

Implementation Plan for the Healthy Children initiative

NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

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 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 South Australia, represented by [the Minister for Health or the position of the Minister's authorised delegate] (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 to South Australia as facilitation payments for the Healthy Children initiative is \$17.61 million.
10. The maximum possible financial contribution to be provided by the Commonwealth as reward payments to South Australia for the National Partnership is \$11.10 million. Reward payments will be made following the COAG Reform Council's assessment of South Australia's achievement against the seven performance benchmarks specified in the National Partnership. Facilitation and reward payments will be payable in accordance with Table 1 from July 2011 to 2018 in accordance with the National Partnership. All payments are exclusive of GST.

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

Facilitation Payment for Healthy Children initiative		Due date	Amount
(i)	Facilitation payment	July 2011	\$2.32
(ii)	Facilitation payment	June 2012	\$3.15
(iii)	Facilitation payment	July 2012	\$1.74
(iv)	Facilitation payment	July 2013	\$2.08
(v)	Facilitation payment	July 2014	\$2.08
(vi)	Facilitation payment	July 2015	\$2.08
(vii)	Facilitation payment	July 2016	\$2.08
(viii)	Facilitation payment	July 2017	\$2.09
Reward Payment for NPAPH		Due date	Amount
(ix)	Reward payment	2016-17	\$5.55
(x)	Reward payment	2017-18	\$5.55

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

OVERALL BUDGET

12. Table 2: Overall program budget (\$ million) (Commonwealth contribution only)

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	
Expenditure item	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Salaries	0.74	3.26	2.73	1.86	1.2	0.45	0.49	10.73
Grants (e.g. Councils, Evaluation)	0.22	1.7	0.9	0.68	0.46	0.2	0.03	4.19
Goods & Services (e.g. Social Marketing, Training.)	0.1	0.94	0.62	0.31	0.31	0.18	0.23	2.69
TOTAL	1.06	5.9	4.25	2.85	1.97	0.83	0.75	17.61

SA Treasury intends to re-cashflow the funding bringing forward the investment to earlier years to achieve greater impact and therefore greater opportunity to achieve the rewards

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

PROGRAM OVERVIEW AND OBJECTIVE

14. OPAL (Obesity Prevention and Lifestyle)

15. The objective in this program is to *improve eating and activity patterns of children, through families and communities in OPAL regions and thereby increase the proportion of 0-18 year olds in the healthy weight range.*

16. OPAL is inclusive of the following activities:

a) OPAL IMPLEMENTATION

- b) COPAL IMPLEMENTATION – Please note, as simply an additional OPAL site, this activity is listed but not ‘unpacked’. Northern Territory will provide the detail around this activity and South Australia will liaise to ensure both jurisdictions are able to deliver on OPAL/COPAL.

17. The senior contact officer for this program is Health Promotion Branch, Public Health and Clinical Systems, SA Health. Phone: Telephone: (618) 8226 6329; Fax: (618) 8226 6133; Level 4 11 Hindmarsh Square, Adelaide 5000

ACTIVITY DETAILS

18. Activity: OPAL IMPLEMENTATION

19. **Overview:** OPAL is a community-based, childhood obesity prevention program based on the successful French program EPODE (*Together we can prevent childhood obesity*). OPAL works across multiple sites, sectors, settings and employs a wide range of strategies to bring about healthy lifestyle changes. It will build community capacity, supporting programs and initiatives already working toward increasing healthy weight and developing programs, policy and environments that are supportive of healthy eating and physical activity. It will especially focus on

those in greatest need – for example those of lower SES, Indigenous, culturally diverse, regional and remote communities. OPAL’s comprehensive evaluation will significantly contribute to international understanding of how to address overweight and obesity.

With a focus on children, bringing about a decrease in population weight, increasing physical activity and healthy eating, OPAL is addressing the issues central to the Healthy Children initiative.

