

New Zealand Health Education Association

Newsletter

September, 2026

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Tēnā koutou katoa

Well, the waiting is over. The refinements to the remaining learning areas have been made and the Health and Physical Education Phase 1-4 curriculum was released after an unexpected delay on September 15th. An overview of the refinements (and changes to the 2025 HPE draft) feature later in this newsletter.

The finalised version of Te Waiora Tau 1-10 (Te Marautanga o Aotearoa) was published 25 September. There are teaching resources for TMOA here:

[Teaching resources to support the updated TMOA.](#)

At this time, we are still waiting to hear when the refined versions of all the Phase 5 curricula will be available.

In relation to Phase 1-4 it is useful to note the implementation statement on page 2 of the HPE curriculum:

The content of this document is proposed to be made by the Minister of Education as a National Curriculum Statement under section 90(1)(a) of the Education and Training Act 2020. Once made and published in the *New Zealand Gazette*, it will set the requirements for the teaching of Years 0–10 Health and Physical Education in state schools, and schools will be required to start using it in Years 9–10 from 1 January 2027 and in Years 0–8 from 1 January 2029.

Depending on their contexts, some schools may not be ready for full implementation on day one of the specified school year, so the following transition arrangements are proposed to apply:

- **For students in Years 0–8**, schools will need to make a start by developing, and then executing, a plan that achieves full implementation as soon as practicable and by no later than the end of 2030.
- **For students in Years 9–10**, schools will need to make a start by developing, and then executing, a plan that achieves full implementation as soon as practicable and by no later than the end of 2027.

Also, the [HPE landing page](#) on Tāhūrangi contains a chart showing the phasing out of the 2007 curriculum and phasing in of the 2026 one.

The purpose of Health Knowledge in a national curriculum: *Health in the curriculum is a disciplined course of study about Health.*

For many years there has been persistent confusion and misunderstanding over the role and place of Health (education) in schools. All too often health

education and health promotion are conflated (even though - as a matter of policy - they have been distinct for many years).

This curriculum will force that distinction to become clearer.

- Sometimes students may be able to use their learned Health Knowledge in their own lives (where conditions and circumstances allow).
- Sometimes that Health Knowledge will enable them to better understand the health experiences of others.
- Some Health Knowledge may connect with and support wider/whole school approaches to the promotion of student health and well-being.
- Some Knowledge will 'simply' be about understanding the nature of health as it features in people's lives across the world so that when a situation is encountered in person or in media, the student has the knowledge to understand the health aspects of that situation – in the same way students learn and use science, or social science or technology (etc) knowledge to understand their world.
- Some Health Knowledge will lead students to Phase 5 qualifications and on to tertiary and career pathways beyond school.

That is, the long-assumed health promotion purpose of learning about Health in the curriculum is only a (small) part of the story.

Ministry led PLD for Phases 1-4: We are aware that nationwide Ministry of Education funded PLD for all learning areas is about to be contracted. From the official request for proposals (RfP) on 1 September we note this PLD has to be for the whole learning area and cover all years 1-10 which means these contracts will go to some of the major PLD providers or networks who have the infrastructure for large scale PLD. More details to come once we know more.

NZHEA PLD for Phase 4: By the time you are reading this, our Phase 4 (only) NZHEA workshops will be underway (albeit our Wellington and Auckland ones had to be cancelled due to the late arrival of the curriculum). We are making bespoke arrangements in term 4 for some regions, and in response to local jumbo days (where these are being planned).

NZHEA PLD for Phase 5: PLD to support Phase 5 Knowledge teaching will begin in earnest in 2027. We plan to develop a lot of online accessible content for self-directed PLD that can be viewed any time (mini lectures and online learning modules focused on Health content Knowledge). Phase 4 is likely to dominate in-person PLD in 2027 so any in person support for Phase 5 will need to be in regional clusters and work around Phase 1-4 developments.

Ministry funded resourcing: The Ministry is in the process of contracting the services of a resource developer to develop learning kits for Phase 1-4 covering all learning areas and for all Phase 5 subjects. We expect to hear more about this soon.

There is also a [range of material](#) accompanying the curriculum document as follows. Note especially the guidance around the changes to Section 91 ***Informing the community about the Health curriculum***. This also contains material related to Section 51 (release from sexuality education).

-  [Health-and-PE-0-10-What's-new-supporting-document.pdf](#)

-  [Health-and-PE-0-10-Conceptual-mapping.pdf](#)

-  [Health-and-PE-0-10-What-you-told-us-report.pdf](#)

-  [Health-and-PE-0-10-Consultation-feedback-analysis.pdf](#)

-  [Health-and-PE-0-10-15Sep26.pdf](#)

-  [Informing-your-school-community-about-health-curriculum.pdf](#)

-  [Physical-Education-Activities-for-Years-0-10.pdf](#)

NZHEA resourcing: Any resourcing we develop as part of our Networks of Expertise outputs will be open access. The first iteration of this material will accompany the term 3&4 workshops and be accessible via the link on the NZHEA website (see [New Curriculum PLD and resourcing](#) on the landing page).

By the end of the year, we aim to provide teachers with:

1. A **Teacher guide** – the first draft is already in the folder with the workshop materials – see link above.
2. An ‘unpacking’ of all Year 9&10 Knowledge with suggestions for teaching approaches and the development of the Practices.
3. Some examples of units and yearlong course plans (note that 2027 Ministry materials will also do this).
4. Learning journal and workbook source materials (to cut and paste, adapt and make your own).

NCEA: In the meantime, NCEA continues for this year and another one (Level 1), two (Level 2) or three (Level 3) years. The Ministry have advised us that there will be no changes to Health Studies or Health Standards in 2027. The minor changes that were made to 3.2 and the changes in NZQA practice around the way Level 1 is marked is causing some consternation for those marking practice/derived grade exam. A brief statement follows about this.

