Implementation Plan for The Healthy Children Initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

DECEMBER 2012

NOTE: The Australian Government may publish all or components of this jurisdictional implementation plan, following initial consultation with the jurisdiction, without notice in public documents pertaining to the National Partnership Agreement.

PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health (NPAPH) 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.

   The measures funded through this Agreement include provisions for the particular needs of socio-economically disadvantaged Australians, and those, especially young women, who are vulnerable to eating disorders.

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 State of New South Wales 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 New South Wales for the Healthy Children initiative is $79.27 million.

10. The maximum possible financial contribution to be provided by the Commonwealth as reward payments to New South Wales for the National Partnership is $49.78 million. Reward payments will be made following the COAG Reform Council's assessment of New South Wales' 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

Facilitation Payment for Healthy Children initiative	**Due date**	**Amount (m)**
(i) Facilitation payment	Jul-11	$10.66
(ii) Facilitation payment	Jun-12	$14.12
(ii) Facilitation payment	Jul-12	$7.74
(iii) Facilitation payment	Jul-13	$9.35
(iv) Facilitation payment	Jul-14	$9.35
(v) Facilitation payment	Jul-15	$9.35
(vi) Facilitation payment	Jul-16	$9.35
(vii) Facilitation payment	Jul-17	$9.36
Reward Payment for NPAPH	**Due date**	**Amount (m)**
(v) Reward payment	2016-17	$24.89
(vi) Reward payment	2017-18	$24.89

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

The overall program budget (exclusive of GST) is set out in Table 2, and addresses the delivery of ten major activities grouped into 6 settings-based and programmatic areas.

Table 2: Overall program budget ($ million)

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
1.1 **Playgroup Obesity Prevention Support Service** (*Healthy Supported Playgroups*)	$0	$0.53	$0.48	$0.48	$0.53	$0.53	$0.53	$3.08
1.2 **Early Childhood Settings Obesity Prevention Support Service** (*Munch and Move®)*	$1.97	$2.47	$2.02	$2.02	$2.02	$2.02	$2.02	$14.54
2.1 Primary School Obesity Prevention Support Service *(Live Life Well at School)*	$1.74	$2.49	$2.14	$2.21	$2.19	$2.19	$2.14	$15.10
2.2 Primary School Nutrition Support Service *(Crunch&Sip®)*	$0.68	$0.78	$0.73	$0.73	$0.73	$0.73	$0.73	$5.11
2.3 High School Canteen Support Service	$0.00	$0.48	$0.49	$0.59	$0.74	$0.54	$0.44	$3.28
3.1 Social Marketing to Young People	$0.13	$0.06	$0.93	$0.76	$0.68	$0.76	$0.73	$4.05
4.1 Healthy Junior Community Sport (*Healthier Choices in Sporting Settings*)	$0.07	$0.16	$0.50	$0.66	$0.96	$0.94	$0.81	$4.10
5.1 Communicating to Children and their Families	$0.00	$0.08	$1.08	$1.78	$1.78	$1.53	$1.13	$7.38
5.2 Obesity Prevention Service for Overweight Children *(Go4Fun®)*	$1.65	$1.65	$1.65	$1.65	$1.65	$1.65	$1.65	$11.55
6.1 Social Inclusion Engagement Service	0	$1.40	$2.05	$2.03	$1.88	$1.86	$1.85	$11.07
TOTAL	**$6.24**	**$10.18**	**$12.00**	**$12.93**	**$13.26**	**$12.67**	**$11.98**	**$79.26**

Notes: The manner in which these funds are spread over the 7 years assumes that roll-over will be possible within NSW Ministry of Health. Within each intervention the allocation of funds reflects the state of readiness of proposed interventions and the manner in which they will be phased in over the 7years given the need for formative research and development work across a number of NPAPH interventions. Discrepancies in the table between totals and sums of components reflect rounding.

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

1. **Services for Early Childhood Settings**

2. The objectives of this program are to:

   - provide practical resources to early childhood teachers, childcare workers, family day carers and supported playgroup leaders relevant to healthy eating and active play and limiting small screen recreation;
   - increase the capacity of early childhood services to promote healthy eating and active play and limit small screen recreation;
   - increase the proportion of early childhood services that develop and implement policies and practices supportive of healthy eating, active play and limit small screen recreation; and
   - increase the frequency of relevant communication between early childhood teachers, child care workers, family day carers and supported playgroup leaders and parents/carers in relation to healthy eating, active play and small screen recreation.

3. The *Services for Early Childhood Settings* Program includes two activities:

   a) Playgroup Obesity Prevention Support Service *(Healthy Supported Playgroups)*; and
   b) Early Childhood Settings Obesity Prevention Support Service *(Munch and Move®)*.

4. The senior contact officer for this program is:

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Activity 1.1: Playgroup Obesity Prevention Support Service (*Healthy Supported Playgroups*)

1. **Overview:** The *Playgroup Obesity Prevention Support Service (Healthy Supported Playgroups)* encourages and supports playgroup leaders to create environments within the playgroup setting that encourage healthy eating and active play, and to deliver consistent, appropriate messages regarding healthy eating, active play and small screen recreation to parents/carers attending playgroups.

Supported playgroups are located in locations of high need and target families that would not normally access mainstream children's healthy eating and physical activity programs. This includes Aboriginal families as well as socially and geographically isolated families, single and young parents, Aboriginal families and culturally and linguistically diverse families.

Healthy Supported Playgroups comprises the components outlined below.

- Attendance by supported playgroup leaders at two professional development workshops. One workshop focuses on healthy eating while the other focuses on active play.
- Provision of resources containing information and activities that encourage healthy eating and active play at playgroup that are relevant and appropriate to the supported playgroup setting; including parent-focused activities and take home information relevant to the family setting.
- Practical resources including equipment, games and books to encourage implementation of healthy food and active play policies and practices within the supported playgroup setting.
- Ongoing support provided by a health professional over a period of 12-months. Ongoing lower level support following the initial 12-months and/or more intensive ongoing support for those supported playgroups requiring this service.
- Development of refresher training modules for supported playgroup leaders.

Healthy Supported Playgroups will have flow-on effects to the home environment by influencing parent/carer knowledge and skills relevant to creating home environments which actively support children to consume healthy foods, engage in active play and reduce sedentary behaviours.

2. **Outputs:**

Description	**Quantity**	**Timeframe**
Delivery of training workshops on healthy eating	60% of supported playgroup auspice organisations will participate in healthy eating training for play group leaders	Dec 2017
Delivery of training workshops on active play	60% of supported playgroup auspice organisations will participate in active play training for play group leaders	Dec 2017
Delivery of training workshops on healthy eating to supported playgroup leaders working with Aboriginal specific supported playgroups	60% of auspice organisations of Aboriginal Specific supported playgroups will participate in healthy eating training for play group leaders	Dec 2017
Delivery of training workshops on active play to supported playgroup leaders working with Aboriginal specific supported playgroups	60% of auspice organisations of Aboriginal Specific supported playgroups will participate in active play training for play group leaders	Dec 2017
Healthy eating and active play resource packs for participating supported playgroups, including culturally specific resource packs for Aboriginal specific supported playgroups	Resource packs distributed to all participating supported playgroups as a staged roll-out	July 2013 – Dec 2017
Support for participating supported playgroups, including those that are Aboriginal specific	Participating supported playgroups each receive 4 occasions of contact in the year following training - 2 face-to-face and 2 other e.g. network meetings, telephone support.	June 2018
Evaluation		Ongoing

3. **Outcomes:**

Short term	**Medium term**	**Long term**
Increased proportion of supported auspice organisations receive information and training on healthy eating for children under 5-years	Increase in supported playgroup leaders awareness and knowledge of healthy eating messages for children under 5-years Increased capacity and intentions of supported playgroup leaders to promote healthy eating through playgroup Supported playgroup services use information and resources to support healthy eating in the playgroup setting	Increased proportion of supported playgroup settings promote healthy eating through their policies and practices Increased proportion of children attending supported playgroup participate in activities to promote healthy eating
Increased proportion of supported playgroup leaders' receive information and training on age appropriate physical activity for children under 5-years	Increase in supported playgroup leaders awareness and knowledge of physical activity messages for children under 5-years Increased capacity and intentions of supported playgroup leaders to promote physical activity through playgroup Supported playgroup services use information and resources to support active play in the playgroup setting	Increased proportion of supported playgroup settings promote age appropriate physical activity through their policies and practices Increased proportion of children attending supported playgroup participate in activities to promote physical activity
Increased proportion of supported playgroup leaders' receive information relevant to communicating healthy eating and physical activity messages to parents/carers	Increased capacity of supported playgroup leaders to communicate healthy eating and physical activity messages to parents/carers Increased proportion of playgroup leaders provide information to parents/carers on healthy eating and physical activity	Increased proportion of supported playgroups regularly promote healthy eating and physical activity messages to parents/carers who attend supported playgroup

Rationale: Supported playgroups offer young children and their parents/carers access to support as well as opportunities to socialise with other parents/carers and children. In addition, they provide learning opportunities for children, as well as their parents/carers, in a positive, structured environment reaching parents, and their children, who would not otherwise access playgroup. Consequently, this Service will reach children and their parents/carers across NSW with specific needs and/or those living in areas of social disadvantage.

An evaluation of the Families NSW Supported Playgroups Scheme in 2008 shows that these playgroups are supportive in structure and that the setting has potential through which services focussing on health-related behaviours can be delivered. The evaluation found that in excess of 200 supported playgroups had been established and maintained in areas of disadvantage across NSW. These playgroups reached an estimated 3000 parents/carers at any given time, many of whom would not otherwise attend a playgroup[1]. In 2010 there was in excess of 300 supported playgroups funded through their model across NSW.

The 2008 evaluation reported that of the playgroups and the families attending supported playgroups across NSW:

- 73% were located in areas of highest disadvantage;
- 58% identified young parents as a key target group;
- 65% of children were between 2 and 5 years old;
- 12% of families identified as Aboriginal or Torres Strait Islander; and
- 33% of parents were born in a country other than Australia[1].

The evaluation found that:

- parents expressed a high degree of satisfaction with the playgroups;
- the benefits to children included opportunities to socialise with other children as well as exposure to a range of learning experiences and activities and equipment;
- parents/carers learnt new parenting skills and techniques;
- parent/carer knowledge increased through receiving information and advice; and
- opportunities were provided to create and enhance family relationships[1].

The *Playgroup Obesity Prevention Support Service* will provide an opportunity to:

- directly reach children from disadvantaged populations;
- directly reach and influence parents/carers of these children;
- deliver consistent and appropriate messages to parents/carers regarding healthy eating, active play and small screen recreation relevant to young children; and
- increase parent/carers' knowledge and skills specific to healthy eating, active play and limiting small screen recreation.

The advantages of directly reaching and influencing parents/carers as well as their children are numerous. Life-long health related behaviours, which can impact on health during adulthood, are established in the early years of life[2]. Children first learn their patterns of eating, physical activity and sedentary behaviours, especially small screen use, within the context of the family. Therefore parents/carers, as well as the broader family play a crucial role in shaping children's attitudes towards food and physical activity and creating environments which enable healthy eating and physical activity[3]. As such, this Service provides an ideal opportunity to influence the food and physical activity environments children are exposed to at playgroup as well as in the home setting.

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[1] ARTD Consultants. (2008). *Supported Playgroups Evaluation – Phase 2. Final report to the Communities Division of the NSW Department of Community Services*. ARTD: Sydney

[2] Campbell K, Hesketh KD. (2007). Strategies which aim to positively impact on weight, physical activity, diet and sedentary behaviours in children from zero to five years. A systematic review of the literature. *Obesity Reviews 8*: 327-338.

[3] Gill T, King L, Webb K. (2005).Best options for promoting healthy weight and preventing weight gain in NSW. Sydney: NSW Centre for Public Health Nutrition and NSW Department of Health.

Healthy Supported Playgroups is modelled on an existing service developed by one NSW Local Health District. Quantitative evaluation results are forthcoming, but qualitative data has shown that this service is feasible and highly acceptable to supported auspice organisations and playgroup leaders and the families they support. Over 90% of supported playgroups that attended training, used the support materials and made changes to their practice. Results from similar interventions demonstrate the efficacy of providing professional development, relevant resources and support to those working in early childhood settings[4] [5] [6].

The current reach of this Service has been limited to small geographical areas within three Local Health Districts. Including *Healthy Supported Playgroups* in the HCI will result in the state-wide delivery of this promising targeted Service, substantially increasing its reach across NSW (to include all 15 Local Health Districts). Families NSW estimate that there are currently in excess of 300 supported playgroups funded through their model in NSW. In addition, there are in excess of 50 supported playgroups funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FAHCSIA) in NSW and a range of similar models funded through the NSW Department of Education and Communities. Approximately 17 families, on average, attend each playgroup session. *Healthy Supported Playgroups* will reach large numbers of children from vulnerable families and their parents/carers.

Initial discussions with key stakeholders including Families NSW and FAHCSIA, suggest a high level of interest in accessing the Service. The NSW Department of Education and Communities has also indicated interest in accessing this Service as part of their Schools as Communities Centres program.

Including this Service in the HCI will also allow for the adaptation of resources and tailoring of messages to meet the needs of Aboriginal families as well as families from specific cultural backgrounds. This work will be guided by the work undertaken as part of the *Social Inclusion Engagement Service* described later in this Implementation Plan. As part of the HCI, strategies will also be put in place to ensure all new supported playgroup leaders receive training resources and support and that there are opportunities for already trained auspice organisations and playgroup leaders to access refresher type activities as required.

[4] De Silva-Sanigoriski AM et al. (2010). Reducing obesity in early childhood: results from Romp and Chomp, an Australian community-wide intervention program. American Journal of Clinical Nutrition doi:10:3945/ajcn.2009.28826.
[5] Munch and Move – NSW Department of Health (unpublished results)
[6] Tooty Fruity Vegie – North Coast area Health Service (unpublished results)

4. **Contribution to performance benchmarks:**

Healthy Supported Playgroups **contribution**	**NPP Performance benchmark**
Increase in the number of supported playgroups creating environments supportive of healthy eating and physical activity. Improved nutritional quality of food and drinks consumed by young children and their parents/carers while attending supported playgroup (whether brought from home or provided by the playgroup). Increase in the number of active play activities run at supported playgroup and decrease in sedentary time while at supported playgroup. Increase in communication between supported playgroup leaders and parents/carers specifically on topics related to healthy eating, active play and limiting small screen time.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Supported playgroup leaders will promote fruit and vegetables as snacks in the playgroup environment. Supported playgroup leaders will provide information to parents/carers on how to encourage consumption of fruit and vegetables in young children. Young children will increase their consumption of fruit and vegetables as snacks while attending playgroup. Young children of families attending supported playgroup will increase their consumption of fruit and vegetables in the home environment.	Increase in mean number of daily serves of fruit and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2016; and 0.6 for fruits and 1.5 for vegetables by 2018.

Healthy Supported Playgroups **contribution**	**NPP Performance benchmark**
Supported playgroup leaders will provide a range of active play experiences at playgroup. Supported playgroup leaders will provide information to parents/carers on age-appropriate active play and limiting small screen time. Children's participation in age-appropriate active play experiences while attending playgroup will increase. Participation in age-appropriate active play in the home environment will increase among children of families attending supported playgroup. Time children of families attending supported playgroup spend engaging in small screen recreation in the home will be limited.	Increase in the proportion of children participating in at least 60 minutes of moderate physical activity each day of 5% from baseline by 2016; and 15% from baseline by 2018.

5. **Policy consistency:** This Service, which is delivered in a supported playgroup setting, builds upon small scale existing efforts the childhood setting while maintaining the flexibility for adaptation to meet the needs of specific population groups that access this setting. It is a targeted primary prevention service with a focus both healthy eating and physical activity as well as limiting small screen recreation targets young children under 6 years of age and their parents/carers. It acknowledges the role of parents and the family environment in shaping life-long health-related attitudes and behaviours.

   The Service directly addresses equity issues; it has been designed to target and meet the specific needs of children from vulnerable families who are at increased risk of being overweight or obese, eating poorly and engaging in low levels of physical activity.

   Support for participating auspice organisations will be provided by health professionals most likely those working in Local Health Districts and/or non-government organisations. Consequently, a local level approach, which takes account of specific population groups as well as specific enablers and barriers are embedded into the delivery model for this service which gives added flexibility within the general model.

6. **Target group(s):** *Healthy Supported Playgroups* will target the following groups and settings:

   - children aged between 0-6 years attending a supported playgroup
   - parents, carers or family members attending a supported playgroup
   - families NSW funded Supported Playgroups and
   - FAHCSIA funded Supported Playgroups in NSW

7. **Stakeholder engagement:** NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Ministry of Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for services which require multiple implementation partners; and
- ensuring appropriate engagement and support for the NSW Ministry of Healthy Children Initiative.

Consultation has included stakeholders internal to NSW Ministry of Health, Local Health Districts, other NSW Government Departments, non-government organisations and academic institutions.

Further, NSW Ministry of Health has met with key stakeholder groups and organisations of specific relevance to delivering *Healthy Supported Playgroups*. This includes the Local Health District that developed the existing Service on which *Healthy Supported Playgroups* is based, Families NSW and Department of Families, Housing, Community Services and Indigenous Affairs, all of which fund Supported Playgroups in NSW.

NSW Ministry of Health will continue to consult and work in collaboration with key partners, including the Aboriginal Health and Medical Research Council as the NPAPH is further developed, implemented and evaluated. This will include NSW Ministry of Health's *Early Childhood Healthy Eating and Physical Activity Working Group*, which has representatives from relevant government agencies as well as early childhood development and education peak bodies.

Additionally, NSW Ministry of Health has established a formal governance structure as part of the NSW Ministry of Healthy Children Initiative and the broader NPAPH. This will includes a program specific working group as well as higher level advisory group involving internal and external stakeholders.

8. **Risk identification and management:**

Risk	**Management Strategy**
Supported playgroup schemes choose not access the Service	Engagement with relevant government agencies and auspice organisations has already begun to ensure support for the delivery of the Service across the state. These agencies and organisations will be involved in the promotion and oversight of the delivery of this Service. The existing Service was designed in collaboration with supported playgroup leaders which has ensured that training is relevant to their needs and the resources are practical and useful in the supported playgroup setting. The Service has been well adopted in those areas in which it has been delivered.
Supported playgroup leaders do not implement the learning and key messages from the training workshops	The implementation model proposed for this Service includes the intensive support following training. The purpose of this is to provide support for the implementation of key messages. Resources were designed in collaboration with supported playgroup leaders. This ensures they are practical and useful in the supported playgroup setting. The provision of resource packs will assist in the practical implementation of key messages and activities within the supported playgroup setting.
The Service is not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Each working group will report to an overarching Advisory Group being established as part of the NPAPH governance structures.
Services across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH. NSW Ministry of Health Local Health Districts have a well-developed program in place and so a model for delivering this Service is well advanced.

9. **Evaluation:** The evaluation of *Healthy Supported Playgroups* will occur within the context of a comprehensive evaluation framework currently being developed by NSW Office of Preventive Health which reports through the Centre for Population Health, NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

The evaluation of *Healthy Supported Playgroups* will include quality assurance measures as well as process and impact evaluation, and an analysis of the costs involved in delivering the Service against the results achieved.

- **Process evaluation** will include measuring the adoption of *Healthy Supported Playgroups* and the extent to which it has been delivered as intended. It is anticipated that a minimum data set will be used to gather process data as well as support total quality improvement. This could include measures such as the numbers of participating playgroups, training sessions conducted, support contacts made.
- **Impact evaluation** will include measuring effects on supported playgroup leaders including changes in knowledge, skills, attitudes and behaviours and changes in policy and practice at the playgroup level. The potential to directly measure knowledge, skills, attitudes and behaviours of parents/carers will also be explored with the appropriate agencies.
- **Cost evaluation** will assess the costs of delivering the *Healthy Supported Playgroup* Service.

Opportunities to undertake appropriate evaluation of the Service in Aboriginal specific supported playgroups will be explored as a means of building evidence on promoting healthy eating and physical activity to Aboriginal children and their parents, carers and families. The evaluation will be designed and conducted in collaboration with the Centre for Aboriginal Health within NSW Ministry of Health, the Aboriginal Health and Medical Research Council as well as Families NSW and the Department of Families, Housing, Community Services and Indigenous Affairs.

NSW Ministry of Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

The final evaluation plan for *Healthy Supported Playgroups* will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

10. **Infrastructure:** Delivery of this Service will require a combination of existing and newly developed infrastructure.

- The Service will use the existing supported playgroup models of Families NSW and FAHCSIA, which includes existing governance structures, network of regional managers and staff working as supported playgroup leaders. This is existing infrastructure that will be accessed to deliver this service in a systematic manner across this sector to achieve a state-wide coverage. This is existing infrastructure that will be accessed to deliver this service in a systematic manner across this sector to achieve a state-wide coverage. There is no cost impact on the NPAPH to NSW in this regard.

- Ongoing support for participating supported playgroup auspice organisation will be provided through the existing infrastructure provided by Local Health Districts and non-government organisations. These organisations have expressed an interest in and commitment to providing this ongoing support.

- New infrastructure provided by an external organisation procured by NSW Ministry of Health, may be required to deliver this Service across the state. Such an organisation would need to allocate staff time to:

    a) manage the implementation of the Service across multiple supported playgroup models and regions that exist in NSW;
    b) organise and deliver training to supported playgroup auspice organisations across NSW, including new staff as their enter the system;
    c) in consultation with NSW Ministry of Health undertake the process of modifying training and/or resources to meet the needs of specific groups including Aboriginal and CALD specific playgroups; and
    d) manage the development of refresher training for playgroups auspice organisations already trained, as a means of promoting sustainability of key messages.

- Additional administrative infrastructure is also likely to be required to fulfil a coordination role within the central health agency. The role of any additional staff will include:
    a) support and manage the overall development of the Service and resources;
    b) managing resource development, design, layout and printing;
    c) manage procurement as well as ongoing contracts with external providers;
    d) lead strategic overarching stakeholder engagement and management and as part of the NPAPH and would processes;
    e) ensure social inclusion is embedded into the Service;
    f) contribute to the development and implementation of ongoing program monitoring and supporting the national evaluation (including the national evaluation if appropriate/required);
    g) contribute to ongoing reporting as part of the NPAPH; and
    h) participate in and report appropriate committees as part of the NPAPH.

11. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone		Due date
i.	Production of the Healthy Supported Playgroups Resources	June 2013
ii.	Delivery of training to Supported Playgroup auspice organisations as staged roll out	July 2013 to Dec 2017
iii.	Production of a modified training and resource pack for Aboriginal specific Supported Playgroups	June 2014
iv.	Delivery of training to Aboriginal Specific Supported Playgroup auspice organisations	July 2014 – Dec 2017
v.	Ongoing support of participating Aboriginal Supported Playgroups	Jan 2013 – Dec 2017
vi.	Program monitoring and evaluation	Ongoing
vii.	Development and implementation of sustainability strategies	Ongoing to June 2018

12. **Responsible officer and contact details:**

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13. **Activity budget:**

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	TOTAL ($ million)
Project management, adoption and maintenance in supported playgroups	$0	$0.25	$0.18	$0.18	$0.23	$0.23	$0.23	$1.30
Embedding the needs of Aboriginal and other vulnerable populations	$0	$0.13	$0.13	$0.13	$0.13	$0.13	$0.13	$0.78
Central office project coordination	$0	$0.07	$0.07	$0.07	$0.07	$0.07	$0.07	$0.42
Monitoring and evaluation	$0	$0.08	$0.10	$0.10	$0.10	$0.10	$0.10	$0.58
TOTAL	$0	**$0.53**	**$0.48**	**$0.48**	**$0.53**	**$0.53**	**$0.53**	**$3.08**

Notes: Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6%of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Inclusion. Discrepancies in the table between totals and sums of components reflect rounding

Activity 1.2: Early Childhood Settings Obesity Prevention Support Service (*Munch and Move®)*

1. **Overview:** The *Early Childhood Settings Obesity Prevention Support Service* (*Munch and Move®)* is an innovative, games and activities-based Service for early childhood settings. It supports the healthy development of young children from birth to five years of age attending preschools, long day care centres and family day care services in NSW. *Munch and Move®*:

   - supports fundamental movement skills through developmentally appropriate play-based activities;
   - supports staff to incorporate unstructured physical activity into children's regular routine;
   - exposes children to a diverse range of healthy foods and food-based learning experiences;
   - supports staff to reduce time spent in small screen recreation (TV, computers, DVDs); and
   - provides ideas and information suitable for communicating with parents/carers.

   Munch and Move® provides:
   - face-to-face professional development for staff from early childhood settings across NSW;
   - practical resources to support the development and implementation of settings-level policies and practices promoting healthy eating and physical activity and limiting small screen time;
   - ongoing support from health professionals to implement *Munch and Move®* within the early childhood setting. This includes support to develop and implement policies, alter practice, communicate with parents/carers and deliver innovative learning experiences;
   - online learning modules to reinforce and further develop knowledge and skills development; and
   - opportunities to attend refresher training to further reinforce knowledge and skills development.

   It is a joint initiative of NSW Ministry of Health. To date more than 2200 early childhood services and 71 family day care schemes across NSW have participated in *Munch and Move®* workshops and implemented its messages in the early childhood setting.

2. **Outputs:**

Description	Quantity	Timeframe
Delivery of face to face *Munch and Move®* training to staff in centre based children's services.	80% of all centre based children's services services participate in training	June 2015

Description	Quantity	Timeframe
Delivery of face to face *Munch and Move*® training to family day care schemes.	50% of all family day care schemes receive train the trainer (49 schemes) 80% of all family day care schemes receive train the trainer (78 schemes) 70% of all family day carers receive the training (approx 3500 carers)	December 2011 June 2012 June 2015
Development of online learning modules.	At least 1 online learning module developed. At least 40% of participating settings complete online learning modules At least 75% of participating settings complete online learning modules	Dec 2013 Dec 2014 June 2017
Identify appropriate delivery modes for ongoing *Munch and Move*® training and make available to staff in preschools (refresher training opportunity)	30% of all preschools receive the second round of training and of these preschools,	June 2012- June 2017

3. **Outcomes:**

Short term	**Medium term**	**Long term**
Increased proportion early childhood staff receive information and training relevant to promoting healthy eating and physical activity in early childhood settings	Increase in early childhood staffs' awareness and knowledge of healthy eating and physical activity messages relevant to the early childhood setting Increased capacity and intentions of early childhood settings to promote healthy eating and physical activity Early childhood settings use information and resources to promote healthy eating and physical activity	Increased proportion of early childhood settings promote healthy eating and physical activity though their policies and practices Increased proportion of children attending early childhood settings participate in health promoting activities while attending the service
Increased proportion of early childhood staff receive information relevant to communicating with parents/carers about healthy eating and physical activity	Increased capacity of early childhood settings to communicate healthy eating and physical activity messages to parents/carers of children attending the service Increased proportion of early childhood settings provide information to parents/carers on healthy eating and physical activity	Increased proportion of early childhood settings regularly promote healthy eating and physical activity messages to parents/carers of children attending the setting
Increased proportion of food preparation staff receive information and training on the nutritional needs of young children	Increased knowledge and awareness of food preparation staff in childcare settings of nutritional needs of young children Increased capacity food preparation staff to prepare meals that meet the nutritional needs of young children Food preparation staff use information and resources to plan and prepare meals that meet the nutritional needs of young children	Improved nutritional quality of meals provided to young children in those settings in which food is provided Increased proportion of children who attend a setting at which food is provided consume a balanced diet while in the setting

4. **Rationale:** Overweight and obesity develop over time and once they occur are difficult to treat[7]. Further, lifelong health-related behaviours which impact on health during adulthood are established in the early years of life[8]. Therefore, promoting healthy weight, healthy eating and physical activity in young children can have a positive influence on health throughout life.

A number of key dietary and physical activity behaviours have been linked to greater risk of obesity. These include excessive consumption of high fat, high sugar, energy-dense nutrient poor foods and sweetened drinks as well as increased time spent in sedentary behaviours, particularly small screen recreation. These risk factors are modifiable and can be addressed from an early age through positive and supportive health promoting messages and strategies.

Whilst there is limited NSW prevalence or trend data for overweight and obesity in children between 2 and 5 years of age, initial analysis of the first wave of data from the Longitudinal Study on Australian Children indicated that 1 in 5 preschoolers were overweight or obese (15.2% overweight and 5.5% obese). Indigenous status and lower disadvantage quintile were associated with a higher Body Mass Index (BMI) category compared to children who are more advantaged[9]. South Australian data showed a similar prevalence rate with 20% of 4 year-old children classified as overweight or obese[10].

The early childhood setting is ideal for promoting healthy lifestyle behaviours to a large number of children and their parents/carers. Children spend a considerable amount of time in childcare arrangements so these settings provide the opportunity for extended health promotion practice. Staff working in the child care sector view promoting the health of children as being central to their role and take this responsibility very seriously[11].

A large proportion of children in NSW spend a significant amount of time in formal child-care sand as such, it is important that they provide an environment that encourages and actively supports participation in physical activity, specifically the development of fundamental movement skills (FMS) as well as healthy eating[11]. Critical to this are staff with appropriate training and skills as well as system level policies and practices that encourage environments supportive of healthy eating and physical activity. Research consistently demonstrates that factors which positively impact on physical activity and healthy eating include: children attending services with supportive policies and practices, higher quality facilities and equipment, and care givers who have a higher level of training[12, 13].

Several national and international interventions have targeted young children through early childhood settings and provided training resources and support to early childhood professionals. These interventions include *Tooty Fruity Vegie* (NSW)[14], *Romp and Chomp*[15] (VIC) and *MAGIC*[16] (UK). Results from these interventions demonstrate the efficacy of this approach in achieving positive changes in physical activity, healthy eating and /or weight status of young children.

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[7] Must A. (2003). Does overweight in children have an impact on adult health? *Nutrition Reviews 61 (4): 139-142.*
[8] Campbell K, Hesketh KD. (2007). Strategies which aim to positively impact on weight, physical activity, diet and sedentary behaviours in children from zero to five years. A systematic review of the literature. *Obesity Reviews 8*: 327-338.
[9] Wake, M (2004). Editorial comment: Australasian childhood longitudinal studies: exciting yet challenging times. *Journal of Paediatrics and Child Health 40 (3)*: 85-86.
[10] Vaska VL and Volkmer R (2004). Increasing Prevalence of Obesity in South Australian 4 year olds: 1995-2002. *Journal of Paediatrics and Child Health 40 (7)*: 353-355.
[11] Pagnini et al. (2007). Early Childhood sector staff perceptions of child overweight and obesity: the Weight of Opinion Study. *Health Promotion Journal of Australia 18:* 149-154.
[12] Bower JK et al. (2006). The childcare environment and children's physical activity. *American Journal of Preventative Medicine 34 (1):* 23-29.
[13] Dowda M et al (2009). Policies and characteristics of the preschool environment and physical activity of young children. *Pediatrics 123 (2*): e261 – e266.
[14] Tooty Fruity Vegies (results are unpublished)
[15] De Silva-Sanigoriski AM et al. (2010). Reducing obesity in early childhood: results from Romp and Chomp, an Australian community-wide intervention program. *American Journal of Clinical Nutrition (9February 2010) doi:10.3945/ajcn.2009.28826.*
[16] Reilly J et al. (2006). Physical activity to prevent obesity in young children cluster randomised controlled trial. *BMJ 333:*1041-1045.

Munch and Move® provides professional development, resources and ongoing support to early childhood settings to implement policies and practices conducive to healthy eating and physical activity. Provisional quantitative and qualitative evaluation demonstrated that *Munch and Move*® is feasible, highly acceptable to early childhood settings and the health sector and is an appropriate way of building the knowledge and skills of early childhood professionals[17]. The evaluation results showed that the Service had a positive impact on FMS, water consumption and setting level practices, and showed some promise for reducing the amount of energy dense nutrient poor foods consumed while at preschool[17].

Parents/carers are also an important target group when seeking to influence health related behaviours of young children. *Munch and Move*® seeks to reach and influence parents/carers through increasing the frequency of communication between child care staff and the parents/carers of the children for whom they are providing care. This communication may take many and varied forms e.g. face-to-face, presentations, newsletters and fact sheets. Consequently the health related messages promoted in the child care setting will also be promoted to parents/carers to implement within the home setting.

Since 2008, 228 training workshops have been held across all 15 LHDs locations across NSW reaching staff from over 2200 centre based childcare services (65% of all centre based child care services including preschools, long day care and occasional care in NSW). Additional funding from the NPAPH has allowed for an enhanced rolled-out of *Munch and Move*® across the state to encompass a broader range of early childhood settings. This includes reaching up to 2000 long day care centres and 86 Family Day Care schemes across NSW. To date staff from 71 (83%) schemes have attended *Munch and Move*® training. This will result in a substantial increase in the number of children influenced by this Service as well as the number of early childhood settings implementing policies and practices actively promoting and supporting healthy eating and physical activity. As a consequence of the increased reach of this Service, more parents/carers of young children accessing early childhood services will also receive key health messages and information.

[17] Hardy L et al (2009). *Munch and Move Implementation and Evaluation Phase 1 (2008-2009) Report.* Sydney; Prevention Research Collaboration.

5. **Contribution to performance benchmarks:**

How *Munch and Move*® will contribute	**NPP Performance benchmark**
Increase in the number of childcare settings implementing healthy eating and physical activity policies. Improvement in the nutritional quality of food and drinks consumed by young children while in care (whether brought from home or served at childcare). Increase the time children spend engaging in physical activity (structured and unstructured) while in care. Decrease in the time children spend engaging in sedentary behaviours (particularly small screen activities) while in care. Increase the regularity and quality of communication between early childhood staff and parents/carers specifically regarding healthy eating, physical activity and limiting small screen time.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Increase in the number of childcare settings implementing healthy eating policies with a specific reference to fruit and vegetables. Increase the amount of fruit and vegetables consumed by children while in care (whether brought from home or served at childcare). Increase the regularity of communication between early childhood staff and parents/carers regarding fruit and vegetable consumption. Increase children's consumption of fruit and vegetables within the home setting.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.

How Munch and Move® will contribute	NPP Performance benchmark
Increase in the number of childcare settings implementing physical activity policies. Increase the number of structured physical activity opportunities included in setting routines, while retaining unstructured physical activity time. Increase the time children spend participating in physical activity while in the childcare setting. Support the development of children's fundamental movement skills, which are necessary for lifelong participation in physical activity. Increase the regularity and quality of communication between early childhood staff and parents/carers regarding physical activity and limiting small screen time. Increase in children's participation in physical activity within the home setting and decreased/limited time spent engaging in small screen recreation.	Increase in the proportion of children participating in at least 60 minutes of moderate physical activity each day of 5% from baseline by 2016; and 15% from baseline by 2018.

6. **Policy consistency:** This Service, which is delivered in the early childhood setting, builds upon existing state-wide efforts and investment while maintaining the flexibility for adaptation to meet local needs. This universal, primary prevention Service, which focuses on healthy eating and physical activity, directly targets early childhood settings as well as the children attending these settings. It will also reach parents/carers in a less direct manner.

   Embedding policies and processes within early childhood settings, as well as the development of the on-line modules and access to refresher training, will ensure the longer-term sustainability of this Service. This will underpin continued promotion and support of healthy eating and physical activity in and through early childhood settings. The Service's general approach, resources and delivery and support mechanisms can be adapted as required to meet the needs of vulnerable populations and thus *Munch and Move*® takes account of and address a range of equity issues.

   Health professionals, including those working in Local Health Districts provide support to early childhood settings. Consequently, a local level approach, which takes account of specific vulnerable populations as well as enablers and barriers, is embedded into the delivery of this service which gives added flexibility within the general overarching structure.

   Munch and Move® complements the *NSW Government Plan for Preventing Overweight and Obesity in Children, Young People and their Families 2009 -2011* and will reflect the priorities of the cross-government NSW State Obesity Plan, which is currently in draft form.

Target group(s): *Munch and Move*® has a number of key target groups including the following.

- The early childhood sector and its workforce (including pre-school, long day care and family day care). In NSW there are approximately 3400 centre based child care services and 86 family day care schemes.
- Children attending preschool, long day care and family day care. The 2006 Australia Government Census of Childcare Services estimates that approximately 800,000 children attend childcare services (Australia wide).
- Parents/carers of children attending preschool, long day care and family day care.

7. **Stakeholder engagement:** NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Healthy Children Initiative (HCI) including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for services which require multiple implementation partners; and
- ensuring appropriate engagement and support for the NSW HCI

NSW Ministry of Health also has existing formal and informal collaborative partnerships with key stakeholder groups and organisations relevant to the development and delivery of this Service. These partnerships will be used to facilitate the enhanced roll-out of *Munch and Move*® as part of the HCI. This approach has ensured that stakeholders likely to have some interest and/or involvement in the delivery of this service are supportive and committed. Key groups include:

- NSW Department of Education and Communities;
- preschools, long day care and family day care services;
- early childhood peak bodies (Family Day Care Association, Early Childhood Australia);
- NSW Local Health Districts; and
- Registered Training Organisations specialising in early childhood education.

NSW Ministry of Health has established a formal governance structure as part of the NPAPH. This will include program specific working groups as well as linking into higher-level Advisory Group involving internal and external stakeholders.

8. **Risk identification and management:**

Potential risk	**Management strategy**
Ability to roll out a high number of training sessions to a large and varied sector.	All key stakeholders will be engaged in to ensure they are supportive and committed to an enhanced roll-out across NSW. This has proven very effective for NSW Ministry of Health in the current program delivery across the State. Registered Training Organisations with extensive experience in the childcare sector and capacity to deliver a large number of workshops have already been contracted to deliver training to date. This approach will be maintained throughout the NPAPH. Support provided to the Local Health Districts will enable a large number of services to be recruited as well as intensive ongoing follow-up support after the training workshops. Communication channels and processes have been established between Local Health Districts and the current training organisation/s. This maximises the reach into the sector and capacity of training organisation/s to deliver a large number of workshops across the state.
Ensuring that early childhood centres/programs implement the learning from the training.	Engagement of Local Health Districts to provide ongoing medium to high intensity local support to early childhood services attending training assists in the implementation of key messages within the service and overcomes setting level barriers. Comprehensive, relevant and innovative resource materials are available for services to use following the training. The early childhood sector has had substantial input into the design and content of these resources, thus increasing relevance to the end users. The newly implemented National Quality System will continue to provide motivation and direction for continued activity with the sector.
The Service is not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Each working group will report to an overarching Advisory Group being established as part of the NPAPH governance structures.

Potential risk	Management strategy
Services across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH.

9. **Evaluation:** The evaluation of *Munch and Move*® will occur within the context of a comprehensive evaluation framework currently being developed by NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

The evaluation of *Munch and Move*® will include quality assurance measures as well as process and impact evaluation, and an analysis of the costs involved in delivering the Service against the results achieved.

- **Process evaluation** will include measuring the adoption of *Munch and Move*® and the extent to which it has been delivered as intended. It is anticipated that a minimum data set will be used to gather process data as well as support total quality improvement. This will include measures such as the numbers of services approaches, numbers of participating services, training workshops delivered and support visits made.
- **Impact evaluation** will include measuring changes in policy and practice at the service level. The potential to directly measure the effects of changes in setting level policy and practice on the food children eat and their levels of physical activity while in care, as well as their fundamental movement skills in a sample of participating services will be explored when planning the evaluation.
- **Cost evaluation** will assess the costs of delivering *Munch and Move*®.

NSW Ministry of Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

The final evaluation plan for *Munch and Move*® will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

10. **Infrastructure:** To deliver this Service a combination of existing and newly developed training and support infrastructure will be required.

- Training is currently provided by two Registered Training Organisations with expertise in early childhood education. This existing infrastructure has underpinned the success of the Service in preschools and will be accessed as much as possible to deliver this service as part of the NPAPH. However, in order to increase the state-wide reach of *Munch and Move*®, additional training infrastructure may be required. This will be provided by the same, or additional, external training organisations which will be procured by NSW Ministry of Health following appropriate processes.

- The NSW Local Health Districts provide ongoing support to early childhood settings participating in *Munch and Move*®. This existing support infrastructure is being used in the enhanced roll-out of *Munch and Move*. Local Health Districts have strong relationships with the early childhood sector and have expressed a commitment to continuing in this role as part of the HCI.

- Additional infrastructure in the form of online training will be developed allowing rural and remote areas of NSW to access the Service. This is not always possible under the current training model which requires face-to-face attendance at a workshop. The online training will increase the sustainability of *Munch and Move*® in the longer-term.

11. **Implementation schedule:**

Deliverable and milestone		**Due date**
i.	Delivery of *Munch and Move*® training to centre based children's services	July 2011 -June 2015
ii.	Delivery of *Munch and Move*® train the trainer to family day care schemes	July 2011- June 2012
iii.	Development of online training module	By Dec 2013
iv.	Participation in online training	January 2014 - June 2017
v.	Delivery of *Munch and Move*® training to family day carers	July 2011 - June 2015
vi.	Delivery of refresher training	June 2012 to Dec 2017
vii.	Review of *Munch and Move*® resources and training	As required
viii.	Program monitoring and evaluation	Ongoing
ix.	Development and implementation of sustainability strategies	Ongoing to June 2018

Notes: Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6%of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Inclusion. Discrepancies in the table between totals and sums of components reflect rounding

12. **Responsible officer and contact Details:**

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13. **Activity budget:**

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	TOTAL ($ million)
Project management, adoption and maintenance in services	$1.49	$1.49	$1.49	$1.49	$1.49	$1.49	$1.49	**$10.43**
Embedding the needs of Aboriginal and other vulnerable populations	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23	**$1.61**
Monitoring and evaluation	$0.25	$0.75	$0.30	$0.30	$0.30	$0.30	$0.30	**$2.5**
TOTAL	**$1.97**	**$2.47**	**$2.02**	**$2.02**	**$2.02**	**$2.02**	**$2.02**	**$14.54**

Note: This budget accounts for NPAPH facilitation funds only. An additional $11.375m of NSW funding will be allocated to Munch and Move® over the 7-years of the NPAPH. The table below outlines the NSW contribution to this intervention throughout the NPAPH. Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6% of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Service. Discrepancies in the table between totals and sums of components reflect rounding.

Table 5: Additional / supplementary funding provided by NSW Ministry of Health

Year	NSW Ministry of Health contribution
Year 1	$1,625,000
Year 2	$1,625,000
Year 3	$1,625,000
Year 4	$1,625,000
Year 5	$1,625,000
Year 6	$1,625,000
Year 7	$1,625,000
TOTAL	**$11,375,000**

Notes: This is the existing funding from DOH allocated to *Munch and Move®*.
NSW Ministry of Health will contribute these funds to delivery of this intervention in addition to the facilitation funds received from the Commonwealth Government.

PROGRAM OVERVIEW AND OBJECTIVE

1. **Services for School Settings**

2. The objective in this program are to:

   - increase teachers' knowledge, skills and confidence in delivering innovative learning experiences related to healthy eating and physical activity;
   - increase the number of schools implementing whole of school healthy eating and physical activity policies;
   - create school environments which provide opportunities for children and young people to consume healthy foods and engage in physical activity;
   - improve the nutritional quality of food and drink students consume while at school; and
   - increase the time primary school students spend being physically active while at school;

3. The *Services for School Settings* Program includes three activities:

   a) Primary School Obesity Prevention Service (*Live Life Well@ School*);
   b) Primary School Nutrition Service (*Crunch and Sip*®); and
   c) High School Canteen Support Service.

The senior contact officer for this program is:

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Activity 2.1: Primary School Obesity Prevention Support Service *(Live Life Well @ School)*

Overview:

The *Primary School Obesity Prevention Support Service* (*Live Life Well @ School)* is an existing Service established under a partnership between the NSW Department of Education and Communities and NSW Ministry of Health in 2007. The Service aims to build teacher capability through developing their knowledge, skills and confidence in teaching nutrition education and fundamental movement skills (FMS) as part of the K-6 Personal Development, Health and Physical Education (PDHPE) syllabus.

Following attendance training, participating schools are supported to develop and implement an Action Plan tailored to the needs of their school community. Schools can include a range of curriculum and environmental activities in their Action Plans including: *Fresh Tastes @ School: NSW Ministry of Healthy School Canteen Strategy, Crunch&Sip® Get Skilled Get Active* and *Live Outside the Box. Live Life Well @ School* seeks to promote 'whole of school' physical activity and nutrition strategies in a manner that is consistent with classroom teaching and incorporates community links supported by resources for teachers, parents and carers.

The key components of *Live Life Well @ School* (LLWatS) include:

- attendance at a two-day face-to-face workshop for teachers;
- developing a school Action Plan within 3-months of the workshop which is endorsed by the school Principal and submitted to the Department of Education and Communities;
- provision of support resources to the value of $2000 for schools developing an Action Plan which has a specific focus on whole of school activities which promote healthy eating and/or physical activity;
- completion of online learning modules, three of which are mandatory; and
- ongoing support from health professionals working in the Local Health Districts, provided in various forms e.g. face-to-face, workshops, networks, electronic means.

4. **Outputs:**

Description	**Quantity**	**Timeframe**
Delivery of *Live Life Well @ School* workshops to teachers from DEC primary schools	80% of all DEC primary schools attend *LLWatS* workshop	July 2011-June 2015
Delivery of *Live Life Well @ School* workshops to teachers from Catholic and Independent primary schools	80% of all Catholic and Independent primary schools attend *LLWatS* workshop	July 2012 – June 2015
Delivery of *Live Life Well @ School* workshops to teachers from disadvantaged schools (may include social disadvantage and disability)	20% of all primary schools attending *LLWatS* workshop classified disadvantaged	July 2011 – June 2017
Delivery of *Live Life Well @ School* Refresher workshops to teachers from school sectors	60% of all schools who have attended a *LLWatS* workshop attend a refresher workshop within 2 years	July 2011 – June 2017
Live Life Well @ School Action Plans submitted and support funding provided.	Over 70% of schools that attend training submit an Action Plan and receive support funding	July 2011-June 2017
Development of *Live Life Well @ School* online learning modules	At least 4 online modules developed 45% of participating schools complete at least 1 optional module 70% of participating schools complete the 3 mandatory modules	June 2014 July 2014- June 2017 July 2041- June 2017

5. **Outcomes:**

Short term	**Medium term**	**Long term**
Increased proportion of primary school teachers receive information and training relevant to promoting healthy eating and physical activity in the school setting	Increase in teachers' awareness and knowledge of healthy eating and physical activity relevant to the primary-school setting Increased capacity and intentions of teachers and schools to promote healthy eating and physical activity across the whole school Schools use information and recourses to promote healthy eating and physical activity across the school setting	Increased proportion of primary schools promote healthy eating and physical activity across the whole school through classroom activities as well as policies and practices Increased proportion of children attending primary schools that participate in activities to promote healthy eating and physical activity
Increased proportion of teachers receive information relevant to communicating healthy eating and physical activity messages to parents/carers	Increased capacity of schools to communicate healthy eating and physical activity messages to parents/carers Increased proportion of schools provide information to parents/carers relevant to healthy eating and physical activity	Increased proportion of primary schools that regularly promote healthy eating and physical activity messages to parents/carers of children attending the school

6. **Rationale**: Primary school-based Services can reach a large number of children aged 5-12 years as well as their parents/carers. These Services are most successful when they adopt a 'whole of school' approach, incorporating school policies, practices, environments and curriculum. Nutrition and physical activity policies, healthy canteens, fruit and vegetable promotion, access to drinking water and encouraging children to play actively – in conjunction with professional development for teachers and support staff and the involvement of parents and the community – are all recommended strategies to comprehensively address obesity prevention within a school setting[18].

