Implementation Plan for the Healthy Children initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH (NPAPH)

PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health and should be read in conjunction with that Agreement. The objective in the National Partnership is to address the rising prevalence of lifestyle related chronic diseases, by:

   1.1 laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and

   1.2 supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

2. The Healthy Children initiative provides funding to support implementation of healthy lifestyle programs in childhood settings across Australia.

3. Under the Healthy Children initiative jurisdictions are responsible for developing programs that may include a range of different activities. Some of these activities may be grouped according to similarities.

TERMS OF THIS IMPLEMENTATION PLAN

4. This Implementation Plan will commence as soon as it is agreed between the Commonwealth of Australia, represented by the Minister for Health and Ageing, and the Australian Capital Territory, represented by the Minister for Health (known as the Parties to this Implementation Plan).

5. This Implementation Plan may be varied by written agreement between authorised delegates.

6. This Implementation Plan will cease on completion or termination of the National Partnership, including the acceptance of final performance reporting and processing of final payments against performance benchmarks specified in this Implementation Plan.

7. Either Party may terminate this agreement by providing *30 days* notice in writing. Where this Implementation Plan is terminated, the Commonwealth's liability to make payments to the State is limited to payments associated with performance benchmarks achieved by the State by the date of effect of termination of this Implementation Plan.

8. The parties to this Implementation Plan do not intend any of the provisions to be legally enforceable. However, that does not lessen the parties' commitment to this Implementation Plan.

FINANCIAL ARRANGEMENTS

9. The maximum possible financial contribution to be provided by the Commonwealth as facilitation payments to the Australian Capital Territory for the Healthy Children initiative is $4.05 million.

10. The maximum possible financial contribution to be provided by the Commonwealth as reward payments to the Australian Capital Territory for the National Partnership is $2.58 million. Reward payments will be made following the COAG Reform Council's assessment of the Australian Capital Territory's achievement against the seven performance benchmarks specified in the National Partnership. Facilitation and reward payments will be payable in accordance with Table 1 from July 2011 to 2018 in accordance with the National Partnership. All payments are exclusive of GST.

Table 1: Facilitation and Reward Payment Schedule (million)

Facilitation Payment for Healthy Children initiative		Due date	Amount
(i)	Facilitation payment	July 2011	$0.51
(ii)	Facilitation payment	June 2012	$0.74
(iii)	Facilitation payment	July 2012	$0.40
(iv)	Facilitation payment	July 2013	$0.48
(v)	Facilitation payment	July 2014	$0.48
(vi)	Facilitation payment	July 2015	$0.48
(vii)	Facilitation payment	July 2016	$0.48
(viii)	Facilitation payment	July 2017	$0.48
Reward Payment for the NPAPH		Due date	Amount
(ix)	Reward payment	2016-2017	$1.29
(x)	Reward payment	2017-2018	$1.29

11. Any Commonwealth financial contribution payable will be processed by the Commonwealth Treasury and paid to the State Treasury in accordance with the payment arrangements set out in Schedule D of the *Intergovernmental Agreement on Federal Financial Relations*.

Overall Budget

12. The overall program budget (exclusive of GST) is set out in Table 2.

Table 2: Overall program budget

Expenditure item	**Year 1** 2011-12	**Year 2** 2012-13	**Year 3** 2013-14	**Year 4** 2014-15	**Year 5** 2015-16	**Year 6** 2016-17	**Year 7** 2017-18	**Total**
KAP|FMS* *Kids at Play|Fundamental Movement Skills	*100,000*	35,000	102,500	52,500	52,500	52,500	55,000	350,000
Healthy Food @ School	*154,000*	70,000	162,500	97,500	122,500	142,500	130,000	725,000
Ride or Walk to School	*207,425*	127,207	188,775	146,110	164,561	188,133	189,331	1,004,117
It's Your Move ACT	*200,000*	30,000	205,000	30,000	0	0	0	265,000
Healthy Food@Sport	*140,000*	180,000	160,000	160,000	50,000	0	0	550,000
Parent Engagement	*40,000*	100,000	82,500	52,500	85,500	69,200	108,502	498,202
ETD* Facilitation Officer *ACT Gov: Education & Training Directorate	*150,000*	135,000	***140,000	50,000	30,000	30,000	0	385,000
Additional Staffing**	151,504	77,488	45,195	0	0	0	0	274,187
TOTAL	**151,504**	**754,695**	**1,086,470**	**588,610**	**505,061**	**482,333**	**482,833**	**4,051,506**
ACT Government Funding	*991,425*							

Notes: Figures in *italics* are from ACT Government funds for 2011-12 and not included in the total figure

* * Additional Staffing provided a Senior Manager to establish the HC initiative and an Evaluation Manager/ Epidemiologist for year one to collect baseline data and support development of evaluation plans for each activities.

*** Note phasing of this amount in 2013-14 may be amended in accordance with consultation currently underway with other Directorates to support activities in line with revision of the NPAPH to 2017-18.

13. Having regard to the estimated costs of program and associated activities specified in the overall program budget, the State will not be required to pay a refund to the Commonwealth if the actual cost of the program is less than the agreed estimated cost. Similarly, the State bears all risk should the costs of the program and/or a project(s) exceeds the estimated costs. The Parties acknowledge that this arrangement provides the maximum incentive for the State to deliver projects cost-effectively and efficiently.

PROGRAM OVERVIEW AND OBJECTIVE

14. ACT Healthy Children's Initiative

15. In addition to National Partnership funding, the ACT Healthy Children's Initiative received funding from the ACT Government for the 2009-2012 Healthy Kids, Healthy Future – Preventative Health Program. This funding enabled programs to be developed and designed in preparation for piloting and delivery using the National Partnership funding.

16. Integral to the successful implementation of this initiative are the staffing resources within the Health Improvement Branch, ACT Health Directorate to manage and coordinate the programs. This staffing includes three Senior Officer Grade (SOG) C positions, and three Administrative Service Officer (ASO6) positions. These resources will be maintained by funding from the ACT Government throughout the life of the programs.

17. Consultation with key partners and stakeholders is an ongoing process which precedes this Implementation Plan and will continue throughout program delivery. Active partnerships have been developed across Governments; with NGOs and local business partners to ensure each activity (intervention/program) uses a collaborative and joined up approach to health improvement.

18. The overall objective of this program is to increase the proportion of children and their families in the ACT who adopt and maintain healthy lifestyles through increased physical activity and healthy eating.

19. The ACT Healthy Children's Initiative will focus on culture change in settings where children are present and is inclusive of the following environments:

    a) Early Childhood Environments
    b) School Environments
    c) Sport and Active Recreation Environments
    d) Family/Parent Focused Environments

20. The senior contact officer for this initiative is:

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ACTIVITY DETAILS

21. Activity Group: Culture Change in Settings for Children

Six activities will be implemented to achieve culture change in four main environments:

1. Early Childhood Education and Care (ECEC) Environments
2. School Environments
3. Sport and Active Recreation Environments
4. Family/Parent Focused Environments

Activity| Intervention outlined in new Implementation Plan	Environment	Previous IP Activity |Intervention	To be read in conjunction with separate activity plans for:
Fundamental Movement Skills incorporating Kids at Play	Early Childhood (ECEC) Pre-schools Primary School		*A Plan to increase FMS for young children (under development)*
Healthy Food@School	Early Childhood (ECEC) Primary and High Schools	Healthy School Canteens and Crunch&Sip®	*A Recipe to encourage Healthy Food and Drink in ACT Schools (under development)*
Ride or Walk to School	Primary and High Schools	Active Travel to School	*A Game Plan to encourage Active Travel in ACT Schools (approved)*
It's Your Move ACT	High Schools	Young people focused intervention in schools	*School Action Plans (approved)*
Healthy Food@Sport	Sport and Active Recreation Environments	Healthy Sporting Canteens	*Healthy Food@Sport (approved)*
Five Ways to Wellbeing: Parental Engagement	Family/Parent Focused Environments	Lifestyle Triple P	*Plan under development with concept testing underway*

22. Overview:

Healthy Environments for Children | Culture Change in Settings

Establishing healthy behaviours during childhood and adolescence and maintaining a healthy weight are crucial to the health and wellbeing of the next generation of young Australians. Overweight and obesity are among the most important health risks to children in Australia. The causes of and influences on overweight during childhood and adolescence are complex and involve all of the environments and settings with which children and young people interact.

There is strong evidence for prevention and early intervention programs that promote healthy lifestyle behaviours for families with young children. Unhealthy behaviours developed in childhood can carry through into adolescence and adulthood.[i] Long term, children may have a higher degree of success with weight management than adults.[ii] It can be difficult for individuals to change unhealthy behaviours; particularly as they get older and establish habits and routines. This is compounded if the environment and settings are not conducive to healthy living.

Given that schools, as well as early years settings and sporting clubs to a degree, are an important and direct route by which Government can influence the eating habits of children and the amount of physical

activity they have, in line with obesity imperatives, the Healthy Children's Initiative provides a clear opportunity to encourage healthy environments and settings thereby ensuring all schools, early childhood services and sports clubs provide healthy food and drink and support the development of physical activity.

The school is the one setting where all children can be reached - irrespective of their socioeconomic status, ethnicity, or location; and through which their health concerns can potentially be addressed. The school years are a time of rapid individual and social development, where many elements of attitude and behaviour, health literacy and skills which impact on future health are formed. The interaction between schools, children and young people, and the overall experience of attending school, provides unique opportunities for health promotion which can be sustained and reinforced over time by the school.

With more than 13,000 children in the ACT attending early childhood education and care services (ECEC) and around 70% of children aged 5-14 years participating in organised sport outside school hours, these provide a unique opportunity to influence the health of children, young people and their families as well as ensuring these settings are supportive environments that encourage healthy living.

To achieve the changes needed in these settings the Healthy Children's Initiative will use systems based interventions. Taking a systems approach means considering not just the behaviours we want to influence (for example, unhealthy eating, physical activity and sedentary behaviour) but also how these things could be supported by leadership, policy, resources and what sort of information and professional development helps increase the chances of success in each setting (i.e. a school/ECEC). Taking a systems approach provides sustainability and culture change, and can support shifts in a changing environment.

Using systems based interventions has implications across a number of government directorates; as a result, a number of cross-government Reference Committees will be formed for each relevant activity area with the aim of coordinating and addressing issues that are beyond the control of the setting. The Health Directorate will retain the direction and lead for activities while working collaboratively with non-government partners and business/private partners to increase the benefits of activities, avoid duplication and maximise resources.