Being receptive to external interests and support vs patch protection and looking after education business

Any developments that put Health curriculum matters in the news inevitably draws attention to what we do, some of it un(der)informed, unwanted and unhelpful. If you are approached by anyone from the media for comment, please ensure any response goes via your principal.

Once your Year 9&10 programmes are developed, we would recommend following Ministry guidance to have a statement about these permanently on your school website (behind a login) so it can be viewed by parents at any time (see the new Ministry guide on Education and Training Act 2020 Sections 51&91).

We are also aware that many health promotion and health education-aligned agencies are (understandably) seeking to redirect or repurpose their services

and materials to align with this new curriculum. *Can we respectfully recommend you are very wary of materials and other offerings from agencies that claim to support the new curriculum over the coming months.* As you will be discovering – working *within* the education sector - the changes are substantial so question the position and authority of external agencies who claim to be up to speed with these changes.

Unless these services and resources have come from a known and reputable educational resources developer who have been heavily invested in resourcing curriculum and implementation (and that is a VERY small and exclusive group at this time), it is highly unlikely these materials will be compliant with new Health curriculum. *This is not a case of making a few tweaks and then back to business as usual.*

We expect many agencies will still be producing resources and/or providing services for teachers or students more suited to the whole school (non-curriculum) space.

Being cognisant of our inherent vulnerabilities given our subject matter

To protect our interests, and yours, from unsupportive individuals, groups and organisations, we try to conduct most of our business away from public view (especially on social media) which is why we keep the Facebook community closed. If you are inviting someone to join the NZHEA Secondary group, please direct them to the questions they need to fill in. Without a suitable response to these questions, we decline.

Annual General Meeting

AGM obligations were fulfilled for another year on the 9th September. At such a pivotal point in time, with curriculum materials just out, and with so many unknowns ahead, association business was largely perfunctory. With major resourcing and PLD initiatives about to get underway, which NZHEA expect to make some sort of contribution to, we will need to revise our strategic plan. More about this in the new year once more is known.

In this newsletter

- From the Kaikōtuitui Arataki Oranga - Leigh Morgan - includes NCEA Advice and Guidance
- PLD Events – for the remainder of 2026
- Overview of refinements (i.e. changes) to the Phase 1-4 HPE Health Strand
- A brief history of ‘hauora’
- A sample of recent books and reports.

Pace your yourselves. The juggernaut of educational change is now up and rolling (finally). It won't be fast (despite the assumptions made by the published timelines). Let's hope the place of Health in the national curriculum is seen as having the same status and value as other subject matter – evident in the amount of timetabled time, qualifications, training and expertise of teachers, and the quality of resourcing.

Ngā mihi

Leigh Morgan (chair), Jenny Robertson, Shelley Hunt, Annie Macfarlane, & Vicki Nicolson (executive)

From the Kaikōtuitui Arataki Oranga - Leigh Morgan

Kia ora koutou katoa

There is a lot of important information in this newsletter so I will aim to keep my report as concise as possible. It includes some feedback about the Phase 4 Health Education curriculum PLD and NCEA advice and guidance.

NZHEA Phase 4 Health Education PLD:

After the delayed release of the Phase 4 HPE curriculum it was pleasing to facilitate one of our three planned workshops in Ōtautahi Christchurch on 17th September with nearly 70 kaiako.

I have been asked if the cancelled workshops in Wellington and Auckland will go ahead in term 4 now the curriculum has been released and unfortunately, I can't give a definitive answer *at the moment*. I have other commitments scheduled for term 4 and we are trying to work around those. Also, as the first 4 weeks of term 4 are generally "no go" because of senior exams prep, prize giving's, etc, there isn't much time left for this to happen!

NZHEA will prepare a full folder of materials for teachers including voiceover PowerPoints and supporting resources. We will also look at holding online webinars after school in term 4. Our PLD will continue into 2027, so if I can't arrange a face-to-face session this year, we will schedule one for 2027.

I will keep members informed via email groups of those who RSVP'd, cluster groups, our newsletter, and the NZHEA secondary Facebook page.

NCEA advice and guidance:

With practice/derived grade exams featuring on many school calendars late term 3 and early term 4 there are a few questions surfacing. Please note, each year it is NZQA's prerogative to change the exam format, but it should be aligned to the standard. The 2026 NZHEA practice exams "generally" follow the layout of the previous years' NZQA exam. NZHEA responses for some common concerns with particular practice exams are provided below.

- **Level 1 Health studies (1.3 & 1.4)**

NZHEA noticed NZQA has changed the way these exams are marked. See the NZHEA May [newsletter](#) p5.

This is why we put the following disclaimer on both the 1.3 and 1.4 NZHEA practice exam

We are not confident that the 2025 exam that this practice exam is based on meets the standard as originally intended. NZQA appear to have adapted their approach to the level 1 examinations whereby evidence is able to come from across the paper, seemingly from questions that do not specifically ask an A, M or E question, but where evidence could be interpreted to fulfil requirements. As this seems to be currently accepted practice, we have retained this approach.

The best advice I can give for level 1 health studies is DON'T mark by question, mark by the A, M and E explanatory note requirements across the exam paper.

- **Level 2 Health Education (2.1)**

The influences question in the practice exam caused some confusion. The question as framed was asking about influences on mental health, as a result of social media (use). These could be positive or negative: "Explain how teenage mental health may be influenced by social media. Include one personal, one interpersonal, and one societal influence".

This framing emphasises the influences that impact mental health through/as a result of social media use, not the influences on social media behaviours as such. As Jenny mentioned in a Facebook reply, another way to think about it is people engage with/use social media in different ways. So what factors influence people to use social media in positive ways = ways that influence mental health in positively? And what factors influence people to engage with social media in ways that have negative impacts on mental health?

- **Level 3 Health Education (3.2)**

A few of you spotted the mistake in the International Health Issue assessment schedule where I had left the word “determinants” and it should have read “factors”. The practice exam did use the word factors. Thank you for picking that up.

