Community activities that promote physical health
3. The leaders note that although the government is not able to control the private sector, this does not mean it cannot influence what happens in the public sector. For this reason, leaders agree that the "healthy foods" in schools policy should be brought back.

[Ministry of Pacific Island Affairs, Pacific Youth Leadership and Transformation (PYLAT) Communiqué, 12-16, April 2010, Christchurch]

Community Education

• What's Working:

- Church based Programmes: (e.g., Enea Ola and Healthy Village Action)
- Zumba classes
- Walking and Water jogging groups

• What Could Change:

- Materials and other visual media should be developed in language rather than being adapted (e.g., Pacific messages may need to vary, youth as a culture)
- Utilise oral culture - storytelling, whakapapa, proverbs, concrete examples - to convey messages about the history and value of healthy eating and activity for Pacific peoples

Church based Programmes:

- Enea Ola - Waitemata DHB, using HEHA funds [third largest Pacific population 30,441 - 2006 census) - involved 850 people in 26 Pacific church and community groups in west Auckland and the North Shore. Weekly group physical activity sessions, monthly nutrition advice, training group leaders, and data collection and evaluation by Center for Health Services Research and Policy, and Pacific Health at the School of Population Health, University of Auckland
- Healthy Village Action

Cultural specificity: Messages need to vary depending on Samoan, Tongan, Cook Islands, etc.

Educating Providers

What's Working:

- Pacific Heartbeat Certificate in Pacific Nutrition (2 day and 9 day)

What Could Change:

- A. Create more pathways for Pacific youth and community members to enter nutrition and physical activity workforce
- B. Create/support scholarships and internships (remove barriers such as only Nutrition internship being at Otago)
- C. Actively involve community members in monitoring and evaluation activities
- D. Engage youth providers to incorporate healthy eating and physical activity into existing youth projects

1. \$7.5 million available for Pacific providers for Workforce Development in current budget – if 40% of diseases faced by Pacific peoples are nutrition/activity related, why doesn't 40% of workforce development go towards Pacific health workers that can address these issues?
2. To increase number of Pacific students studying nutrition:
 - address barrier of doing internship/course at Otago (Dunedin), it's a hardship for most Pacific youth (distance, expense, climate, away from family)
 - potential solutions: develop internship/course opportunities in NZ; explore developing a joint agreement with nutrition internship program in Samoa and/or Tonga

Fostering Coalitions and Networks

• What's Working:

- Pacific Island Food and Nutrition Group (PIFNAG) in Auckland
- National Fono in Wellington September 16, 2010

• What Could Change:

- Develop a strategy to obtain funding to support healthy lifestyle programs by working with community trusts and foundations (e.g., ASB Trust and Pacific educational achievement, Vodaphone Foundation and at-risk youth, National Convergence Partnership in US)

[Business and Economic Research Ltd (2007): Giving New Zealand, Philanthropic Funding 2006 Wellington: Philanthropy New Zealand]

Annual distributions by family trusts and foundations was estimated at \$353.7 million NZD recorded by BERL in 2006.

The four activities that received the greatest amount of funding accounted for over three quarters of grant funding. These activities were culture, sport and recreation (27 percent), education and research (24 percent), social services (16 percent) and health (10 percent). BERL estimates that gaming machine societies provided just over 45 percent of the funding in the first category to sports. p.2

US Example: National Convergence Partnership consists of all of the largest health foundations in the US, pooling their resources to address Healthy People, Healthy Places

Changing Organisational Practices

- **What's Working:**
 - Pacific Community leaders are stepping up and becoming role models for healthy eating and physical activity
- **What Could Change:**
 - Strengthen governance, leadership, accountability, and fundraising capabilities of Pacific organisations
 - Convene dialogues on cultural beliefs and attitudes that support and hinder Pacific peoples' attainment of healthy lifestyles

Example: Cultural beliefs and attitudes such as generosity, portion size, meal components

Influencing Policy and Legislation

• What's Working:

- "Ala Mo'ui - Pathways to Pacific health and Wellbeing 2010-2014" action plan - launched March 12, 2010
- MoH funding (via HEHA) is going to Community Action Projects in Pasifika communities

• What Could Change:

- A. Policy implementation needs to more completely align with principles of Pacific engagement and community development
- B. Community Action Projects - current funding levels are too low, oversight and governance are often driven by DHB and Government priorities rather than community wisdom, funding is not sustainable

“Ala Mo’ui - Pathways to Pacific Health and Wellbeing 2010-2014” action plan - launched March 12, 2010. “Ala Mo’ui” means “pathways to the essence of life force” and encompasses physical, mental, cultural and spiritual wellbeing. (replaces the Pacific Health and Disability Action Plan of 2002)