   Research also suggests that Fundamental Movement Skills (FMS) are vital in addressing issues of participation in physical activity and also in addressing the increasing overweight and obesity levels amongst children. If students achieve proficiency in FMS, they are more likely to participate in games and sports and to establish a life-long commitment to a healthy, active lifestyle[19].

   Over the years, a number of physical activity and healthy eating programs have been implemented in primary schools by both NSW Ministry of Health and the NSW Department of Education and Communities. However, in some cases, these have been conducted independently without the pooling of expertise, knowledge and resources. Therefore, it was identified that a state-wide Service, which would consolidate existing programs, resources and policies under one framework and develop further evidence about the most effective strategies to support healthy, active school communities was needed. *Live Life Well @ School* adopts such an approach.

   Live Life Well @ School is a professional learning and ongoing support Service for teachers and schools. The professional learning focuses on delivery of physical education and nutrition education as part of the PDHPE curriculum, and promotes 'whole-of-school' strategies that provide supportive environments for this learning. The professional learning is designed to empower school communities to take action at the local level. By providing teachers with current information and practical resources on physical activity and healthy eating, and providing ideas for 'whole of school' change, schools can take ownership of *Live Life Well @ School* and adapt it to the specific and changing needs of their own school community.

   Live Life Well @ School was first implemented in 2008 and since this time staff from approximately 1175 NSW Government schools have accessed this Service. This represents a reach of 65% of all NSW Government primary schools. Since January 2012 Catholic and Independent sector schools have been invited to participate in *Live Life Well @ School*. To date approximately 155 (34%) of Catholic primary schools and 72 (20%) of Independent primary schools have attended *Live Life Well @ School* training. The current program under the NPAPH includes:

   - ongoing revisions to the workshop program and resources;
   - development and delivery of online of learning modules;
   - engagement of school Principals from DEC, Catholic and Independent sectors in *Live Life Well @ School*;
   - emphasis on developing and implementing a school *Live Life Well @ School* Action Plan;
   - local level health professional support for participating schools;
   - provision of support and funding for schools to develop and implement an Action Plan that directly links to promoting healthy eating and physical activity; and
   - development of a website to reinforce *Live Life Well @ School* messages and activities.

[18] Gill T, King L and Webb K. (2005). Best options for promoting healthy weight and preventing weight gain in NSW. Sydney: NSW Centre for Public Health Nutrition.
[19] Oakley Ad et al. (2001). Relationship of physical activity to fundamental movement skills among adolescents. *Medicine and Science in Sports and Exercise 33*: 1899-1904.

7. **Contribution to performance benchmarks:**

Live Life Well @ School **contribution**	**NPP Performance benchmark**
Increase in primary school teachers' knowledge, confidence and skills in teaching about healthy eating and providing opportunities for students to engage in physical activity. Increase in the proportion of primary schools that have environments supportive of healthy food and drinks and engaging in physical activity. Increase curriculum time allocated to learning experiences related to healthy eating as part of the PDHPE Key Learning Area Increase in the proportion of primary school students' consuming healthy food and drinks while at school. Increase in the proportion of primary school students engaged in structured and unstructured physical activity periods while at school.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Increase in primary school teachers' knowledge, confidence and skills in teaching nutrition, especially in relation to the importance of fruit and vegetable consumption. Increased access to fun, age-appropriate teaching materials that will engage students in learning about fruit and vegetables. Increase in primary school students' consumption of fruit and vegetables while at school - provided in their lunchboxes by their parents/carers and/or accessed via the school canteen.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.

***Live Life Well @ School* contribution**	**NPP Performance benchmark**
Increase in primary school teachers' knowledge, confidence and skills in teaching physical activity, especially FMS. Increase curriculum time allocated to learning experiences related to physical activity as part of the PDHPE Key Learning Area Opportunities provided in primary school environments for students to engage in unstructured physical activity during recess and lunch-time. Increase in the time primary school students spend being physically active while at school.	Increase in the proportion of children participating in at least 60 minutes of moderate physical activity each day of 5% from baseline by 2016; and 15% from baseline by 2018.

8. **Policy consistency:** *Live Life Well @ School* is an existing Service that has involved substantial quality assistance and process evaluation. Inclusion of this Service in the HCI allows for significant enhancements in response to feedback from stakeholders. These enhancements include a redesign of the service delivery model and inclusion of additional and more intensive support to increase its adoption within schools. As part of the NAPAPH the Service has been made available to government schools as well as the Catholic and Independent school sectors.

   Live Life Well @ School is a primary prevention Service is being offered universally to all schools across the state. The Service directly targets children attending primary schools as well as staff working in schools and the parents/carers of children attending schools in which the Service is delivered. This Service also seeks to influence school environments so that they are more health promoting and therefore reinforce curriculum-based activities delivered as part of *Live Life Well @ School*.

   Equity issues are an important consideration to ensure all schools are able to access and implement *Live Life Well @ School*. Funding, tied to the development of an Action Plan to provide support for teachers to attend training, as well as on-line training modules and information will increase equity of access to this Service for all schools, especially among schools in rural and remote areas and those in disadvantaged communities.

   Local-level support for participating schools will continue to be provided by health professionals working in Local Health Districts. Consequently, a local-level approach, which takes account of specific population groups as well as enablers and barriers at the school level, is an integral part of the Service giving added flexibility within the general structure of *Live Life Well @ School*.

This Service aims to increase teachers' knowledge and skills and also supports whole of school environmental change, and links to parents/carers, which promotes longer-term sustainability of the changes made at the school level.

9. **Target group(s):** *Live Life Well @ School* has a number of key target groups including:

- teachers and Principals from Government, Catholic and Independent primary schools;
- children attending Government, Catholic and Independent primary school across NSW; and
- parents/carers of children attending Government, Catholic and Independent primary school in NSW.

10. **Stakeholder engagement:** NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Ministry of Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for services which require multiple implementation partners; and
- ensuring appropriate engagement and support for the NSW Ministry of Healthy Children Initiative.

Consultation has included stakeholders internal to NSW Ministry of Health, Local Health Districts, other NSW Government Departments, non-government organisations and academic institutions.

NSW Ministry of Health has an existing relationship with the NSW Department of Education and Communities (DEC) and has worked in close consultation with the Curriculum Directorate to deliver *Live Life Well @ School* to date. The DEC has been integral in the redesign of the Service ensuring its salience to teachers and schools within the current educational context in NSW. This collaborative partnership is likely to continue as part of the NPAPH. Since 2012, NSW Ministry of Health has also engaged key organisations from the Catholic and Independent sectors to seek their commitment to and support of *Live Life Well @ School.*

Additionally, NSW Ministry of Health has established a formal governance structure as part of the NSW Ministry of Healthy Children Initiative and the broader NPAPH. This will include program specific working groups as well as higher level Advisory Committee involving internal and external stakeholders.

11. **Risk identification and management:**

Risk	**Management Strategy**
Low rates of school participation in *Live Life Well @ School*	The *Live Life Well @ School* model has been modified to increase its feasibility and acceptability with key stakeholders and now also includes increased involvement of school Principals. This ensures a commitment at a senior level, which is a critical success factor in this setting. The existing NSW Ministry of Health investment in *Live Life Well @ School* will be leveraged to ensure that NPAPH funds are directed to an enhanced program model reducing the risk of low participation compared to a totally new program model.
Introduction of the National Curriculum might affect schools' ability and willingness to attend training related to other curriculum areas such as PDHPE.	The *Live Life Well @ School* service delivery model has been modified to increase its feasibility and acceptability. This includes reduced face-to-face workshop time from 3 days to 2 days, paid teacher relief to allow teachers to attend training, and highlighting links between *Live Life Well @ School* and broader curriculum areas including numeracy and literacy. Principals from participating schools will be actively engaged to ensure they understand the value of the training and links to other curriculum areas. NSW Ministry of Health will continue to work in close consultation with the DEC, which will allow NSW Ministry of Health to respond to changing educational contexts and concerns of key stakeholders.

Risk	**Management Strategy**
Unknown acceptance of *Live Life Well @ School* in Catholic and Independent schools	NSW Ministry of Health will proactively engage peak bodies from these sectors in planning processes to ensure commitment and timely implementation. This process began with seeking comment and feedback from these peak bodies on the Healthy Children Discussion Paper. The Service will be phased in across these sectors. NSW Ministry of Health will work collaboratively with these sectors to identify, where required, alternative options for delivery of training and ongoing support.
The Service is not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Each working group will report to an overarching Advisory Group being established as part of the NPAPH governance structures.
Interventions across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH.

12. **Evaluation:** The evaluation of *Live Life Well @ School* will occur within the context of a comprehensive evaluation framework currently being developed by NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

    The evaluation of *Live Life Well @ School* will include quality assurance measures as well as process and impact evaluation and an analysis of the costs involved in delivering the Service against the results achieved.

    - **Process evaluation** will measure the extent to which *Live Life Well @ School* has been delivered as intended, as well as its reach into the setting and to the target populations. Process measures will include the number of schools approached to participate, the number of schools participating, number of training workshops delivered.
    - **Impact evaluation** will include measuring changes in policy, practice and environments at the school level, number of schools developing and implementing action plans.
    - **Cost evaluation** will assess the costs of delivering *Live Life Well @ School*.

    NSW Ministry of Health has established a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

    The final evaluation plan for *Live Life Well @ School* will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

13. **Infrastructure:** A combination of new and existing infrastructure has been required to deliver the Service as part of the NPAPH.

    - Soft infrastructure such as *Live Life Well @ School* training resources are developed by the DEC in consultation with NSW Ministry of Health. Online training options will be developed as part of this Service. The initial development of these resources was undertaken in the 2010/2011 financial year using NSW Ministry of Health funds.

    - Currently training infrastructure is provided through the DEC. Additional training infrastructure will be required to increase the reach across NSW ensuring the successful delivery of this service across the state. Staff are based at the DEC and responsible for promoting the Service as well as developing, delivering and managing the two-day workshops. In collaboration with the Local Health Districts, the DEC also provide support to schools participating in *Live Life Well @ School*.

    - Health professionals from Local Health Districts currently provide support to schools participating in *Live Life Well @ School*. This existing infrastructure is being utilised to provide intensive ongoing support to participating schools as part of the NPAPH. The LHDs have established excellent working relationships with school and have expressed a desire and commitment to continue their involvement in *Live Life Well @ School* as part of the NPAPH, including through NSW funds.

14. Implementation schedule:

Table 3: Implementation schedule

Deliverable and milestone		Due date
i.	Redesigned training materials and supportive resources completed	July 2011
ii.	Delivery of LLW@S workshops to Government schools	June 2017
iii.	Delivery of LLW@S workshops to Catholic and Independent schools	June 2017
iv.	Ongoing support to LLW@S schools by health professionals	June 2017
v.	Delivery of refresher training	July 2011 to June 2017
vi.	Review of resources and training	Ongoing and as required
vii.	Program monitoring and evaluation	Ongoing to June 2018
viii.	Development and implementation of sustainability strategies	Ongoing to June 2018

Notes: Planning for the enhanced redesign of Live Life Well @ School under the NPAPH will be underway in the 2010/2011 financial year using NSW Ministry of Health funds.

15. Responsible officer and contact Details:

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16. **Activity budget:**

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Project management, adoption and maintenance in DET schools	$1.21	$1.21	$1.26	$1.28	$1.26	$1.26	$1.21	**$8.70**
Project adoption and maintenance in Catholic and Independent schools	$0.00	$0.30	$0.35	$0.35	$0.35	$0.35	$0.35	**$2.05**
Embedding the needs of Aboriginal and other vulnerable populations	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23	$0.23	**$1.61**
Monitoring and evaluation	$0.30	$0.75	$0.30	$0.35	$0.35	$0.35	$0.35	**$2.75**
TOTAL	**$1.74**	**$2.49**	**$2.14**	**$2.21**	**$2.19**	**$2.19**	**$2.14**	**$15.1**

Notes: This budget is for NPAPH facilitation funds only. An additional $13.3m of NSW funding will be allocated to Live Life Well @ School over the 7-years of the NPAPH. The table below outlines the NSW contribution to this intervention throughout the NPAPH. Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6% of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Service. Discrepancies in the table between totals and sums of components reflect rounding.

Table 5: Additional / supplementary funding provided by NSW Ministry of Health

Year	NSW Ministry of Health contribution
Year 1	$1,900,000
Year 2	$1,900,000
Year 3	$1,900,000
Year 4	$1,900,000
Year 5	$1,900,000
Year 6	$1,900,000
Year 7	$1,900,000
TOTAL	**$13,300,000**

Notes: This is the existing funding from DOH allocated to *Live Life Well @ School*
NSW Ministry of Health will contribute these funds to delivery of this intervention in addition to the facilitation funds received from the Commonwealth Government.

Activity 2.2: Primary School Nutrition Support Service *(Crunch&Sip®)*

Overview: The *Primary School Nutrition Service* (*Crunch&Sip®)* encourages schools to provide a set break as part of the school day specifically for children to eat some fruit or salad vegetables and drink water in the classroom. *Crunch&Sip*® schools must demonstrate a commitment to teaching children about healthy eating, with a particular focus on fruit and vegetable consumption, as well as developing and implementing a fruit and water policy within their school. Children are expected to bring the fruit and/or vegetables they will eat as part of this break from home and therefore this Service also targets parents/carers.

Once schools registers interest in implementing*Crunch&Sip*® they receive *Crunch&Sip*® information and resources including materials for children to take home to their families. Schools are then supported to become certified *Crunch&Sip*® schools.

A school achieves full implementation after achieving the following conditions

- *Crunch&Sip*® is formalised in a policy – either as a stand-alone policy or as part of another policy (such as a nutrition or student welfare policy);
- at least 70% of classes in the school are having a *Crunch&Sip*® break at least 4 days per week ;and
- parents have been notified of *Crunch&Sip*®.

Schools registering interest in *Crunch&Sip*® are offered additional support from a health professional. This assists schools with implementing *Crunch&Sip*® and achieving full implementation status.

Under the HCI,, additional strategies have been added to the existing Service to broaden its reach and increase the intensity of support provided. There has also been an increased focus on addressing equity issues. The current program includes:

- provision of support and follow-up to participating schools (assisting them to achieve full implementation);
- promotional activities such as Fruit and Veg Month to engage children in experimental learning about fruit and vegetables;
- enhanced communication and networking amongst *Crunch&Sip*® schools; and
- review of existing resources and development of new materials as required.

Specific strategies to reach and support schools in disadvantaged areas will be informed by the *Social Inclusion Engagement Service.* They will be informed by advice from key stakeholders on priority target populations, alternative delivery models and support mechanisms as well as modifications that may be required to increase the salience of the Service and resources.

Outputs:

Description	**Quantity**	**Timeframe**
Review existing resources and develop new materials as required	Review all existing resources	July 2011 and ongoing as required
Support participating primary schools to fully implement *Crunch&Sip*® schools	80% of all primary schools (DEC, Catholic and Independent) satisfy the conditions for full implementation (approx 1860 schools)	July 2011 –December 2017
Promote Fruit and Veg Month to *Crunch&Sip*® schools	65% of *Crunch&Sip*® schools participate in Fruit and Veg month	July 2011-June 2018
Increased focus on reaching those schools classed as disadvantaged	Of those schools classed as disadvantaged, 30% participate in *Crunch&Sip*®	Jan 2012- June 2017
Offer tailored support and follow up to schools	All schools receive additional support for adoption and maintenance	July 2011-June 2017

17. **Outcomes:**

Short term	Medium term	Long term
Increased proportion of primary schools register for and receive information on *Crunch&Sip*®	Increase in teachers' knowledge and awareness of *Crunch&Sip*® messages Increased capacity and intentions of schools to promote *Crunch&Sip*® messages to parents and across the school.Schools use *Crunch&Sip*® information and resources to promote the *Crunch&Sip*® messages to parents and across the school	Increase in the proportion of primary schools implementing *Crunch&Sip*® Increase in the proportion of primary schools achieving full *Crunch&Sip*® implementation Increased fruit and vegetable intake and water consumption among children attending *Crunch&Sip*® schools, while at school

18. **Rationale:** *Crunch&Sip*® is an adaptation of the Fruit and Water Policy in Schools Project originally delivered in Western Australia. The project demonstrated that including fruit and water breaks during the school day can have positive effects on children's fruit and vegetable consumption[20]. Further and importantly, teachers reported that the approach was feasible and highly acceptable.

Fruit and vegetable consumption plays an important role in preventing disease, therefore inadequate intake of fruit and vegetable is a nutritional issue. In NSW in 2007-2008, approximately 71.3% of children 2-15 years old consumed the recommended daily fruit intake[21]. While the overall proportion of children consuming the recommended serves of fruit each day is encouraging, it should be noted that fruit consumption declines with age. In NSW in 2007-2008 only 50% of school-aged children consumed the recommended amount of fruit each day and the proportion of children consuming the recommended fruit serves has been declining since 2001[17].

For vegetables, only 41.8% of children 2-15 years old consume the recommended serve of vegetables[17]. While this represents an increase since 2001, as with fruit intake, there is significant room improvement. There is therefore potential to increase fruit and vegetables consumption in primary school-aged children through including a specific primary school nutrition service in the NPAPH.

Crunch&Sip® is an existing state-wide Service currently delivered in partnership with the Healthy Kids Association and NSW Local Health Districts. The Service adopts the principles of the whole-of-school approach and also targets parents/carers of children, thus representing good practice. As with all school-based services, extensive reach can be gained across NSW.

Crunch&Sip® is also an ideal service through which increased consumption of water can be encouraged. Approximately 50% of children reported drinking three or less cups of water each day in NSW in 2007-2008[17] and therefore, *Crunch&Sip*® will support children to increase their intake of water.

[20] Healthway (2009). *Successful Healthway Projects. Fruit and Water Policy in School Pilot Project.* Perth: Healthway
[21] Centre for Epidemiology and Research. (2010). *Report on Child Health from the NSW Population Health Survey.* Sydney: NSW Department t of Health

The HCI provides an opportunity to introduce additional strategies to enhance the existing Service including:

- providing more intensive support and follow-up to participating schools;
- conducting promotional activities, such as Fruit and Veg Month and other activities to engage children in experimental learning about fruit and vegetables;
- enhancing communication and networking amongst *Crunch&Sip*® schools; and
- reviewing existing resources and developing of new materials as required.

The 2007-2008 NSW Child Health Survey showed that children from the most disadvantaged quintiles were less likely to consume the recommended daily serves of vegetables. A specific focus on disadvantaged schools is required as *Crunch&Sip*® is delivered more broadly across NSW. Specific strategies to reach and support schools in disadvantaged areas will be informed by the *Social Inclusion Engagement Service* and will be responsive to advice from key stakeholders on priority target populations, alternative service delivery models as well as modifications that may be required to increase the salience of *Crunch&Sip*® resources.

19. **Contribution to performance benchmarks:**

***Crunch and Sip*® contribution**	**NPP Performance benchmark**
Increased proportion of NSW primary schools provide a fruit and vegetable break to students. Provision of healthy eating resources and messages to children and their families. Increased primary school students' consumption of fruit and vegetables while at school Increase in primary school students' consumption of water and decrease in their consumption of sugar-sweetened drinks while at school. Increase in primary school aged children's daily consumption of water and decrease in their daily consumption of sugar-sweetened drinks.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Increase in the number of NSW primary schools providing a fruit and vegetable break to students. Increased access to and sue of fun, age-appropriate teaching materials that will engage students in learning about fruit and vegetables. Increase in the consumption in fruit and vegetables among primary school children while at school. Increase in primary school aged children's daily consumption of fruit and/or vegetables.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.

20. **Policy consistency**: *Crunch&Sip*® is an existing NSW universal primary prevention Service directly addressing fruit and vegetable consumption and water intake of primary school-aged children. The Service reaches parents, as the fruit and vegetables consumed by children during *Crunch&Sip*® time are brought in from home. In doing so, *Crunch&Sip*® acknowledges the role parents and the family play in shaping health-related attitudes and behaviours.

    Strategies are being embedded into *Crunch&Sip*® to ensure it addresses equity issues and that all children and all schools have access to this Service. While some strategies have already been identified, others will be informed through the *Social Inclusion Engagement Service*, described later in this Implementation Plan. The *Social Inclusion Engagement Service* will provide ongoing advice on how to modify and/or tailor *Crunch&Sip*® to meet the needs of a range of populations including Aboriginal, rural and remote, CALD communities, the disabled and socially disadvantaged.

    Crunch&Sip® links with *Live Life Well @ School*. It is one of a suite of programmatic activities schools participating in *Live Life Well @ School* may include in their Action Plan. The links between *Crunch&Sip*® and LLWatS will be strengthened and reinforced through the HCI.

21. **Target group(s):** *Crunch&Sip*® has several primary key target groups including:

    - primary schools and primary school teachers working in the Government, Catholic and Independent sectors across NSW;
    - children attending Government, Catholic and Independent primary schools across NSW; and
    - parents/carers of children who attend primary school.

22. **Stakeholder engagement:** NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for interventions which require multiple partners; and
- ensuring appropriate engagement and support for the NSW Ministry of Healthy Children Initiative.

Consultation has included stakeholders internal to NSW Ministry of Health, Local Health Districts, other NSW Government Departments, non-government organisations and academic institutions.

NSW Ministry of Health has an existing relationship with the NSW Ministry of Healthy Kids Association which administers *Crunch&Sip*® on its behalf. This collaborative working relationship will be continued as part of the NPAPH and the NSW Healthy Kids Association is committed to an enhanced roll-out of *Crunch&Sip*®.

Additionally, NSW Ministry of Health has established a formal governance structure as part of the NSW Ministry of Healthy Children Initiative and the broader NPAPH. This will includes program specific working groups as well as a higher level Advisory Group involving internal and external stakeholders.

23. **Risk identification and management:**

Risk	**Management Strategy**
Schools register for *Crunch&Sip*® but do not progress to achieve full implementation status.	Additional efforts will focus on working with schools to support and assist them to achieve full implementation. This includes intensive and tailored support for schools, which takes account of individual enablers and barriers to *Crunch&Sip*® within the school setting.
Children from families that do not have access to fruit and vegetables do not participate in *Crunch&Sip*®	Tailored support will be offered for disadvantaged schools to ensure that all children can participate in *Crunch&Sip*®
The extent to which *Crunch&Sip*® will impact on vegetable consumption is unknown.	Development of resources and materials for families which focus on preparation of vegetables to bring to school. Fun and innovative classroom activities and promotions focused on vegetable consumption will be developed.
The service is not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Working groups will report to an overarching Advisory Group being established as part of the NPAPH governance structures.
Interventions across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH.