As per the advice in the [NZHEA Level 3 Health Education Handbook](#) p52

Note that for 2026 the RAMP process changed the term ‘determinants’ to just ‘factors’ in the standard, for consistency with AS91461 (NZ health issues) that had made the same change the year before. The nature of international health issues still requires students to understand the determinants of health because these ARE THE FACTORS that cause and sustain these large-scale population issues.

The factors that students write about don’t have to exactly match the wording of the determinants of health noting that Explanatory note 4 in the [3.2 standard](#) states:

Factors that influence a health issue could include:

- *economic considerations*
- *social norms*
- *policy decisions*
- *location.*

We can think of **social norms** as cultural attitudes, values and practices. The term **location** is not something NZHEA has used in previous resourcing or exams.

In addition to practice exams, through moderation we picked up a question about referencing of level 3 internal assessments e.g. 3.3 and 3.4 which don’t specifically ask for “evidence” in the explanatory notes (compared to 3.1 which does). Referencing and using a particular format to do this is not a requirement of these standards, but we recommend students clearly identify and distinguish any material that is not their own in ANY of the internal assessments.

I hope you can schedule some down time over the school holidays.

Ngā mihi nui
Leigh

For all NEX queries about NZHEA support email us at kaiarahi@healtheducation.org.nz

PLD Events – for the remainder of 2026

Needless to say, our time and financial resources will prioritise the new curriculum implementation for the remainder of 2026.

Networks of Expertise supported Phase 4 workshops are underway. Regional arrangements are still being made for Term 4 (e.g. through existing NZHEA clusters and regional jumbo days). These workshops will be ongoing into 2027 when we also expect to start supporting the introduction of Phase 5.

Online webinars and discussions are also an option for this year.

At this time some of these plans are quite ‘fluid’ and communication about these is through regional networks.

Nationwide Ministry funded PLD will also begin in 2027.

Self-directed PLD for Phase 4

If you are unable to attend a PLD event this year (due to our cancellation of Wellington and Auckland or a lack of access to an in-person event), we will be providing extended recordings of the workshop presentation and the workshop materials in the [Google folder](#) accessed through the NZHEA website (**see folder ‘A’ and use the subfolder headings to identify and access the various materials**). You can use these materials individually or as a department.

Asking questions

If you have urgent implementation questions, please email us at kaiarahi@healtheducation.org.nz and we will answer what we can.

We have also set up a Google survey form as a way to collect questions for a Q&A resource. You will find the beginnings of this resource in the PLD folder. We will check incoming questions periodically, and especially round days when we know PLD events are occurring and add your Q with answers as best we can.

Submit non-urgent questions for our Q&A resource through this link <https://forms.gle/1XCAUBERey98AQ55A>

NCEA support

Your NZHEA membership provides us with enough resource to continue supporting NCEA and broader health education related queries online and via email.

Overview of refinements (i.e. changes) to the Phase 1-4 HPE Health Strand

What has changed?

As we predicted, the HPE draft has undergone considerable redevelopment. The following list summarises the main changes to Health. These will be explored in more detail in our workshops and through resourcing (see the draft Teacher Guide in the PLD folder for more details).

- All health-related Knowledge is organised under the **Health strand**. The term ‘Health Education’ – where ‘education’ implies a teaching and learning process – is no longer included in the curriculum. Schools can still call their courses health education or choose another term. The point is this is Health (curriculum) Knowledge. It is a ‘disciplined’ course of study about Health.
- The two Health **Elements** are now named by the more familiar **Physical and Mental Health** and **Relationships** (Phase 1-2) and **Relationships and society** (Phase 3-4) (aka social well-being) to reflect the World Health Organization definition of health and the Phase 5 framing.
- The **sub-elements (or topics)** are as follows, noting how some topics phase in and phase out across the year levels to allow for learning progression reflecting students’ cognitive, physical, social, and other development, and their increasingly diverse experiences of the world as they get older.

Phase	Years	Element: Physical and mental health	Element: Relationships (Phase 1-2) Relationships & Society (Phase 3-4)
1	1-3	- Approaches to health - Body care - Mental health	<i>Relationships*</i> - Boundaries and safety
2	4-6	- Approaches to health - Body care - Mental health - Online safety - Puberty (years 5-6)	<i>Relationships</i> - Consent - Inclusive communities
3	7-8	- Approaches to health - Nutrition (year 7) - Alcohol and other drugs (year 8) - Mental health - Online safety - Puberty	<i>Relationships</i> - Consent - Sexual relationships (year 8) - Inclusive communities
4	9-10	- Approaches to health - Nutrition (year 9) - Alcohol and other drugs (year 10) - Mental health - Online safety - Sexual health	<i>Relationships</i> - Sexual relationships (<i>includes consent</i>) - Inclusive communities

*Note the use of the term ‘relationships’ is problematic as it is needed for both the Element name and to refer to some of the sub-element topics. *In the curriculum ‘Relationships’ only appears as the name of the Element* but for summaries like this, it is useful to head the first few Knowledge statements in the Relationships (Phase 1-2) and Relationships and society (Phase 3-4) Elements with this term (meaning any platonic, non-sexual relationship).

In essence the Relationships (Phase 1-2) and Relationships and society (Phase 3-4) Element is all about social well-being. As a matter of ‘health’ the collective Knowledge of this Element all relates to social wellbeing in the WHO definition.

- **Knowledge** statements are now phrased as statements of Knowledge, not health promotion messages as dominated the draft.
- The approach to **Practices** has been completely redeveloped and follows the same approach used by several other learning areas (noting PE has not used this). Practices help to ‘discipline’ the subject Knowledge – **this is what students can do with their Knowledge in a course of study about health**. In the draft these Practices had (in error) been framed mostly as behavioural outcomes which did not reflect a knowledge-rich approach.

There are only three practices. They are the same for every year level and lie across all Knowledge for each year level. These Practices are accompanied by examples that show how to teach them in progressively more complex ways. **The mandated requirement is to teach the three practices (that is the bolded statements in the curriculum)** – and see below. The examples in the curriculum are *just examples* and are NOT mandated.