- plan recognises that child and youth health, reducing obesity are amongst greatest health concerns in Pacific populations
- govt is putting \$4 million into Pacific provider Workforce and Development Fund

POLICY RECOMMENDATIONS:

1. Just implement it!
2. Utilise Whānau Ora to improve healthy lifestyles by working with Māori (and Pacific) communities to develop eating and physical activity whānau outcomes
3. Develop strategies that work outside of church settings, especially for youth
4. Adopt a Health At Every Size (HAES) approach to shift emphasis to chronic disease prevention and physical, mental well-being, and remove weight stigma

1. There are numerous well-written policy reports and documents that outline policies and strategies needed to address healthy eating and physical activity. Yet, there seems to be “analysis paralysis” when it comes to implementing programmes. Resist the urge to conduct more studies, and instead work on the challenges involved in implementing quality, culturally-relevant programs in Pacific communities.
3. The age structure of the New Zealand Pacific population reflects a dynamic trend in immigration status with sixty percent of the current Pacific population being New Zealand born. However in those under 15 years old, 81% (46,126) were born in New Zealand, 2026 Projections: 482,300 Pacific under 25 yr old (53% of the under 25 population) [Statistics New Zealand and Ministry of Pacific Island Affairs (2010). Demographics of New Zealand’s Pacific Population. Wellington]
 - In the 2006 Census, 14% of Pacific ethnicity said they had no religion. Half of Pacific peoples with no religion were aged under 15 years. [Statistics NZ]
4. Health at Every Size is based on the simple premise that the best way to improve health is to honor your body. It supports people in adopting good health habits for the sake of health and well-being (rather than weight control). Health at Every Size encourages:
 - Accepting and respecting the natural diversity of body sizes and shapes.

- Eating in a flexible manner that values pleasure and honors internal cues of hunger, satiety and appetite.
- Finding the joy in moving one's body and becoming more physically active.



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POLICY RECOMMENDATIONS:

- 5. Monitor Government's role (i.e., funding, training, evaluation, community based participatory research (Pacific Governance rather than Relevance), workforce development) in providing resources to Pasifika organisations
- 6. Share knowledge and collaborate/coordinate with other Pasifika organisations to optimize value and reduce duplication
- 7. Support the organisation of National and Regional Pacific Nutrition and Physical Activity networks and coalitions

5. Adopt a “Pacific Governance” (rather than “Pacific Relevance”) framework for all future HEHA-type work - Health Research Council New Zealand website (July, 2010)

Community-based Participatory Research (CBPR) is a strategy at the intersections of research, practice, and policy; and as such, can be used as a vehicle for helping to promote and support healthy public policies, which in turn can help eliminate health disparities. Inherent in CBPR are two concepts relevant to eliminating health disparities: distributive justice and procedural justice.

“...distributive justice also can relate to disproportionate lack of access to resources or assets, such as safe recreation areas and stores selling high quality and affordable fresh fruits and vegetables.” while procedural justice is defined as “equitable processes through which low-income communities of color, rural residents, and other marginalized groups can gain a seat at the table-and stay at the table, having a real voice in decision making affecting their lives.” pS81

“CBPR can help create policy environments that promote procedural as well as distributive justice and develop, enact, and enforce measures aimed at eliminating health disparities.” pS86

[Minkler, Meredith. “Linking Science and Policy Through Community-Based Participatory Research to Study and Address Health Disparities”. American Journal of Public Health. 2010; 100: S81-S87]



POLICY RECOMMENDATIONS:



8. Support creation, rehabilitation, and maintenance of parks, playgrounds, and recreation facilities in low decile areas and offer quality programming to encourage and support physical activity
9. Hold District Health Boards (DHBs), Primary Health Organisations (PHOs), and the Ministry of Health (MoH) accountable for addressing the nutrition and physical activity needs of Pacific people
10. Advocate for healthy food and physical activity opportunities at your church, workplace, and within your family



8. See CANFIT (2009), After School Physical Activity Guidelines and Expanding Opportunities for After School Physical Activity policy briefs for examples
9. There are 81 PHOs throughout the country. By 2006, 95 percent of the New Zealand population had enrolled with a PHO including nearly all Pacific people. The majority of Pacific peoples (216,766 or 83 percent) are served by 16 PHOs in seven DHBs with the biggest Pacific populations.