23. Outputs:

Table 3: Outputs funded by the NPAPH for Healthy Environments for Children

Output	Description	Timeframe
1. Development and implementation of the FMS initiative within the early childcare sector and early primary sector of the ACT school system	The FMS initiative will focus on promoting the development of gross motor skills for children aged 0 - 6 years. Funding will support the implementation of activities at early childhood services and lower primary school level. Development of an inter-departmental policy will be undertaken to influence integration of FMS.	July 2012 - June 2018
2. Development and implementation of Healthy Food@School within ACT childcare settings, preschools and primary schools, and limited numbers of ACT high schools and colleges	HF@S takes a whole of school approach which aims to create a healthy food and drink culture throughout every part of school life. Schools will implement a number of modules to change the culture, including: garden to table; food for sale at school (incorporating canteens); classroom learning; policy; and Veg and Fruit Breaks. Schools are supported to ensure food choices encourage and reinforce healthy eating patterns in students.	July 2011 - June 2018

3. Development and implementation of the Ride or Walk to School (Active Travel) initiative within ACT schools	Ride or Walk to School will focus on promoting active travel to school-aged children and their families. Funding will support the implementation of activities at the school level and the development of inter-departmental policy and collaborative action at an ACT Government level.	July 2011 - June 2018
4. Implementation of It's Your Move (IYM) ACT; a young people focused school-based research intervention to promote healthy lifestyles within three ACT high schools, with a further three schools monitored as control schools.	The IYM ACT intervention aims to reduce unhealthy weight in young people aged 12-17 years by adopting healthy eating patterns and participating in regular physical activity. Community development principles feature in this student led project with the school-based strategies being developed and delivered with the whole school community. This will provide an evidence base into the systems approach in high schools.	October 2011 - October 2014
5. Implementation of the Healthy Food@Sport Program	The Healthy Food@Sport program will focus on promoting a healthy food and drink culture throughout sporting organisations, peak bodies and local clubs. The program will also explore opportunities for increasing physical activity of those not involved in the sports club.	July 2011 – December 2015
6. Implementation of Parental and Family Engagement	Parents and families influence the health behaviours of children. This program will ensure parents are engaged in all settings to promote consistency of messages. This will be supported by the Ways to Wellbeing social marketing campaign.	April 2012 – June 2018

24. **Activity Outcomes:**

Outcomes for each activity grouping are identified in each separate activity statement.

25. **Rationale:**

The following summarises themes from the literature regarding best practice approaches to improving the health and wellbeing of families with children and looks at the learning from local health improvement programs. Together this provides a rationale for why the ACT Implementation Plan for Health Children's Initiative focuses on changing cultures in settings where young children are at.

Research suggests it is important to emphasise a holistic approach to health when planning and delivering programs and services that promote healthy lifestyles. It recognises the need to work with families and the settings in which they interact to create supportive environments for sustainable behaviour change. This approach also recognises the importance of having a mix of interventions that are inter-sectoral to improve health.[iii]

Understanding behaviour and behaviour change are necessary for developing effective and efficient population-based interventions[iv]. Research suggests using Prochaska and DiClemente's stages of change model to determine individual, family and community readiness to change. Lifestyle interventions need to have long-term, on-going support for sustainable behaviour change.[iii]

Parents and family remain significant influences throughout childhood.[i,ii] Multi-component healthy lifestyle interventions that target the family or the parents are most effective compared to working with the child alone.[v] Parental and family engagement are crucial elements of each activity in this plan; recognising the importance of role modelling and positive self efficacy backed up with mechanisms to communicate with parents and families, in particular, a single integrated social marketing campaign being the most effective.[vi]

The activities in this Implementation Plan focus on settings and environments that interact with all children using a Population Health approach. It takes into account that there are vulnerable children at every SES level of society. A much higher proportion of children in low SES groups are vulnerable, however, the largest number of vulnerable children are in the middle class ranges. Consequently, 'proportionate universality' is used in designing activities, programs, services and policies to ensure these are universal, but with a scale and intensity that is proportionate to the level of disadvantage. This requires addressing barriers to access so that support and services are available to all families[vii].

The Cochrane Review on childhood obesity released in December 2011 indicates the following to be promising policies and strategies for child obesity prevention:

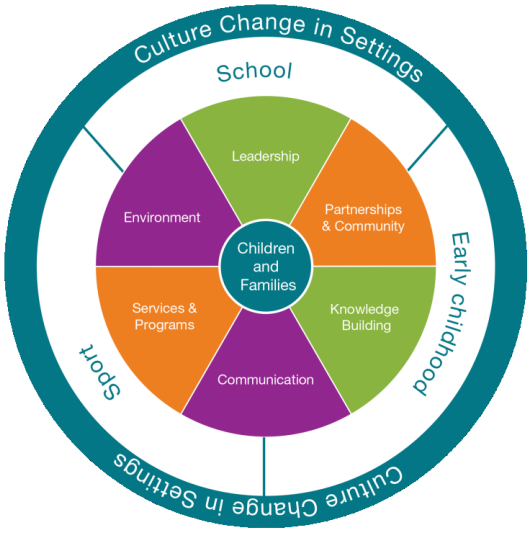
- increased sessions for physical activity, and the development of FMS;
- improvements in nutritional quality of the food supply in schools;
- environments that support children eating healthier foods and being active throughout the day;
- professional development and capacity building strategies for teachers to implement health promotion activities; and
- parent support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen-based activities.

The following summarises the key learnings from a number of recent Healthy Children programs funded by the ACT Health Improvement Branch:

- Parents that actively participated in a lifestyle intervention demonstrated positive change to behaviours in the family environment. Parents are more likely to be engaged while their children are in the early years, and younger children are more likely to participate with their peers in a group.
- There are a myriad of barriers that prevent parental engagement in lifestyle interventions including: poor health literacy; poor recognition of the issues therefore not seeing a need; busy lifestyle; group format of programs; dealing with competing family issues/demands; access to services; cost; and poorly targeted communication
- People are more likely to participate in a lifestyle intervention because of the social benefits rather than health benefits.
- Children, parents and communities need to demonstrate readiness (or intention) to change for programs to have effective engagement and achieve desired outcomes. Currently, families are being referred to programs but are not ready for change.
- Families are reluctant to participate in group activities at contemplation stage. A range of barriers prevent participation including timing of sessions, location and confidence level.
- Children with a healthier lifestyle generally have increased confidence, concentration and participation in the learning environment.
- Children need to be supported in the development of FMS in the family, childcare and learning environments to improve their confidence and ability to participate in active play.
- There is a need to continue to offer programs that support FMS and healthy eating behaviours in the Early Childhood setting. There is a need to have a whole-of-school approach in primary schools to promote healthy eating and additional physical activity (over and above school physical education). Leadership at various levels is essential for action.
- There needs to be coherence between the family setting and the settings in which the family interact so that both can support each other to change lifestyle behaviour. Thought needs to be given to transition periods between different settings (i.e. childcare to preschool, or preschool to Kindergarten).

- Programs need to be collaborative utilizing partnerships across government, non-government and relevant private/business partners. While evaluation shows that programs are most effective and efficient if the Health Directorate (HIB) take the lead role, a whole of government approach and wider partnerships are essential for successful outcomes.
- Programs can achieve more when aligned with strategic priorities and synergies made across a number of health improvement programs.
- The New Economics Foundation (nef) concept of 'five ways to wellbeing' was tested in focus groups with ACT residents in 2011. Based on this research, the original 'Five ways to wellbeing' have been refined to suit the ACT community to: Connect - with people around you; Be Active - discover activities you enjoy; Eat Well - discover new foods; Give - smile, do something nice; and Be Curious - stretch your mind. The healthy children's initiative supports the five ways to wellbeing campaign.

Based on the evidence and findings outlined above, the approach for each Activity outlined in the Implementation Plan is based on a model developed by the ACT Government Health Improvement Branch. This model aims to change the culture in a range of settings (schools, early childhood providers and sporting clubs). The activities encompass a range of discrete interventions through a range of approaches to promoting healthy eating and increased physical activity.



The interventions selected for funding through the NPAPH represent one part of the overall Healthy Children's Initiative which is in turn integrated into other programs and policies within ACT Health Directorate and the ACT Government. Specifically, this Implementation Plan will outline the proposal for the delivery of six interventions within settings for children. These include:

- **Fundamental Movement Skills (FMS)** *
- **Healthy Food @ School (HF@S)** *
- **Ride or Walk to School (Active Travel to School)**
- **It's Your Move**
- **Healthy Food @ Sport** *
- **Parental Engagement** * (Working Title: Ways to Wellbeing)

* Each of these activities has working titles as the final activity title will be based on consultation and will link to the ways to wellbeing campaign.

Each of the six interventions are explained in a separate activity statement and needs to be read in conjunction with details in this section. Below is a summarised and collated response to the 'Activity Details' section of the Implementation Plan which provides the overall context for the planning, delivery and evaluation of the plan within the settings for children.

26. Contribution to performance benchmarks:

The interventions will provide resources and support for early years, schools and sporting clubs to create environments in which policy, cultural and physical changes will encourage healthy eating and physical activity. These interventions aim to reach every primary school and a proportion of early years services, high schools, colleges and sporting clubs in the ACT. This will at the very least increase children and young people's exposure to information about healthy eating and physical activity and will improve access to healthy foods and opportunities for physical activity. Sustained activity will be required to meet the performance benchmarks by building and enhancing partnerships with stakeholders and enabling children and families to make healthier choices.

The benchmarks outlined under the NPAPH that relate to this activity are:

a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2016; proportion of children at healthy weight returned to baseline level by 2018.

b) Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2016; 0.6 for fruits and 1.5 for vegetables by 2018.

c) Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each State by five per cent by 2016; by 15 per cent by 2018.

27. Policy consistency:

This activity group is consistent with the Healthy Children policy principles (Attachment A) in the following ways:

- The primary target groups for this suite of interventions are children, young people and their families. The interventions will be rolled out in school settings with a view to make the school and community environment more supportive for healthy lifestyles (2.2.2, 2.2.8, 2.2.9). The school is the one setting where all children can be reached – irrespective of their socioeconomic status, ethnicity, or location (2.3.3, 2.3.4, 2.3.17).

- The interventions will focus on collaborative actions at a government level to provide the impetus for policy change within relevant agencies; and sustainable behaviour change regarding physical activity and healthy eating in a school and community environment (2.2.1, 2.3.2).

- Initial discussions with relevant government agencies about the proposed programs have been positive and there has been an indication of commitment to the development of each program (2.3.9).

- The program and associated evaluation will have protocols in place to protect the privacy of individuals, and will comply with the specified requirements under the NPAPH (2.3.7).

- The program will use existing ACT Health monitoring and evaluation systems to ensure capable reporting against identified program outputs and outcomes (2.3.13) as well as allow continuous quality improvement to take place (2.3.14).

- The programs delivered under the Healthy Children's Environments activity are new approaches for the ACT and will be based on other programs that have demonstrated efficacy elsewhere in Australia. The programs identified have influenced positive change in school policies, and behaviour change in school communities. (2.3.2, 2.3.10)

- School and/or student participation in the any of the programs will be voluntary (2.3.5).

- Programs will promote positive body image and not further stigmatise obesity and other health conditions and behaviours (2.3.6). For example, HF@S/HF@SP focuses on vegetable/fruit and water consumption rather than weight; and It's Your Move ACT, the young people focused interventions will create an awareness of different healthy body size/shape and decrease episodes of inappropriate dieting amongst the students.

28. Target Groups:

The Healthy Environments for Children activity interventions will target all age groups within the ACT school system from Kindergarten (5 years) to Year 12 (up to 18 years), as well as children in Early Years Services, aged from a few months to 5 years. In 2012, approximately 67,536 students were enrolled in 83 public and 44 non-government schools in the ACT (Table 5).

Table 5: Number of ACT schools and student enrolments

Public Schools	Number	Students Enrolled
Pre-school program sites	76	4,159
Primary Schools (Kindergarten to Year 6)	61	19,831
High Schools (Years 7-10)	17	9,614
Colleges (Years 11-12)	8	6,066
Special Schools	4	403
Non-government Schools	Number	Students Enrolled
Primary and High Schools	44	27,462
Total Number of all Schools|Students in the ACT	**210**	**67,535**

The reach and target population of each intervention differs to suit the specific childcare or school environment, the characteristics of the age group and the issues identified through a needs assessment process.