- *Describe a health and well-being situation*
- *Use evidence to explain influences on health and well-being*
- *Select, evaluate, and justify actions to maintain or enhance health and well-being*

These Practices should be highly familiar to anyone who has used Health (Studies) Achievement Standards. Resourcing will provide guidance about how often to use these and the likelihood these will form the basis of assessment. Each Knowledge statement is closely aligned with one of the Practice statements. Whereas Knowledge requires some form of overt or direct teaching, teaching the Practices is where critical thinking will feature.

- There is no longer an incongruous ‘sex education’ element. All **sexuality Knowledge** is included as sub-elements of **Physical and Mental Health (puberty or sexual health)** or **Social well-being (sexual relationships)** to emphasise these aspects of sexuality as Health Knowledge and how it links with other (non-sexuality) learning in these elements. Some aspects of sexuality may also be included with consent (although at Phase 4 this is integral to sexual relationships anyway), online safety, or identity (as an aspect of mental health). All human reproduction Knowledge is in Science: Body systems with the basics of all reproduction in Year 4 and a detailed focus on human reproduction, including menstruation, at year 8.
- The **Approaches to health** sub-element provide a progression to Phase 5. We need to avoid treating it like the previous underlying concepts – it is not. Instead, it is some foundation Knowledge to gradually build understanding of health as a concept.
- There is some limited consideration of **te ao Māori**, that is a Māori perspective on ‘health’ and a perspective on ‘relationships’. This framing as ‘te ao Māori’ (i.e. from a Māori world view or perspective) is deliberate and is not to be conflated with or assumed to be mātauranga. Health-related knowledge claimed as mātauranga features in Te Waiora in Te Marautanga o Aotearoa where it remains culturally located and taught through the medium of te reo Māori which is critical for giving mātauranga its meaning. *See following summary of the history of the term hauora and the meaning the curriculum has used since the 1990s.*
- Law reform changes to Section 91 (effective as of 6 July 2026) means that schools no long need to consult their school community (i.e. parents) about the health curriculum, only inform. See the Ministry guidance document about this accompanying the curriculum.

- Te Mātaiaho has been redeveloped (see 9 September version). This is an important document as it provides the overarching framework for all learning area curriculum statements.
- There are no longer key competencies but capabilities. See te Mātaiaho for more details.

What hasn't changed from the 2025 draft

- The requirement is to teach ALL Knowledge at each year level. That is all Knowledge is mandated, as are the three Practices.
- The way the Knowledge is organised into units and the order in which the Knowledge is taught is up to schools to decide.
- Schools can bring in local knowledge, or examples that responds to learner interests and current issues where 'such as', 'including' and 'e.g.' are used.
 - **'Including'** means that what is stated must be covered but other ideas can be added.
 - **'Such as'** are just examples and do not have to be included but it is suggested that they are as these are usually some of the more useful examples to include.
 - **'e.g.'** tends to be used in cases where there are many possible examples and the selection of only a few relevant ones is required.

Note that guidance around assessment is pending but we imagine it will feature the Practices in some way.

Next steps

There is much more to discover about this new curriculum, and we would encourage teachers to engage with the NZHEA resourcing – *some of it may save you time*. Our involvement in the development process gave us some insights we are able to pass on. We see our resources as complementing those the Ministry provides by offering greater depth of understanding of the specialist subject matter.

Over the next couple of months, we aim to make available the following resources. These (for the moment) will be filed in the PLD folder accessible via the [NZHEA website](#) link.

- We are making available a **DRAFT Teacher Guide** which we aim to refine and complete by early 2027, once we see how it 'lands' and what we need to add or change.
- The term 3&4 **workshop PPT** has been **divided into sub sections**, each expanded to include more detail (from the Teacher Guide). The recorded versions of these PPTs can be accessed any time in addition to or instead of attending the workshop.
- **'Unpacking' the Knowledge statements**, with additional suggestions for Practices is a major piece of resourcing that we aim to complete for Phase 4 by the start of term 4. To be able to teach each Knowledge statement requires unpacking it sufficiently to work out what to teach so that year 9&10 students will understand it, as well as decide which examples to add (where there is choice), and what added context can be applied (e.g. through scenarios). Hand in hand with unpacking the Knowledge is deciding how to teach it in a way that students will understand it and be able to learn it.

NZHEA does NOT expect every teacher of Health to individually and independently unpack every Knowledge statement. *You can if you want to, but ...*

Workshop materials include an unpacking task and an example to get an idea of what is involved. Although teachers will need to plan their learning programme (see below) it is not expected that every teacher will (or will want to) unpack every Knowledge statement to work out what to teach – this is where NZHEA will help.

The key premise of this curriculum design is to achieve far greater consistency and less variability within and between schools, across all learning areas. The Knowledge being taught in every school should be very similar, albeit with local examples and contexts added.

Planning (from the workshop materials)

Suggested process – but do what works for you/your school

Initial discussion - as required:

- Review and discuss the overall topic coverage of Year 9 and 10 in the new curriculum. *What's familiar? What's new? Does anything raise issues for you around the presence or absence of Knowledge at that year level? Look at the Year levels before and after – is it covered there?*
- What (does it appear) you can 'recycle' from your current Year 9&10 programme?
- Start to think about the units/topics you would include earlier in a programme. What Knowledge would lend itself to an introductory unit? What would come later?
- Which sub-element Knowledge statements would seem to connect well – where one leads on from another, or where one sub-element could be broken up (e.g. with some mental health Knowledge statements connecting with one topic and the remainder with another)?
Note: Don't feel you need to teach each sub-element (as documented in the curriculum) as a contained topic of itself. It is expected that Knowledge from 2-3 sub-elements could be combined into a unit and it is called something other than the sub-element name.
- What would seem to be the most natural order of topics (in context of your school)?
- **Develop a 'working list' of MAIN unit or topic titles for each year level (these may change a bit as you develop your course). As far as possible, recycle units/topic titles from your existing Year 9&10 Health programme that 'work' and you want to keep (noting the details may need to change).**

Planning the details

We haven't provided templates for this on the understanding your school may be directing you to how they want planning formatted or you have existing templates for this.