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Fulbright New Zealand

Community members and health professionals that shared their time with me

Aloha



APPENDIX 3: IMPLEMENTATION STRATEGY IDEAS

- A. To increase number of Pacific students studying nutrition:
 - address barrier of doing internship/course at Otago (Dunedin), it's a hardship for most Pacific youth (distance, expense, climate, away from family)
 - potential solutions: develop internship/course opportunities on North Island: explore possibility of developing a joint agreement with nutrition internship programme in Samoa
 - establish scholarship programme (similar to Kai O Te Hauora programme established by Kelloggs).
- B. Develop a programme that encourages takeaways to serve healthier food (incentives, promotions, training for staff) – pilot in a specific community.
- C. Create a week-long, marae-based total immersion nutrition and physical activity hui
 - for youth, for people who will be working in Whānau Ora programmes
 - participants are trained to shop, cook healthy food
 - learn physical activity and relaxation tips they can practice at home (and teach to others)
 - all food is healthy, totally supportive environment
 - lots of korero
 - end goal is having a community that can market itself to tourists as a place to visit and maintain a healthy lifestyle, even on vacation
 - cultural aspect à la Rotorua.
- D. Create a “whakapapa” about genealogy of eating for Māori and Pacific – video tape, create in language.

APPENDIX 4: PRESENTATIONS GIVEN

February 22, 2010 – Ministry of Pacific Island Affairs, Wellington

March 26, 2010 – Hapai te Hauora Tapui, Auckland

June 30, 2010 – Clinical Trials Research Unit, University of Auckland

July, 16, 2010 – Agencies for Nutrition Action, Strategic Council, Wellington

August 11, 2010 – Māori Health and Nutrition Providers and District Health Boards (Auckland, Manukau, Waitemata), Auckland

August 23, 2010 – Institute of Public Administration New Zealand, Wellington

September 9, 2010 – Pacific Medical Association, Auckland

September 15, 2010 – Victoria University, Wellington

September 16, 2010 – National Pacific Fono: Improving Nutrition and Physical Activity, Wellington

September 21, 2010 – Te Kupenga Hauora, Medical and Health Sciences, University of Auckland

APPENDIX 5: GLOSSARY

Ako	Learn, teach.
‘Ala Mo’ui	A plan published by the Ministry of Health in March 2010. It sets out the strategic direction and actions for improving health outcomes for Pacific peoples and reducing inequalities between Pacific and non-Pacific peoples.
Aotearoa	New Zealand.
Built environment	The phrase built environment refers to the human-made surroundings that provide the setting for human activity, ranging in scale from personal shelter to neighbourhoods to the large-scale civic surroundings.
Burden of Disease Report	A report entitled <i>Nutrition and the Burden of Disease New Zealand 1997–2011</i> and published by the Ministry of Health in August 2003. It assesses how many premature deaths and years of life lost are attributable to nutrition-related factors in this country.
Community Action Projects (CAPs)	HEHA-funded community projects, aimed at engaging and mobilising Māori and Pacific communities through district health boards.
Community-Based Participatory Research (CBPR)	Community-based participatory research is a strategy at the intersections of research, practice, and policy that can be used as a vehicle for helping to promote and support healthy public policies, which in turn can help eliminate health inequities.
Colonisation	Iwi (tribes) became minority populations in their own lands.
District health boards (DHBs)	Organisations established to protect, promote and improve the health and independence of a geographically defined population. Each DHB will fund, provide or ensure the provision of services for its population.
Enua Ola	Community programme located in Waitemata DHB, (third largest Pacific population 30, 441 – 2006 census) – involved 850 people in 26 Pacific church and community groups in west Auckland and the North Shore. Weekly group physical activity sessions, monthly nutrition advice, training group leaders, and data collection and evaluation by Centre for Health Services Research and Policy, and Pacific Health at the School of Population Health, University of Auckland.
Feeding our Futures	HEHA social marketing campaign.
Fono (fonoj plural)	Meeting, conference.
Fruit in Schools programme	A pilot programme which provides a daily piece of free fruit to primary school children.
Green Prescription (GRx)	Written advice for physical activity delivered in a primary health care setting. The initiative is designed to address a range of diseases resulting from inactivity. Currently a range of primary health organisations, DHBs, Māori health providers and physical activity providers are