20. **Outputs:**

2011-2012	State level
	Programs & Services: <ul style="list-style-type: none"> Commence interventions/implementation of plans (including theme use) at site level
	Research and Evaluation: <ul style="list-style-type: none"> Administer OPAL evaluation framework Audit new OPAL council regions (HE & PA initiatives/environments) Support and take advice from Scientific Advisory Committee (SAC) Support and take advice subgroups of SAC such as social marketing and Aboriginal engagement
	Coordination & Partnerships: <ul style="list-style-type: none"> Five additional councils as OPAL sites – staff and contracts in place Ten existing councils supported Support to NT COPAL site Establish & maintain local advisory groups in each new OPAL council
	Policy & Planning: <ul style="list-style-type: none"> Local plans developed for each site – indicating the range of interventions to be undertaken at each site Establish local OPAL plans in new Councils
	Social marketing & Awareness: <ul style="list-style-type: none"> One theme developed and conducted in financial year
	Education and training: <ul style="list-style-type: none"> Comprehensive training sessions for all staff (2x/year minimum)
2012-13	AS ABOVE – limit of 20 reached (+NT site)
2013-14	AS ABOVE but without new OPAL Councils – limit of 20 reached (+NT site)
2014-15	AS ABOVE but without new OPAL Councils – 20 sites in operation – first 6 conclude
2015-16	AS ABOVE but without new OPAL Councils – 14 sites in operation – next 4 conclude
2016-17	AS ABOVE but without new OPAL Councils – 10 sites in operation – next 5 conclude
2017-18	AS ABOVE but without new OPAL Councils – 5 sites in operation – final 5 conclude

21. **Outcomes:**

Year	Term	Outcome
July 2012	Short	Increased awareness of healthy eating and physical activity messages.
July 2013	Medium	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
July 2014-18	Long	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

22. **Rationale:** Children's and young people's levels of overweight and obesity have increased significantly in the past two decades. Albeit there appears to be a recent plateauing, unhealthy weight remains unacceptably high. South Australian data indicates 22.5% of 0-18 year olds and 18.5 % of 4 year olds are overweight or obese.

At the same time overweight and obesity is an issue, so too are low levels of fruit and vegetable consumption and insufficient physical activity. As weight mediators, these behaviours and the social norms that underpin them must be addressed. In particular, increased weight, unhealthy eating and less physical activity are skewed to those people experiencing greater disadvantage.

For these reasons, OPAL (as based on the EPODE program), has been implemented. The EPODE model has demonstrated promising results, adopting a socio-ecological approach to bringing about weight change in populations and is one of few community interventions that is scaleable and transferable – being relevant to different sizes and types of populations.

Discussions with the Northern Territory resulted in Palmerston, a 'satellite city' of Darwin, commencing involvement in the OPAL program in 2011. The program called COPAL (Children's Obesity Prevention and Lifestyle) is supported by the state coordination unit in South Australia for social marketing and evaluation. All details about COPAL should be found in the Northern Territory IP.

The National Partnership Agreement on Preventive Health Healthy Children Initiative is a large injection of resources into States. OPAL offers in return:

- A systematic, evidence-based, internationally recognised, **best practice model** for children's obesity prevention with a responsibility to target resources to those in greatest need
- A **sensible and flexible framework** for applying existing healthy lifestyle programs, policies and campaigns in communities
- An approach that **unites the agendas** of federal, state and local governments and value adds to existing efforts
- A **transferable and scaleable** model that has potential to be administered in a range of sites across Australia
- A program designed to **contribute to understanding** – with a multi-million dollar evaluation framework over the length of the program

23. **Contribution to performance benchmarks:**

OPAL will focus resources within 20 SA communities to bring about positive changes in fruit and vegetable consumption and physical activity levels of children. It is anticipated that up to 25% of

the South Australian population will be directly affected by OPAL contributing to overall State levels of healthy weight, physical activity and healthy eating.

24. **Policy consistency:** OPAL will:

- Emphasise the importance of *healthy lifestyles* promoting national and state healthy eating and physical activity *guidelines*.
- Support OPAL messages with a wide *range of interventions* that are safe, effective and consistent with and/or are drawn from:
 - The *Eat Well Be Active Strategy 2011-2016*
 - *Physical Activity Strategy for South Australia*
 - *South Australia's Strategic Plan*
- Through a *settings based* approach, promote existing State *key initiatives*.
- Ensure population *groups in greatest need* will be preferentially and appropriately addressed (see target groups below).
- Ensure all phases of OPAL are consistent with best practice *body image* policy and protocol.

25. **Target group(s):**

The primary target audiences of the OPAL initiative is 0-18 year olds living in the defined OPAL communities. The primary target audience of the *communication* activities are the people that influence, support and act as role models for these 0-18 year olds.

OPAL target groups fall into several broad categories with a general focus on those in greatest need as reflected in low SES:

Target 1: Parents and caregivers (i.e. decision makers or gatekeepers for children)

Target 2: Children 0-5 years; b) children of primary school age; c) adolescents

Target 3: Organisations and institutions

Target 4: Indigenous

Target 5: Cultural groups

Target 6: Metro & country

Whilst OPAL aims to elicit behavioural changes in children and young people, the mainstay of resources is directed at adults in children's lives. As food providers and facilitators of physical activity for children, especially the 0-12 year olds, it is the behaviour of adults (primarily parents) that needs to change in the first instance.