24. **Evaluation:** The evaluation of *Crunch&Sip*® will occur within the context of a comprehensive evaluation framework currently being developed by NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

The evaluation of *Crunch&Sip*® will include quality assurance measures as well as process and impact evaluation, and an analysis of the costs involved in delivering the Service against the results achieved.

- **Process evaluation** will include measuring the adoption of *Crunch&Sip*® and the extent to which it has been delivered as intended. A data set is be used to gather the number of schools participating and the number of schools reaching full implementation status.
- **Impact evaluation** will include measuring changes in policy and practice at the school level, the proportion of classes participating during the designated *Crunch&Sip*® break. **Cost evaluation w**ill assess the costs of delivering *Crunch&Sip*®.

NSW Ministry of Health has establishied a formal governance structure to guide, advise an*d oversee* evaluatio**n processes bei**ng planned as part of the NPAPH.

The *final evalu*ation plan for *Crunch&Sip*® will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

25. **Infrastructure:** Existing infrastructure will be used to deliver *Crunch&Sip*® across the state.

- NSW Ministry of Health has an existing funding arrangement with an external organisation through which *Crunch&Sip*® has been delivered to date. The organisation is responsible for recruiting schools and providing ongoing tailored support to schools and ensuring schools successfully achieve full implementation.

- Routine delivery and implementation of *Crunch&Sip*® is supported by the Local Health Districts.

- *Crunch&Sip*® is linked to *Live Life Well @ School* though which the program is promoted.

- Additional infrastructure is required to enhance the delivery of *Crunch&Sip*® state-wide. In order to achieve this, existing relationship with the external organisation and structures may be utilised. Alternatively, NSW Ministry of Health may also fund another external organisation to assist with the coordination and delivery of an enhanced *Crunch&Sip*®

26. **Implementation schedule:**

Deliverable and milestone		**Due date**
i.	Review and update of *Crunch&Sip*® resources	July 2011
ii.	Ongoing support provided to participating primary schools	Dec 2017
iii.	Implementation of strategies addressing access and equity, including intensive support	Dec 2017
iv.	Program monitoring and evaluation	Ongoing
v.	Development and implementation of sustainability strategies	Ongoing to June 2018

27. **Responsible officer and contact details:**

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Activity budget:

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure Item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Project management, adoption and maintenance in schools	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	$0.51	**$3.57**
Embedding the needs of Aboriginal and other vulnerable populations	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06	**$0.42**
Monitoring and evaluation	$0.11	$0.21	$0.16	$0.16	$0.16	$0.16	$0.16	**$1.12**
TOTAL	**$0.68**	**$0.78**	**$0.73**	**$0.73**	**$0.73**	**$0.73**	**$0.73**	**$5.11**

Notes: This budget is for NPAPH facilitation funds only. An additional $3.36m of NSW funding will be allocated to *Crunch&Sip*® over the 7-years of the NPAPH. The table below outlines the NSW contribution to this intervention throughout the NPAPH. Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6% of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Service. Any central office staffing required to coordinate this intervention will be funded using NSW funds. Discrepancies in the table between totals and sums of components reflect rounding.

Table 5: Additional / supplementary funding provided by NSW Ministry of Health

Year	NSW Ministry of Health contribution
Year 1	$480,000
Year 2	$480,000
Year 3	$480,000
Year 4	$480,000
Year 5	$480,000
Year 6	$480,000
Year 7	$480,000
TOTAL	**$3,360,000**

Notes: This is the existing funding from DOH allocated to *Crunch&Sip*®.
NSW Ministry of Health will contribute these funds to delivery of this intervention in addition to the facilitation funds received from the Commonwealth Government.

Activity 2.3: High School Canteen Support Service

1. **Overview:** *High School Canteen Support* will target selected high schools NSW to establish a healthy school canteen while maintaining profitability. While the Service is in its formative stages of development, it will likely include a number of strategies to support high school canteens to limit the availability of energy-dense nutrient poor food and drinks and replace these with a range of healthier options. Competitive pricing policies and point of sale promotions will be encouraged to make healthy choices cheaper and more attractive alternatives to unhealthy foods and increase sales. This will also contribute to ensuring that the healthy canteens maintain their profitability. Strategies will be finalised after consultation and formative research and may include :

    - costing studies and business model resources;
    - intensive ongoing support for schools to assist them to develop and implement a healthy school canteen policy and support start-costs associated with the Service;
    - access to the services of a public health nutritionist and/or business consultant; and
    - resources developed and tailored specifically for high schools and the needs, wants and expectations of students and canteen managers within this setting.

    Further developmental work is required to fully develop this support and ensure its appropriateness to the sector, canteen managers as well as high school students. This development work will build on the previous *Fresh Tastes @ School* and the *Booster* programs in which NSW has invested over recent years. While these have had limited success in high schools, the NPAPH allows for significant enhancement and where appropriate redesign of these to increase their salience in the high school setting. This may include embedding a business model approach and offering ongoing intensive support to participating schools.

2. **Outputs:**

Description	**Quantity**	**Timeframe**
Develop partnerships and agreements with key stakeholders across sectors	Strategic key intersectoral partnerships formed and maintained	July 2012 – June 2015
Undertake consultations and formative research to inform the development of strategies.	Consultations and formative research undertaken with appropriate stakeholders.	July 2012- June 2013
Formative development of support resources following feedback from targeted consultations	Service delivery model and support resources developed and focus tested with appropriate stakeholders	July 2013 – June 2014
Business model case studies identified and profitability and costing studies undertaken to support schoolsand develop resources	Case study and business 'tool kit' developed to support schools and canteen managers	July 2013-June 2014
Canteen strategy and support resources finalised and disseminated to high schools and canteen managers across NSW	20% of high schools support and receive resources	July 2014 – June 2017
Participating schools receive intensive ongoing support to assist with adoption and maintenance	All schools accessing the support receive ongoing follow-up and tailored support	January 2015 - January 2018

3. **Outcomes:**

Short term	Medium term	Long term
Increased proportion of schools/canteen managers receive information and training relevant to promoting healthy eating though high school canteens	Increase in schools/canteen managers awareness and knowledge relevant to promoting healthy eating though high school canteens Increase in schools/canteen managers capacity and intentions to promote healthy eating through high school canteens Schools/canteen managers use information and resources to achieve a healthy and profitable high school canteen	Increase in the proportion of high school canteens while promote healthy eating though policies, practices and foods availability Increase in high school students intention to make healthy food choices when purchasing food from the school canteen Increase in the proportion of high school students making healthy food and drinks choices when purchasing foods from the school canteen

4. **Rationale:** Environments play an important role in influencing health behaviours and school environments are no different. Healthy food choices are important for achieving and maintaining a healthy weight as well as preventing disease. High school is a setting through which young people can learn about making healthy eating and school canteens provide opportunities for young people to put into practice what they learn about healthy eating in the classroom. Therefore school canteens can contribute to a broader heath promoting school environment by providing healthier food and drink options that are tasty, interesting and affordable. This can influence food choices made by young people not only at school, but also outside of this environment. However, in reality healthy eating messages delivered through classroom-based activities are often undermined by the less healthy food and drink options available for purchase in school canteens[22].

Young people who regularly purchase snacks and lunch from the school canteen consume a substantial portion of their daily energy intake from this source[23]. Therefore, it is important that school canteens make healthy choices more widely available and position these products favourably against less healthy options. In 2010 NSW undertook formative research with young people to guide and inform youth focused directions under the NPAPH[24]. This research suggested that school canteens provide a regular opportunity for young people to make decisions about food purchases without direct parental influence[24]. Further, this research reported that young people 'live in and for the moment' and do not necessarily see health as an immediate concern[24] and so do not consider health when making these choices. Environmental strategies, which make healthy choices the easiest and most desirable choices, are required. In this same research, young people and teachers clearly articulated that more could be done to increase the availability of healthy food in school canteens. Young people themselves suggested that if 'cheap, healthy and tasty' food and drink was available from school canteens, then they would opt for these options[24].

[22] Katz DL et al. (2008). Strategies for the prevention and control of obesity in the school setting: systematic review and meta-analysis. *International Journal of Obesity* 32 (12).
[23] Bell AC and Swinbrun BA. (2004). What are the key food groups to target for preventing obesity and improving nutrition in schools? *European Journal of Clinical Nutrition 58* (2).
[24] Smith C and Gagg K (2010). Informing the Adolescent Healthy Lifestyle Program. Qualitative Research Report. Prepared by

Competitive pricing policies and point of sale promotions to make healthy choices a cheaper and an attractive alternative to unhealthy foods will be included as a key component of the *Canteen Strategy for High Schools*. This also builds on the formative research, which suggested giving young people a sense of autonomy and control as a potential lever in encouraging healthier lifestyle behaviours[24]. Promoting well priced and tasty healthy food and drink options will give young people an opportunity to exercise their desire for greater autonomy and control while making healthy choices. A review of the evidence on the effects of food prices on weight outcomes concluded that pricing policies are particularly effective in low SES population groups and young people[25]. Nutrition information at point of sale information also appears to positively influence high school students' food selection towards more healthy options[26].

One of the sensitivities in relation to school canteens in NSW is the extent to which they can provide healthy food and drink options and maintain profitability. This will be addressed by applying a business model to the Service and developing resources to support a business model approach. This might include providing school canteens with case studies and resources which will provide strategies for good business practices and increase the focus on price and position of healthy options. Schools accessing this Service will also receive funding support linked to making improvements to the food and drink options available in the canteen. Schools will be required to report on the progress made in this regard on an annual basis.

In NSW, the *Fresh Tastes @ School* canteen strategy has been implemented since 2005. While this strategy has shown some success in NSW primary schools, additional support and a new re-designed strategies to encourage high schools to provide a healthy canteen are required. A Booster Service for high schools which was implemented in NSW, its reach hsa been limited with 64 of a possible 400 DEC high schools accessing this Service. To learn from previous experience with high schools in NSW it is proposed that comprehensive stakeholder consultation together with extensive formative research be conducted to identify enablers and barriers and redesign an enhanced high school canteen service.

GfK bluemoon for NSW Health (unpublished).

[25] Powell LM and Chaloupka FJ (2009). Food Prices and Obesity: Evidence and Policy Implications for Taxes and Subsidies. *Millbank Quarterly 87* (1).

[26] Conklin M et AL. (2005). Nutrition information at point of selection affects foods chosen by high school students. The Journal of Child Nutrition and Management

5. **Contribution to performance benchmarks:**

Canteen Strategy in High School **contribution**	**NPP Performance benchmark**
Increase in the availability of healthy food and drink options offered for sale in high school canteens and a decrease in the availability of energy-dense nutrient poor food and drink options. Increase in the proportion of young people purchasing healthy food and drinks from school canteens. Decrease in the proportion of young people purchasing energy-dense nutrient poor foods and drinks from school canteens. Increase in the proportion of high schools operating a healthy canteen while maintaining profitability (initial focus on government high schools).	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Increase in the availability of fruit and vegetable options for sale in school canteens. Increase sales of fruit and vegetable options available in school canteens. Increase in the proportion of young people purchasing fruit and vegetable options from school canteens.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.

6. **Policy consistency:** This support strategy, targets environments within the high school setting. Through the HCI this former service in NSW will be redesigned and enhanced for roll-out to a large number of high schools. The re-designed Service will be developed consultation with key stakeholders ensuring it is relevant and appropriate to the setting, but participation of individual schools/canteen managers in the strategy will be voluntary.

Strategies will be embedded into the *High School Canteen Support* to ensure it addresses equity issues and that all high schools have access to the Service. While some strategies have been identified in this Implementation Plan, others will be informed through the *Social Inclusion Engagement Service*, described later in this Plan. The *Social Inclusion Engagement Service* will provide ongoing advice on how to modify and/or tailor this Service to meet the needs of a range of populations including Aboriginal, rural and remote, CALD communities, the disabled and socially disadvantaged.

Intensive on-going support for schools will be provided by health professionals and /or business experts. Consequently, a local-level approach, which takes account of the enablers and barriers at the school level, is an integral part of the Service and will give added flexibility which will, in turn, contribute to sustained changes in schools beyond the life of the NPAPH.

7. **Target group(s):** The key target group for *High School Canteen Support* is young people aged between 12 and 18 years attending high schools in NSW. Secondary target groups are high school principals, teachers, school canteen managers as well as paid and volunteer staff who work in canteens.

8. **Stakeholder engagement:** NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Ministry of Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for interventions which require multiple service delivery partners; and
- ensuring appropriate engagement and support for the NSW Ministry of Healthy Children Initiative.

Consultation has included stakeholders internal to NSW Ministry of Health, Local Health Districts, other NSW Government Departments, non-government organisations and academic institutions.

The NSW Ministry of Health will initiate formal discussions with the NSW Department of Education and Communities (DEC), Catholic and independent school sectors and key stakeholders for this intervention. NSW Ministry of Health has existing collaborative working relationships with the DEC and the Catholic and independent schools sector as these will be built upon through this intervention. Other key stakeholders including the NSW Healthy Kids Association, canteen managers, business consultants, food providers, school principals and students will be involved in consultation and formative development processes.

Additionally, NSW Ministry of Health has established a formal governance structure as part of the NSW Ministry of Healthy Children Initiative and the broader National Prevention Partnership. This includes program specific working groups as well as higher level Advisory Committees involving internal and external stakeholders.

9. **Risk identification and management:**

Risk	**Management Strategy**
Schools will not wish to access the Service	The final *High School Canteen Strategy*, Implementation model and resources will be developed following extensive stakeholder consultation and formative development. This will ensure that NSW has identified factors crucial to the success of this Service and that is has been designed accordingly. The service delivery model will be modified from the previous Booster program to increase its feasibility and acceptability with key stakeholders. The DEC will be integral to the design and delivery of the Service. NSW Ministry of Health will fund a cross-department liaison officer to lead the development and delivery of the Service. A position similar to this was involved in developing the NSW school canteen strategy and contributed to its initial success.
The Service is not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Working groups will report to an overarching Advisory Group being established as part of the NPAPH governance structures.
Interventions across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH.

10. **Evaluation:** The evaluation of *High School Canteen Support Service* will occur within the context of a comprehensive evaluation framework currently being developed by NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

    The evaluation of the *High School Canteen Support Service* will include quality assurance measures as well as process and impact evaluation, and an analysis of the costs involved in delivering the Service against the results achieved.

    - **Process evaluation** will measure the extent to which the Service has been delivered as intended as well as its reach into the setting and to the target populations. It is anticipated that a minimum data set will be used to gather process evaluation data as well as support total quality improvement processes. Data collected could include number of schools/canteens approached to participate the number of schools/canteens participating and support received by participating schools/canteens.
    - **Impact evaluation** will measure changes in policy and practice at the school canteen level including the proportion making changes to the food and drinks available for purchase and the extent of these changes, as well as changes is sales and purchasing patterns of students.
    - **Cost evaluation** will assess the costs of delivering the Service.

    NSW Ministry of Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

    The final evaluation plan for *High School Canteen Support* will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

11. **Infrastructure:** The *High School Canteen Support* requires a combination of existing and newly developed infrastructure will be required.

    - Public health nutritionist and/or business consultant time is likely to be required to successfully develop and deliver this Service to high schools. This infrastructure will be integral to developing appropriate resources and also providing support to high school canteens accessing the *High School Canteen Support* to establish and maintain a profitable and healthy school canteen.

    - Soft infrastructure including support materials and resources for school principals and canteen managers and workers will be developed. The design and content of these will be modelled on existing infrastructure from the primary school focused Fresh tastes Strategy although changes will be required to ensure they are relevant to high school canteens and the adolescent market.

    - Additional administrative infrastructure is also likely to be required to fulfil a coordination role within the central health agency. The role of any additional staff will include:
        a) support and manage the overall development of support and resources;
        b) managing resource development, design, layout and printing;
        c) manage procurement as well as ongoing contracts with external providers;
        d) lead strategic overarching stakeholder engagement and management and as part of the NPAPH and would processes;
        e) ensure social inclusion is embedded into support services;
        f) contribute to the development and implementation of ongoing program monitoring and supporting the national evaluation (including the national evaluation if appropriate/required);
        g) contribute to ongoing reporting as part of he NPAPH; and
        h) participate in and report to appropriate committees as part of the NPAPH.

12. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
i. Consultation processes undertaken with key stakeholders	June 2013
ii. Development of resources and tools for high school canteens	June 2014
iii. Recruitment of high school canteens and distribution of resources	July 2014 -June 2017
iv. Support high schools to implement policy and procedures for a healthy school canteen	July 2014 -June 2017
v. Monitoring and evaluation	Ongoing
vi. Develop strategies for sustainability	Ongoing to June 2018

13. **Responsible officer and contact details:**

Christine Innes-Hughes
Manager, Healthy Children Initiative
NSW Office of Preventive Health,
Liverpool Hospital
Locked Bag 7103,
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Activity budget

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure Item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Project management, adoption and maintenance in schools	0.000	0.300	0.300	0.400	0.550	0.350	0.250	**2.150**
Central office project coordination	0.000	0.035	0.038	0.038	0.038	0.038	0.038	**0.225**
Embedding needs of Aboriginal and other vulnerable populations	0.000	0.100	0.100	0.100	0.100	0.100	0.100	**0.600**
Monitoring and evaluation	0.000	0.050	0.050	0.050	0.050	0.050	0.050	**0.300**
TOTAL	**0.000**	**0.485**	**0.488**	**0.588**	**0.738**	**0.538**	**0.438**	**3.28**

Activity 3: Youth Settings Program

PROGRAM OVERVIEW AND OBJECTIVE

1. **Youth Settings Program**

2. The objectives of this program are to:

   - increase young people's awareness and knowledge of lifestyle related health behaviours;
   - increase young people's intentions to adopt specific lifestyle related health behaviours ;
   - increase young people's skills to adopt specific lifestyle related health behaviours ;and
   - improve the lifestyle behaviours adopted by young people.

3. The *Youth Settings* Program involves the following activity:

   a) Social Marketing to Young People

4. The senior contact officer for this program is:

   Louise Farrell
   Manager, Strategy and Operations
   NSW Office of Preventive Health
   Level 1 Don Everett Building
   Liverpool Hospital
   Ph 02 92828 6505

   louise.farrell@sswahs.nsw.gov.au

3.1: Social Marketing to Young People

5. **Overview:** A social marketing framework will be used to develop and deliver messages to young people in relation to specific lifestyle-related health behaviours using appropriate channels and mechanisms. This is likely to include a mix of relevant communication strategies such as some above-the-line media as well as digital media (social media, paid online advertising and website) mobile technology and other youth relevant settings e.g. music festivals.

The specific target behaviours, key messages and communication strategies will be informed by formative research, iterative program processes and ongoing youth engagement. It is anticipated that the campaign will adopt a 'why', 'what' and 'how' framework with initial efforts focusing on raising awareness of the importance of a lifestyle related health behaviours within the context of a young person.

As the campaign progresses, and pending evaluation results, the campaign will potentially focus on developing and delivering messages on 'how' specific behaviours might be adopted. This will be achieved through ensuring messages are youth relevant and contribute to young people's self-efficacy and skills to adopt specific lifestyle related health behaviours. The campaign is likely to target young people as individuals and also as peer leaders, capable of influencing the lifestyle related health behaviours of their peers and broader social networks.

The potential for the *Social Marketing to Young People* to include a parent component, may also be explored as the need for this emerged during the initial formative research.

As part of the *Social Inclusion Engagement Service*, described later in this Implementation Plan, this social marketing campaign will be designed with reference to specific populations across NSW. This will ensure that branding, messages, concepts and delivery channels are inclusive of and target specific populations including disadvantaged populations, Aboriginal people, Culturally and Linguistically Diverse communities, those living in rural and remote areas of NSW as well as the socially disadvantaged.

6. **Outputs:**

Description	Quantity	Timeframe
Development of a draft Social Marketing Plan for young people and initial formative research with young people using a youth engagement approach.	One comprehensive strategy is developed to guide social marketing to young people as part of the HCI including recommendations for future phases of the campaign development, delivery and evaluation	January 2012
Consultation with key stakeholders on the draft Social Marketing Plan and the recommendations for future	Consultation report completed	March 2012
Undertake Phase 2 of campaign development through formative research that uses a youth engagement approach and links with key stakeholders	Phase 2 campaign development report written, that identifies target health behaviours, framing of key messages, key communication and other youth engagement strategies and the approach to evaluation.	July 2013
Campaign Production	Creative executions developed, tested and finalised and other supportive activities identified	March 2014 and then ongoing as needed in response to evaluation
Campaign activities delivered, evaluated and refined in an iterative process over time		Ongoing from August 2014 - 2018

* Due to resource limitations during 2012, undertaking work to progress the development and delivery of this campaign has not been possible until December 2012.

7. **Outcomes:**

Short term	**Medium term**	**Long term**
20% of young people have prompted and unprompted awareness of the campaign branding and messages	35% of young people have awareness of specific campaign messages* 35% of young people report a high level of understanding of specific campaign messages	55% of young people have awareness of specific campaign messages 55% of young people report a high level of understanding of specific campaign messages
Increase in young people's awareness of messages related to specific health-related lifestyle behaviours	Increase young people's knowledge, intentions, attitudes and beliefs in relation to specific to health related lifestyle behaviours	Increased proportion of young people consume a healthy diet or engage in recommended levels of leisure time physical activity or engage in no more than 2 hours of small screen recreation each day

Short term	**Medium term**	**Long term**
15% of parents/carers of young people have prompted and unprompted awareness of the campaign branding and messages*	30% of parents /carers of young people have prompted and unprompted awareness of specific campaign messages* Increase parents/carers knowledge, beliefs and attitudes and intentions related to lifestyle related health behaviour messages	Increase in parents/carers efficacy to support their children to adopt specific health-related lifestyle behaviours Increased proportion of young people consume a healthy diet or engage in recommended levels of leisure time physical activity or engage in no more than 2 hours of small screen recreation each day

- Estimated outcomes are based on results from the VERB campaign
- The parental specific outcomes will only apply should formative research recommend value in also targeting parents through this campaign

8. **Rationale:** In Australia, as well as internationally, the prevalence of overweight and obesity in young people is increasing. In 2008, approximately 21% of young people in NSW were classified as overweight or obese[27]. Young people who are overweight or obese are at increased risk of being overweight in adulthood, which has implications for longer-term health and well-being[28] [29]. Further, the majority of young people do not report consuming sufficient vegetables each day, many, particularly girls, are not sufficiently active and the majority engage in more than 2-hours of small screen recreation each day[16]. Therefore, there is a clear imperative to promote specific lifestyle-related health behaviours to young people, in a youth relevant manner, and support them to adopt these behaviours.

This new and innovative campaign has not previously been delivered by NSW Health. While substantial work has been undertaken with primary school-aged children and in more recent times, preschool-aged children, young people are often considered a difficult group to reach and influence. None the less, the NPAPH provides a timely opportunity to strategically build on this substantial work in primary schools to influence and support lifestyle-related health behaviours in young people in a manner that takes account of their needs, interests and their social context. Because this is a new and innovative area for NSW Health, considerable effort will be focused on the formative development of the campaign messages to ensure they resonate with young people.