	engaged in the programme and support for patients is serviced by the regional sports trusts.
Hapū	Sub-tribe.
Health at Every Size (HAES)	HAES is a health promotion based on the simple premise that the best way to improve health is to honour your body. It supports people in adopting good health habits for the sake of health and well-being (rather than weight control). Health at Every Size encourages: accepting and respecting the natural diversity of body sizes and shapes; eating in a flexible manner that values pleasure and honours internal cues of hunger, satiety and appetite; and finding the joy in moving one's body and becoming more physically active.
Healthy Action-Healthy Eating (HEHA)	Government programme to address the increasing prevalence of non-communicable diseases.
Health Research Council (HRC)	The major government-funded agency responsible for purchasing and coordinating health research and fostering the health research workforce in New Zealand.
Health workforce	Includes any providers that contract for health services including DHBs and PHOs.
He Korowai Oranga	The Māori Health Strategy. The overall aim is whānau ora: Māori families supported to achieve their maximum.
High-needs group	A group that has a high level of health inequality relative to the local community or wider society to which the group belongs. Ethnic identity (Māori, Pacific peoples) and poverty are associated with high levels of health inequality.
Hui	Meeting.
Iwi	Tribe.
Kaiawhina/kaimahi	People who work within and amongst whānau, hapū and iwi to deliver services that are based around support rather than clinical objectives.
Kaimoana	Seafood.
Kai tōtika	Healthy food.
Kaiwhakahaere	Administrator.
Kāinga	Home.
Kaumātua	Elder.
Kumera	Sweet potato.
Kura Kaupapa Māori	Māori language immersion school.
Manuwhiri	Guest.
Māori kaupapa	Māori values, traditions and aspirations.
Manaakitanga	Responsibility and care of whānau members.
Marae	Enclosed space in front of a Māori meeting house.
Mission-On	Initiative aimed at improving food and nutrition in schools and early childhood centres.
New Zealand Health Strategy	A strategy published by the Ministry of Health in December 2000. It provides the framework within which district health boards and other organisations across the health sector will operate and highlights the priorities the

	Government considers to be most important.
Non-communicable disease	A disease which is not contagious, examples of non-communicable diseases include heart disease, cancer, asthma, and diabetes.
Obesity	Having a body mass index (BMI) greater than or equal to 32 for Māori and Pacific peoples, and a BMI greater than or equal to 30 for all other New Zealanders.
Ottawa Charter	Document produced by the World Health Organization in 1986 which describes the process of enabling people to increase control over and improve their health status.
Overweight	Having a BMI greater than or equal to 27 for Māori and Pacific peoples and a BMI of greater than or equal to 25 for all other New Zealanders.
Pacific peoples/Pasifika	Encompasses a diverse range of peoples from the South Pacific region (e.g. Tongan, Niuean, Fijian, Cook Island Māori, Samoan and Tokelauan) living in New Zealand, who have migrated from those island nations or identify with them because of ancestry or heritage.
Pākehā	non-Māori, European, Caucasian.
Physical activity	Movement, produced by the contraction of skeletal muscles, which people need to do on a daily basis, and at recommended levels of intensity and duration to sustain a healthy life.
Physical activity workforce	Workers who are employed by organisations that promote physical activity such as regional sports trusts, YMCA, YWCA, local authorities community providers and gyms.
Primary health organisations (PHOs)	A group of health providers whose job it is to provide primary health care to all people enrolled with them. The group will always include a GP and may also include some or all of nurses, Māori providers, Pacific providers, health promotion and public health workers, pharmacists, dietitians, mental health workers, community health workers and dentists – often working in teams. PHOs are the local provider organisations through which district health boards will implement the Primary Health Care Strategy.
Public Health Services Handbook	A manual produced by the Ministry of Health to describe the range of public health services purchased by the ministry.
Rangatahi	Adolescent.
Regional sports trusts (RSTs)	Independent charitable trusts, governed by boards of trustees, based in 17 regions of New Zealand. They are contracted by Sports and Recreation New Zealand (SPARC) to promote sport and physical activity, to deliver targeted interventions, and to support the other sport and physical activity providers in their region.
Rūnanga	Tribal authority.
SPARC	Sport and Recreation New Zealand

Strengths-based approaches	Approaches that build on the positive capabilities of Māori whānau, individuals and communities. It requires a shift of focus from what doesn't work to what does, and the potential in an individual, whānau or community.
Tangata whenua	Local person, person of the land, implies Māori.
Tikanga	Customary practice, rule.
Tipuna	Ancestor, grandparent.
Treaty of Waitangi	New Zealand's founding document, signed in 1840 between Māori and English.
Wairua	Spirit, soul, attitude.
Wānanga	Seminar, series of discussions.
Whakapapa	Genealogy, cultural identity, whakapapa links Māori through their ancestors (tipuna) to the land of New Zealand.
Whakataukākī	Proverb.
Whānau	Family.
Whānau ora	Healthy family. The government's new family-based approach to delivering social services to families in need.
Whānaungatanga	Having a shared vision and connectedness.
WHO 2-1-22 Plan	Strategy for Pacific countries and territories to reduce incidences of non-communicable diseases.
WHO Global Strategy	The WHO Global Strategy on Diet, Physical Activity and Health is a strategy under development by the WHO in recognition of the heavy and growing burden of non-communicable diseases.

Source: Adapted from *Healthy Eating – Healthy Action: Oranga Kai – Oranga Pūmau: Implementation Plan 2004–2010*, 2004