An equity lens will be integrated into the detailed planning of each of the activities. This process is underpinned by an assessment of the differential impacts of the activities (as a whole and individually) on the health of the child/student population, in terms of gender, age, ethnic background and socio-economic status; and secondly, to assess whether the differential impacts are remedial and unfair.

On a higher level, schools identified as disadvantaged by ETD (using the Socio-Economic Indexes for Areas indicators) will be offered additional support for specific activity implementation (such as the HF@S and Active Travel to School program).

29. Partnerships and Stakeholder Engagement | Collaboration:

The Activity interventions outlined in the Implementation Plan have originated in the health sector; however it is recognised that little can be done to change unhealthy living conditions and improve health without the support of other people, organisations and policy sectors. Partnerships hold the potential for effecting greater change than any one body could achieve by itself.

To be successful in culture change in the environments where children are at, the ACT Government will increase our work across Government Directorates to build relationships and deliver beyond our capacity. The Health Directorate will retain the direction and lead for activities and interventions while continuing to work collaboratively with non-government partners and business/private partners to increase the benefits, avoid duplication and maximise resources.

Each Activity area provides a list of the Partnerships established or being developed.

30. Risk identification and management:

This section will identify the risks to the overall implementation within the ACT school setting.

Table 6: Number of ACT schools and student enrolments

Risk	Risk Rating	Risk mitigation/control strategies
Low or incomplete uptake of activities by schools due to: • external demands (e.g. National curriculum roll-out) • unexpected internal demands (e.g. school policy change)	High	Adequate funding and resourcing allocated to activities to provide support to schools particularly at the initial stages of activity development and delivery. Maintenance of the formal and informal partnership and communication strategies with ETD (e.g. ETD Facilitation Officer) to identify or anticipate issues as they arise and seek joint solutions. Development of communication systems within each activity to understand and identify localised issues and seek joint solutions. Provide adequate supervision of ACT Health staff managing activity contracts or direct project delivery to regularly review the implementation schedule and monitor process evaluation data. Recruitment of well qualified and experienced staff for project delivery.
Low commitment from Education and Training Directorate (ETD) corporate services.	Medium	ACT Health fund an ETD Facilitation Officer (ETD FO) to assist in developing a relationship between the ACT Health funded school activities and ETD policy commitments. ETD FO role to reduce to part time in later years as activities will be underway in schools and policy developed. Maintenance of the formal and informal partnership and communication strategies with ETD (e.g. ETD Facilitation Officer; Health and Wellbeing Schools Reference Committee; inclusion of ETD Minister into media releases) to identify or anticipate issues as they arise and seek joint solutions. Identify common ETD and ACT Health policy commitments and focus achievement of jointly supported milestones and objectives.

31. Evaluation:

Process evaluation will be undertaken for each activity, mainly for summative purposes. This involves the collection of information primarily to make a judgement about the extent to which the intervention was implemented as planned and reached the intended participants. This information can in turn be used to interpret and explain program outcomes, analyse how a program works, and provide input for future planning.

Comprehensive impact evaluation will be applied only to innovative activities or interventions without a significant evidence base supporting their intervention. Evaluations will focus on assessing the immediate effects on individuals and the changes made to social and physical settings. For individuals, the immediate effects include improved health knowledge, skills and motivation, and changes to health actions and behaviour. In relation to settings, changes made to existing systems, the creation of new organisations,

programs and services to promote health, improvements to the physical environment and changes to organisational policies and practices.

Outcome evaluation for the whole ACT Healthy Children Initiative will be undertaken collectively using established surveys. Health will collect baseline data in 2011, and undertake ongoing monitoring and surveillance in 2016 and again in 2018 using the: ACT Years 6 Physical Activity and Nutrition Survey (ACTPANS); ACT General Health Survey (ACTGHS); ACT component of the Australian Secondary School Students Alcohol and Drug Survey (ASSSAD); and ACT Kindergarten Screening program.

32. Infrastructure:

Administrative infrastructure funded by the ACT Government and NPAPH includes:

- the employment of a team of six FTE Program Officers to lead the development, management and evaluation of the six activities|interventions. Two of these positions are funded under the NPAPH; the remainder are funded by the ACT Government Health Directorate.

- one of the above positions funded by the NPAPH is an ETD Facilitation Officer; the primary role being to support the implementation of It's Your Move, the Young People focused intervention in three high schools; and to provide a facilitation and liaison function between Program Officers employed to deliver the IP activities; develop cross-Directorate policies; and assist with professional development and the development of curriculum resources which will help to embed elements of the activities into ACT-wide school policy and the classroom. This position has been funded by ACT Health from 2010 until June 2012, and is funded by the NPAPH in 2012/13 and 2013/14. The role will be reduced to part time from 2014/15 to 2016/17 to maintain cross-Directorate support.

- the second position funded by the NPAPH is a Program Officer to develop, direct, manage and evaluate the Ride or Walk to School activity. This is funded by the NPAPH from June 2012 to June 2018.

ACT Government funded infrastructure includes the:

- annual Healthy Schools, Healthy Children grants funding round delivered by ACT Health to support projects in ACT schools and early childhood centres. The round provides funding to projects that promote physical activity and healthy eating. From 2012 onwards the funding round will focus specifically on early years and schools that indicate an interest in implementing any of the activities outlined in this activity grouping and that meet the strategic priorities of the Branch.

33. Implementation schedule:

Table 7: Implementation schedule for Healthy Environments for Children

Deliverable and milestone	Due date
Kids at Play 1 Evaluated and Kids at Play 2 implemented and evaluated	July 2012 – June 2018
Ride or Walk to School implemented and evaluated	June 2011 – June 2018
Healthy Food@School implemented and evaluated	July 2011 – June 2018
Healthy Food@Sport implemented and evaluated	July 2011 – December 2015
It's Your Move ACT implemented and evaluated	October 2011 – October 2014
ETD Facilitation Officer employed (Role reduces to part time)	July 2011 – June 2017
Parental Engagement Strategies implemented and evaluated	April 2012 – June 2018

Responsible officer and contact details:

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ACT Health
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Telephone: 02 6205 3627

34. Activity budget:

Table 8: Activity project budget

Expenditure item	Year 1 2011-12	Year 2 2012-13	Year 3 2013-14	Year 4 2014-15	Year 5 2015-16	Year 6 2016-17	Year 7 2017-18	Total
KAP|FMS* *Kids at Play|Fundamental Movement Skills	*100,000*	35,000	102,500	52,500	52,500	52,500	55,000	350,000
Healthy Food @ School	*154,000*	70,000	162,500	97,500	122,500	142,500	130,000	725,000
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It's Your Move ACT	*200,000*	30,000	205,000	30,000	0	0	0	265,000
Healthy Food@Sport	*140,000*	180,000	160,000	160,000	50,000	0	0	550,000
Parent Engagement	*40,000*	100,000	82,500	52,500	85,500	69,200	108,502	498,202
ETD* Facilitation Officer *ACT Gov: Education & Training Directorate	*150,000*	135,000	140,000	50,000	30,000	30,000	0	385,000
Additional Staffing **	151,504	77,488	45,195	0	0	0	0	274,187
TOTAL	**151,504**	**754,695**	**1,086,470**	**588,610**	**505,061**	**482,333**	**482,833**	**4,051,506**
ACT Government Funding	*991,425*							

Notes: Figures in *italics* are from ACT Government funds for 2011-12 and not included in the total figure
* Project Budget is NPAPH funds only. The budgets throughout do not include additional funding and support in kind offered by the Partners delivering the programs.
** Additional Staffing provided a Senior Manager to establish the HC initiative and an Evaluation Manager/ Epidemiologist for one year to collect baseline data and support development of evaluation plans for each activity area.

35. Activity: Fundamental Movement Skills incorporating Kids at Play

36. Overview:

The Fundamental Movement Skills (FMS) activity in the ACT is an extension and adaptation of the Kids at Play program; currently being implemented by the Heart Foundation ACT. The new FMS program will focus on promoting gross motor skills to children in Early Childhood Services, pre-school children and children in the first year of primary school to take into account the transitional period. As with all programs in this IP, the program will also work with parents and families to ensure they are aware of the importance of children developing FMS at an early age.

The detail of the FMS activity is under development taking into consideration local data (including the AEDI results) and evaluation data. A range of partnerships are being developed to ensure effective and efficient delivery and a cross Government approach. Existing staff within the Health Improvement Branch would have a program development and management role for this initiative.

37. Rationale:

There is growing evidence that poor physical development is becoming a universal problem. Children with poor physical development often have an inability to sit still, have poor concentration, poor coordination and low self esteem. This can manifest itself in poor behaviour and becoming disinterested in and less likely to participate in physical activity. Children who lack proficient motor skills often choose not to participate in physical activities as they get older and as games become more competitive[1].

The 2012 *Evidence update on Obesity Prevention: Across the life course* supports this focus, stating that 'ongoing teacher development for physical activity and FMS in both primary school aged children (5-12 years) and preschool-aged children (0-5 years) settings are some of the most promising areas for action for intervening to reduce obesity at the population level'.

The 2011 Cochrane Review on *Interventions for preventing obesity in children* concludes that increased sessions for physical activity and the development of FMS throughout the school week, environments and cultural practices that support children eating healthier foods and being active throughout each day, and support for teachers and other staff to implement health promotion strategies and activities (e.g. professional development, capacity building activities) are key actions to prevent childhood obesity.

FMS are a specific set of skills used to enjoy a wide variety of activities. These skills are important because they are the "building blocks" or foundation movements for more complex and specialised skills required by children throughout their lives to competently and confidently play different games, sports and recreational activities offered at school and in the community.

Evidence shows that FMS interventions need to start during the preschool and early school years as such interventions have shown significant improvement in children's physical development and FMS competence. Characteristics of interventions that are effective are duration of more than one year; introduction into the regular routines at the childcare service or school; parental involvement; professional development of teachers; and environments that support being active throughout the day. Munch and Move facilitated in New South Wales found that 60% of preschool teachers agreed that concerns about safety limit active play opportunities in the preschool setting.

It is important when looking at FMS not to overlook the role of unstructured play. A literature review by Play England summarised that 'several studies have shown that playing is good for developing motor functioning and most infants and toddlers acquire FMS through unstructured physical activity and play'.

[1] Graham and others 2005 cited in Low Deiner and Qiu 2007

Play England also found that fun and enjoyment are the greatest motivators for physical activity and, whilst children see health reasons as important, they are more attracted by 'unhealthy' activities if they are more fun than 'healthier' activities[2]. Young children are innately active, but the natural tendency is easily overridden by external constraints, including adult supervision[3]. Opportunities for spontaneous play may be the only requirement that young children need to increase their physical activity'[4].

In the ACT context, professional learning and development for pre-school teachers has in recent years included awareness and promotion of the principles behind the Reggio Emilia approach to education, which focuses on the educational importance of community and free inquiry. The Reggio approach is based around fundamental values on how children learn, including the: child as an active participant in learning; significance of environment; teacher, parent, and child as collaborators in the process of learning. The focus is on providing an environment that encourages and supports imagination, creativity and active play.

Recent data from the ACT shows a positive influence of physical education on academic achievement and the importance of the role of the family and the environment in creating opportunities for physical activity. Telford (2012) would argue a "fitter school is a smarter school"[5].

