Implementation Plan for the Healthy Children initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

PRELIMINARIES

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

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

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

   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 Northern Territory, represented by Minister or Health and Families (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 of the specified program, including the acceptance of final performance program 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 Northern Territory is limited to payments associated with performance benchmarks achieved by the Northern Territory 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 for the Healthy Children initiative is $4.078 million. Payments will be structured as 50 percent facilitation and 50 percent reward. The reward payments are conditional on achievement against performance benchmarks specified in the National Partnership.

10. Facilitation payments will be payable in accordance with Table 1 from July 2011 to 2014 in accordance with the National Partnership. All payments are exclusive of GST.

Table 1: Facilitation and Reward Payment Schedule ($ million)

Facilitation Payment		Due date	Amount
(i)	Facilitation payment	1 July 2011	$0.41
(ii)	Facilitation payment	1 July 2012	$0.81
(iii)	Facilitation payment	1July 2013	$0.40
(iv)	Facilitation payment	1July 2014	$0.42
Reward Payment *		Due date	Amount
(v)	Reward payment	2013-2014	$0.82
(vi)	Reward payment	2014-2015	$1,22

* note the actual amount of reward payment is conditional on assessment of achievement against performance benchmarks as set out in the National Partnership

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

Overall Budget

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

Table 2: Overall program budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
Implementation of COPAL	.41	.81	.40	.42	2.04

Note: Part of the funding would go to SA Government to cover social marketing material, monitoring and evaluation.

13. Having regard to the estimated costs of program and associated activities specified in the overall program budget, the Northern Territory 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 Northern Territory 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 Northern Territory to deliver projects cost-effectively and efficiently.

PROGRAM OVERVIEW AND OBJECTIVE

14. **Childhood Obesity Prevention and Lifestyle (COPAL) Program**

15. The objective of this program is to implement and evaluate a multi-strategy community based initiative aimed at halting the rising rates of childhood overweight and obesity in the 0-18 year age group in the city of Palmerston, and, subject to receipt of reward funding, in two other sites in the NT. This initiative, based on the European EPODE methodology, will be initially done in partnership with the SA OPAL team and the City of Palmerston Council and will run for five years from July 2011. AG funding would cover the first four years of operation.

16. The Childhood Obesity Prevention and Lifestyle Program is inclusive of the following activities:

    a) Coordinating healthy eating, physical activity and social marketing activities and programs through a variety of settings including child care, school, local government, health services, clubs, sporting organisations, community groups and food retailers and outlets in the city of Palmerston. Monitoring and evaluating the impact of this intervention.

    b) Identifying elements from the Palmerston program that have potential to be applied in other settings, identifying two additional sites (including a remote Aboriginal community setting) and establishing partnerships with key stakeholders, developing/ adapting material, and implementing the modified childhood obesity prevention and lifestyle programs in these two settings. Monitoring and evaluating the impact of this intervention. (Note all of part b) is dependent on receipt of reward payments).

ACTIVITY DETAILS

. Activity: 1. Implementing the COPAL project in the city of Palmerston

17. **Overview:** The NT will partner with the SA Government and the City of Palmerston to implement the EPODE methodology in the city of Palmerston, under the SA franchise, over a period of five years commencing July 2011. The SA program, OPAL (Obesity Prevention and Lifestyle), will be rebadged in the NT as COPAL (Childhood Obesity Prevention and Lifestyle). The target group for this intervention is children aged between 0 and 18 years and their parents/carers.

The NT site will operate exactly as other SA sites with the exception that all social marketing materials will be badged under the name COPAL. The NT will run with the same themes currently running in SA, and the social marketing team from SA will visit the NT prior to the introduction of any theme to ensure appropriateness of content and wording for the NT. They will also oversee any modifications to material, or the development of new material for the Aboriginal population of Palmerston, if this is deemed necessary. A representative from the NT Department of Health and Families (DHF) will sit on the Scientific Advisory Group for OPAL and will have input into program development and evaluation and the OPAL Evaluation Manager will visit the NT to ensure appropriate evaluation processes are in place.