Some of the initial ideas regarding this campaign's overall direction have been informed by a several key pieces of work commissioned by NSW Health. These include:

- a review of the literature on the effectiveness of primary and secondary obesity prevention interventions targeting adolescents[30];
- a review of the literature on interactive electronic media interventions targeted at adolescents for prevention of overweight and obesity[31]; and
- initial formative research to inform youth-based approaches for the HCI [32].

The review by Bellew, King and Chau[30], found limited evidence of effective primary prevention interventions addressing overweight and obesity in young people. However, it did recommend that using a social marketing framework to target young people is worthy of consideration. Social marketing can provide tangible reasons and opportunities to adopt specific health related behaviours by demonstrating alternatives to current behaviours that tap into the wants, needs and interests of young people[33]. In this respect, a social marketing framework applies the principles of commercial marketing to deliver a call to action, to reframe beliefs and attitudes and achieve health behaviour change[25].

While examined comprehensive social marketing interventions to promote a healthy lifestyle to young people are limited, the *VERB*® campaign provides strong evidence of their potential effectiveness. *VERB*® was a large international public health intervention that successfully used a social marketing framework to promote increased participation in physical activity to young people in the United States[34].

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[27] Centre for Epidemiology and Research. (2009). *New South Wales School Students Health Behaviours Survey: 2008 Report.* Sydney: NSW Department of Health.
[28] Singh AS et al (2008). Tracking of childhood overweight into adulthood: a systematic review of the literature. *Obesity Reviews 9*: 474-488.
[29] Reilly JJ et al. (2003). Health consequences of obesity. *Archives of Disease in Childhood 88: 748 – 752.*
[30] Bellew B, King L and Chau J. (2010). *Health promotion interventions targeting adolescent obesity: An evidence check brokered by the Sax Institute for the Centre for Health* Advancement, NSW Health (unpublished).
[31] Kornman KP, Nguyen B and Baur L (2010). *Interactive electronic media interventions targeted at adolescents for prevention of overweight and obesity: a rapid review.* A review brokered by the Sax Institute for the NSW Department of Health (unpublished).
[32] Smith C and Gagg K (2010). Informing the Adolescent Healthy Lifestyle Program. Qualitative Research Report. Prepared by GfK bluemoon for NSW Health (unpublished).
[33] Evans D. (2008). Social Marketing Campaigns and Children's Media Use. *Future of Children 18 (1)*: 181-203.
[34] Wong F et al. (2004). VERB® - A Social Marketing Campaign to Increase Physical Activity Among Youth. *Preventing Chronic Disease 1 (3)*: A10.

After one year approximately 75% of young people were aware of the campaign branding and messages, which is similar to or better than social campaigns targeting other behaviours of relevance to this age group[35]. Raising awareness of campaign branding and specific messages is an important first step in shifting attitudes and influencing behaviour change. Further, evaluation of *VERB®* showed that campaign awareness at 1 year was associated with 34% greater time spent engaging in physical activity. That is, young people who were aware of the campaign spent more time engaging in recreational physical activity than those who were not aware of the campaign[36]. The evaluation of *VERB®* also showed positive longer-term effects on physical activity participation and importantly maintenance of physical activity behaviours through to the older adolescent years[37].

The review of interactive electronic media interventions targeting young people reported that technological advances provide opportunities to use more youth friendly interactive modes of communication for health promotion[31]. The review recommended that, despite existing gaps, innovative electronic media interventions should be considered as a means of reaching young people. It recommended interventions be designed specifically to meet the needs, interests and context of adolescence as distinct from those of children and adults, and also suggested interventions should be developed with input from adolescents[31].

In 2010 NSW Health undertook some initial formative research with young people and key informants including their parents, to inform the early development of approaches to target young people as part of the NPAPH[32]. This research found that:

- young people live in and for the moment;
- technology is a constant and very important part of their lives;
- health, and the implications of an unhealthy lifestyle, are not an issue for the vast majority;
- many feel they lack control over their lives, despite being 'connected' 24-hours each day;
- while they understand what it means to adopt a 'healthy' lifestyle, this understanding is from an academic perspective rather than as a concept personally relevant to them;
- many believe if they are either physically active OR eat a healthy diet they are healthy enough; and
- many barriers exist which can prevent young people from adopting a healthier lifestyle.

The research recommended that the campaign adopt a 'why', 'what' and 'how' framework, and that the priority in the first stage is to focus on delivering messages which focus on 'why' a change is required, given the motivational barriers that currently prevent young people from adopting more healthy lifestyles. It was suggested that several communication channels may be required to deliver key messages to young people, and their parents, as part of the strategy. A number of motivational hooks were identified for framing messages on the importance of a healthy lifestyle. These include using a healthy lifestyle to manage the pressures of being a young person, increase individual control and autonomy/independence and achieve a positive social image[27]. These hooks capitalise on the desire of young people to look good, fit in and be socially accepted; to gain independence and be treated as an adult; and manage their hectic lives.

The initial formative research also recommended that social marketing target young people as individuals, and also as peer leaders, as the first stage in delivering key health messages to this population. Parents were also identified as a potential target group for this strategy, because they shape attitudes and behaviours of their adolescent children and because they create home environments that either support or prevent their adolescent children from adopting healthy lifestyles[32]. Evidence exists which suggests that, even in adolescence, parents play a role in the food patterns of their children[38].

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[35] Huhman M et al. (2008). Initial Outcomes of the VERB Campaign. Tweens' Awareness and Understanding of Campaign Messages. *American Journal of Preventive Medicine 34: S241- S248.*

[36] Huhman et al. (2005). Effects of a Mass Media Campaign to Increase Physical Activity Among Children: Year-1 Results of the VERB Campaign. Pediatrics 116

[37] Huhman M et al. (2010). The Influence of the VERB Campaign on Children's Physical Activity in 2002 – 2006. *American Journal of Public Health 100 (4):* 638-645.

[38] Campbell KJ et al. (2007). Associations Between the Home Food Environment and Obesity-promoting Eating Behaviours in Adolescence. *Obesity 15 (3):* 719 –730).

The *VERB*® campaign did include strategies that targeted parents as potential agents of support for their children to engage in more physical activity. The evaluation of this component of the strategy found that parents' awareness of the campaign increased over time. Further, and encouragingly, it found that parental awareness of the campaign resulted in increases in their perceptions of the importance of physical activity and the level of support they provided their adolescent children to be physically active[39].

The evidence and findings from the initial and phase 1 formative research will need to be explored in more detail in the process of developing a contextually relevant strategy and testing concepts and delivery mediums with young people and if relevant their parents. As suggested in the initial formative research and the review of electronic media interventions, ongoing input from young people will be sought at each stage of the development of this campaign to ensure it resonates with the target group and is delivered in an appropriate manner.

The potential evaluation of this campaign is described later in this section. It should be noted that the campaign's development and delivery will be iterative. Ongoing monitoring and evaluation of the strategy will inform its direction over the life of the NPAPH. Regular evaluation will inform the ongoing development and refinement of the campaign to ensure it remains relevant to young people and can adopt to the changing needs, interests and contexts of young people and ensure specific segments of the target population not being reached are identified and strategies put into place to address any gaps. Ongoing monitoring will allow the campaign to adjust to the changing awareness of young people and respond to changes in attitudes and intentions to adopt healthy lifestyle behaviours over the course of the NPAPH. This best practice approach was taken by the *VERB*® campaign and contributed to its overall effectiveness[22].

[39] Price S et al. (2008). Influencing the Parents of Children Aged 9-13 Years. Findings from the VERB® Campaign. *American Journal of Preventive Medicine 34*: S267 – S274.

9. **Contribution to performance benchmarks:**

Social Marketing to Young People **contribution**	**NPP Performance benchmark**
Increase in young people's awareness of the importance of eating healthily food, their intention to eat healthier food and their knowledge of how they can improve the nutritional quality of the foods they consume. Parents/carers support of their adolescent children to eat healthily increases (if a parent component is pursued) Increase in the proportion of young people eating healthily e.g. limiting energy-dense nutrient poor foods and drinks and increasing consumption of fruit and vegetables and healthy snacks. Increase in young people's awareness of the importance of physical activity, their intention to be active and their knowledge of how they can be more physically active. Parents/carers support of their children to engage in physical activity increases (if a parent component is pursued) Increase the proportion of young people participating in sufficient physical activity. Decrease in the proportion of young people spending more than 2 hours each day engaged in small screen recreation.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.

***Social Marketing to Young People* contribution**	**NPP Performance benchmark**
Increase in young people's awareness of the importance of consuming fruit and vegetables, their intention to consume more fruit and vegetables and their knowledge of how they can increase their fruit and vegetable consumption. Parents/carers awareness of the importance of consuming fruits and vegetables increases (if a parent component is pursued) Parents/carers support of their children to consume fruit and vegetables increases (if a parent component is pursued) Increase in the amount of fruit and vegetables consumed by young people each day.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.
Increase in young people's awareness of the importance physical activity, their intention to be physically active and their knowledge of how they can be more physically active Increase in young people's awareness of the importance of limiting small screen time, intention to limit small screen time and their knowledge of how they can limit small screen time Parents/carers awareness of the importance of being physically active and support of their child to be physically active increases (if a parent component is pursued) Parents/carers awareness of the importance of limiting small screen recreation and support of their child to limit small screen recreation increases (if a parent component is pursued) Parents/carers support of their children to engage in physical activity and limit their small screen recreation increases (if a parent component is pursued) Increase in the proportion of young people who participate in sufficient physical activity each day. Decrease in the proportion of young people engaging in more than 2 hours of small screen recreation each day.	Increase in the proportion of children participating in at least 60 minutes of moderate physical activity each day of 5% from baseline by 2016; and 15% from baseline by 2018.

10. **Policy consistency:** The *Social Marketing to Young People* campaign is a new and innovative area of focus for NSW Health. While much attention has been directed to promoting healthy lifestyles to preschool and primary school-aged children, young people have been seen as a more difficult population group to reach and influence. Therefore, this campaign will address an identified policy gap and contribute to the evidence on the effectiveness of using a social marketing framework and delivering messages using social media and other mechanisms to influence the health-related lifestyle behaviours of young people.

    This primary prevention campaign will be delivered universally to all young people. Formative research and concept testing will take account of the needs of Aboriginal young people as well as those from CALD backgrounds, those living in rural and remote areas and the socially disadvantaged. By addressing these issues, the campaign will ensure that the health differential is not widened as a consequence of the manner in which messages are framed and delivered to the target population. The *Social Inclusion Engagement Service*, described later in this Implementation Plan will also provide an important mechanism to ensuring this campaign is designed and delivered with regard to promoting equity of access and meeting the needs of specific population groups.

    Iterative approaches to campaign delivery and ongoing evaluation will allow the campaign to respond to changing needs, interests and contexts of the young people as well as identify specific sub-groups for whom the campaign messages are not resonating or appropriate. This will allow messages and delivery channels to be altered accordingly, ensuring that no populations and/or sub-groups within populations are unduly disadvantaged as a consequence of this campaign.

    This campaign may also take account of the role of parents/carers in influencing the health related lifestyle behaviours of young people and links well with the proposed *Social Marketing to Children and their Families* campaign. Parents will be involved in the continued formative research informing campaign development.

11. **Target group(s):** There are two target groups for the *Social Marketing to Young People* campaign.

    The primary target group for the campaign will be young people aged between thirteen and 17 years old. While not the primary target group children in the older primary years and young people over the age of seventeen may also be reached through social marketing activities, as they are accessed by children and young people of all ages.

    Young people will be targeted as individuals who can, and do, make choices regarding their health-related behaviours and also as potential peer leaders whose lifestyle related choices can have an influence on those of their friends. This focus is in response to initial formative research which highlighted the potential value of peers in influencing lifestyle-related choices of young people.

    Pending the next phases of campaign development, a secondary target group of this campaign may be parents/carers of young people. Initial formative research identified that parents/carers of young people play a very important role in the lifestyle choices available to and made by young people. They act as role models for their children's attitudes towards healthy lifestyle. This is not withstanding the fact that adolescence is an important time for seeking independence from the family unit and identifying with friends and other social networks.

12. **Stakeholder engagement:** NSW Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for services which require multiple implementation partners; and
- ensuring appropriate engagement and support for the NSW Healthy Children Initiative.

Consultation has included stakeholders internal to NSW Health, Area Health Services, other NSW Government Departments, non-government organisations and academic institutions.

NSW Health has and will continue to consult with the Aboriginal Health and Medical Research Council and the Physical Activity, Nutrition and Obesity Research Group for the purpose of providing ongoing technical support and evidence-based expert advice relevant to the HCI.

NSW Health will work collaboratively with a range of relevant government, academic and non-government stakeholders to develop and deliver campaign messages. In addition, NSW Health will work in collaboration with the Multicultural Health Communication Service, the Aboriginal Health and Medical Research Council and other key groups as required to ensure that the campaign is appropriate for CALD, Aboriginal and socially disadvantaged populations of young people.

Additionally, NSW Health has established a formal governance structure as part of the NSW Healthy Children Initiative and the broader NPAPH. This includes Service specific working groups as well as higher level Advisory Committees involving internal and external stakeholders.

NSW Health also recognises the importance of young people, and their parents, as key stakeholders in this campaign. To this end, NSW Health has begun formative research with this group and will continue to undertake formative research and concept testing to inform the development campaign messages and creative concepts.

13. **Risk identification and management:**

Risk	**Management Strategy**
Processes required for obtaining NSW Government approval for advertising require appropriate lead-time, often within the vicinity of 3-months.	This will be minimised by finalising the campaign messages and creative concepts in sufficient time to gain the required approvals.
Key messages and methods of delivery are not relevant to the target audience	NSW Health has already undertaken formative research to ensure that key messages and their delivery are appropriate to and resonate with the target population. This will be an ongoing process throughout the Agreement and messages will be altered to respond to increased awareness, knowledge and/or intent to change.
The campaign is not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Working groups will report to an overarching Advisory Group being established as part of the NPAPH governance structures.
Interventions across the NPAPH are siloed and fragmented	NSW Health has established a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross program communication and identify synergies and linkages across the NPAPH.

14. **Evaluation:** The evaluation of *Social Marketing to Young People* will occur within the context of a comprehensive evaluation framework currently being developed by NSW Health in collaboration with experts in the field of evaluation and intervention research.

    The of *Social Marketing to Young People* will include process and impact evaluation, as well as an analysis of the costs involved in delivering the campaign against the results achieved.

    - **Process evaluation** will measure the extent to which social marketing activities have been delivered as intended as well as their reach into the setting and to the target populations. This is likely to include the dose of marketing delivered/received as well as brand and message awareness.
    - **Impact evaluation** will measure changes in attitudes of young people of the health-behaviour and lifestyle-related messages delivered through the campaign as well as any changes in their knowledge and intention to change. Depending on the extent to which 'how' messages are delivered, this might also include actions taken and changes to eating, physical activity and small screen recreation practices made by young people.
    - **Cost evaluation** will assess the costs of delivering the *Social Marketing to Young People* campaign.

    NSW Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

    The final evaluation plan for *Social Marketing to Young People* will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

15. **Infrastructure:** Limited additional infrastructure is required to deliver this social marketing campaign.

    - NSW Health will work in collaboration with relevant agencies to commission the development of an appropriate social marketing strategy which utilises social media and appropriate modes of message delivery.

    - NSW Health will use existing infrastructure within the Local Health Districts, academic as well as non-government organisations to develop and deliver appropriate support systems to underpin the ongoing success of this campaign.

    - Additional administrative infrastructure is also likely to be required to fulfil a coordination role within the central health agency. The role of any additional staff will include:
        a) support and manage the overall development of the campaign and resources;
        b) manage formative research and creative concept testing processes;
        c) manage procurement and ongoing contracts with external providers and creative agencies;
        d) lead strategic overarching stakeholder engagement and management and as part of the NPAPH processes;
        e) ensure social inclusion is embedded into the campaign through development and delivery;
        f) contribute to the development and implementation of ongoing monitoring and supporting the national evaluation (including the national evaluation if appropriate/required);
        g) contribute to ongoing reporting as part of he NPAPH; and
        h) participate in and report to appropriate committees as part of the NPAPH.

16. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
i. Draft Social Marketing Plan Developed and initial formative research undertaken	Jan 2012
ii. Consultation with key stakeholder on the Draft Social Marketing Campaign and recommendations for the future campaign development	March 2012
iii. Formative research to define target market, inform selection of key messages and possible campaign approaches	July - Dec 2013
iv. Campaign development, testing and production	Jan – June 2014
v. Campaign launch	August 2014
vi. Ongoing campaign delivery and refinement	July 2014 – June 2018
vii. Campaign Evaluation development and delivery	Dec 2013 - June 2018

Responsible officer and contact details:

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16. **Activity budget: Table 4: Activity project budget ($ million) exclusive of GST**

Expenditure Item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Draft Social Marketing Plan and Stakeholder consultation	$0.13	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.13**
Formative research to define target market, inform selection of key messages and campaign approaches	$0.00	$0.00	$0.12	$0.00	$0.00	$0.00	$0.00	$0.12
Campaign development, testing and production	$0.00	$0.0	$0.50	$0.00	$0.00	$0.00	$0.00	**$0.5**
Ongoing campaign delivery and refinement	$0.00	$0.00	$0.00	$0.50	$0.42	$0.50	$0.42	**$1.84**
Central office project coordination	$0.00	$0.06	$0.06	$0.06	$0.06	$0.06	$0.06	**$0.36**
Embedding the needs of specific vulnerable populations	$0.00	$0.00	$0.10	$0.10	$0.10	$0.10	$0.10	**$0.50**
Evaluation	$0.00	$0.00	$0.15	$0.10	$0.10	$0.10	$0.15	**$0.60**
TOTAL	**$0.13**	**$0.06**	**$0.93**	**$0.76**	**$0.68**	**$0.76**	**$0.73**	**$4.05**

Notes: The final complement of mass media and other channels used as mechanisms to communicate messages to young people through this campaign will be determined through the formative processes that will be undertaken as part of the proposed approach to the development of this campaign. Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6% of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Service. Discrepancies in the table between totals and sums of components reflect rounding.

PROGRAM OVERVIEW AND OBJECTIVE

1. **Recreational Settings Program**

2. The objectives of this program are to:

- promote healthy food and drink choices in community-based organised sporting clubs;
- provide education and training for recreational sporting clubs on how to provide and promote healthy food and drink choices within their canteens;
- develop and disseminate resources on providing healthy food and drink choices to community-based organised sporting clubs;
- develop and disseminate resources promoting the consumption of water consumption to coaches and managers of junior level community-based organised sport;
- increase the proportion of children 5-12 years of age consuming water, rather than sugar sweetened drinks, while participating in community-based sport;
- increase the proportion of community-based organised sport canteens providing healthy food and beverage options;
- decrease the availability of energy-dense, nutrient poor foods available in community-based organised sport canteens; and
- decrease the availability of sugar-sweetened beverages available in community-based organised sport canteens.

3. The Recreational Settings Program involves the following activity:

a) Healthier Choices in Recreational Settings

4. The senior contact officer for this program is:

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Activity 4.1: Sporting Canteen Nutrition Support Service *(Healthier Choices in Recreational Settings)*

1. **Overview:** The *Sporting Canteen Nutrition Support Service* (*Healthier Choices in Recreational Settings)* referred to as the ***Healthy Junior Sports Club Project***, will provide education, resources and support to community-based junior sporting clubs to promote water consumption and discourage the consumption of sugar sweetened drinks, including sports drinks to children and families when participating or spectating in sport, and improve the nutritional quality of food available from the canteen in these settings.

   This Service comprises three components:

   I. D*rink Water First @ Sport program:* will develop and deliver a program relevant to water consumption specific to junior, community-based, non-elite organised sport through team coaches and managers; and
   II. *Healthy Sporting Canteens*: which will develop and deliver practical education, resources and communication tools to enable community-based sporting clubs and recreational settings to provide healthier food and drink choices.
   III. *Role modelling*: will empowering parents and coaches to promote and make healthy choices, by providing resources and environments which empower parents to make healthy food choices for themselves and their families

   Community-based sporting clubs will receive ongoing practical support to make realistic, achievable and sustainable changes to their policies and practices while maintaining profitability.

2. **Outputs:** Component 1*: Drink Water First @ Sport Program*

Description	**Quantity**	**Timeframe**
Meetings held with representatives from state sporting organisations and other key stakeholders to gain support for and commitment to the campaign and the proposed roll-out.	Four sports codes	Aug 2012 – Dec 2012
Undertake formative review of the literature to determine the content and messages for *the Drink Water First @ Sport* Program	Literature review completed outlining evidence for fluid intake in community-based non-elite sporting settings	Sept 2012
Undertake formative research to better understand consumer perceptions regarding purchasing choices for this setting	Research complete outlining consumer perceptions for fluid intake in community-based non-elite sporting settings	December 2012
Formative work with clubs to test feasible and effective strategies to promote *Drink Water First @ Sport Program*	At least 50 Clubs across the four codes which have agreed to participate.	July 2013
Phase 1 of concept testing and research with target audience to select best approach to the program	Concept testing with relevant proportion of target audience (children parents/coaches)	July 2013- September 2013
Phase 2 of concept testing with target audience undertaken	Concept testing with relevant proportion of target audience (children, parents/coaches)	October 2013 – December 2013

Resources developed to promote and support the program.	Appropriate resources completed	Ongoing from July 2013
Staged program roll-out	Program framework and plan completed and delivered across 300 clubs	Feb 2017

Outputs: Component 2*:* *Healthy Sports Canteens*

Description	**Quantity**	**Timeframe**
Healthy junior sports clubs advisory group Sporting Industry Reference Group established comprising representatives from State Sporting Organisations, Local Government, and NSW Ministry of Health, to inform and support Service development and delivery	Reference Group established and quarterly meetings held	Ongoing from Aug 2012
Undertake formative research to better understand the structure of clubs and the role of the canteen in relation to purchasing choices	Stakeholder interviews complete with sports clubs describing the structure and function of sports canteens	Dec 2012
Workshops held with nominated State Canteen Liaison Officers to support service delivery, training, distribution of resources and education materials to sporting clubs and canteen managers	2 workshops held with representatives from State Sporting Organisations	Aug 2012 – Nov 2012
Support systems and networks established to provide advice and tailored support for participating community-based sporting clubs	Systems and advice/support resources established	Sept 2014
Delivery of training workshops for canteen managers – *Managing Healthy Profitable Canteens*	30 training workshops delivered to canteen managers representing 300 sporting clubs participating in the program	Feb 2013 – Dec 2017

3. **Outcomes:** Component 1: *Drink Water First @ Sport Program*

Short term	**Medium term**	**Long term**
30% of participating clubs will have prompted and unprompted awareness of Drink Water First Program messages Program is adopted and implemented in x number of clubs. Resources have been implemented in x number of clubs	60% of coaches, parents/carers and children and young people have prompted and unprompted awareness of drinking water messages Increase in coaches' , children and parents understanding of drinking water (unless otherwise directed) as the primary dink to quench thirst during sports. Increase the club capacity to promote water as the preferred drink	Increase in the proportion of sporting clubs reporting they promote water as the preferred drink at junior non-elite community-based sport through their policies and practices Increase in the proportion of coaches reporting they promote water as the preferred drink at junior non-elite community-based sport Increase in the proportion of parents/carers reporting they provide water for their children while participating in non-elite community-based sport Increased proportion of children and young people participating in junior, non-elite community-based sport drink water as the preferred fluid

Outcomes: Component 2: *Healthy Sports setting – building capacity to embed healthy eating and drinking into sports clubs*

Short term	Medium term	Long term
Increased proportion of community-based sporting clubs receive information, and support relevant to providing healthy food and drink choices in sporting canteens	Increased awareness and knowledge of healthy eating recommendations by sporting club canteen managers Increased capacity and intention of canteen managers to provide nutritious food and drink choices in the community-based sporting setting Canteen managers will utilise education, resources and support services to introduce healthy foods and drink options into canteens in the community-based sporting setting	Increased proportion of community based sporting clubs reporting they promote healthy eating through their canteen policies and practices Increase in the provision of healthy food and drink options in canteens of participating community-based sporting clubs, while maintaining profitability Increased sales of healthy food and drink options of participating community-based sporting clubs

4. **Rationale:** A large proportion of children 5-14 years old participate in community-based sporting and leisure pursuits on a regular basis. In the 12-months to April 2009, 60% of all children 5-12 years old living in NSW participated in organised sport and physical activity. This is approximately 536,000 NSW children[40].