For most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. It is important to work with families as part of the FMS program; a common parental perception is that outside play without adult supervision is dangerous. There has been a decline in the percentage of children who are allowed to play independently outside; 12 percent of people over 65 did not play outside as children, whereas almost half of today's children never play outside[6].

38. Outcomes:

Table 23: Outcomes funded by the NPAPH for the FMS activity

Short Term Outcomes (2011-13)	Medium Term Outcomes (2013-15)	Long Term Outcomes (2015 onwards)
KAP Evaluation complete and FMS Development Plan produced	20% Early years providers (for children aged 0-6 years) participating in the FMS program	Increased proportion of children demonstrating FMS acquisition
Awareness of FMS issues raised within relevant government and non-government departments	Policies around FMS adopted in early years providers (for children aged 0-6 years)	50% Early years providers (for children aged 0-6 years) participating in the FMS program
Mechanism established for partnership collaboration to address FMS	Parental awareness increased of FMS	FMS program embedded through relevant infrastructure and policies
FMS program promoted to all early years providers (for children aged 0-6 years)	FMS increased among children	

39. Target Group(s):

The primary target audience for this program is young children aged 0 – 6 years, their parents/carers, and the Early Years services. The secondary target audience involves key ACT Government agencies and non-government organisations that influence local active play. Programs are most successful when

[2] Hemmings 2007
[3] Jebb 2007
[4] Dietz 2001: 314
[5] Telford R, Cunningham R, Fitzgerald R, Olive L, Prosser L, Jiang X, Telford R 2012 Physical education, Obesity and Academic Achievement
[6] ICM and Playday 2007

communities, organisations and government work together to create the social and environmental conditions that promote active play and physical activity.

40. Stakeholder Engagement | Collaboration:

The effectiveness of the formal and informal mechanisms of advocacy and building partnerships with inter-departmental stakeholders will be one of the key factors for this intervention's success. This will form one of the key functions of the Project Officer to develop and maintain these relationships. Formal mechanisms for engaging with these partners will be undertaken in 2012.
Key stakeholders critical to the FMS activity includes:

ACT Government	Non-Government Organisations	Private | Business Sector
Health Directorate	Heart Foundation ACT	Childcare Providers
Community Services Directorate	Physical Activity Foundation	GECKO
Education & Training Directorate	The Smith Family	Early Childhood
Transport and Municipal Services	Kidsafe ACT	Recreational Providers
Economic and Sustainable	Bluearth	
Development Directorate	Kulture Break	
Early Childhood Services	ACT Council of P&C Associations	
Directors Network	Canberra Institute of Technology	Parents/carers and
School Principals & teaching staff	Independent Schools Association [ACT]	community
	Catholic Education Office [ACT]	

41. Implementation schedule:

Table 25: Implementation schedule for FMS program

Deliverable and milestone	Due date
KAP1 Evaluated	August 2013
FMS Program developed and plan agreed	September 2013
FMS Program partnerships developed and formalised	December 2013
FMS Program pilot commencement	January 2014
FMS Program pilot implemented and refined	June 2014
FMS full program commencement	July 2014
FMS year one implemented. Year end - annual progress report with monitoring	June 2015
FMS year two implemented. Year end - annual progress report with monitoring	June 2016
FMS year three implemented. Year end - annual progress report with monitoring	June 2017
FMS Program completion and final evaluation	June 2018

Notes:

42. Activity budget:

Table 26: Activity project budget for NPAPH funds for FMS program

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	
Expenditure item								**Total**
Revised FMS Program Development	*100,000*	30,000	25,000	0	0	0	0	55,000
FMS Implementation/Incentives	0	0	75,000	50,000	50,000	50,000	45,000	270,000
FMS Program Evaluation	0	5,000	2,500	2,500	2,500	2,500	10,000	25,000
Total	*100,000*	**35,000**	**102,500**	**52,500**	**52,500**	**52,500**	**55,000**	**350,000**

Notes: Funding from the ACT Government will be used to employ a Program Officer to undertake program development, management and contribution to evaluation. Figures in *italics* are from ACT Government funds for 2011-12 for formative/developmental work and are not included in the total figure. * Project Budget is NPAPH funds only.

43. Activity: Healthy Food@School

44. Overview:

Healthy Food@School (HF@S) is about transforming the food and drink culture in schools to support children, and ultimately their families, to make changes to their eating habits and increase the proportion of vegetables and fruits eaten daily. This cannot be achieved by working with the canteen alone; a wealth of evidence shows that a broader approach is required to make a real and long lasting difference.

Analyses of student characteristics show statistically significant associations between healthy eating and participation in growing and cooking food at school or at home and participation in learning about food growing and production. The evidence also shows that this approach leads to healthy behaviours with parents eating more fruit and veggies as well as influencing their food buying patterns.

By the time children in early years finish high school, many will have eaten thousands of meals at school (either bought at school or brought from home); this equates to thousands of opportunities to introduce and strengthen lifelong healthy eating habits. The huge number of times that food is sold at childcare and schools combined with the complementary education programs can have a profound effect on issues of population health; academic performance; the economy and the environment.

To have a greater impact on the setting, HF@S will go beyond the childcare and school setting to influence the broader environment. A Whole of Government approach will be utilised to address structural issues, for example, canteen and kitchen facilities in schools; access to water refilling stations; student access to convenience foods outside of the school grounds; and the need to ensure education and health take precedence over commercial interests in regards to food and drinks sold at school. HF@S is also working closely with local businesses and suppliers to deliver the HF@S initiative.

The ACT HF@S program will primarily target children in early year's settings, pre-schools and primary Schools from Kindergarten to Year 6, as well as a small number of High schools and Colleges.

45. Rationale:

Schools are influential environments that help to shape the attitudes, knowledge and behaviour of children. In line with the obesity imperative, there should be a clear commitment to ensuring the school environment supports a culture of healthy food and drink and that food sold at school is healthy.

Most States and Territories (including the ACT) have in place some form of traffic light system for school canteens. Although the current systems are similar, there are inconsistencies that mean some products are not able to be sold in all States and Territories. It is anticipated the national system could address the discrepancies to produce a nationally consistent system.

According to the 2008 ACT Chief Health Officer's Report, 65.1% of children in Year 6 ACT primary schools consume energy dense snacks (e.g. lollies, chips, ice-cream, pies, chips, chocolates, energy bars) at least four time a week, and 45.6% drink coke or other sugary drinks at least once a week[7]. The HF@S program will aim to have a positive effect on both children's fruit and vegetable consumption as snacks as well as increasing the consumption of water as the drink of choice.

This project will also have a focus on promoting vegetables over fruit where possible as the most recent ACT data indicates that 41.7% of children (aged 2 – 12 years) eat the recommended minimum daily serves of fruit but only 22% consumed the recommended daily serves of vegetables[8].

[7] ACT Health, 2008, Australian Capital Territory Chief Health Officer's Report 2008, Population Health Division, Canberra, p. 158.
[8] ACT Health, 2008, Australian Capital Territory Chief Health Officer's Report 2010, Population Health Division, Canberra, p13.

The HF@S program will incorporate an adaptation of the Crunch&Sip® program originally delivered in WA as this demonstrated that including fruit and water breaks during the school day has positive effects on children's fruit and vegetable consumption. Teachers involved in the project reported that the approach was feasible and highly acceptable[9]. In a recent survey in the ACT (2011), 80% of schools already have daily water and fruit breaks; therefore the emphasis will be to encourage schools to embed and further enhance this program.

46. **Outcomes:**

Table 10: Proposed outcomes of the ACT HF@S program

Short Term Outcomes (2011-13)	Medium Term Outcomes (2013-15)	Long Term Outcomes (2015 onwards)
Stakeholder engagement/Partnerships established for activity delivery	ACT HF@S program ready for Territory-wide implementation	Over 50% of ACT primary schools participate in the HF@S program
Minimum 12 schools and 2 pre-schools pilot HF@S Pilot implemented and evaluated	HF@S policy in place at registered schools and childcare centres	Healthy food choices embedded in school/childcare culture and philosophy.
The food categorisation system implemented in 20% of school canteens.	The food categorisation system implemented in 30% of school canteens	The food categorisation system implemented in 90% of school canteens by 2018
Teachers, parents, students, school and canteen staff support program		All schools have nutrition policies which includes food sold at school
		Increased number of children report consuming vegetables, fruit and water at school
		Increased number of young people and parents/caregivers with an understanding of healthy eating and food preparation skills.

47. **Target Group(s):**

The primary target audience for this program is children aged 1 to 5 years at early years providers and children aged 5 to 12 years in primary schools in the ACT. A limited number of high schools and colleges will also be engaged working with young people aged 13 to 18 years.

The secondary target audience for this program are parents/carers of early years and primary school children aged 1 to 12 years; and teachers of schools participating in the program. Parents/carers are targeted to encourage them to provide their child with a piece of fruit or vegetable snack and are encouraged and supported to implement healthy changes to the home diet. Teachers are targeted to encourage them to integrate the promotional and evaluation resources; to promote the program in the classroom; and be a role model for students.

48. **Stakeholder Engagement | Collaboration:**

[9] Hawkings, K., Gill, L. 2001, *Fruit and Water Policy in Schools Pilot Project Final Report*, Greater Southern Public Health Services, Western Australian Health Promotion Foundation, WA.

A range of key partners and stakeholders are integral to the success of Healthy Food@School. A number of new partnerships have been created and strategies to engage more stakeholders and maintain existing partnerships are being developed. A Cross Government Reference Committee will be established to address environmental issues beyond the control of individual schools.

Partnerships established:

ACT Government	Non-Government Organisations	Private | Business Sector
Health Directorate Education & Training Directorate Community Services Directorate Economic and Sustainable Development Directorate Work Safe ACT Australian Sustainable Schools Initiative in the ACT ACT Garden Smart School Principals, teaching staff, canteens, students	Nutrition Australia ACT The Smith Family The Red Cross ACT Physical Activity Foundation ACT School Canteen Association ACT Council of P&C Associations Canberra Institute of Technology University of Canberra The Rotary Club (Farmers Market) Independent Schools Association Catholic Education Office [ACT] Stephanie Alexander Kitchen Gardens	Kids Pantry Canberra Raiders The Garden Belconnen Markets Toms SuperFruits Local fruit and vegetable suppliers Parents/carers and students

49. Implementation schedule:

Table 12: Implementation schedule for the ACT HF@S program

Deliverable and milestone	Due date
Phase One delivered and evaluated - Nutrition support to canteens	December 2012
Phase Two development and Project Plan produced	May 2013
Stakeholders engaged and Partnership delivery bodies appointed	June 2013
Year One (Pilot year) delivered and reviewed	June 2013 – June 2014
Year Two implemented. Year end - annual progress report with monitoring	January – December 2014
Year Three implemented. Year end - annual progress report with monitoring	January – December 2015
Year Four implemented. Year end - annual progress report with monitoring	January – December 2016
Year Five implemented. Year end - annual progress report with monitoring	January – December 2017
HF@S activity phased to conclusion and final evaluation	June 2018

50. Activity budget:

Table 13: Activity project budget for the ACT HF@S program

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	
Expenditure item	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	**Total**
HF@S Development	*80,000*	15,000	20,000	5,000	0	0	0	40,000
HF@S Implementation/Incentive	*70,000*	50,000	140,000	90,000	120,000	140,000	85,000	625,000
HF@S Evaluation	*4,000*	5,000	2,500	2,500	2,500	2,500	45,000	60,000
Total	*154,000*	**70,000**	**162,500**	**97,500**	**122,500**	**142,500**	**130,000**	**725,000**

Notes: Funding from the ACT Government will be used to employ a Program Officer to undertake program development, management and contribution to evaluation. Funding (outlined in *italics*) from the ACT Government's Healthy Kids, Healthy Future initiative was used to undertake formative work prior to the NPAPH funding. This has not been calculated into the NPAPH funds above.