Two staff (a program coordinator and a support staff) will be appointed to coordinate activities and will work from the City of Palmerston offices. These staff will be trained by the OPAL central coordinating unit in SA and will attend regular face to face workshops with other OPAL coordinators as well as participate in regular teleconferences with this network. A representative from DHF will also attend these workshops to ensure that timely information is available to DHF and that opportunities to utilise elements of the program can be considered throughout the duration of the project

The program coordinator and support staff will be responsible for:

- Establishing a local steering committee with key stakeholders from a range of settings including playgroups, early childhood, schools, after school facilities, sporting clubs, health services, community groups, Palmerston Indigenous Village, and food retailers. This committee will oversight activities and provide advice on local implementation of initiatives.
- Establishing networks with government and non-government service providers.
- Purchasing in services to complement existing activities around promotion of healthy eating and physical activity.
- Coordinating a range of social marketing activities around specific themes.
- Introduction of information/education sessions around specific themes in a range of settings eg early childhood, schools
- Keeping records of all activities in the database developed as part of OPAL.

This program in Palmerston will be evaluated with both qualitative and quantitative measures as part of the OPAL evaluation.

18. **Outputs:** The output measures for this activity include:

- formal agreement with City of Palmerston Council
- the appointment of the project manager and support staff
- training of the staff
- the establishment and maintenance of the local steering committee
- the range, number and quality of activities initiated
- the number of social marketing opportunities undertaken
- the numbers of participating agencies and the estimated population reach.

19. **Outcomes:** Anticipated outcomes for this activity in the city of Palmerston include:

Short term: (July 2012)

Increased awareness of healthy eating and physical activity messages.

Medium term (July 2013)

Increased opportunities to participate in a range of physical activities

Increased opportunities for children to access healthy meals

Improved attitudes to healthy eating and physical activity

Long term (July 2014-15)

Increased intake of fruit and vegetables by children

Increased proportion of children participating in at least 60 minutes of physical activity

Reduced rate of increase in childhood overweight and obesity

20. **Rationale:** Rates of overweight and obesity in Australian children have escalated between 1985 and 1995. In the NT, prevalence of overweight and obesity in children aged 0-12 years was, in 2006, consistent with national data (24.1% for boys and 21.1% for girls). In 2009 the SA Government introduced a major childhood obesity initiative based on the EPODE methodology. EPODE translates as “together we can prevent childhood obesity” and is a French multi-strategy community based obesity prevention initiative that

brings together healthy eating and physical activity programs. EPODE commenced in two cities in France in 2003 and has now spread to over 250 cities throughout Europe and other countries. EPODE is one of the few programs that has been successful in halting the escalating rates of childhood overweight and obesity. In the 8 EPODE pilot sites the prevalence of childhood overweight and obesity decreased significantly from 20.57% in 2005 to 18.83% in 2009. The SA Government has entered into an agreement with Proteines, the group managing EPODE in Europe, to use the EPODE methodology. SA currently has 6 sites implementing the methodology, badged under the name OPAL (Obesity Prevention and Lifestyle). The NT does not have the capacity to enter into a franchise agreement with Proteines directly, but they have an opportunity to partner with the SA Government and implement the methodology in the NT under the SA franchise. In the NT the initiative would be called COPAL (Childhood Obesity Prevention and Lifestyle).

The city of Palmerston has been selected as the site for the intervention for several reasons. Firstly it has a population of approximately 24,000 (12% of the total NT population) which is the ideal size for consideration as a site for the intervention. Palmerston has a young population with a median age of 28 years (compared to an NT median age of 31 years and an Australian median age of 37 years) and approximately 30% of the population is less than 15 years of age. Approximately 20% of individuals over 15 years have very low weekly incomes (less than $249 per week) and a further 9% had low incomes ($250-$399 per week. Also Palmerston has a relatively high proportion of Aboriginal residents (11.7% compared to Darwin with 9.7%). Palmerston has previously demonstrated capacity and interest in hosting healthy lifestyle programs. The Activate NT/ Palmerlesstonnes program is a 10 week healthy lifestyle program that has been run since 2006 in the Palmerston community. Palmerston is also a site for the *Healthy Communities* initiative and a component of the *Healthy Workers* initiative will focus on Palmerston.