Participation in community-based organised sport is a very positive thing for children and young people. It makes a contribution to their overall levels of physical activity, and is a positive health-related lifestyle behaviour that should be encouraged. However, within the community-based organised sporting setting, less healthy dietary behaviours are often promoted through the food and drink choices available from canteens.

Research from several states, including NSW, indicates that food and drink available in community-based sporting canteens is perceived to be unhealthy, and that many common food and beverages choices made by children and young people while in these settings are energy-dense, nutrient poor. In a survey of over 400 parents conducted in NSW, 53% considered the foods and beverages available in the sporting and leisure canteens accessed by their children to be mostly unhealthy[41]. Further, of the parents surveyed:

- 48% reported that their child usually purchased chocolate and confectionary;
- 48% reported that their child usually purchased soft drinks or sports drinks; and
- 44% reported that their child usually purchased ice-cream and ice confection[31].

Young people were significantly more likely than younger children to purchase soft drinks and sporting drinks (63% versus 40%) and pies and pasties (38% versus 23%). In contrast, younger children were

[40] Australian Bureau of Statistics (2009). Children's Participation in Cultural and Leisure Activities, Australia, April 2009. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4901.0 [Accessed 14 May 2010].
[41] Kelly B, Chapman A, King L, Hardy L and Farrell L. (2008). Double standards for community sports: promoting active lifestyles but unhealthy diets. *Health Promotion Journal of Australia*, 19 (3): 226-228.

more likely than young people to purchase ice cream and ice confection (51% versus 21%) and snack foods (45% versus 30%)[31]. Consequently this Service could encourage practices within sporting clubs which promote more healthy food and drink choices to young people as well as younger children, by limiting the availability of less healthy options and providing well-priced, nutritious and tasty alternatives.

The NSW research also reported that 63% of parents surveyed agreed that government should restrict the types of foods and beverages that canteens in this setting can sell[35]. In addition, a community attitudes survey of 1500 adults in Victoria[42] reported that:

- 51% believed community sports clubs do not provide sufficient healthy food options;
- 82% believed community sports clubs have a responsibility to promote healthy eating; and
- 85% agreed that in the interests of children's health, community sports clubs should reduce the sale and consumption of junk food.

Research such as this provides a clear mandate and support from parents and the broader community to address food environments within community-based sporting settings. Therefore, there is a clear rationale to work within sport and recreation settings, and support those responsible for running community-based sport to promote healthy eating as part of the sporting experience.

This is a relatively new health promotion service delivered in NSW and consequently will make an important contribution to the body of evidence related to developing healthy settings as well as contributing to the prevention of overweight and obesity in children and young people. It is a setting in which the NSW Government has demonstrated a commitment to work as outlined in the *NSW Government Plan for Preventing Overweight and Obesity in Children, Young People and their Families 2009 -2011.* This cross-government Plan is applying a coordinated effort across agencies to support children, young people and their families to improve their health.

The cross-government Plan, which is currently being updated makes a commitment to promote the principles of *Fresh Tastes,* the NSW School Canteen Strategy, to canteens in community-based sporting clubs by working with volunteers to increase the availability of healthy food and drink and promote water consumption for children and young people participating in community-based organised sport. To date, the work undertaken this setting has been limited due to a lack of funding to undertake this work. The NPAPH provides the opportunity to substantially increase efforts in this setting.

A small-scale randomised controlled trial of an intervention similar to the Service being proposed has been undertaken in one NSW Local Health District. The trial results demonstrate the feasibility of working with community-based sporting organisations to improve the nutritional value of food and drink available in the canteen. Canteens in the trial increased the number of 'amber' foods and drinks available and decreased the number of 'red' foods available in their canteen while maintaining profitability.

The Drink Water First @ Sport component builds on a social marketing campaign delivered as part of the Hunter New England *Good for Kids* Obesity Prevention Program,in transferring the messages to the community-based organised sport setting. After the campaign parents' knowledge and awareness of the sugar content of sweetened drinks increased and there was a decline in the children's consumption of sugar-sweetened drinks 4 weeks after the campaign finished[43]. While the program therefore would need to be appropriately framed for ongoing delivery, it resonated with the target audience and should translate to an alternative setting to be sustained as confirmed by the stakeholder consultation .

[42] Victorian Health Promotion Foundation (2010). *Community Attitudes Survey: Healthy community sporting environments*. South Carlton: Victorian Health Promotion Foundation.
[43] Orr N, Milat AJ, Lin M, Neville L, Develin L (2009).

5. **Contribution to performance benchmarks:**

Healthier Choices in Recreational Settings **contribution**	**NPP Performance benchmark**
Increase in the number of community-based sporting clubs developing and implementing a healthy eating policy. Improved nutritional quality of food and drinks available in the canteens of community-based sporting settings. Decrease in the availability of foods of low nutritional quality in the canteens of community-based sporting clubs. Increase in the proportion of children and young people purchasing healthy foods from canteens of community-based sporting clubs. Decrease in the proportion of children and young people purchasing energy-dense nutrient poor food options from canteens of community-based sporting clubs. Increase in the proportion of coaches and managers promoting water for children and young people participating in non-elite community-based sport. Increase in the proportion of children and young people consuming water while participating in community-based sport. Decrease in the proportion of children and young people consuming sugar-sweetened drinks (including sports drinks) while participating in community-based sport.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Increase in the proportion of fruit and vegetable options available in the canteens of community-based sporting clubs. Increase in the nutritional quality of fruit and vegetable options consumed by children and young people in community-based sporting clubs. Increase in the proportion of children and young people purchasing fruit and vegetable options from canteens of community-based sporting clubs.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.

6. **Policy consistency:** This is a universal primary prevention Service targeting children and young people between the ages of 5 and 17, through community-based organised sporting settings. While not directly targeting parents and carers, they are likely to also be reached as key messages are delivered and changes made to foods and drinks available at the settings-level.

   This is a new Service and will therefore contribute to the evidence-base in this area. It will draw upon existing knowledge of working with canteens in schools, and to a lesser extent sporting settings, as well as previous social marketing campaigns promoting the consumption of water.

   This Service recognises the role of community in promoting and supporting the health of children and young people and the need for structural support for healthy lifestyles, including increased access to healthy food and drink choices. The Service will be delivered across NSW, including rural and remote communities as well as those of greater social disadvantage which will be specifically targeted as part of the *Healthier Choices in Recreational Settings*. The *Social Inclusion Engagement Service* described later in this Implementation Plan will form specific approaches taken to address equity and ensure equity of access to this intervention across all population groups.

   All community-based sporting clubs and recreational settings are different, and are likely to experience different enablers and barriers. The manner in which the Service is delivered at the setting level will be dependent on these factors. It will be designed with sufficient flexibility and ongoing support to respond to local-level needs, which will increase the longer-term sustainability of changes to food and drinks available within this setting.

   Further, this *Healthier Choices in Recreational Settings* will complement the Healthy Worker and Healthy Communities Initiatives. Sport and recreation settings are community-based and because of this will reach people of all ages and from all population groups. As a consequence the promotion of water and increased availability of healthy food options within the canteens will also impact on parents, younger children (under 5 years of age) and a very large number of community volunteers as they spend time in this setting.

7. **Target group(s):** The primary target group for *Healthier Choices in Recreational Settings* is children and young people 5-17 years old participating in community-based organised sporting activities in their leisure time.

   The secondary target group is parents and other family members who attend these sporting settings with their children; sporting coaches as well as team managers when applicable. This might include community volunteers who spend time in these settings as well.

8. **Stakeholder engagement:** NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Ministry of Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for services which require multiple implementation partners; and
- ensuring appropriate engagement and support for the NSW Ministry of Healthy Children Initiative.

Consultation has included stakeholders internal to NSW Ministry of Health, Local Health Districts, other NSW Government Departments, non-government organisations and academic institutions.

NSW Ministry of Health has consulted directly with Communities NSW – Sport and Recreation and will work collaboratively with Communities NSW – Sport and Recreation to develop, deliver and evaluate this service. They have expressed their support for this service and are committed to working collaboratively with NSW Ministry of Health, as well as relevant non-government organisations and Local Health Districts to maximise its reach and effectiveness.

A Sporting Industry Reference Group has been established to inform and support the development and implementation of both components of this service. Further, extensive formative research and consumer focus testing will be undertaken to develop messages and resources that are relevant to and resonate with the community-based sporting club setting as well as key audiences within this setting.

Additionally, NSW Ministry of Health will establish a formal governance structure as part of the NSW Ministry of Healthy Children Initiative and the broader National Prevention Partnership. This will include program specific working groups as well as higher level Advisory Committees involving internal and external stakeholders.

9. **Risk identification and management:**

Risk	**Management Strategy**
Sporting clubs do not access the service	Extensive formative research and focus testing during campaign development will be undertaken ensuring campaign messages are appropriately framed and resonate with key audiences. A Sporting Industry Reference Group will be established to provide advice on service components and their roll-out. The Reference Group/s will also be used to gain support for and commitment to the Service. Campaign Coordinators will be identified for participating sports to support and assist in the delivery of campaign messages and materials to clubs and coaches ay the grass-roots level.
Participating sporting clubs will be unable to achieve desired changes to food and drink available in their canteens	Support will be available to sporting clubs and canteen managers in both face-to-face and on-line formats. Industry Reference Group/s and stakeholder forums will garner support for the Service components and the proposed implementation models as well as identify key enablers and barriers. Campaign Coordinators will be identified for participating sports to support and assist in the delivery of campaign messages and materials to clubs and coaches at the grass-roots level.
Sporting clubs will be unable to promote water as a drink of choice while children and young people are participating in non-elite community-based sporting activities	Support will be available to sporting clubs and canteen managers in both face-to-face and on-line formats. Incentives will also be provided to facilitate the promotion of water in this setting. Industry Reference Group/s and stakeholder forums will garner support for the Service and the proposed delivery models as well as identify key enablers and barriers. Extensive formative research and focus testing will ensure messages and the manner in which they are framed are appropriate to this setting. Campaign Coordinators will be identified for participating sports to support and assist in the delivery of campaign messages and materials to clubs and coaches at the grass-roots level.

Risk	Management Strategy
The Service is not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Working groups will report to an overarching Advisory Group being established as part of the NPAPH governance structures.
Interventions across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH.
The NSW Government will be going to an election in March 2011 and will necessarily involve a caretaker period prior to the election.	NSW Ministry of Health will seek approval to undertake the necessary activities as soon as practical after the results of the election are known.

10. **Evaluation:** The evaluation of *Healthier Choices in Recreational Settings* will occur within the context of a comprehensive evaluation framework currently being developed by NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

The evaluation of *Healthier Choices in Recreational Settings* will include quality assurance measures as well as process and impact evaluation, and an analysis of the costs involved in delivering the Service against the results achieved.

- **Process evaluation** measures will include measuring the adoption of *Healthier Choices in Recreational Settings* across NSW as well as the extent to which the Service is delivered as intended. It is anticipated that a minimum data set will be used to gather process data as well as support total quality improvement processes. This might include the number of clubs reached by the water campaign, canteens participating in the healthy canteen component and resources distributed.
- **Impact evaluation** will include measuring the number of participating sporting and recreational clubs that develop and implement healthy eating and water policies, the proportion of participating clubs which promote and sell healthy food and drinks as well as the proportion of food and drinks available in participating canteens classified as healthy and less healthy.
- **Cost evaluation** will assess the costs of delivering *Healthier Choices in Recreational Settings*.

NSW Ministry of Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the HCI.

The final evaluation plan for *Healthier Choices in Recreational Settings* will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

11. **Infrastructure:** In order for NSW to deliver this service a combination of existing and newly developed administrative infrastructure will be required.

- The existing Communities NSW Department of Sport and Recreation structures will contribute to the development, delivery and evaluation of specific components of the final service strategies.

- State Sporting Organisations will also provide strategic and context specific advice to the NSW Ministry of Health and potentially contribute to the evaluation of the service.

Soft infrastructure in the form of relevant resources and other support materials are likely to be required for this service.

- Additional administrative infrastructure is also likely to be required to fulfil a coordination role within the central health agency. The role of any additional staff will include:
    a) supporting and managing the overall development of the Service and resources;
    b) managing resource development, design, layout and printing;
    c) managing procurement as well as ongoing contracts with external providers;
    d) leading strategic overarching stakeholder engagement and management and as part of the NPAPH and would processes;
    e) ensuring social inclusion is embedded into the Service;
    f) contributing to the development and implementation of ongoing program monitoring and supporting the national evaluation (including the national evaluation if appropriate/required);
    g) contributing to ongoing reporting as part of he NPAPH; and
    h) participating in and reporting to appropriate committees as part of the NPAPH.

12. **Implementation schedule:** *Drink Water First @ Sport Program*

Table 3: Implementation schedule

Deliverable and milestone	Due date
(i) Literature review and formative research	Dec 2012
(ii) Phase 1 of program concept tested	Sept 2013
(iii) Program messages finalised and campaign framework and plan developed	Feb 2014
(iv) Program implemented as staged roll-out	March 2014 to December 2017
(v) Monitoring and evaluation	Ongoing from July 2013

13. **Implementation schedule:** *Healthy Sporting Canteens Component*

Deliverable and milestone	Due date
i. Literature scan and formative research	Dec 2012
ii. Sporting Industry Reference Group established	Aug 2011
iii. Training workshops delivered	Dec 2017
iv. Resource distribution	Dec 2014
v. Ongoing support for participating clubs	Sept 2014 -Dec 2017
i. Monitoring and evaluation	Ongoing from Nov 2012
ii. Develop and implement strategies for sustainability	Ongoing to June 2018

14. **Responsible officer and contact Details:**

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Activity budget:

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure Item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Formative research and development	$0.00	$0.00	$0.10	$0.00	$0.00	$0.00	$0.00	**$0.10**
Project management, adoption and maintenance in sporting canteens	$0.07	$0.07	$0.23	$0.50	$0.80	$0.78	$0.65	**$3.10**
Water first program	$0.00	$0.03	$0.03	$0.02	$0.02	$0.02	$0.02	**$0.14**
Embedding the needs of Aboriginal and other vulnerable populations	$0.00	$0.04	$0.04	$0.04	$0.04	$0.04	$0.04	**$0.24**
Monitoring and evaluation	$0.00	$0.02	$0.10	$0.10	$0.10	$0.10	$0.10	**$0.52**
TOTAL	**$0.07**	**$0.16**	**$0.50**	**$0.66**	**$0.96**	**$0.94**	**$0.81**	**$4.10**

Note: Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6% of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Service. Discrepancies in the table between totals and sums of components reflect rounding.

PROGRAM OVERVIEW AND OBJECTIVE

1. **Services for Family Settings**

2. The objectives of this program are to:

   - increase parents' awareness of the importance of healthy eating and physical activity and limiting small screen time for children and young people;
   - improve parents' knowledge relevant to healthy eating, physical activity and limiting small screen time for children and young people;
   - improve parents' knowledge of how they can support their children to consume a healthy diet, engage in physical activity and limit time spent engaging in small screen recreation; and
   - increase the proportion of children and young people, as well as their families, consuming a healthy diet, engaging in physical activity and limiting their small screen recreation.

3. The *Services for Family Settings* Program includes two activities:

   a) Social Marketing to Children and their Families; and
   b) Obesity Prevention Service for Overweight Children *(Go4Fun®)*.

4. The senior contact officer for this program is:

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Activity 5.1: Communicating to Children and their Families

1. **Overview:** The *Communicating Children and their Families* activity will work through existing settings and programs to deliver messages and programs promoting health-related lifestyle behaviours to parents and their children. It will focus on raising awareness, increasing knowledge, and building skills in relation to creating home environments supportive of healthy eating, physical activity and limiting small screen time for children as a means of complementing the broader setting-based HCI programs.

   A number of programs are likely to be developed and delivered through key HCI settings as a means of communicating with children and their families about health-related lifestyle behaviours. This includes, but will necessarily be limited to:

   a) *Healthy Beginnings* – delivered through key early childhood health settings childhood services, this program supports families of very young children to establish breastfeeding, introduce solids in timely manner and adopt other healthy lifestyle habits in the family setting; and
   b) *Healthy Habits* – delivered through playgroup, child and family health and early childhood services, this program supports families to eat healthily, be physically active and limit their small screen time.

   As part of the *Social Inclusion Engagement Service* described later in this Implementation Plan, the specific strategies included in the *Communicating Children and their Families* activity will be designed with reference to specific populations across NSW. This will ensure that branding, messages, concepts and delivery are able to target particular population groups including Aboriginal people, CALD communities, those living in rural and remote areas of NSW as well as the socially disadvantaged.

2. **Outputs:**

Description	Quantity	Timeframe
Identification of programs to communicate key health messages to families through HCI settings	Specific key programs identified to communicate key messages	Ongoing from July 2011
Develop the Healthy Beginnings program for staged roll-out through specific settings with a focus on disadvantaged population groups	Components identified, developed and tested and rolled-out using a staged approach	From June 2013 onwards
Scope and develop the components of the Healthy Habits program for staged roll-out through specific settings with a focus on disadvantaged population groups	Components identified, developed and tested and rolled-out using a staged approach	From June 2013 onwards (there will be ongoing development of these over time to meet family need)
Comprehensive evaluation of the Healthy Beginnings and Healthy Habits programs and their component parts	Evaluation report produced	Ongoing for each module and overall by June 2017
As relevant, development and delivery of other programs to communicate key health messages to parents		Ongoing from July 2014
Comprehensive evaluation of any additional programs that are developed to communicate key health messages to parents	Evaluation report produced	Ongoing from July 2014
Promotion of the Healthy Beginnings and Healthy Habits Programs and other HCI communication programs as relevant to and through key settings	Communication strategy/s developed and implemented	From Dec 2013

3. **Outcomes:**

Short term	Medium term	Long term
Increase in parents/carers improve their knowledge and awareness of eating healthily, being physically active and limiting small screen recreation	Improvements in parents/carers intentions, attitudes and beliefs related to eating healthily, being physically active and limiting small screen recreation Parents skills to support their children to eat healthily, be physically active and limit small screen recreation	Parents/carers report increased support for their children to eat healthily, be physically active and limit small screen recreation Increased proportion of children are eating healthily Increased proportion of children are engaging in the recommended levels of leisure time physical activity Increased proportion of children are engaging in no more than 2 hours of small screen recreation each day

Rationale: The role of parents/carers and the broader family environment in shaping food, physical activity and small screen attitudes, beliefs, preferences and behaviours of children and young people is well documented[44] [45] [46]. Parents/carers are important role models for healthy eating, physical activity and small screen behaviours and children will often emulate behaviours of their parents/carers, both healthy and non-healthy[47]. Therefore, reaching and influencing parents/carers will be an important for the overall success of the HCI. This will also complement the work being undertaken in the broader settings-based programs being delivered though the HCI.

Communicating specific health messages to parents/carers and the broader family has been identified as an effective strategy for increasing awareness and influencing attitudes and behaviours at a population level[48], as well as engaging parents/carers and prompting them to influence the health-related behaviours of their children[38] [49]. Appropriate communication of health messages can challenge attitudes and social norms regarding health-related behaviours as well as provide information on 'why', 'what' and 'how' to parents of children and young people[38]. Further this communication encourages and supports parents to model positive lifestyle related health behaviours for their children[38]. Therefore, appropriate communication programs that deliver clear and consistent messages to parents/carers, and reinforce messages delivered across HCI, will maximise opportunities to positively influence the eating, physical activity and small screen time behaviours of children and young people across NSW.

A number of interventions, internationally and within Australia, have used communication strategies as a means of reaching and influencing parents. The *VERB*® campaign in the United States provides an example of how communicating to parents can reinforce a broader range of interventions and contribute to

[44] Gill T, King L, Webb K. (2005). *Best Options for promoting healthy weight and preventing weight gain in NSW*. Sydney: NSW Centre for Public Health Nutrition and NSW Department of Health.
[45] Wen Lm et al (2007). Early intervention of multiple home visits to prevent childhood obesity in a disadvantaged population: a home-based randomised controlled trial (Healthy Beginnings Trial). *BMC Public Health 7*: 76.
[46] Campbell KJ et al. (2007). Associations Between the Home Food Environment and Obesity promoting Eating Behaviours in Adolescence. *Obesity 15 (3):* 179-730.
[47] Evans WD et al. (2010). Social Marketing as a Childhood Obesity Prevention Strategy. *Obesity 18, Supplement 1*: S23 – S26.
[48] Milat AJ et al. (2005). Culturally and linguistically diverse population health social marketing campaigns in Australia: a consideration of evidence and related evaluation issues. *Health Promotion Journal of Australia 16 (1):* 20 – 25.
[49] Evans D. (2008). Social Marketing Campaigns and Children's Media Use. Future of Children 18 (1): 181- 203.

positive changes in attitudes, beliefs and behaviours of children and young people. *VERB*® successfully delivered key messages to parents and encouraged them to be more supportive of their children to be physically active[50].

The *5-4-3-2-1 Go*! campaign also targeted parents in their role as potential change agents as part of a broader set of interventions[51]. Messages delivered to parents aimed at influencing not only their own eating habits and physical activity behaviours but also those of the family. While the final evaluation results of this campaign are yet to be published, it adopted best practice communication principles and delivered relevant messages to the target audience.

More recently in NSW, Hunter New England *Good for Kids Good for Life* obesity prevention program included a stream to promote increased water consumption and decreased consumption of sugar-sweetened drinks to parents. This campaign was subsequently delivered across NSW and evaluated. The Service achieved positive short-term changes in the water consumption of children and young people[52], thus demonstrating the potential efficacy of communicating to NSW parents. Importantly, the evaluation demonstrated increased knowledge of the high sugar content of sugar-sweetened drinks[41].

A comprehensive mix of communication strategies targeting children and their parents/carers can achieve an extensive reach across the NSW population and is a relatively cost-effective way of delivering relevant, clear and consistent messages to a large numbers of parents/carers[53]. The final messages of the proposed communication program are yet to be finalised. However, they will be evidence-based and informed stakeholder consultation and formative research to ensure the messages and supporting strategies, and the manner in which they are delivered, are relevant to parents/carers and will resonate across a range of populations of parents/carers. Stakeholders are supportive of the *Communicating to Children and their Families* activity and consider it an integral part of the overall HCI.