51. Activity: Ride or Walk to School (Active Travel to School)

52. Overview:

The Ride or Walk to School initiative in the ACT will focus on promoting active travel to school-aged children, their families/carers, and school communities.

Active travel refers to a method of travel that typically involves walking, cycling or public transport to get to and from places rather than travelling by car[10]. Active travel provides health benefits through increased levels of physical activity. It also provides environmental benefits to the broader community through: reduced traffic congestion; reduced noise and air pollution; reduced greenhouse emissions; the creation of safer environments[11]; and improved social interactions.

ACT Government funded the YWCA of Canberra to deliver a Walking School Bus (WSB) program in the ACT. As with other Australian states, ACT has moved away from WSB programs and has moved towards a broader, more integrated active travel program[12].

Under the ACT Government's Healthy Kids, Healthy Future initiative, ACT Health Directorate considered results of the review of the ACT's WSB program; examined current practice for active travel in schools; and consulted with stakeholders. Following this, NPAPH funds have supported the development of a whole of Government strategy to support school to encourage more students to ride and walk to school. NPAPH funds will continue to support the implementation of active travel activities/programs in schools; collaborative action at an ACT Government level; and social marketing activities to raise awareness of the benefits of walking and cycling to and from school, and other local destinations.

An Active Travel to School Program Officer has been appointed to facilitate the development and lead the delivery of Ride or Walk to School with key partners. Support and input from relevant staff working across government is crucial to the success of this program, therefore an Active Travel to School Government Reference Committee has been established to support the initiative. A Partnership Management and Delivery Group has also been established to play a vital role in the activity implementation.

The 'Game Plan', a plan to encourage active travel in ACT schools has been produced following extensive consultation with children, young people and stakeholders. Ride or walk to School was launched in September 2012.

53. Rationale:

For most people, the easiest and most acceptable forms of physical activity are those that can be incorporated into everyday life. Examples include walking or cycling instead of travelling by car[13]. Cycling and walking are simple ways for children to incorporate extra physical activity into their everyday lives. When this replaces car journeys to school it can improve health outcomes through increased physical activity; ease traffic congestion; reduce greenhouse gas emissions; create safer environments; and improve social cohesion[14]. By encouraging children to walk and cycle we may contribute to habits that could last a life time[15].

[10] Department of Economic Development, 2005, *Live Life Get Moving: Tasmanian Physical Activity Plan*, Sport and Recreation Tasmania, Tasmania.
[11] Ibid
[12] Bartram, A., 2009, *Active Travel Discussion Paper*, Government of South Australia (SA), Department for Transport, Energy and Infrastructure, SA.
[13] Department of Health. Physical Activity, Health Improvement and Prevention, 2004, *At Least Five a Week: the (UK) Chief Medical Officer's report on physical activity*, Department of Health, London, United Kingdom.
[14] Garrard, L., 2009, 'Active Transport: Children and young people An overview of recent evidence', VicHealth, Victoria.
[15] Department for Transport, 2010, *Active Travel Strategy*, Department of Transport, Great Britain, UK, p. 31.

Since the 1970's there has been a steady decline in active transport among Australian children[16]. A survey conducted in 2006 of year 6 students in the ACT revealed that 50% of children never walk or cycle to school, and a further 20% walk or cycle just once a week[17]. If given the choice, children would prefer to walk or cycle to school and to other locations.[18] Many parents express preferences for active travel to school, but are constrained by social, policy and environmental factors[19].

Recently, the Victorian and South Australian Governments have produced reports, discussion papers and literature reviews regarding issues and best practice for active travel in schools. Internationally, the United Kingdom (UK) and New Zealand (NZ) Governments have well established strategies on their active travel in schools program. These have all informed the ACT Government's decision to develop an Active Travel in Schools program.

Since 2008, the ACT Government has supported a non-government organisation to manage a WSB program in the ACT to increase active travel in a school setting; however this program did not significantly increase the number of children walking to school.

Ride or Walk to School has developed a cross-government strategic approach to provide the impetus for policy change within relevant agencies. A number of ACT Government agencies are interested in addressing the issue of active travel and it is timely under the NPAPH for ACT Health Directorate to be the lead agency.

The ACT initiative has been guided by programs that have demonstrated efficacy in Queensland, South Australia and Victoria. These programs encourage schools to identify particular problems and barriers to active travel in their community, and provide a range of initiatives/solutions best suited to their location[20].

Active travel programs in Australia and other countries (UK and USA) have been successful when they have been embedded in departments that have responsibility for transport issues and policies[21]. Ride or Walk to School has been integrated in Transport for Canberra[22] and has the support of Transport Planning and Roads ACT

54. **Outcomes:**

Table 23: Outcomes funded by the NPAPH for Active Travel to School program

Short Term Outcomes (2011-13)	Medium Term Outcomes (2013-15)	Long Term Outcomes (2015 onwards)
Active Travel to School Game Plan that reflects the ACT school and ACT Government policy contexts published	Primary and secondary schools participating in the Active Travel to School program	Increased proportion of children and young people using active travel to get to and from school
Awareness of active travel issues raised within relevant government departments	Policies around active travel in schools adopted in schools	Active Travel to School program embedded through relevant infrastructure and policies

[16] Van der Ploeg, H.P., Merom, D., Corpuz, G., Bauman, A.E., 2008, 'Trends in Australian children travelling to school 1971-2003: Burning petrol or carbohydrates?', *Preventive Medicine,* Issue 46, pp. 60-62.
[17] ACT Health, 2007, Report on the 2006 ACT Year 6 Physical Activity and Nutrition Survey, Population Health Division, Canberra
[18] Thomson, L., 2009, 'How times have changed: Active transport literature review', VicHealth, Victoria
[19] Garrard, L., 2009, 'Active Transport: Children and young people An overview of recent evidence', VicHealth, Victoria.
[20] Bartram, A., 2009, *Active Travel Discussion Paper*, Government of South Australia (SA), Department for Transport, Energy and Infrastructure, SA.
[21] Department for Transport, 2010, *Active Travel Strategy*, Department of Transport, Great Britain, UK.
[22] ACT Government Environment and Sustainable Development Directorate, 2012, *Transport for Canberra, Transport for a Sustainable City 2012-2031*

Mechanism established for intergovernmental collaboration to address identified barriers to active travel	Attempts at active travel behaviour change increased among students
Active Travel to School program promoted to all ACT schools	

55. **Target Group(s):**

The primary target audience for this activity is school-aged children, their parents/carers, and the school community. The rationale for this target audience is backed by a survey of Year 6 students in the ACT which revealed that 50% of children never walk or cycle to school, and a further 20% walk or cycle just once a week[23]. Parental (or carer) involvement in the change process is crucial (to the success of active travel programs), as parental opposition to active travel to school is one of the main barriers for children walking or cycling to school[24].

The secondary target audience involves key ACT Government agencies and non-government organisations that influence local active travel. Programs are most successful when 'communities, organisations and all tiers of government work together to create the social and environmental conditions under which short trips by walking and cycling gradually replace car trips as the default travel choice for children, parents and the wider community'[25].

56. **Stakeholder Engagement | Collaboration:**

The effectiveness of the formal and informal mechanisms of advocacy and building partnerships with inter-departmental stakeholders will be one of the key factors for this intervention's success. This will also form the key function of the Active Travel Coordinator to develop and maintain these relationships.

Key stakeholders critical to the Active Travel to School program include:

ACT Government	Non-Government Organisations	Private | Business Sector
Health Directorate	Physical Activity Foundation	Ride 365
Education & Training Directorate	Pedal Power ACT	Backbone BMX
Environment and Sustainable Development Directorate	The Smith Family ACT	
Economic Development Directorate	FACT (Freestyle BMX ACT)	
Justice and Community Safety Directorate	Kidsafe ACT	
Australian Federal Police	The Smith Family	
School Principals, teaching staff	CANwalk	
	ACT Council of P&C Associations	
	Independent Schools Association	
	Catholic Education Office [ACT]	
	Students, parents/carers and community leaders	

[23] ACT Health, 2007, Report on the 2006 ACT Year 6 Physical Activity and Nutrition Survey, Population Health Division, Canberra
[24] Garrard, L., 2009, 'Active Transport: Children and young people An overview of recent evidence', VicHealth, Victoria, p. 17
[25] Ibid

57. Implementation schedule:

Table 25: Implementation schedule for Active Travel to School program

Deliverable and milestone	Due date
Ride or Walk to School Coordinator employed	June 2011
Partnerships developed and delivery bodies appointed	June 2012
Ride or Walk to School Game Plan developed and published	September 2012
Ride or Walk to School launched	October 2012
Ride or Walk to School (RWTS) program piloted in 11 schools (Year One)	January - December 2013
Year Two implemented. Year end - annual progress report with monitoring	January - December 2014
Year Three implemented. Year end - annual progress report with monitoring	January - December 2015
Year Four implemented. Year end - annual progress report with monitoring	January - December 2016
Year Five implemented. Year end - annual progress report with monitoring	January - December 2017
Ride or Walk to School activity phased to conclusion and final evaluation	June 2018

Notes:

58. Activity budget:

Table 26: Activity project budget for NPAPH funds for Active Travel to School program

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	
Expenditure item	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	**Total**
ATTS Coordinator	*79,425*	82,207	95,275	98,610	102,061	105,633	109,331	593,117
ATTS Development	*78,000*	10,000	21,000	0	0	0	0	31,000
ATTS Implementation	*50,000*	30,000	70,000	45,000	60,000	80,000	60,000	345,000
ATTS Evaluation		5,000	2,500	2,500	2,500	2,500	20,000	35,000
Total	*207,425*	**127,207**	**188,775**	**146,110**	**164,561**	**188,133**	**189,331**	**1,004,117**

Notes: Funding from the ACT Government's Healthy Kids, Healthy Future initiative will be used to employ a Program Officer (FTE) from October 2010 – June 2011, to undertake formative work and purchase incentives, prior to the availability of NPAPH funding. Figures in *italics* are from ACT Government funds for 2011-12 for formative/ developmental work and are not included in the total figure. Project Budget is NPAPH funds only.

59. Activity: It's Your Move ACT (Young People focused intervention in high schools)

60. Overview:

It's Your Move ACT (IYM ACT) is a 'whole school approach' intervention which aims to reduce unhealthy weight gain in young people. Using a health promoting school approach, this intervention will encourage young people aged 12-17 years in high school to adopt healthy eating patterns and participate in regular physical activity. This pilot program will improve the capacity of families, schools and community organisations in the participating schools to sustain the promotion of healthy eating and physical activity.

The World Health Organization Collaborating Centre for Obesity Prevention (WHO CC) at Deakin University has recently demonstrated significant successes in a number of community-based obesity prevention programs, including the flagship program 'It's Your Move!' implemented in Geelong, Victoria. The program demonstrated success in reducing the prevalence of overweight and obesity. These are among the first results of their kind internationally, and represent an important shift in approaches toward preventing obesity in communities.