If the DHF was successful in receiving reward funding then this money would be used to review the elements of the COPAL program and adapt/ modify those that have potential to be taken up in other settings. A modified version of COPAL would then be implemented and evaluated in two additional sites, including a remote Aboriginal community.

21. **Contribution to performance benchmarks:** It is envisaged that this activity will contribute to increased consumption of fruit and vegetables, increased participation in physical activity, and ultimately to reductions in the proportions of overweight and obesity in children in the city of Palmerston. This initiative aims to promote positive messages about healthy eating and being physically active and has a strong community development focus working with children, families and their communities

22. **Policy consistency:** COPAL will promote and strengthen coordination with a broad range of initiatives in the areas of healthy eating and physical activity, for example with Go for 2&5 (the national fruit and vegetable campaign), GoNT (the NT physical activity strategy) and the Department of Education and Training's Schools Canteen and Nutrition policy. It will also link with the *Measure Up* and *Tomorrows People* campaign and the *Healthy Communities* initiative in Palmerston which focus on adults over 18 years, many of whom are the parents and carers of the target group for *Healthy Children.* This activity will ensure that planning for the delivery of this intervention will involve representatives from the Aboriginal community and that the

Aboriginal population will be a priority focus group to prevent a widening of the gap in health outcomes between Aboriginal and non Aboriginal children. The activity is also consistent with targets in other COAG agreements aimed at closing the gap in Indigenous disadvantage. For example, Danila Dilba, the urban AMS based in Palmerston, is currently recruiting two healthy lifestyle workers who will be important partners in this initiative.

23. **Target group(s):** The target group for this intervention is children 0 -18 years, and their parents/carers, in the city of Palmerston. As mentioned previously, Palmerston has a population of approximately 24,000 with about 30% of the population being under 15 years and approximately 12% of the population being of Aboriginal descent.

24. **Stakeholder engagement:** A local steering committee of key stakeholders will be established and they will provide advice and guidance during the duration of the project. Extensive consultation and a mapping of services/activities will be undertaken at commencement of the project.

25. **Risk identification and management:** The primary risk is in the recruitment of a suitably qualified and experienced person to manage this project. To attract suitable staff this position will be offered at a slightly highly level than other similar positions within the department, and this position will be supported by DHF and the Palmerston City Council, as well as the SA OPAL team. Also, as the NT activity is confined to the city of Palmerston, the chance of large scale behaviour changes against the Performance Benchmarks being measurable across the whole population is extremely unlikely.

    DHF has internal processes for risk management.

26. **Evaluation:** This activity will be evaluated as part of the SA OPAL evaluation. This will involve collection of both qualitative and quantitative data covering outcome, impact and process indicators. The quantitative study is quasi-experimental with one control community. Outcome measures include height and weight measures for children from 4-5 years old, 10-12 years old (Years 5-7) and 13-15 years (Years 8-9) at pre, primary and high schools respectively. Data will be collected at three time points across the five year life of COPAL (1, 3 and 5 years). Impact indicators include healthy eating, physical activity and body image behaviours and measures of environment and community will be ascertained through questionnaires. Process indicators including attitudes, values and beliefs, health literacy at individual and community levels will be measured qualitatively via questionnaires, focus groups and interviews. These qualitative data will complement the quantitative data collected and provide insight and meaning to the outcome findings. Below are proposed indicators for the COPAL evaluation:

Outcome indicators:

- positively influences healthy weight in children (0-18 years)

Impact indicators:

- increased levels of healthy eating (eg fruit and vegetable consumption) and decreases in intake of energy dense food and drinks
- increased physical activity and reduced sedentary behaviour
- increased capacity, skills, knowledge, behaviour and attitudes in stakeholders/organisations/community to promote and deliver healthy eating and physical activity opportunities, environments and policies
- communities and their environments are more conducive to healthy eating and physical activity
- change in community/social norms toward healthy eating and physical activity

Process indicators:

- extent of vertical and horizontal collaborations arising from COPAL
- increased partnerships
- level of engagement and participation in COPAL program
- equity and cultural inclusiveness in the delivery of COPAL

27. **Infrastructure:** Infrastructure to deliver COPAL falls into two categories: hard and soft infrastructure. Soft infrastructure refers to people, knowledge, concepts and capacity building. This includes the SA OPAL State Coordination Unit, the local council teams, staff training around the EPODE methodology and training/capacity building of the community through a variety of settings. Hard infrastructure refers to the tangible objects required to make COPAL function and this includes infrastructure that might be required to support the specific themes, social marketing merchandise or support for nutrition and physical activity initiatives. At this stage this hard infrastructure is not known. OPAL has established a database to allow collection of data for the purpose of monitoring the activities of OPAL. This database will be used to monitor activities under COPAL.

28. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone		Due date
(i)	Project staff recruited and trained	Sept 2011
(ii)	Local steering committee formed	Oct 2011
(iii)	Baseline data collected	Dec 2011
(iv)	Annual activity reports completed	Sept 12, Sept 13, Sept 14, Sept 15
(v)	Year 3 data collected	Dec 2013

Notes:

29. **Activity budget:**

Table 4: Activity project budget ($ million)

Expenditure item	Year 1	Year 2	Year 3	Year 4	Total
TOTAL	.41	.81	.40	.42	2.04

Notes:

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

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

Role of the Northern Territory

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

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

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

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

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

PERFORMANCE REPORTING

33. The Northern Territory will provide performance reports to the Commonwealth to demonstrate its achievement against the following performance benchmarks as appropriate to the initiative at 31 Dec 2013 and 31 December 2015:

    a) Increase in proportion of children in the city of Palmerston at unhealthy weight held at less than five per cent from baseline by 2013; proportion of children in the city of Palmerston at healthy weight returned to baseline level by 2015.

    b) Increase in mean number of daily serves of fruits and vegetables consumed by children in the city of Palmerston by at least 0.2 for fruits and 0.5 for vegetables from baseline by 2013; 0.6 for fruits and 1.5 for vegetables by 2015.

    c) Increase in proportion of children in the city of Palmerston participating in at least 60 minutes of moderate physical activity every day from baseline by five per cent by 2013; by 15 per cent by 2015.

34. 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.

35. 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.[1] 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).[2]

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.

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[1] Australian Bureau of Statistics (2009); National Health Survey 2007-08 – Summary of results, Canberra

[2] Australian National University (2007); Children's Nutrition and Physical Activity Survey – Fact Sheet – Key Findings 2007, Canberra

- *Monitoring and evaluation* of all program components should be established during program planning and inception.

PART 2: HEALTHY CHILDREN

Terminology, Scoping Statement and Guiding Policy Principles

2.1 Terminology

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

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

- the size of the organisation or setting and relative capacity to access, take up, participate in and/or be reached by programs and implement programs;
- consideration of the characteristics of children and young people, and their families at both a group and individual level including gender, cultural and linguistic background, Aboriginal and Torres Strait Islanders, people with a disability, physical location and socio-economic status. These factors should be considered in program design, delivery and evaluation;
- equity of outcome that considers all the elements above in relation to the outcomes for individuals (for example, were there organisations and individuals who experienced better results than others in the same cohort); and
- elements outlined in the Australian Government's *Social Inclusion Toolkit.*[3]

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;

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[3] www.socialinclusion.gov.au/Documents/SIToolKit.pdf

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)[4] 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.

[4] 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.