Option 1. Planning from the Knowledge statements

This approach starts with the Knowledge and moves through to the Practices. There may need to be some movement back and forth between steps.

1. Organise ALL the Knowledge statements under the relevant unit headings.
2. Map out the likely teaching order of all the Knowledge statements for each unit.
3. A useful planning task worth doing is to code each Knowledge statement in terms of which Practice it contributes to:

Practice	Look for Knowledge statements that:
Describe a health and well-being situation	Focus on understanding what the health aspects of a topic are about – how it affects physical, mental and/or social well-being.
Use evidence to explain influences on health and well-being	Refer to influencing factors, what has contributed to a health situation, or the reasons why the situation has come about.
Select, evaluate, and justify actions to maintain or enhance health and well-being	Are self-evidently referring to strategies and ways of taking action, use of personal/self-management or interpersonal communication skills, advocating or contributing to community actions.
A Practices 'shorthand' might be useful when thinking about the connections between Knowledge and Practice e.g. P1. Health, P2. Influences, P3. Actions	

Note that most Knowledge statements will link only to one Practice.

4. Document some initial examples of Practices for each of the three Practice statements – one of each for each main 'unit' of teaching and learning *is suggested* (at this time). You can develop multiple Practices but given time constraints it would seem (for critical thinking purposes) that one 'good

quality' development of each of the three Practices for each unit is preferable to several smaller ones.

5. Where there is scope for adding 'e.g.' identify what these examples could be (also where 'including' features, what if anything would be added – remembering 'including' must be taught but these can be added to).
6. 'Unpack' the Knowledge statements (or use the resources provided that do this) to expand the Knowledge details. Decide how you will deliberately and explicitly TEACH the Knowledge and the student learning activities that will help embed this Knowledge. Note any resources and information sources to use for ideas, and/or any existing planning materials that can be repurposed and recycled. Note any learning activities that would produce learning artefacts useful for developing the Practices and for assessment purposes.

This unpacking task only needs to be done once (save minor ongoing refinements) as the Knowledge shouldn't change much. That said, some Health Knowledge will inevitably change and provision for revising curricula on a regular basis is now a feature of the Education and Training Act.

Planning from the Practices

1. Based on your working list of units, **write an example of a topic specific Practice that you would want students to develop for EACH unit - for each of the three Practices.** *It may help to reframe these three practices as topic specific questions when using this approach.*
 - Describe a health and well-being situation
 - Use evidence to explain influences on health and well-being
 - Select, evaluate, and justify actions to maintain or enhance health and well-being
2. Code the Knowledge statements with their related Practice(s) (optional)
3. Organise the Knowledge statements related to and needed for developing each Practice.

Check – compared to the Knowledge to Practice approach, does this approach work any better? What are the pros and cons for each approach? Would some units benefit from one approach or the other?

If using this approach proceed as follows (noting this just reorganises the steps for the Knowledge to Practice planning):

4. Map out the likely teaching order of all the Knowledge statements for each unit.
5. Where there is scope for adding 'e.g.' identify what these examples could be (also where 'including' features, what if anything would be added – remembering 'including' must be taught but these can be added to).
6. 'Unpack' the Knowledge statements. decide how you will deliberately and explicitly TEACH the Knowledge and identify student learning activities. Note any resources and information sources and/or any existing planning materials that can be repurposed and recycled. Note any learning activities that would produce learning artefacts useful for assessment purposes.

Subject (topic) resourcing

Existing resources

- We're hoping a lot of existing resourcing will be useful for teaching Practices – albeit with some adaptation.
- Some existing resourcing may still be useful for teaching the Knowledge statements – where this focuses on content knowledge about health topics.

Future resourcing

- This will need to be year level specific and feature the Knowledge required to be taught at that year level.
- Once the basic understanding of the Knowledge is documented (the unpacking task above), future resourcing will be needed to provide a variety of examples, different scenarios that could be used to teach various Knowledge statements.

A brief history of 'hauora'

With the changing way hauora is included in the curriculum we went down bit of a rabbit hole tracking the history of the use of the term hauora. A summary of findings to date is provided below along with an article from the 1980s. [An extended account of this summary is provided with the Phase 4 workshops materials, accessible via the NZHEA website.](#)

Key developments	References
The origins of 'hau ora' goes back centuries. However, the use of the term 'hauora' to mean 'health' or 'well-being' in the decades leading to the 1980s is unclear based on evidence currently available.	Anne Slamond's book <i>Tears of Rangi: Experiments across worlds</i> (2017), Chapter 1: Hau - The Wind of Life details the concept of 'hau' and includes a very early reference to 'hau ora': <i>Because hau animates all phenomena, in this way of being there are no Cartesian gulfs between mind and matter, animate and inanimate beings, people and environment, Culture and Nature. As the nineteenth-century thinker Nepia Pohuhu remarked: 'All things unfold their nature (tupu), live (ora), have form (ahua), whether trees, stones, birds, reptiles, fish, quadrupeds or human beings.' Hau flows through all things, whether rivers, mountains, forests, reefs, fishing grounds, plants, animals or people.</i> <i>If their hau is in a state of ora (hau ora: health, well-being, prosperity), they will flourish; but if it is in a state of mate (hau mate: sickness, ill-being, misfortune), they will decline and perish. As Tamati Ranapiri explained to Elsdon Best, in catching birds, for example, one must offer the first bird captured to the hau of the forest, to ensure its ongoing ora – its well-being, and protect one's own health and good fortune. This also applies to catching eels in a river, or fish in the ocean. The fundamental kinship between people and other life forms is never forgotten.</i> Note that this entire chapter needs to be read as the explanation of 'hau' is extensive and is not fully captured in this brief extract. Check to see if your school library has a copy of this book.
Early 1980s and the development of a Māori definition of health	The Hui Whakaoranga (1984), attended by many notable Māori health experts of the time, adopted a Māori definition of health. This work was published at the time by: - Ngata, P., Dyal, L. (1984). Health: A Māori view. <i>Health</i> 36(2), p3-5. ('Heath' was the newsletter for the Department of Health at the time.) See copy following. - Durie, M. (1985). A Māori perspective of health. <i>Social Science and Medicine</i> 20(5) p483-486 - It was also reported in Tu Tangata Marae and tribally based health care gets the nod, Issue 18, 1 June 1984, Page 18 Key to note at this time is that the term 'hauora' was not being used and although the definition of health included the familiar taha wairua, taha hinengaro, taha tinana and taha whānau ('taha' being 'the side of'), te whare tapa whā model had not yet been developed (as noted in Durie, 1994) – contrary to several later reflections on these events at the time. As Durie notes in <i>Whaiora: Māori health development</i> (p68-69, 1998 reprint): <i>... For many years it had been acknowledged that there were many dimensions to health. It its 1947 definition the World Health Organization concluded that health was greatly influenced by social and cultural factors: 'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'. The definition was a reminder to the world that there was more to health than biological dysfunction and that it went well beyond the province of the health sector.</i> <i>... During the 1970s Māori were beginning to insist that narrow focus on micro-organisms or even on physical illness created a distorted framework within which to consider health</i>