The success of It's Your Move! Victoria led to the development of a new approach to obesity prevention which combines the lessons learned from community programs with systems-thinking theory and methodologies to create 'whole of systems' intervention approaches. This recognises both the complexity of obesity as a problem and the complexity of the existing context and systems in which prevention activities occur. The approach has attracted a great deal of attention internationally and the WHO CC group has been recognised as leading in the development of a whole of systems approach for the prevention of obesity.

Funding from the NPAPH has been allocated to supporting this intensive intervention for delivery in three ACT high schools over a three year period, with a further three schools engaged as controls (six in total). This intervention will be based on the model developed by Deakin University and Department of Health Victoria. The ACT project is a unique opportunity to trial this innovative systems-oriented approach to obesity prevention, which aims to provide holistic health promotion and contribute to the evidence base around the success of such interventions in preventing obesity in adolescents. The 'It's Your Move!' approach, along with the newly developed systems-based intervention methodologies from the WHO CC group are being applied to It's Your Move ACT as a pilot obesity prevention program in three ACT high schools for a three year period which started in July 2011.

IYM ACT uses a community capacity building approach to develop obesity prevention interventions that focus on creating supportive environments in secondary schools for healthy eating and physical activity. Each school community has developed a locally-tailored community (school) action plan with strategies to address a wide range of nutrition and physical activity issues according to their own priorities and resources. Strategies included training 'student ambassadors' to be leaders and champions of the project within the school, development and implementation of water and school food policies, programs to increase physical activity and curriculum development around healthy body image and avoidance of inappropriate dieting.

The ETD Facilitation Officer is managing the development and delivery of this intervention; working with the schools; providing liaison and support to participating schools and nominated Coordinators from each school; and form relevant partnerships.

61. Rationale:

In 2008, the ACT secondary student alcohol and drug survey found that 19.5% of ACT secondary school students aged 12 to 17 years were overweight or obese. Results of this survey reported that only 41.7% of secondary students eat sufficient fruit on a daily basis and only 22% of secondary students eat sufficient

vegetables. The report also found that only 15.6% of ACT secondary school students aged 12 to 17 years participated in physical activity at levels that meet national guidelines[26].

Adolescence is a crucial period in life and implies multiple physiological and psychological changes that affect lifestyle habits. A diverse variety of settings have an impact on children's and adolescents' behaviour. Many environments and numerous stakeholders, including parents, teachers, peers and many more, can or should be involved to stimulate activity and/or improve dietary patterns[27].

Physical activity in adolescents is on the decrease and low levels of activity seem to persist into adulthood. Not only does lack of physical activity increase a young person's risk for overweight and obesity but may contribute to cardiovascular disease, cancer and osteoporosis in later life.

When identifying potential strategies for what may work at community, school or home levels, it is important to remember that strategies which may be more effective are those which build on ideas for appropriate interventions derived from children's views and experiences[28]. Evidence supports the involvement by adolescents on matters concerning the promotion of their healthy eating and physical activity behaviours[29].

This project will pilot the approach taken by the project called 'It's Your Move!' in Geelong, Victoria overseen by Deakin University and funded by the 'Go For Your Life' Victorian Government Initiative. It was implemented in five high schools from 2005 to 2008. Results from this intervention showed that overweight/obesity reduced by 3.4% in the students and there was an increase in the number of times per week that students used active transport between school and home. There was also an increase in the capacity and readiness of the intervention in the school communities to act on healthy eating and physical activity through supplementing policy change such as state-wide food guidelines.

62. Outcomes:

Table 16: Outcomes funded by the ACT Government and the NPAPH for the IYM ACT

Short term (2011-12)*	Medium term (2012-13)	Long term (2014 onwards)
Sys-Angelou process undertaken and School Action plans developed	Intervention is mapped and refined within each school; each school has built a solid platform to sustain changes across and within the school environment once research intervention is complete and funding period has ended.	Participants of this intervention will have a reduction in levels of overweight and obesity.

[26] ACT Health, 2008, *Unpublished results of the 2008 ACT secondary student drug and health risk survey*, Population Health Division, Canberra.
[27] Waters, E., Swinburn, B., Seidell, J., Uauy, E., 2010, *Preventing Childhood Obesity: evidence policy and practice,* Blackwell Publishing, United Kingdom, pp. 88-93
[28] Waters et al., p.89
[29] Waters et al., p.90

School Action plans implemented	School Action plans mapped, refined and reported on to provide evidence for future school interventions.	Healthy School ethos is supported by senior executive, staff, students, school community, policy and a sound educational framework allowing for continuation of initiatives, adapting as school population grows and changes. Other schools learn from these projects, select from the 'tools' and begin implementing change processes for improved health outcomes of students

Note: * Funded by the ACT Government's Healthy Kids, Healthy Future Initiative

63. **Target Group(s):**

The primary target audience for this intervention is high-school aged young people, their parents/carers and the school community. The rationale for this target audience is supported by a survey in 2008 of secondary school students aged 12 to17 years in the ACT which revealed that 19.5% were overweight or obese[30]. Parental involvement in obesity prevention is a very important factor. Parents who are motivated to change their own behaviour will have a large influence on changing the behaviour of their adolescent children[31]. This intervention was offered to all public high schools in the ACT with the support of ETD to identify which schools are most in need and would most benefit from this intervention.

The secondary target audience involves key ACT Government agencies and non-government organisations that influence the health and wellbeing of young people. Programs are most successful when environments and numerous stakeholders, including parents, teachers, peers and many more, can or should be involved to stimulate activity and/or improve dietary patterns[32].

64. **Stakeholder Engagement | Collaboration:**

The key stakeholders critical to IYM ACT includes:

ACT Government	Non-Government Organisations	Private | Business Sector
Health Directorate Education & Training Directorate Transport and Municipal Services Economic and Sustainable Development Directorate School Principals, teaching staff, canteens, students ACTPLA - Planning Services	ACT Council of P&C Associations (ACTCPCA) Nutrition Australia ACT Smith Family ACT Parents/carers and community leaders associated with school communities	Outsource Food Service providers operating within implementation schools (Metropolitan Food Service)

It is the role of the ETD Facilitation officer (Project Coordinator) to lead this intervention and form the relevant partnerships. They organise and facilitate planning workshops and consolidate the information into an action plan with the school coordinators.

[30] ACT Health, 2008, *Unpublished results of the 2008 ACT secondary student drug and health risk survey*, Population Health Division, Canberra.
[31] Thomas J, Sutcliffe K, Harden A et al, 2003, *Children and Healthy Eating: A Systematic Review of Barriers and Facilitators,* EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.
[32] Waters et al. , p.89

65. **Implementation schedule:**

Table 18: NPAPH Implementation schedule for It's Your Move ACT

Deliverable and milestone	Due date
Implementation schedule to be developed based on Project Action Plan.	April 2011
Target schools identified and action plan developed with all participating schools (incl. appointment of Project Coordinator and School Coordinators)	September 2011
Project management structures established	April 2012
Baseline data captured and evaluated and Baseline systems mapping completed	September 2012
Supporting Policy documents introduced to school stakeholders, Principals and Project Coordinators support adoption of policy within/across school	November 2012
First year evaluation reported. Plans for 2013 project development outlined	February 2013
Evaluation and reporting processes continues quarterly throughout 2013|2014	June 2014
Intervention implemented and collation of final data completed	August 2014
Final mapping and evaluation report on intervention strategies complete	October 2014
Lessons learnt distributed to all ACT High schools	December 2014
ETD Facilitator to provide a facilitation and liaison function to deliver the IP activities in ACT schools and assist with embedding activities into ACT ETD policy.	January – June 2015
ETD Facilitator to continue to provide a facilitation and liaison function to deliver the IP activities in ACT schools	July 2015-June 2016
ETD Facilitator to continue to provide a facilitation and liaison function to deliver the IP activities in ACT schools	July 2016 – June 2017

Notes:

66. **Activity budget:**

Table 20: Activity project budget for the IYM ACT young people focused intervention

	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**Year 7**	
Expenditure item	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	**Total**
ETD Facilitator/IYM Coordinator	*150,000*	135,000	140,000	50,000	30,000	30,000	0	385,000
IYM ACT	*200,000*	30,000	205,000	30,000	0	0	0	265,000
Total	*350,000*	**165,000**	**345,000**	**80,000**	**30,000**	**30,000**	**0**	**650,000**

Notes: Funding from the ACT Government's Healthy Kids, Healthy Future initiative will contribute to the NPAPH funding to deliver IYM ACT. Figures in *italics* are from ACT Government funds for 2011-12 for formative/ developmental work and are not included in the total figure. * Project Budget is NPAPH funds only.

* The systems based intervention will be used in all other activity areas to support culture change in the settings used by children.

67. Activity: Healthy Food@Sport

68. Overview:

The project aims to increase healthy food choices available to children and young people through canteens run by sporting clubs and to promote water as the drink of first choice. Community sports clubs are recognised as places that promote opportunities to socialise and to be physically active. They also provide an ideal setting to promote good nutrition. The project is managed by ACT Health in collaboration with ACT Sport and Recreation Services (EDD).

69. Rationale:

Data from the April 2006 Survey of Children's Participation in Culture and Leisure Activities indicates that 71% of children aged 5-14 years in the ACT (~29,500 children) participated in organised sport outside school hours[33]. A key objective of Sport and Recreation Services ACT is to encourage life long participation in sport and recreation, so supporting the participation of children and young people in weekend sport is vital. It is equally important to promote the importance of healthy eating so young people and their families receive comprehensive healthy lifestyle messages.

Many ACT community sports clubs rely on unhealthy food and drinks sales and sponsorship to support their operations. However, it is unclear to what extent the broader community supports this dependency. A survey of community attitudes in Victoria undertaken by VicHealth in 2009 found support for reducing community sporting clubs' reliance on junk food sales and sponsorship. The survey found that 49% of respondents were opposed to the sale of junk food, and 53% were opposed to junk food sponsorship at community sports clubs. There was very high support (81%) for the removal of junk food sponsorship at community sports clubs if clubs are supported to replace any lost revenue.

The availability of healthier foods sold in canteens will assist with the promotion of healthy eating patterns in children and young people that are consistent with Australia's dietary guidelines for children and adolescents. The project will also help parents and other adults involved with sporting clubs to understand the importance of providing healthy food and drink choices.

There is a lack of evidence on the effectiveness of healthy sporting canteen programs, so this program will collect data to help build the evidence base.

70. Outcomes:

Table 41: Outcomes funded by the NPAPH for Healthy Food@Sport

Short Term Outcomes (2011-12)	Medium Term Outcomes (2012-13)	Long Term Outcomes (2013 onwards)
Sporting clubs and associations support program Resources developed and disseminated Pre and post audit of pilot sporting club canteen menus with Incentive items distributed	Increased availability and visibility of water as drink of choice for children and young people at sporting club venues Increased availability and visibility of healthy food choices at sporting club venues	Healthy food choices embedded in the culture and philosophy of 20-50% of sporting clubs. Participating clubs will have developed policies that promote healthy food and drink choices.

[33] Australian Bureau of Statistics (ABS) 2009, Sports and Physical Recreation: A Statistical Overview, Australia, 2009, ABS, Canberra, viewed 16 June 2010, <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4B7A0089A8534912CA2576570015C606?opendocument>.