Supporting health messages at the local level is important to respond to local contexts and meet needs of specific populations. Key settings for these supportive activities include preschools, playgroups, schools and sport and recreation. The inclusion of supportive strategies is an important and necessary component of any well designed and successful social marketing campaign[43]. These strategies reinforce the key health messages as well as promote and support the adoption of behaviour changes in the target populations[54]. Including the *Communicating to Children and their Families* in the HCI will result in a multilevel health promotion approach with consistent messages delivered and reinforced in various settings including early childhood services, schools, sport and recreation and health settings as well as the home environment.

[50] Price SM, Huhman M and Potter LD. (2008). Influencing the Parents of Children Aged 9-13 Years. Findings from the VERB Campaign. *American Journal of Preventive Medicine 34*: S267-S274.
[51] Evans WD et al. (2007). The 5-4-3-2-1 Go! Intervention: social marketing strategies for nutrition. *Journal of Nutrition Education and Behaviour 39*: S55 –S59.
[52] Orr N et al. (2008). Evaluation of the 2008 NSW Water Campaign. *Health Promotion Journal of Australia* (to be published in August)
[53] Reid D (1996). How effective is health education via mass communication? *Health Education Journal 55*: 332-344.
[54] Miles R et al. (2001). Using the mass media to target obesity: an analysis of the characteristics and reported behaviour change of participants in the BBCs 'Fighting Fat, Fighting Fit' campaign. *Health Education Research 16 (3)*: 357-372.

4. **Contribution to performance benchmarks:**

Communicating to Families **contribution**	**NPP Performance benchmark**
Decreased availability of energy-dense and nutrient-poor foods and sugar-sweetened drinks in the home. Increased availability of healthy snacks and other healthy food options in the home. Parents will increase their support of their children to consume a healthy diet. Children and young people's consumption of energy-dense nutrient poor foods and sugar sweetened-drinks will decrease. Children and young people's consumption of healthy snacks and other healthy food options will increase. Parents will encourage their children to engage in physical activity and provide more opportunities for their children to be physically active. Increase in the proportion of children and young people engaging in sufficient physical activity. Increase in the number of parents setting boundaries around time spent engaging in small screen recreation. The time children spend engaging in small screen recreation will decrease.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.

Communicating to Families contribution	NPP Performance benchmark
Increased availability of fruit and vegetables in the home. Increased proportion of parents/carers consuming fruit and vegetables and providing their children with opportunities to consume more fruit and vegetables. Increased provision of fruit and vegetables in lunch boxes and as part of family meals. Children and young people's consumption of fruits and vegetables will increase.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.
Parents will support their children to engage in physical activity and provide opportunities for their children to be physically active. Increase in the proportion of children and young people engaging in sufficient physical activity. Increase in the number of parents setting boundaries around time spent engaging in small screen recreation. The time children and young people spend engaging in small screen recreation will decrease.	Increase in the proportion of children participating in at least 60 minutes of moderate physical activity each day of 5% from baseline by 2016; and 15% from baseline by 2018.

5. **Policy consistency:** This primary prevention activity will target parents/carers of children in their role as a parent/carer. As such it acknowledges the role of parents in shaping the food and physical activity attitudes, beliefs and behaviours of their children and the subsequent positive and/or negative impacts on their child's lifestyle.

   Through the *Social Inclusion Engagement Service*, described later in this Implementation Plan, the specific needs of identified population groups will be considered in the planning and delivery of messages. Consequently the needs of specific population groups, including Aboriginal people, CALD communities and the socioeconomically disadvantaged will be embedded into this campaign. This will ensure that no populations and/or sub-groups within populations are unduly disadvantaged as a consequence of delivering this campaign.

   The strategies included in this activity underpin and support all HCI programs through delivering messages directly to children and their parents/carers and the broader family, including children, which are consistent with those included across all programs.

6. **Target group(s):** There are two primary target groups of the *Social Marketing to Children and their Familles* campaign:

    - parents/carers of children 0-12 years old; and
    - children 0-12 years old.

7. **Stakeholder engagement:** NSW Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for services which require multiple implementation partners; and
- ensuring appropriate engagement and support for the NSW Healthy Children Initiative.

Consultation has included stakeholders internal to NSW Health, Local Health Districts, other NSW Government Departments, non-government organisations and academic institutions.

NSW Health will work collaboratively with key stakeholders to develop and deliver the strategies included this activity messages to families. This includes, Local Health Districts, NGOs, peak bodies, academic institutions ion with the Multicultural Health Communication Service and the Aboriginal Health and Medical Research Council.

Additionally, NSW Health has established a formal governance structure as part of the NSW Healthy Children Initiative and the broader National Prevention Partnership. This will include program specific working groups as well as higher level Advisory Committee involving internal and external stakeholders.

8. **Risk identification and management:**

Risk	Management Strategy
The communication strategies are not delivered within the proposed time frame and within available resources	Program specific working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Working groups will report to an overarching Advisory Group being established as part of the HCI governance structures.
Interventions across the NPAPH are siloed and fragmented	NSW Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the HCI.

9. **Evaluation:** The evaluation of *Communicating to Children and their Families* will occur within the context of a comprehensive evaluation framework currently being developed by NSW Health in collaboration with experts in the field of evaluation and intervention research.

The evaluation of *Social Marketing to Children and their Families* will include process and impact evaluation, and an analysis of the costs involved in delivering the campaign against the results achieved.

- **Process evaluation** may include measuring the awareness of key health messages. It is anticipated that a minimum data set will be used to gather process data as well as support total quality improvement. This is likely to include the dose of communication strategies delivered, parent/carer awareness of the campaign and specific messages.
- **Impact evaluation** will include measuring changes in parent/carer attitudes, knowledge, efficacy, skills and behaviours in relation to the key messages of the campaign. It is likely to also include a measure of support by parents for their children to adopt a healthy lifestyle, and information in relation to changes made to the home environments.
- **Cost evaluation** will assess the costs of delivering *Social Marketing to Children and their Families*.

NSW Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

The final evaluation plan for the *Communicating to Children and their Families* campaign will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

10. **Infrastructure:** In order for NSW to deliver this campaign a combination of existing and newly developed administrative infrastructure will be required.

- NSW Health will commission the development of an appropriate communication strategies and supporting activities.

- NSW Health will use existing infrastructure within the Local Health Districts as well as academic, peak body and non-government organisations to communicate key messages as well as potentially develop and deliver support activities, where appropriate and feasible.

- Additional administrative infrastructure is also likely to be required to fulfil a coordination role within the central health agency. The role of any additional staff will include:
    a) support and manage the overall development of the communication strategies and associated resources;
    b) manage procurement and ongoing contracts with internal and external providers;
    c) lead strategic overarching stakeholder engagement and management;
    d) ensure social inclusion is embedded into the activity;
    e) contribute to the development and implementation of ongoing monitoring and supporting the national evaluation (including the national evaluation if appropriate/required);
    f) contribute to ongoing reporting as part of the HCI; and
    g) participate in and report to appropriate committees as part of the HCI.

11. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone		**Due date**
(i)	Programs to communicate key health messages to families through HCI settings identified	Dec 2012
(vi)	Healthy Beginnings program developed	Dec 2014
(vii)	Healthy Beginnings program implemented as staged roll-out	January 2015 – June 2018
(viii)	Other programs to communicate key health messages to parents developed as appropriate	Ongoing from July 2014
(ix)	Evaluation and monitoring	July 2014 – July 2018

12. **Responsible officer and contact details:**

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13. **Activity budget:**

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure Item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Communication strategy and formative research	$0.00	$0.00	$0.03	$0.03	$0.03	$0.03	$0.03	**$0.15**
Healthy Beginnings program delivery and resources	$0.00	$0.00	$0.75	$1.00	$1.0	$0.75	$0.50	**$4.00**
Additional communication strategy development and delivery	$0.00	$0.00	$0.00	$0.40	$0.40	$0.40	$0.30	**$1.50**
Central office coordination	$0.00	$0.03	$0.10	$0.10	$0.10	$0.10	$0.10	**$0.53**
Evaluation and monitoring	$0.00	$0.05	$0.20	$0.25	$0.25	$0.25	$0.20	**$1.20**
TOTAL	**$0.00**	**$0.08**	**$1.08**	**$1.78**	**$1.78**	**$1.53**	**$1.13**	**$7.38**

Note: This strategy will focus on targeting vulnerable populations and therefore embedded across all line items are strategies to engage vulnerable groups including Aboriginal communities. Discrepancies in the table between totals and sums of components reflect rounding.

Activity 5.2: Targeted Family Healthy Eating and Physical Activity Program (*Go4Fun®)*

1. **Overview:** The ***Targeted Family Healthy Eating and Physical Activity Program*** (*Go4Fun®*) addresses childhood overweight and obesity by assisting children with existing overweight and obesity and their parents/carers to develop a long lasting and healthy approach to living. This targeted secondary prevention service provides education on healthy eating, physical activity and limiting small screen time and seeks to develop skills required to make healthy lifestyle choices.

Children who are overweight or obese and their parents/carers attend face-to-face sessions with health professionals over 10 weeks. The interactive service incorporates practical learning to assist children and their parents/carers, to acquire knowledge and develop skills central to the adoption of healthy lifestyles. The Service aims to:

- modify family lifestyles and improve parenting skills around healthy eating, physical activity and sedentary small screen behaviours;
- promote healthy weight and weight management through sustainable behaviour change;
- encourage, inform and improve children's food choices and eating behaviours;
- encourage, inform and improve children's physical activity skills and behaviours; and
- increase children's sense of well-being, confidence and self-esteem.

2. **Outputs:**

Description	**Quantity**	**Timeframe**
Go4Fun® service delivered to overweight and obese children and their parents/carers in all Local Health Districts.	All 15 LHDs will be delivering the Service. By the 4th year (June 2015), approximately 7000 children will have participated in Go4Fun®	July 2011-June 2015
Ensure the *Go4Fun®* service has an equity focus.	Undertake community development to improve uptake of *Go4Fun®* services within at least 2 LHDs with a high proportion of CALD and/or Aboriginal community members. Offer at least 50% of *Go4Fun®* services in areas of low SES and/or with a high proportion of CALD or Aboriginal communities	July 2013-2017
Develop, implement and evaluate a culturally-appropriate Go4Fun® service for Aboriginal families.	Service developed in consultation with Aboriginal Stakeholders, LHDs and other relevant stakeholders.	July 2013- June 2017

'Graduate Program' delivered to children and parents/carers who have completed the standard or alternative delivery model Go4Fun®.	50% of participants go on to participate in the Graduate Program.	July 2011-June 2017
Develop, pilot, implement and evaluate alternative lower cost implementation models of Go4Fun®.	Pilot and evaluate in at least 3 LHDs	July 2013-June 2017
Tailor Go4Fun® services for vulnerable children at risk of overweight and obesity, which may include children who are at risk of social inclusion for example those with disability	Offer tailored Go4Fun®. services in 3 LHDs.	July 2014-June 2017
Increase awareness of relevant health professionals and organisations around the importance of achieving and promoting healthy weight in children to support recruitment into Go4Fun® services	Routine implementation of strategies across all LHDS. Pilot new strategies in at least 3 LHDs	July 2011 – June 2018 July 2013 -June 2017

3. **Outcomes:**

Short term	**Medium term**	**Long term**
Improved dietary habits of participating children.	The BMI of participating children will decrease The waist circumference of participating children will decrease	BMI and waist circumference of participating children will be maintained within a healthy range.
Participating children will increase time they spend being physically active.		
Reduction in sedentary (particularly small screen) time of participating children.		
Increase sense of wellbeing, confidence and self-esteem of participating children	Increased self-confidence and self-esteem of participating children is enhanced and maintained	Increased self-confidence and self-esteem maintained.
Parent/carer knowledge and skills around healthy eating, physical activity and sedentary small screen behaviours will improve	Participating parents/carers efficacy to improve the lifestyle adopted by the family will increase Participating parents/carers will apply their new knowledge and skills to improve the lifestyle adopted by the family	Participating families will achieve and maintain a healthy lifestyle in the longer-term

4. **Rationale:** Unhealthy diets and physical inactivity are major risk factors for a number of chronic diseases including cardiovascular disease, diabetes, stroke and cancer. Significantly, young people who are overweight or obese have a 25 to 50% chance of becoming overweight adults. This rate may increase to as much as 78% in older obese young people[55]. Research in NSW has shown that the proportion of school-aged children who are overweight or obese has increased markedly over recent decades. In 2004, 25% of boys and 23.3% of girls in NSW were either overweight or obese[56].

[55] Must A and Strauss R. (1999). Risk and consequences of childhood and adolescent obesity. *International Journal of Obesity 23 (Suppl 2):* S2 –S11

[56] Booth M et al. (2006). *NSW Schools Physical activity and Nutrition Survey (SPANS) 2004: Full Report.* Sydney: NSW Department of Health and NSW Centre for Overweight and Obesity.

The importance of universal preventive strategies is acknowledged and required however, there is growing evidence and support for the role that secondary prevention strategies and programs have in managing a public health issue that has such high prevalence[57] [58]. Importantly secondary prevention programs also provide an opportunity to support other programs aimed at preventing childhood obesity through their ability to specifically target and support high risk and vulnerable groups [59] [60].

Many commercial providers offer face-to-face nutrition, physical activity or healthy weight advice but these services tend to primarily address the needs of adults. In contrast, *Go4Fun*® aims to address the needs of overweight and obese children (7 to 13 years) and their parents/carers by assisting them to develop a long-lasting healthy approach to living. Research suggests that parental involvement is crucial for the implementation and maintenance of new health behaviours in younger children[61].

It is also important to note that aside from *Go4Fun*® there are no Government funded programs being offered to this important target group.Parents serve as important health-related role models for their children. They model appropriate behaviours and act as gatekeepers to both opportunities and barriers, and are the major sources of reinforcement in children's lives.

Go4Fun® is an existing Service that will be delivered in all 15 Local Health Districts in NSW. The Service uses current and proven evidence-based overweight and obesity research, as well as effective program strategies, to ensure success. With an emphasis on practical and fun based learning, the *Go4Fun*® is designed to deliver sustained improvements in families' diets, fitness levels and overall health.

Go4Fun® is based on the United Kingdom's Mind, Exercise, Nutrition…Do it! (MEND) program, but has been modified to ensure it is applicable to the Australian context. MEND Australia, which is a separate organisation to MEND United Kingdom, provides the program infrastructure (including a comprehensive database), resources (training manuals, activity equipment, handouts), and training to Local Health District health professionals and support to Local Health Districts to implement the Program in NSW.

Internationally, results from the MEND program have been very positive with the program showing a decrease in children's body mass index and other indicators including decreased waist circumference as well as improved cardiovascular fitness[62] [63]. Early evaluation data from the NSW program is showing great promise. In terms of quantitative results, the following has been achieved:

- waist circumference decreased by 2.2 cm;
- BMI decreased from 27.1kg/m^2 to 26.4kg/m^2 (an average 0.7 BMI unit reduction);
- 6.3 hour decrease in sedentary activities per week;
- average increase of 4.8 hrs per week in physical activity; and
- an increase in the number of days of moderate physical activity from 1.5 days to 3.3 days per week.

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[57] Wake MA, McCallum Z (2004) Secondary prevention of overweight in primary school children: what place for general practice?. *MJA* 181 (2) 82 - 84

[58] Dehghan M, Akhtar-Danesh N, Merchant AT (2005) Childhood obesity, prevalence and prevention. *Nutrition Journal*, 4:24

[59] Muller MJ, Asbeck I, Mast M et al (2001) Prevention of Obesity – more than an intervention. Concept and first results of KOPS. *Int J Obes Relat Metab Disord*. 24 s66-74.

[60] Doak CM, Visscher TLS, Renders CM & Seidell JC (2006) The prevention of overweight and obesity in children and adults: a review of interventions and programs. *Obesity Reviews* 7: 111- 136

[61] Cheryl L et al. (1988). Parental Involvement with Children's Health Promotion: The Minnesota Home Team. *American Journal of Public Health 78 (*9): 1156 – 1160.

[62] Sacher PM et al. (2007a). The MEND RCT: Effectiveness of Health Outcomes in Obese Children. *International Journal of Obesity 31:* S1.

[63] Sacher PM et al. (2007b). The MEND Trial: Sustained Improvements in health Outcomes in Obese Children at One Year. *Obesity 15:*A92.

As part of the HCI, *Go4Fun*® will be rolled out to all 15 Local Health Districts in NSW. In addition, a 'Graduate Program' will be offered to families who have completed the 10 week *Go4Fun*® program to promote maintenance of weight loss achieved over teh first 10 weeks of eth program..

As part of the expansion of this Service there will be an increased focus on disadvantaged groups, particularly Aboriginal communities and families of lower socioeconomic status.. It is proposed that a specific *Go4Fun*® service for Aboriginal families be developed and rolled out in all Local Health Districts. This will form a key component of the *Social Inclusion Engagement Service* and will be developed in close consultation with key stakeholders, including Aboriginal groups. CALD organisations as well as groups working with socially disadvantaged children and their families will also be consulted regarding modifications required to increase the accessibility of this Service for these populations of children and their families.

5. **Contribution to performance benchmarks:**

How *Go4Fun* will contribute	**NPP Performance benchmark**
Decreased BMI and waist circumference of participating children. Increased availability of healthy food choices in the home environment and decreased availability of less healthy food choices particularly energy dense nutrient poor foods and sugar-sweetened drinks. Parents of participating children will encourage and promote consumption of a healthy diet including decreased consumption of energy-dense nutrient poor foods, and sugar sweetened drinks; increased consumption of fibre rich foods and fruit and vegetables. Improved dietary habits of participating children including decreased consumption of energy-dense nutrient poor foods, and sugar-sweetened drinks; increased consumption of fibre rich foods and fruit and vegetables. Participating children will decrease their time spent engaging in sedentary activities particularly small screen recreation. Participating children will increase the amount of time they spend engaging in of physical activity.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Increased availability of fruit and vegetables within the homes of participating children. Parents of participating children will promote and encourage consumption of fruits and vegetables. Participating children will increase their daily consumption of fruit and vegetables.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.

How *Go4Fun* will contribute	NPP Performance benchmark
Parents of participating children will encourage and support their children to participate in physical activity and limit the time spent engaging in sedentary behaviours, particularly small screen recreation. Participating children will increase the amount of time they spend participating in structured and unstructured physical activity each day. Participating children will decrease the time they spend engaging in sedentary activities, particularly small screen recreation.	Increase in the proportion of children participating in at least 60 minutes of moderate physical activity each day of 5% from baseline by 2016; and 15% from baseline by 2018.

6. **Policy consistency:** This is an effective evidence-based secondary prevention Service targeted to children who are overweight and obese and their parents. International evidence, as well as the unpublished results from NSW, demonstrates the effectiveness of this high intensity Service.

   The current approach to the delivery of this Service within the Local Health Districts already has a strong equity focus. Local Health Districts have identified populations with a high prevalence of overweight and obesity and delivered the Service in a targeted manner based on need. Further as part of the *Social Inclusion Engagement Service,* additional strategies will be identified and embedded into *Go4Fun*® to ensure it is accessible to population groups with specific needs.

   This service directly targets and reaches parents/carers as well as children who are overweight and obese. Thus, it takes account of the importance of parents/carers in achieving a healthy lifestyle and includes parent/carer specific strategies to support parents/carers to establish and maintain a healthy lifestyle within the home setting. This will benefit not only the children participating in *Go4Fun*® but also all children and young people within the family unit.

7. **Target group(s):** The *Obesity Prevention Service for Overweight Children* has a two key target groups:

   - children aged 7-13 years of age who are overweight or obese; and
   - parents/carers of children from 7-13 years of age who are overweight or obese.

   Appropriate screening and assessment of potential participants ensures that participants are selected against the eligibility criteria of the program to ensure their suitability for the *Go4Fun*® Service. Selection into the *Go4Fun*® is determined by the presence of one or more of the following risk factors: overweight or obesity, poor diet or physical inactivity.

   Go4Fun® is promoted and will continue to be promoted to and in communities with a greater prevalence of overweight and obesity. Accordingly those from lower socioeconomic groups and other disadvantaged groups have been identified as important sub-targets for the program. This includes Aboriginal people, people from culturally and linguistically diverse communities and rural and remote communities.

   Health professionals, community health providers and schools are all considered important referrers to the program.

8. **Stakeholder engagement:** The NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

- facilitating discussion and commentary on the NSW Ministry of Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
- harnessing support for services which require multiple implementation partners; and
- ensuring appropriate engagement and support for the NSW Ministry of Healthy Children Initiative.

NSW Ministry of Health has formal agreements with the Aboriginal Health and Medical Research Council and the Physical Activity, Nutrition and Obesity Research Group for the purpose of providing ongoing technical support and evidence-based expert advice relevant to the NPAPH.

Specifically, in relation to *Go4Fun*®, ongoing consultation on this intervention involves key stakeholders including:

- MEND Australia Pty Ltd;
- Local Health Districts;
- schools;
- general practice;
- NGOs and not-for-profit organisations; and
- local government.

This ongoing consultation will continue as delivery of this service is expanded as part of the NPAPH. NSW Ministry of Health is also consulting with relevant organisations to ensure that *Go4Fun*® meets the needs of and is relevant to children from Aboriginal children as well as those from culturally and linguistically diverse backgrounds, the socially disadvantaged and those living in rural and remote communities. This will occur as part of the *Social Inclusion Engagement Service* of the NPAPH.

Additionally, NSW Ministry of Health has established a formal governance structure as part of the NSW Ministry of Healthy Children Initiative and the broader NPAPH. This will include intervention specific working groups as well as higher level Advisory Group involving internal and external stakeholders.

9. **Risk identification and management:**

Potential risk	**Management strategy**
Low participant numbers recruited to *Go4Fun*	A recruitment and marketing strategy for LHDs implementing the program has been developed by MEND in consultation with NSW Ministry of Health. Standardised promotional materials are available to advertise the program. Use of private providers/NGOs to deliver the program maximises capacity and reach in communities. Identifying and engaging key referral agencies will assist in ongoing program promotion and boost referrals.
Low recruitment/retention of program facilitators	Targeted recruitment of facilitators to ensure commitment and intention to deliver *Go4Fun*®. Ongoing support provided to facilitators from the LHD Program Manager and MEND.
Loss of fidelity when LHD sub-contract the delivery of *Go4Fun*® to NGOs	A standardised process for engaging NGOs will be developed and NSW Ministry of Health approves all contracts between LHDs and NGOs. NGOs have access to all standardised MEND infrastructure and are expected to use this infrastructure. Program fidelity will be monitored as part of the evaluation.
The service is not provided within the proposed time frame and within available resources	Program working groups will be established to develop project plans, prioritise tasks and deliverables, monitor implementation progress as well as identify and respond to implementation issues in a timely manner. Working groups will report to an overarching Advisory Group being established as part of the NPAPH governance structures.

Potential risk	Management strategy
Interventions across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH.
The NSW Government will be going to an election in March 2011 and will necessarily involve a caretaker period prior to the election.	NSW Ministry of Health will seek approval to undertake the necessary activities as soon as practical after the results of the election are known.

10. **Evaluation:** An independent external evaluation for *Go4Fun*® commenced in school Term 2 2010 and was completed in school Term 3, 2011. The evaluation collected information from children and parents/carers on height and weight and waist circumference (physically measured) as well as secondary measures such on health behaviours (specifically physical activity and nutrition) and mental health (confidence and self-esteem).

As the program is expanded under the NPAPH, any evaluation of *Go4Fun*® will occur within the context of a comprehensive evaluation framework currently being developed by NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

The evaluation of*Go4Fun*® will include quality assurance measures as well as process and impact evaluation, and an analysis of the costs involved in delivering the Service against the results achieved.