	<i>and plan for the future ... As Māori participation in the health debate escalated, a number of Māori perspectives were advanced. All emphasised the value of traditional belief systems to health, though not necessarily at the expense of western medical practice. Indeed, seldom did the debate move toward an exclusively Māori system.</i> <i>... Several views emerged, but one gained wide acceptance as ‘the Māori health perspective was a four-sided health construct, <u>later known as</u> whare tapa whā (a four-sided house). <u>Though often described as a traditional Māori approach to health, more correctly it was view of health which accorded with contemporary Māori thinking.</u>’</i> The text then proceeds to explain te whare tapa whā.
Late 1980s and the connection of the term ‘hauora’ with the four dimensions of health	There are two known sources from later in the 1980s that specifically connect the term ‘hauora’ with this ‘Māori perspective of health’. Henare, M. (1988). Ngā tikanga me ngā ritenga o te ao Māori - Standards and foundations of Māori society. In <i>April report of the Royal Commission on Social Policy</i>. Wellington : Royal Commission, 3 (1), p.24-32. Source through the National Library. This is where Nga pou mana, referenced by Durie in <i>Whaiora: Māori health development</i> (1998) (as above) is documented. <i>‘Hauora describes the breathing of the spirit from the atua at the moment of creation and also at birth. Its basis is in creation itself. Hauora refers to the physical sense of wellbeing and was formerly used in reference to warriors being fighting fit. Hauora and health and not synonymous from a Māori view. The healthy physique is seen only as a contributing factor to health, with contributions from the taha wairua (spiritual dimension), the taha hinengaro (psychic dimension), and the taha whanau (family dimension). Despite hauora being an individually held quality, its integral part in the health amalgam renders it impotent without collectively held qualities such as whanaungatanga and turangawaewae. In this way hauora is lined to mana, a quality sometimes bestowed collectively, but with individual benefits.’</i> Rikihana, H.T. (1989). <i>Hauora mātauranga (Health Education)</i>. A resource developed for schools which reproduced the Ngata and Dyal article above but then didn’t use the term ‘hauora’ anywhere beyond the title of the resource.
Early 1990s and the adoption of the term ‘hauora’ in education	The development of <i>The New Zealand Curriculum Framework</i> and <i>Te Anga Marautanga o Aotearoa</i> (Ministry of Education, 1993) framed seven learning areas, later extended to eight (to include learning languages). In <i>The New Zealand Curriculum Framework</i> the learning area was originally called Health and Physical Wellbeing. By the time of contracting the curriculum writing group, sector feedback had this changed to Health and Physical Education. In <i>Te Anga Marautanga o Aotearoa</i> the learning area was called Hauora. These curriculum frameworks, while never formally mandated of themselves, provided the foundation for: • <i>Health and Physical Education in the New Zealand Curriculum</i> the first draft of which was available in 1997 and finalised for implementation in 1999. • <i>Hauora i Roto I te Marautanga o Aotearoa: He Tauira</i> which was developed by 2000 but was never mandated as an official curriculum for use in Māori medium kura. It wasn’t until 2007 that <i>Te Marautanga o Aotearoa</i>, including the Hauora learning area, was mandated.
Mid 1990s and the recommendation for whare tapa whā	Helen Shaw (1994), commissioned by the Ministry of Education, wrote the Health Education and Physical Education literature reviews that led to the development of the 1999 HPE curriculum. The extract below relates to what led to the introduction of ‘te