Changes to menus in pilot clubs assessed and information about pilot clubs disseminated	10% of sporting clubs making healthier food and drink choices available	More than 20-50% of sporting clubs making healthier food and drink choices available
Increased support for program amongst sporting club management		Increased sales and visibility of healthy food choices at sporting club venues
Awareness of program amongst sporting clubs established	Decreased availability and visibility of sugar-sweetened beverages and caffeine energy drinks at sporting club venues	Decreased sales of sugar-sweetened beverages and caffeine energy drinks at sporting club venues
Availability of support materials to provide healthy options for canteen managers	Decreased availability and visibility of energy-dense nutrient poor foods at sporting club venues	Decreased sales of energy-dense nutrient poor foods at sporting club venues

71. Target Group(s):

Children and young people who participate in weekend and after school sports, ages 5-18.

72. Stakeholder Engagement | Collaboration:

Key stakeholders will include: Sport and Recreation ACT within EDD, sporting clubs and associations, nutrition/dietitian professional groups for nutrition education. Strategies to engage with the sporting clubs will be integrated into established sport and recreation functions that manage the relationships between sports and government. Other peak sporting organisations will be engaged as the program progresses; including the Sports Commission and School Sport ACT.

73. Implementation schedule:

Table 43: Implementation schedule for Healthy Food@Sport

Deliverable and milestone	Due date
Pilot year implemented and evaluated providing Information and education [8xclubs]	December 2012
HF@Sport year two activity implemented with annual progress report at year end	July 2013 - June 2014
Year Three implemented. Year end - annual progress report with monitoring	July 2014 - June 2015
HF@S activity final evaluation and Good Practice Guide distributed	December 2015

Notes:

74. Activity budget:

Table 44: Activity project budget for Healthy Food@Sport (HF@SP)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	
Expenditure item	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	**Total**
HF@SP Development	*140,000*	160,000	160,000	160,000	40,000	0	0	520,000
HF@SP Implementation and Evaluation		20,000	0	0	10,000	0	0	30,000
Total	*140,000*	**180,000**	**160,000**	**160,000**	**50,000**	**0**	**0**	**550,000**

Figures in *italics* are from ACT Government funds for 2011-12 for formative/developmental work and are not included in the total figure. * Project Budget is NPAPH funds only.

75. Activity: Parent and Family Engagement

76. Overview:

The Parent and Family Engagement activity will focus on mechanisms that support families to make sustainable behaviour change around healthy eating and physical activity. Existing research has identified that one of the key influences that challenge parents' attempts to provide a healthy lifestyle for their children are settings and environments where families are most likely to interact. In acknowledging these findings combined with evidence that points to parents as the key agent for change, this activity is crucial to positively influence the role that parents play in contributing to a healthy culture in such settings.

The activity will complement the existing activities outlined in the Implementation Plan to ensure there is consistency in messaging and programs throughout all settings where children interact; resulting in healthy lifestyle behaviours becoming more appealing and easy for families to adopt.

This activity follows on from the Lifestyle Triple P program identified in the first Implementation Plan (August 2010) to address lifestyle behaviour issues within families of overweight or obese children aged five to ten years old.

77. Rationale:

Parents of young children are particularly interested in their child's growth and development, particularly in relation to meeting developmental milestones. Despite this, health is not top of mind; education, self esteem and social skills are of higher concern. Parents recognise the need for their children to be healthy but would often not make the connection to the implications of long-term chronic disease and potential long-term health costs. As a consequence; the long term impact of healthy lifestyles are not a motivating factor to change.

Research has shown that parents with higher self-efficacy are more likely to be able to raise healthy children than those with lower self efficacy. Parents with high self-efficacy are more likely to have firm parenting styles with consistent boundaries; good level of knowledge about healthy foods, cooking skills and recipes; more time; low consumption of takeaway foods; believe in the importance of role-modelling and more likely to encourage active play or physical activity. Parents with low self-efficacy tend to have soft, inconsistent boundaries; less time; fewer cooking and recipes; high consumption of takeaway foods and less likely to encourage physical activity.

Parents of preschoolers have high motivation and high degree of control to influence diet and physical activity. Parents of primary school children find control and motivation is starting to slip and as children move into adolescence many parents find ability to control and motivation is very low. Children start to be reluctant to eat at school; they have access to their own money allowing the freedom to purchase own food and drinks; they have increased levels of sedentary activity and are strongly influenced by their peers.

78. Outcomes:

Table 35: Outcomes funded by the NPAPH for Parent and Family Engagement

Short Term Outcomes (2011-13)	Medium Term Outcomes (2013-15)	Long Term Outcomes (2015 onwards)
Trial and evaluate Lifestyle Triple P with parents from low SES groups	Increase in the confidence of parents/carers to improve the health of their child/family	Increase in physical activity levels for children

NGO to pilot the incidental effect to 'nudge' parents and families to healthy living	Increase in awareness of healthy living of parents/carers	Increase in the consumption of fruit and vegetables by children
Trial programs and concepts to increasing awareness of healthy eating and importance of physical activity	Effective communication and marketing to stakeholders to ensure continued appropriate referrals for this new program	Decrease in screen-based and non-screen based sedentary activities
Increased awareness of activities by schools, parent groups, allied health services	Improvement in children's healthy behaviours	Increase in proportion of children who are at a healthy weight
Ways to Wellbeing parent engagement concepts agreed	Increased availability of programs and information to support healthy lifestyle behaviours	30% of parents report an increase in their confidence and skills to support healthy lifestyles for their children

79. Target Group(s):

The primary target audience for parent and family engagement are parents and carers of children aged 0 to 12 years. It is a family intervention designed for delivery in settings where children interact, in particular Early Childhood Education and Care (ECEC); schools and sporting clubs

The secondary target audience influenced by this program are health professionals, staff in government directorates that work directly with families and non-government organisations that work with children and their parents/carers.

80. Stakeholder Engagement | Collaboration:

ACT Health will establish a number of partnerships prior to program implementation. Close consultation with stakeholders, including face to face meetings and an open information evening will be held to detail the program and outline the model of delivery. Stakeholders may include, but are not limited to: DHCS, Child and Family Centres, Community Health Centres, Medicare Local, School Nurses, school counsellors, psychologists, social workers and early intervention workers in various government departments as well as NGO's.

81. Implementation schedule:

Table 37: Implementation schedule for Parent and Family Engagement

Deliverable and milestone for Parent and Family Engagement	Due date
Lifestyle Triple P trial implemented and evaluated	*December 2012*
Literature review and Concept testing with parents complete	December 2012
Parent and Family Engagement approaches piloted with regular review	January 2013 - June 2014
Parent and Family Engagement approaches implemented across ACT	July 2014 – June 2015
Parent and Family Engagement approaches implemented across ACT including NGO to develop incidental work/nudge theory for healthy lifestyle behaviour	July 2015 – June 2016
Parent and Family Engagement approaches implemented across ACT including NGO to develop incidental work/nudge theory for healthy lifestyle behaviour	July 2016 – June 2017
Parent and Family Engagement approaches phased to completion and evaluated	July 2017 - June 2018

Note: *Italic* area relates to ACT Government funded elements

82. **Activity budget:**

Table 38: Activity project budget for NPAPH funds for Parent and Family Engagement (PFE)

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	
Expenditure item	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	**Total**
PFE Development	*40,000*	100,000	30,000	0	20,000	15,000	15,502	180,502
PFE Implementation		0	50,000	50,000	63,000	51,700	73,000	287,700
PFE Evaluation		0	2,500	2,500	2,500	2,500	20,000	30,000
Total	*40,000*	**100,000**	**82,500**	**52,500**	**85,500**	**69,200**	**108,502**	**498,202**

Figures in *italics* are from ACT Government funds for 2011-12 for formative/developmental work and are not included in the total figure. ACT Healthy Futures funding also covered the cost of the pilot of the Lifestyle Triple P program. * Project Budget is NPAPH funds only.

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

83. The Commonwealth is responsible for reviewing the Territory's performance against the program and activity outputs and outcomes specified in this Implementation Plan and providing any consequential financial contribution to the Territory for that performance.

Role of the Territory

84. The Territory is responsible for all aspects of program implementation, including:

(a) fully funding the program, after accounting for financial contributions from the Commonwealth and any third party;

(b) completing the program in a timely and professional manner in accordance with this Implementation Plan; and

(c) meeting all conditions of the National Partnership including providing detailed annual report against milestones and timelines contained in this Implementation Plan, performance reports against the National Partnership benchmarks, and a final program report included in the last annual report that captures lessons learnt and summarises the evaluation outcome.

85. The Territory agrees to participate in the Healthies Steering Committee or other national participation requirements convened by the Commonwealth to monitor and oversee the implementation of the initiative, if relevant.

PERFORMANCE REPORTING

86. The Territory will provide performance reports to the Commonwealth to demonstrate its achievement against the following performance benchmarks as appropriate to the initiative at 30 June 2016 and 31 December 2017:

a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state/territory by 2016; proportion of children at healthy weight returned to baseline level by 2018.

b) Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state/territory by 2016; 0.6 for fruits and 1.5 for vegetables by 2018.

c) Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each state/territory by five per cent by 2016; by 15 per cent by 2018.

d) Increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state/territory by 2016; proportion of adults at healthy weight returned to baseline level by 2018.

e) Increase in mean number of daily serves of fruits and vegetables consumed by adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state/territory by 2016; 0.6 for fruits and 1.5 for vegetables from baseline by 2018.

f) Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline for each state/territory by 2016; 15 per cent from baseline by 2018.

g) Reduction in state/territory baseline for proportion of adults smoking daily commensurate with a two percentage point reduction in smoking from 2007 national baseline by 2011; 3.5 percentage point reduction from 2007 national baseline by 2013.

87. The requirements of performance reports will be mutually agreed following confirmation of the specifications for measuring performance benchmarks by the Australian Health Minister's Conference.

88. The performance reports are due within two months of the end of the relevant period.

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[i] Lewis, V., 2011, *Background paper on social marketing for improved health outcomes for young children – the influences on the health behaviours and wellbeing of children under seven years of age,* University of Canberra
[ii] National Health and Medical Research Council, 2003, *Clinical Practice Guidelines for the Management of Overweight and Obesity in Children and Adolescents*, Australian Government, Canberra.
[iii] Early Head Start National Resource Centre, 2004, *A Holistic Approach to Health and Safety – Technical Assistance Paper No. 7*, U.S. Department of Health and Human Services.
[iv] Science and Technology Select Committee, 2011, *Behaviour Change: 2nd Report of Session 2010-12*, Authority of the House of Lords
[v] National Health and Medical Research Council, 2011, *Systematic review of the obesity literature*, Australian Government, Canberra.
[vi] Population Health Policy Branch, 2010, *Development and Delivery of Health Promotion Campaigns and Programs in Western Australia*, Government of Western Australia: Department of Health.
[vii] Human Early Learning Partnership, 2011, *Policy Brief: Proportionate Universality*, University of British Columbia

ATTACHMENT A

National Partnership Agreement on Preventive Health

HEALTHY CHILDREN

Scoping Statement and Guiding Policy Principles

PART 1: INTRODUCTION AND OVERVIEW

1.1 Purpose

This document, developed in consultation with states and territories, is designed to provide guidance in developing jurisdictional implementation plans and support a consistent approach to the implementation of the Healthy Children initiative under the National Partnership Agreement on Preventive Health (NPAPH).