- **Process evaluation** will include monitoring of the delivery of *Go4Fun*® and the extent to which it has been delivered as intended. It is anticipated that a minimum data set will be used to gather process data as well as support total quality improvement. This is likely to include measures of program fidelity, participant numbers, where the intervention is delivered and referral pathways.
- **Impact evaluation** has already been undertaken as part of the existing evaluation of Go4Fun®. However objective measures of weight and self-reported measures on a range of health behaviours are a standard part of the intervention and so these will also be collected.
- **Cost evaluation** will assess the costs of delivering *Go4Fun*®.

NSW Ministry of Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

The final evaluation plan for *Go4Fun*® will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will build incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

11. **Infrastructure:** In order for NSW to deliver this Service a combination of existing and newly developed training and support infrastructure will be required.

- MEND Australia currently provide the soft infrastructure for *Go4Fun*® which includes: manuals and resources for Local Health Districts, operational management and monitoring database (OMMS) and training for program facilitators. This infrastructure forms the basis of delivering the Service and collecting associated evaluation information.

- As *Go4Fun*® expands, additional infrastructure may be required to deliver the Service. Because *Go4Fun*® is intensive and requires participants to attend 2 face-to-face sessions a week over the period of 10-weeks, the capacity of health professionals delivering the group sessions will have limitations and as it currently stands may not meet future demand. The need for any additional infrastructure will be reviewed on an ongoing basis and take into account a range of contextual issues in each delivery site e.g. current and future demand, location in respect to other sites.

12. **Implementation schedule:**

Deliverable and milestone		**Due date**
(i)	Implementation of the Go4Fun® program in all 15 LHDs in NSW	June 2017
(ii)	Development and staged roll out of Aboriginal specific Go4Fun® program in all LHDs	June 2017
(iii)	Graduate program available to all program participants	July 2011 -June 2017
(iv)	Implementation of strategies to address social inclusion	July 2014 onwards
(v)	Program monitoring and evaluation	Ongoing to June 2018
(vi)	Resources revised	As required
(vii)	Develop and implement sustainability strategies	Ongoing to June 2018

13. **Responsible officer and contact Details:**

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14. **Activity budget:**

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure Item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Funding for health and other organisations to deliver *Go4Fun*®	$1.29	$1.29	$1.29	$1.29	$1.29	$1.29	$1.29	**$9.03**
Embedding the needs of Aboriginal and other vulnerable populations	$0.25	$0.25	$0.25	$0.25	$0.25	$0.25	$0.25	**$1.75**
Monitoring and evaluation	$0.11	$0	$0.11	$0.11	$0.11	$0.11	$0.11	**$0.77**
TOTAL	**$1.65**	**$1.65**	**$1.65**	**$1.65**	**$1.65**	**$1.65**	**$1.65**	**$11.55**

Notes: An additional $17.5m of NSW funding will be allocated to *Go4Fun*® over the 7-years of the NPAPH. The table below outlines the NSW contribution to this intervention throughout the NPAPH. Funding to embed addressing the needs of Aboriginal and other identified vulnerable populations within all HCI interventions accounts for 6% of funds allocated to the intervention. Additional funds to address the needs of Aboriginal and other identified vulnerable groups are also allocated as part of the Social Inclusion Engagement Strategy. Discrepancies in the table between totals and sums of components reflect rounding.

Table 5: Additional / supplementary funding provided by NSW Ministry of Health

Year	NSW Ministry of Health contribution
Year 1	$2,500,000
Year 2	$2,500,000
Year 3	$2,500,000
Year 4	$2,500,000
Year 5	$2,500,000
Year 6	$2,500,000
Year 7	$2,500,000
TOTAL	**$17,500,000**

Notes:
NSW Ministry of Health will contribute these funds to delivery of this intervention in addition to the facilitation funds received from the Commonwealth Government.

PROGRAM OVERVIEW AND OBJECTIVE

1. **Social Inclusion Program**

2. The objectives of this program are to:

- ensure equity issues are appropriately identified, prioritised and addressed across the NPAPH;
- ensure that services are designed and implemented in a manner that is relevant to and meets the needs of Aboriginal as well and other identified populations;
- ensure that when required appropriately and/or specific strategies are within the various services are implemented to meet the needs of Aboriginal as well as and other identified populations;
- ensure that population groups with specific needs are not further disadvantaged as a consequence of the NPAPH;
- promote longer-term sustainability of equity focused approaches implemented in the NPAPH; and
- engage appropriate stakeholders to address equity issues through the NPAPH.

3. The *Social Inclusion* Program involves the following activity:

    a) Social Inclusion Engagement Service

The senior contact officer for this program is:

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Manager, Healthy Children Initiative
NSW Office of Preventive Health,
Liverpool Hospital
Locked Bag 7103,
Liverpool BC, NSW 1871Tel 02 9828 6379

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Activity 6.1: Social Inclusion Engagement Service

1. **Overview:** The focus of the *Social Inclusion Engagement Service* will be to ensure equity issues and the barriers, enablers and needs of Aboriginal children and young people as well as those from other identified vulnerable populations including Culturally and Linguistically Diverse (CALD) communities, are appropriately addressed across the HCI. This includes ensuring that the manner in which services are designed and delivered, as well as resources developed to support them, are appropriate. In line with national and state government directions, a primary focus of the *Social Inclusion Engagement Service* will be Aboriginal children and young people.

   Advisory Committees will be established and key stakeholders from other identified vulnerable populations will be engaged as part of the broader governance structures to guide best-practice approaches and processes to address issues of access and equity through the HCI.

   The role of the Advisory Committees will be to support the HCI as a whole for lifestyle related health behaviours in vulnerable populations including, Aboriginal people, as well as identifying specific structures and ensure input from vulnerable communities is considered. The Committee and other stakeholders will work in partnership with NSW Ministry of Health, and relevant stakeholders, to guide and oversee the following:

   - identification of the barriers experienced by vulnerable populations and sub-groups to equitable access to and participation in HCI services;
   - mapping healthy eating and physical activity programs specific and available to vulnerable populations across NSW;
   - ensuring and overseeing appropriate consultation processes across all HCI services;
   - ensuring appropriate and relevant adaptation of to services so the needs of vulnerable populations are adequately addressed;
   - ensuring processes to address equity are embedded across all HCI services and that culturally appropriate protocols are developed to address the needs of Aboriginal people and Culturally and Linguistically Diverse Communities;
   - development and delivery of specific and/or additional services and/or service delivery models as part of the NPAPH to meet the needs of identified vulnerable populations; and
   - ongoing monitoring and evaluation of the HCI in relation to the health outcomes of target vulnerable populations and sub-groups.

   The Advisory Committees and key stakeholders from will be part of and link into broader HCI governance structures and will meet regularly. Clear terms of reference will be developed and will be reviewed annually. Consequently, the *Social Inclusion Engagement Service* and the work of this Committee will remain relevant throughout the HCI.

2. **Outputs:**

Description	**Quantity**	**Timeframe**
Equity framework developed for HCI Programs	Framework developed	June 2013
CALD engagement strategy for HCI programs	CALD engagement strategy developed	June 2013
Key stakeholders for other vulnerable children and young people identified	Scoping document identifying key vulnerable sub populations of children and young people in NSW and key stakeholders	June 2013
Mainstream HCI services enhanced and modified with regard to addressing equity issues faced by vulnerable populations	Equity approaches embedded across all HCI services	July 2014 - Dec 2017
Additional services to meet needs of vulnerable populations developed, delivered and evaluated	At least 2 targeted services delivered	July 2015 – Dec 2017

3. **Outcomes:**

Short term	**Medium term**	**Long term**
Services will address the needs of children and young people form Aboriginal as well as other identified populations Services with parental components will address the needs of parents/carers from Aboriginal as well as other identified populations	Increased proportion of children and young people who are Aboriginal or from other identified populations have access to NPAPH services which promote healthy weight, healthy eating and physical activity Increased proportion of children and young people who are Aboriginal and/or from other identified populations access to NPAPH services that include a parental component	Increased proportion of children and young people who are Aboriginal or from other identified populations participate in NPAPH services which promote healthy weight, healthy eating and physical activity Increased proportion of children and young people from Aboriginal and other identified populations achieve a healthy weight range Increased proportion of children and young people from Aboriginal and other identified populations consume a healthy diet Increased proportion of children and young people from Aboriginal and other identified populations are physically active

4. **Rationale:** The Scoping Statement and Guiding Principles for both the Healthy Children and Healthy Worker Initiatives clearly identify access and equity as key considerations for the design, development, delivery and evaluation of NPAPH services. These Principles emphasise that individuals, families and populations should not be further disadvantaged as a consequence of the NPAPH. In developing, delivering and evaluation the NPAPH initiatives, jurisdictions are encouraged to:

- considering a range of factors impacting on reach of interventions and access to services;
- identifying enablers and barriers to participation in health promotion services; and
- reducing barriers to access and/or increase opportunities to access and participate in services.

While health promotion workers are committed to addressing issues of access and equity when delivering services, in reality achieving this can be difficult[64]. While unintentional, health promotion efforts intended to improve health in disadvantaged populations often improve the health of more advantaged populations and consequently increase the gap in health status between the most advantaged and least advantaged populations within the community[65]. Experts suggest that there is a need to develop and implement strategies to ensure that universal services meet the needs of priority populations in a salient manner[54]. They suggest that equity be a key consideration at all stages of a health promotion program from design and development through to implementation and evaluation[55]. Further, equity considerations should extend beyond equity of access and include equity of opportunity and measuring the equity of impacts and outcomes for the various sub-populations facing health inequalities[66].

A number of best-practice principles have been identified for addressing the needs of Aboriginal and other vulnerable population groups when designing, delivering and evaluating health promotion services. These include:

- working across settings with consideration to dimensions relevant to equity that are appropriate to the setting and well as the target population (embedding equity approaches);
- targeting specific communities as the population (i.e. geographical areas or cultural groups);
- targeting areas and communities or populations where there is the greatest need;
- building collaborative relationships and taking a partnership approach to the design, delivery and evaluation of services;
- developing and delivering services that address the needs of specific groups and/or lifespan stages[54].

Consistent and strong feedback was received from stakeholders in response to the Healthy Children Discussion paper regarding the need to strengthen equity approaches as part of the NPAPH[67]. While there was support for embedding equity across all NPAPH services, stakeholders recommended that NSW Ministry of Health engage in much greater consultation with key stakeholders to support the appropriate development of services and resources.

[64] Waters CR et al. (2009). *Evidence summary: Achieving equity in community-based obesity prevention interventions for children and Adolescents*. Geelong: CO-OPS Secretariat, Deakin University.
[65] Tugwell P et al. (2006). Cochrane and Campbell collaborations; and health equity. *Lancet 365*: 1128 -1130.
[66] Boyn M. (2009*). Enhancing Equity-Based Planning for Health Promotion*. Melbourne: VicHealth
[67] Newson R. (2010) *Report on the Consultation Process for the NSW Healthy Children's Discussion Paper* (unpublished Departmental report)

A number of best-practice solutions were suggested to better identify and address equity issues as part of the NPAPH including:

- scoping and analysing the reach of universal mainstream programs and developing specific programs where gaps and/or needs are identified for particular population groups and/or in specific settings;
- ensuring the needs of Aboriginal communities as well as identified vulnerable populations are addressed in each of the universal services as well as developing services that specifically target the needs of Aboriginal communities and identified vulnerable populations;
- identify existing services that effectively meet the needs of Aboriginal and other identified vulnerable population groups and deliver these more broadly when feasible and appropriate;
- allowing sufficient flexibility for services to engage with Aboriginal and other identified vulnerable populations and meet their needs in an appropriate and sustainable manner;
- increase the focus on Aboriginal people and consult with relevant Aboriginal organisations and communities in a comprehensive manner through the NPAPH; and
- developing processes to ensure Aboriginal communities have input into planning of the NPAPH as a whole as well as specific services; and
- ensuring that evaluations take account of target population groups and measure impacts in these groups.

The Social Inclusion Toolkit, developed by the Commonwealth Government[68] recommends the following steps to promote social inclusion as part of policy and program design and delivery:

- identifying groups at risk of exclusion;
- analysing the nature and causes of disadvantage and exclusion;
- strengthening protective factors and reducing risk factors;
- working across agencies and originations to coordinate efforts across all sectors;
- designing or redesigning delivery systems and promoting change in culture; and
- establishing a clear implementation plan and monitoring delivery.

Including the *Social Inclusion Engagement Service* which includes the establishment of an Advisory Committee and incorporating the needs of Aboriginal and other identified vulnerable populations into service delivery, will support NSW Ministry of Health to apply best-practice principles to address issues of access and equity across the NPAPH. They will also promote collaborative action to address the needs of Aboriginal people as well as other identified vulnerable populations across NSW. In doing so NSW will appropriately identify and meet the needs of less advantaged children, young people and workers in a relevant, salient and sustainable manner and contribute to improved health outcomes for all populations.

[68] Commonwealth of Australia (2009). *The Australian Public Service Social Inclusion policy design and delivery toolkit.* Canberra: Commonwealth of Australia.

5. **Contribution to performance benchmarks:**

Social Inclusion Engagement Strategy **contribution**	**NPP Performance benchmark**
Children and young people from target populations will have equitable access to participate in services in the NPAPH which promote healthy weight. Parents/carers and communities from target populations will have equitable access NPAPH services promoting healthy eating and healthy weight that include a parental component. Children and young people from target populations will decrease their consumption of energy-dense nutrient poor foods and sugar-sweetened drinks. Children and young people from target populations will increase their consumption of healthy snacks and other healthy food options. Increase in the proportion of children and young people from target populations engaging in sufficient physical activity The time children and young people from target populations spend engaging in small screen recreation will decrease. Children and young people from target populations will achieve a healthy weight.	Increase in the proportion of children at unhealthy weight held at less than 5% from baseline for each State by 2016; proportion of children at unhealthy weight returned to baseline level by 2018.
Children and young people from target populations will have equitable access to NPAPH services which promote consumption of fruit and vegetables. Parents/carers and communities from target populations will have equitable access to those aspects of NPAPH services promoting fruit and vegetable consumption that include a parental component. Children and young people from target populations increase their consumption of fruit and vegetables.	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; and 0.6 for fruits and 1.5 for vegetables by 2018.

***Social Inclusion Strategy* contribution**	**NPP Performance benchmark**
Children and young people from target populations will have equitable access to NPAPH services promoting physical activity and limited small screen time Parents/carers and communities from target populations will have equitable access to those aspects of NPAPH services promoting physical activity and limited small screen time that include a parental component. Parents/carers and communities from target populations will develop awareness, knowledge, efficacy and skills to support their children to be physically active and limit their screen time. Increase in the proportion of children and young people from target populations engaging in sufficient physical activity The time children and young people from target populations spend engaging in small screen recreation will decrease.	Increase in the proportion of children participating in at least 60 minutes of moderate physical activity each day of 5% from baseline by 2016; and 15% from baseline by 2018.

6. **Policy consistency:** Through the *Social Inclusion Engagement Service* the vulnerable populations will be identified and considered when planning, delivering and evaluating HCI services. The Scoping Statement and Guiding Principles for both the Healthy Children and Healthy Worker Initiatives identify access and equity as key considerations in the design, development, delivery and evaluation of NPAPH services. Emphasis is given to reinforcing messages that individuals, families and populations should not be further disadvantaged as a consequence of the NPAPH. Jurisdictions are encouraged to:

   - consider a range of factors impacting on reach of interventions and access to interventions;
   - identify enablers and barriers to participation in health promotion interventions; and
   - reduce barriers to access and/or increase opportunities to access and participate in interventions.

   Through the *Social Inclusion Strategy* the needs of children and young people from Aboriginal communities and other identified populations will be identified and addressed across all NPAPH services. It provides scope for additional specific services to be delivered to target groups when a need or gap is identified, or when opportunities arise to deliver a service found to be successful in certain populations on a broader scale. This opportunity to tailor services and enhance existing effective services is in keeping with the overall NPAPH policy principles and will maximise the effectiveness of services targeting specific populations.

   The *Social Inclusion Engagement Service* will allow NSW Ministry of Health to strategically identify, consider and address the needs of children and young people as well as parents/carers from Aboriginal and CALD communities, as well as those living with a disability, living in rural/remote areas and the socially disadvantaged.

7. **Target group(s):** The needs of children and young people from a range of population groups will identified, prioritised and addressed through the *Social Inclusion Engagement Service* as part of the NPAPH.

   The primary target groups for the Social Inclusion Strategy include, but will not necessarily be limited to children and young people:

   - who are Aboriginal or Torres Strait Islander decent;
   - from Culturally and Linguistically Diverse backgrounds;
   - living in rural and remote areas of NSW;
   - who are socially disadvantaged; and

   In addition, the secondary target groups of this strategy will include:

   - parents/carers of children and young people whose needs are identified and met through this strategy;
   - broader family members of the children and young people targeted; and
   - communities in which those children and young people who are targeted live.

   The secondary target groups will be particularly important in the implementation of this service, especially for Aboriginal children and young people for whom the concept and role of family and community in health is crucial.

8. **Stakeholder engagement:** NSW Ministry of Health has undertaken considerable consultation with a range of key stakeholders for the purpose of:

   - facilitating discussion and commentary on the NSW Ministry of Healthy Children Initiative including the appropriateness, efficacy and relevance of services included in this Implementation Plan;
   - harnessing support for services which require multiple implementation partners; and
   - ensuring appropriate engagement and support for the NSW Ministry of Healthy Children Initiative.

   Consultation has included stakeholders internal to NSW Ministry of Health, Local Health Districts, other NSW Government Departments, non-government organisations and academic institutions.

   Stakeholder engagement and collaboration with key stakeholders will underpin the successful integration of the Social Inclusion Strategy across all NPAPH services. Consequently, a key strategy will be the establishment of the relevant Advisory Committees with representatives from a wide range of stakeholder groups. Feedback received from ongoing consultation processes undertaken to date indicates a very high level of support for this approach, with many groups specifically identifying the need for a formal mechanism to address issues of equity and social inclusion as part of the NPAPH.

   Additionally, NSW Ministry of Health will establish a formal governance structure as part of the NSW Ministry of Healthy Children Initiative and the broader NPAPH. This will include service specific working groups as well as higher level advisory and steering groups involving internal and external stakeholders.

9. **Risk identification and management:**

Risk	Management Strategy
Services are not provided within the proposed time frame and within available resources	The establishment of an Aboriginal Advisory Committee and processes to engage stakeholders representing other identified vulnerable populations will underpin this service. A plan will be developed which will identify and prioritise tasks, strategies and deliverables, monitor progress as well as identify and respond to implementation issues in a timely manner. The *Social Inclusion Engagement Service* will link into the program specific working groups being established as part of the NPAPH governance structures.
Interventions across the NPAPH are siloed and fragmented	NSW Ministry of Health is establishing a comprehensive governance structure and will put into place practical strategies e.g. working groups, networks, to encourage cross-service communications and identify synergies and linkages across the NPAPH.

10. **Evaluation:** The evaluation of the *Social Inclusion Engagement Service* will occur within the context of a comprehensive evaluation framework currently being developed by NSW Ministry of Health in collaboration with experts in the field of evaluation and intervention research.

The of the *Social Inclusion Engagement Service* will include quality assurance measures as well as process and impact evaluation, and an analysis of the costs involved in delivering strategies as part of this Service against the results achieved.

- **Process evaluation** will include measuring access to, reach and uptake of Healthy Children Initiatives in population groups specifically targeted as part of the *Social Inclusion Engagement Service*.
- **Impact evaluation** will include measuring changes in parent/carer attitudes, knowledge, efficacy and behaviours and the effects of interventions on the health-related behaviours of children and young people in populations targeted through the *Social Inclusion Engagement Service.*
- **Cost evaluation** will assess the costs of modifying and/or delivering separate interventions as part of the *Social Inclusion Engagement Service.*

NSW Ministry of Health is establishing a formal governance structure to guide, advise and oversee evaluation processes being planned as part of the NPAPH.

The final evaluation plan for the *Social Inclusion Engagement Service* will be designed with regard to the overarching national NPAPH evaluation activities as they are more fully articulated. It will incorporate and contribute to national evaluation activities for the NPAPH where feasible and appropriate.

11. **Infrastructure:** In order for NSW to deliver this service a combination of existing and newly developed administrative infrastructure will be required.

- NSW Ministry of Health will establish an Aboriginal Advisory Committee as well as put into place structures to consider and address the needs of other identified vulnerable populations. At present infrastructure implications for this work of this Committee are unknown.

- Where feasible and appropriate NSW Ministry of Health will use existing infrastructure within the Local Health Districts, non-government organisations and organisations working with target populations to develop and deliver services as part of the Social Inclusion Strategy.

12. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
i. Identification of target populations and sub-populations with equity issues	June 2013
ii. Existing services enhanced and modified, then delivered to specific populations as per the Social Inclusion Strategy work plan components	July 2014 - Dec 2017
iii. Additional services developed and delivered with regard to equity issues, where required, feasible and appropriate	July 2015 - Dec 2017
iv. Monitoring and evaluation	Ongoing to June 2018
v. Develop and implement strategies for sustainability	Ongoing to June 2018

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13. **Activity budget:**

Table 4: Activity project budget ($ million) exclusive of GST

Expenditure Item	Year 1 2011-12 ($ million)	Year 2 2012-13 ($ million)	Year 3 2013-14 ($ million)	Year 4 2014-15 ($ million)	Year 5 2015-16 ($ million)	Year 6 2016-17 ($ million)	Year 7 2017-18 ($ million)	Total ($ million)
Committee establishment and support	$0.00	$0.03	$0.20	$0.03	$0.03	$0.03	$0.03	**$0.15**
Mapping barriers, current activities and work plan development	$0.00	$0.20	$0.27	$0.20	$0.20	$0.20	$0.20	**$1.20**
Community consultation	$0.00	$0.15	$0.20	$0.40	$0.20	$0.20	$0.20	**$1.55**
Establishment, management and adoption of specific strategies and projects included in the work plan	$0.00	$0.87	$1.18	$1.20	$1.25	1.23	$1.22	**$7.04**
Monitoring and evaluation	$0.00	$0.15	$0.20	$0.20	$0.20	$0.20	$0.20	**$1.15**
TOTAL	**$0.00**	**$1.40**	**$2.05**	**$2.03**	**$1.88**	**$1.86**	**$1.85**	**$11.07**

Notes: Discrepancies in the table between totals and sums of components reflect rounding.

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

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

Role of the State

2. The State 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.

3. The State 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

4. The State 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:

   - 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.

   - 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.

   - 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.

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

- 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 by 2016; 0.6 for fruits and 1.5 for vegetables from baseline by 2018.

- 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 by 2016; 15 per cent from baseline by 2018.

- Reduction in state 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.

5. 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.

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

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.[69] 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).[70]

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:

[69] Australian Bureau of Statistics (2009); National Health Survey 2007-08 – Summary of results, Canberra
[70] Australian National University (2007); Children's Nutrition and Physical Activity Survey – Fact Sheet – Key Findings 2007, Canberra

- 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.*[71]

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)[72] and in the context of the Healthy Children initiative mean:

- *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
- *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.

[71] www.socialinclusion.gov.au/Documents/SIToolKit.pdf
[72] National Public Health Partnership (2006), *The Language of Prevention,* Melbourne.

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.