in <i>The New Zealand Curriculum</i>	whare tapa whā' to the curriculum. Note there was no mention of 'hauora' in this literature review even though it featured in the 1993 <i>New Zealand Curriculum Framework</i> and <i>Te Anga Marautanga o Aotearoa</i>. <i>'Māori health perspectives:</i> <i>WHO has recognised the social and cultural components of health since 1947 defining health as "a state of physical, mental and social well-being and not merely the absence of disease or infirmity" (Durie, 1994). The whare tapa whā model described by Durie is in accord with contemporary Māori thinking and incorporates four dimensions of health: the spiritual side (taha wairua), thoughts and feelings (taha hinengaro), the physical side (taha tinana), and the extended family (taha whānau). Taha wairua refers to a capacity to have faith and to understand and respond to links between the human situation and the environment....'</i> Note this only appeared in the Health Education literature review. PE featured Te Reo Kori (not Te Ao Kori as it came to be known). These literature reviews, originally filed with the curriculum archives on Te Kete Ipurangi, are no longer available online.
Mid-late 1990s and the development of <i>Health and Physical Education in the New Zealand Curriculum (1999)</i>	Peter Moeau (then at Lincoln University) was contracted in 1995 as a consultant to the writing of the Christchurch based HPE curriculum writing team. Moeau's explanation of hauora was presented at the 1997 HPE conference at the (then) Auckland College of Education. His keynote address '<i>Hauora</i>' was made available in the conference proceedings. He presented his niho taniwha model. This was based on Durie's Te Whare Tapa Whā model with the added inclusion of whenua. What is not documented from this time is how and why the term 'hauora' from <i>Te Anga Marautanga o Aotearoa</i> and destined for use in Māori medium, also came to be included in <i>Health and Physical Education in the New Zealand Curriculum</i> and why Te Whare Tapa Whā was not adopted for use in what became <i>Te Marautanga o Aotearoa</i>.
2026 Phase 1-4 <i>Health and Physical Education and Te Waiora</i> curriculum statements	Hauora is repositioned in the NZC as offering a te ao Māori perspective alongside other approaches to understanding 'health' – and only in the Health Strand. <i>Te Marautanga Aotearoa</i> moves to the much broader and interconnected conceptualisation offered by 'waiora'. Hauora gets only the briefest mention.

The following article is now over 40 years old. It represents one of the first publications of a 'Māori definition of health' – the four dimensions we've been familiar with since the 1999 curriculum. 'Health' was the Department of Health newsletter at the time. As noted in the summary above, the term 'hauora' had not replaced 'health' at this time and Durie's te whare tapa whā model was still some way off – albeit the foundations were being laid. It is useful to read this article alongside the extracts from *Whaiora* (Durie, 1994,1998) – see summary above. You can read more accounts of this early-mid 1980s development in the full version of NZHEA document.

Health: a Maori view



By Dr. Pat Ngata, Division of Health Promotion, Department of Health, and Ms Lorna Dyall, Review and Development, Department of Health.

Good health is important to any group of people. Every person has their own idea of "what health means to them." Each cultural group also has their own knowledge and beliefs about health and how it can be achieved or maintained through the use of various health and healing practices. It is important to recognise that in a multi-cultural community like New Zealand's, there exist many different cultural beliefs, attitudes, and practices that people have towards health and sickness.

Foundations of health

Health from a Maori perspective embodies a holistic philosophy. It encompasses spiritual, mental, family and physical dimensions. Maori people believe that each one of these dimensions cannot be looked at separately, but are inter-related to form a whole and are the foundations on which good health depends. They have their roots in *Te Ao Tawhito*, The Old World, where the social, cultural and economic circumstances of the Maori was governed by the *Lore of Tapu*, Tapu means more than sacred or religious.

It was a means of social control that was geared to maintaining harmony and balance between a person, his/her Atua (Gods) and his/her environment; to protecting and nurturing existing resources of tribal, spiritual, social and economic

wellbeing and to enhance a continuity with his/her past and future. Through a process of customary practices, *karakia* (incantation) and awesome respect, it ensured the ongoing health and welfare of the community.

The main social, living and learning unit in Maori society was and still is the *whanau*: an extended family system based on genealogical kinship ties. Several *whanau* units made up a *hapu* (sub-tribe) while several subtribes constituted an *iwi* (tribe). A tribe was often named after one of the main *waka* (canoes) that participated in one of the migrations from Hawaiki or an eponymous ancestor. Tribal leadership was vested in the authority of the *rangatira* (chief) and overall wellbeing in the counsel of his main advisor the *Tohunga*: an expert in tribal lore, customs, history and spirituality.

Human manifestations

Individuals were not seen only as members of the *whanau* and *hapu*, but as a human manifestation of their *tipuna* (ancestors) with certain functions, roles and obligations to fulfill during different stages of the life cycle. The *kaumatua* (elderly) were respected and given special status because of their knowledge, wisdom, life's experiences and links with the past. *Mokopuna* and *tamariki* (grandchildren and children) were cherished because they represented continuity with

the future and needed nurturing, protection and guidance. Parental roles extended across the *whanau* or tribal group and decisions concerning the health and wellbeing of a person involved the advice, support and counsel of the wider extended family group.

The focus of family and tribal activity was the *marae*. While now the term *marae* refers to a whole physical complex of buildings, traditionally it is the courtyard in front of the main meeting house. It also embraces a human and spiritual dimension. It is a place where a person has *turangawaewae*: a place to stand and where one has a sense of belonging; it is where Maori language, oratory, values and philosophy are reaffirmed. It fosters self respect, pride, social control and enhances family relationships. It is where the dead are farewelled and meetings, tribal or family issues are debated.

Three parts

It was believed that a person was made up of three parts:

- (i) A *Mauri*; the vitality spark or life essence of a person.
- (ii) A *Wairua*; the spiritual part or soul of a person.
- (iii) A *Tinana*; the physical body of a person.

All things in the Maori world contain a *mauri*. The *mauri* of the *Iwi* (tribe) or

Hapu (subtribe) for example was vested by custom in a special place called a *Tuahu*.

The health and wellbeing of the tribe, subtribe and family members were protected by maintaining inviolate the *tuahu* and by not upsetting the lore of *tapu*. Violating the *tuahu* or *mauri* and upsetting the lore of *tapu* exposed the tribe and its people to harm from evil spirits, angry Gods and *makutu* (witchcraft) resulting in ill health and sickness.

The relationship between people, their spiritual beliefs, the lore of *tapu* and extended family kin ties was and still is a very special and important one.

Definition of health

A Maori definition of health incorporates:

- (i) Te Taha Wairua
- (ii) Te Taha Hinengaro
- (iii) Te Taha Tinana
- (iv) Te Taha Whanau

(i) Te Taha Wairua: Spiritual Wellbeing

Te Taha Wairua is that non-material spiritual 'vital essence' part of a person. It is the life force that determines who you are, what you are, where you come from, where you are going to and provides the vital link with ancestors who are perceived as omnipresent. Spiritual wellbeing is extremely important for Maori people and is acknowledged in their everyday lives by observing certain practices and procedures. The *tangihanga*: funeral ceremony is one of the most important events in Maori life. The deceased is often referred to as a *taonga* (treasure). It is not only seen as an occasion to farewell the deceased and to share the loss with the bereaved family but one to ensure the safe,

untroubled journey of the *wairua* (spirit) to the spirit world and the happy reconciliation of the family into the living world.