1.2 Objectives

The objective of the NPAPH is to reduce the risk of chronic disease by reducing the prevalence of overweight and obesity, improving nutrition and increasing levels of physical activity in adults, children and young people through the implementation of programs in various settings. The NPAPH provides funding for:

- settings based interventions in pre-schools, schools, workplaces and communities to support behavioural changes in the social contexts of everyday lives and focusing on improving poor nutrition, and increasing physical inactivity. For adults also focusing on smoking cessation and reducing harmful and hazardous alcohol consumption;
- social marketing for adults aimed at reducing obesity and tobacco use; and
- the enabling infrastructure to monitor and evaluate progress made by these interventions, including the National Preventive Health Agency and research fund.

1.3 Outputs

To realise these objectives, the Healthy Children initiative will fund states and territories to deliver a range of programs:

a) building on existing efforts currently in place, while adapting them to suit demographic and other factors in play at various sites;

b) covering physical activity, healthy eating, primary and secondary prevention;

c) in settings such as child care centres, pre-schools, schools, multi-disciplinary service sites, and children and family centres; and

d) including family based interventions, settings based interventions, environmental strategies in and around schools, and breastfeeding support interventions.

1.4 Evidence Base

The interim results of the Australian Bureau of Statistics *National Health Survey 2007-08* show the proportion of combined overweight or obese children aged 5 -17 years increased from 20.8 per cent in 1995 to 24.9 per cent in 2007-08.[vii] Further, results from the 2007 *Australian National Children's Nutrition and Physical Activity Survey* indicate that:

- the proportion of children meeting the guidelines for fruit intake (1-3 serves per day depending on age group and gender) declines with age (61 per cent for 4-8 year olds, 51 per cent for 9-13 year olds and 1- 2 per cent for 14-16 year olds); and
- the proportion of children meeting the guidelines for vegetable intake (2-4 serves per day depending on age group and gender) decreases with age (22 per cent for 4-8 year olds, 14 per cent for 9-13 year olds and 5 per cent for 14-16 year olds).[vii]

Key factors emerging from the international and national literature that can determine the success and sustainability of health promotion programs suitable for children and young people include:

- *Well established project planning and implementation* ensures the identified needs and interests of children are met. A participatory approach to planning the program structure and content involving the key influencers in children's lives is beneficial.
- *Recognition of the role of the family and community and involvement in key activities.*
- *A focus on good nutrition and physical activity.*
- *Structural support for healthy lifestyles* including safe places and spaces for physical activity and increased access to healthy food.
- *Effective and consistent communication* of the aims and purpose of the program to build positive engagement.
- *Multi-component programs* can ensure a variety of behavioural risk factors, issues and strategies are addressed to engage greater numbers of children and young people with different preferences and health needs and ensure lasting change.
- *Monitoring and evaluation* of all program components should be established during program planning and inception.

PART 2: HEALTHY CHILDREN

Terminology, Scoping Statement and Guiding Policy Principles

2.1 Terminology

For the purposes of the Healthy Children initiative in the NPAPH, the following terms are defined:

Access and equity is about ensuring that individuals, families and populations are not further disadvantaged in a health and social sense through the programs and activities delivered as part of the NPAPH. It requires consideration of a range of factors that can impact on access to, reach of and appropriateness of programs for certain populations, removing or reducing barriers to health and access to health-based activities. Programs must support equity of outcomes for all by increasing opportunities and removing or reducing barriers for participation. There are a number of interacting factors that must be considered in addressing access and equity, for example:

- the size of the organisation or setting and relative capacity to access, take up, participate in and/or be reached by programs and implement programs;
- consideration of the characteristics of children and young people, and their families at both a group and individual level including gender, cultural and linguistic background, Aboriginal and Torres Strait Islanders, people with a disability, physical location and socio-economic status. These factors should be considered in program design, delivery and evaluation;
- equity of outcome that considers all the elements above in relation to the outcomes for individuals (for example, were there organisations and individuals who experienced better results than others in the same cohort); and
- elements outlined in the Australian Government's *Social Inclusion Toolkit.*[vii]

Children, for the purposes of this initiative, are defined as children and young people from birth to 16 years of age. Young people between the ages of 16 and 18 years are included in the definition of children if they are not participating in higher education as this setting is best addressed by the Healthy Communities and Healthy Workers initiatives.

Healthy living programs, in the context of this initiative, are those programs that cover physical activity and healthy eating. The use of the term 'program(s)' is inclusive of activities targeting individuals, groups of individuals and of activities that are of an organisational wide, enabling or capacity building nature. This may include policy enhancement, system change and minor supporting infrastructure improvements directly related to the implementation in the specific setting that are made to facilitate and support the health of children and young people and associated with behavioural change. The following language will be used to describe the hierarchy of elements of the NPAPH:

1. NPAPH initiatives, such as Healthy Children;
2. jurisdictional programs (i.e., state and territory programs or activities implemented according to an agreed plan); and
3. activities within jurisdictional programs; local government programs or pilot programs..

Primary and secondary prevention definitions are drawn from *The Language of Prevention,* National Public Health Partnership (2006)[vii] and in the context of the Healthy Children initiative mean:

1. *Primary prevention* - limiting the incidence of disease and disability in the population by measures that eliminate or reduce causes or determinants of departure from good health, control exposure to risk and promote factors that are protective of good health; and
2. *Secondary prevention* – reduction of progression of disease through early detection, usually by screening at an asymptomatic stage, and early intervention.

Quality assurance framework, accreditation and standards or other relevant material are already in place and/or currently being developed by the Australian Government under the NPAPH. Programs and program providers will be encouraged to have regards to relevant accreditation processes in order to receive funding under the initiative from jurisdictions.

2.2 Scope

Consistent with the objectives and expected outcomes of the NPAPH, the policy scope for the Healthy Children initiative is summarised below:

2.2.1 The focus of the initiative is the prevention of lifestyle related chronic disease through addressing the modifiable lifestyle risk factors of poor nutrition and physical inactivity through sustained behaviour change for children and young people.

2.2.2 The primary target group is children and young people and program funding should be directed to these groups taking into account the key role and involvement of the family,

particularly parents. Setting based initiatives may involve making the environment more supportive of healthy lifestyles. For example, food and physical activity policies, training of relevant health professionals, curriculum development and activities that target children and their families directly or indirectly through a child care or school setting, and child behaviours through combined parent/child interventions.

2.2.3 Substantial built environment or infrastructure improvements are beyond the scope of the NPAPH and this initiative.

2.2.4 Mental health is not included as a performance benchmark under the NPAPH. While programs may have a mental health element, this should not be the sole focus of the program.

2.2.5 Programs should ensure a positive body image is promoted and that emphasis is on a healthy lifestyle. This should involve consideration of the target audience for programs and individuals and groups who may be vulnerable to forming a negative body image. For example, programs that target groups such as teenage girls may need different support and messages than programs for very young children or for primary school aged children.

2.2.6 Programs should focus on preventive health activities and the promotion of healthy behaviour. Programs with a tertiary management focus (i.e., the clinical management of existing chronic conditions) are not within the preventive scope of this initiative. However, individuals already participating in tertiary treatment programs are not to be excluded. Note that only preventive programs may attract funding.

2.2.7 New and innovative programs can be implemented where gaps exist for children and young people, and their families, or existing programs can be adapted or extended to suit demographic and other factors.

2.2.8 Programs can be delivered in settings such as child care centres, pre-schools, schools, multi-disciplinary service sites, children and family centres and potentially other less formal settings such as play groups or youth sporting groups.

2.2.9 Programs may take the form of settings based initiatives, strategies in and around schools and early childhood settings, and breastfeeding support interventions. Programs must focus on delivery of activities within the defined setting. Delivery of program activities exclusively in the home is not within the scope of the initiative.

2.2.10 Programs should actively support breastfeeding, where relevant.

2.3 Policy Principles

General

2.2.1 Programs under the initiative should be focused on primary and secondary prevention.

2.2.2 Funding for programs should be invested in:

- significant enhancements or expansions to existing program(s) that have already demonstrated they are efficacious;
- new programs that have demonstrated efficacy elsewhere that are directly translatable to the initiative setting;
- programs that can demonstrate significant innovation and/or promise from initial results, but lack formal evidence to demonstrate effectiveness; and/or

- programs that have a high likelihood of being sustainable beyond the funding received under this initiative (should the program be effective and there is a demonstrated continuing need).

2.2.3 Programs should reflect the requirements of the Australian Government's *Social Inclusion Toolkit*.

2.2.4 Access and equity in terms of both access to programs and equity of outcomes as a result of participation in programs must be a key consideration.

2.2.5 Participation in-NPAPH programs is voluntary. However, the voluntary participation requirement does not override specifications of existing or new setting-based legislative requirements or policies (e.g., food supply, curriculum, and requirements for physical activity).

2.2.6 Programs and associated evaluations should not further stigmatise obesity and other applicable health conditions and behaviours and should promote a positive body image. Programs should also consider the potential for any negative body image messages and have appropriate management strategies in place.

2.2.7 Measures must be in place to protect the privacy of individuals as appropriate. Programs must comply with applicable legislation in relation to consent to collect personal and health information and the use, access, storage and disclosure of this information.

2.2.8 Program providers may be expected to comply with specified requirements, including quality assurance frameworks, standards or other guidance in existence or currently being developed under the NPAPH.

2.2.9 Programs should be developed and implemented in consideration of relevant local enablers and barriers (i.e. appropriate stakeholder consultation and support, infrastructure issues and different industry and workforce requirements).

2.2.10 Funding under the initiative may be used to extend existing programs or create new programs. However, the duplication of funding already allocated at a state and territory level, or by an organisation should not be permitted.

2.2.11 Programs will not be funded if they support, promote or utilise sponsorship of food or beverage products considered to be high in sugar, salt and saturated fat, or of tobacco and/or alcohol or promote sedentary behaviour.

2.2.12 Consistency and complementarity with programs already in place should be considered. An assessment of possible efficiencies and effectiveness should be undertaken that recognises activities in other settings (i.e. the community and workplaces).

2.2.13 Programs should have monitoring systems in place to ensure they are capable of reporting in an accurate and timely way on the achievement of program outputs in accordance with performance monitoring and evaluation requirements under the NPAPH.

2.2.14 Programs should have mechanisms in place for continuous quality improvement. Monitoring and evaluation arrangements should, where possible, be developed to help facilitate evaluation at a national level.

And specifically for the Healthy Children initiative

2.2.15 Programs that have a clinical risk assessment component should have identified clear and appropriate referral pathways in place that include complementary support activities that aim to address and lead to a reduction in identified lifestyle risk factors.

2.2.16 Programs should emphasise the importance of healthy lifestyles, good nutrition and regular physical activity and should include a comprehensive mix of interventions. This includes both universal approaches and targeted interventions for children and young people who may be at high risk of overweight/obesity, physical inactivity and/or have poor nutrition.

2.2.17 Consideration should be given to populations of children and young people at higher risk of overweight or obesity, physical inactivity and/or poor nutrition, in particular socioeconomically disadvantaged populations and Aboriginal and Torres Strait Islander communities.

2.2.18 Programs should complement existing effective programs and policies for children and young people.

2.2.19 Programs should explicitly support breastfeeding where relevant.

2.2.20 Programs should comply with requirements for working with children and young people in each state and territory.

2.2.21 Programs must be safe and appropriate for children and young people and their parents and families.