It is a difficult concept to explain as each person has his/her own idea of spirituality, knowing what it means for him/herself and how it can influence his/her way of life.

(ii) Te Taha Hinengaro: Mental Wellbeing

Te Taha Hinengaro is the mental and emotional dimensions of a person. It recognises that the mind, thoughts and feelings cannot be separated from the body or soul and that together they determine how people feel about themselves and thus their state of health. Self esteem and self confidence are important ingredients for good health.

(iii) Te Taha Tinana: Physical Wellbeing

Te Taha Tinana is that dimension which recognises the physical or bodily aspect of a person. It is the part of a person that western medicine focuses upon. Maori people like many other groups believe that the mind, body and soul are all closely inter-related and influence the physical state of wellbeing. Physical health cannot be dealt with in isolation nor can the individual person be seen as separate from the family.

(iv) Te Taha Whanau: Family Wellbeing

Te Taha Whanau acknowledges the importance of the function and role of the family in providing sustenance, support and an environment conducive to good health. There are many definitions of family. Maori people define it to include the

extended family network that embraces all vertical and horizontal kinship members of a *whanau*, *hapu* or tribal group. *Whanaungatanga* (family relationships) is the essential element that provides a sense of belonging, identification and collective strength.

It is for this reason that the *whanau* is the foundation philosophy of the Te Kohanga Reo Movement. Language nests involve the participation of all members of the *whanau* and is able to draw upon all the strengths of its members. Everyone has something special to offer and share, enriching the *whanau* group as a whole.

Defining health

Maori people in general believe that their current health status is ultimately linked to their historical, social, cultural, economic, political and environmental circumstances. In order to achieve any improvement in health status, health initiatives must incorporate a holistic definition and approach and be part of a development strategy to improve the overall status and wellbeing of a Maori community, tribal or family group. In doing so Maori people would like to:

- define health for themselves
- identify their own specific health concerns and to devise solutions to meet their own needs.
- see health as part of who we are, where we have come from and where we are going to.
- take responsibility for their own health.
- be involved in their own health care.
- seek information from health workers so they can make their own decisions.

- work together with health workers but to maintain control of their own growth as individuals and as a group.
- ensure health workers recognise that there are many

- ways of healing and maintaining health.
- have health initiatives community based and where possible centred around a *marae*.

- see a more equitable allocation of health resources into community based, preventive and health promotion programmes.

Books and reports

We spotted this among the [PANZ Book Design Awards](#) announced in September.

Best Education Book or Series — Primary

My First Ikura

By Qiane Matata-Sipu

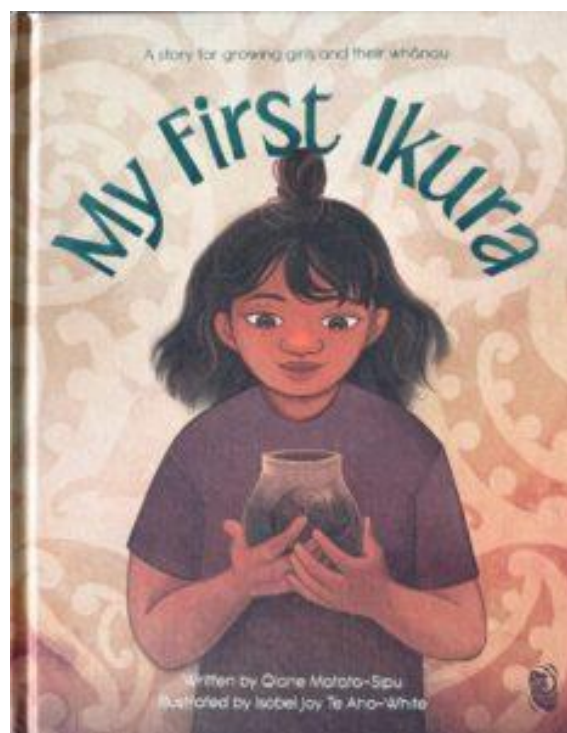
Illustrated by Isobel Joy Te Aho-White

Designed by Chloë Reweti

QIANE <https://www.qiane.co.nz/my-books-1>

Available also through multiple book sellers.

A first ikura (period) is more than just a physical change – it's a time of learning, connection, and celebration. This beautifully told story follows a young girl as she experiences her first ikura guided by the love and support of her whānau. Rooted in a Māori worldview, this book explores the sacredness of this stage in life the important roles of family and community, and the ceremonies that uplift and honour young wāhine.



Professional reading

What Wellbeing@School student data tell us about addressing discrimination in schools—Technical report

By Jessie Dong, Sally Boyd, Elliot Lawes, and Mohamed Alansari (2026)

[Download the pdf.](#)



Youth Health and Wellbeing Survey

[Overview infographic report](#) (March 2026)

An overview report, with the context for the survey and key findings.

The Youth Health and Wellbeing Survey (YHWS) is New Zealand's largest, nationally representative survey of young people aimed at understanding youth health and wellbeing.

The YHWS 2025 was conducted between March and September 2025. A total of around 9,400 young people, aged 13 to 19, completed digital questionnaires in school settings across Aotearoa New Zealand.

Before 1999, there was a crucial data-gap and a need for comprehensive, current and nationally representative information about the health, mental health and wellbeing of young people in New Zealand. This led to the development of the Youth2000 survey series by a group of academics, whose work has since established a foundational evidence base on youth wellbeing. The Ministry of Social Development (MSD) undertook the What About Me? survey in 2021, the findings from which built on those from the Youth2000 series.

See other related materials at this [link](#).