OPAL's social marketing is not directed at children 0-12, rather it is aimed at parents. Information is tailored to encourage parents to make healthy choice. This, according to French model EPODE, is the key to changing social norms.

26. **Stakeholder engagement:** South Australia will engage with a number of key stakeholders across all stages of the NPAPH to facilitate the delivery of the OPAL program and achievement of performance benchmarks across target groups and and strategically align social attitudes to the Healthy Children Initiative across the South Australian Community.

Stakeholders include Local Government, Healthy Weight Experts, Creative Agency/Communication Unit SA Health, Education sector (sites and services), Recreation and Sport, Transport, Planning, Retailers, Non-Government sector, health sector, community members and children's and families.

The strategies employed to engage stakeholders will include (but not be limited to) the establishment of project reference planning groups, delivery of professional development and training, marketing and promotion activities, and distribution of practical resources.

27. Risk identification and management:

Risk	Level	Mitigation Strategy
Staffing recruitment and retention becomes problematic	Medium	<ul style="list-style-type: none"> Recruitment will be enhanced if the position is advertised early and circulated through networks Retention will be enhanced with good work conditions – ensure management support, PD opportunities, good mentoring. Set positions at high level (to attract the best candidates and to retain them).
EPODE/Proteines withdraws support	Low	<ul style="list-style-type: none"> Maintain regular contact with EPODE colleagues to ensure a clear understanding of international circumstances. Document all activities to enable continuation in the event Proteines terminates contract.
Low participation rates of community in OPAL	Low	<ul style="list-style-type: none"> Ensure high quality staff with expertise in community engagement Ensure sufficient funds are available to engage community members. Provide mentoring and direction of staff in Councils to ensure they are implementing best evidence and community called for initiatives. Review communication strategy
Evaluation is not supported	Medium	<ul style="list-style-type: none"> Determine key and likely barriers and develop risk management strategy
OPAL brand is compromised	Low	<ul style="list-style-type: none"> Ensure integrity of OPAL brand by association with evidence based activity Maintain quality control via regularly monitored systems and processes

28. **Evaluation:** OPAL has a comprehensive evaluation planned. It will occur over eight years – 2010-2018.

The evaluation approach will see the meshing of complementary quantitative and qualitative data through the method of triangulation.

An independent evaluator, Flinders University of South Australia, has been appointed to oversee the largest portion of the OPAL evaluation – the child measurement and broader behaviour evaluation.

OPAL will use the following indicators to determine success:

Outcome indicators:

- Positively influences healthy weight by increasing 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 OPAL;
- Increased partnerships at State and Local levels;
- Level of engagement and participation in OPAL program;
- Equity and cultural inclusiveness in the delivery of OPAL within communities.

29. Infrastructure:

Integral to the delivery of OPAL will be the utilisation of existing and development of soft and hard infrastructure.

Soft infrastructure consists of OPAL State Coordination Staff, OPAL Local Council Teams (LCT), OPAL by EPODE (the concept), and staff and community training.

Hard infrastructure consists of theme and non-theme specific local infrastructure including gardens, community spaces etc. and offices, equipment and transport.

As a third consideration, OPAL will use a combination of soft and hard infrastructure for its Social Marketing strategy which involves theme development, interventions, merchandise and training.

30. Implementation schedule:**Table 3: Implementation Schedule**

Deliverable and milestone	Due date
Programs & Services: <ul style="list-style-type: none"> • Commence interventions/implementation of plans (including theme use) at site level 	Annually at 30 June 2012, 2013, 2014, 2015, 2016, 2017, 2018
Research and Evaluation: <ul style="list-style-type: none"> • Administer OPAL evaluation framework • Audit new OPAL council regions (HE & PA initiatives/environments) • Support and take advice from Scientific Advisory Committee (SAC) • Support and take advice subgroups of SAC such as social marketing and Aboriginal engagement 	Annually at 30 June 2012, 2013, 2014, 2015, 2016, 2017, 2018
Coordination & Partnerships: <ul style="list-style-type: none"> • Five additional councils as OPAL sites – staff and contracts in place 2012 • All existing councils supported 	Annually at 30 June 2012, 2013, 2014, 2015, 2016, 2017, 2018

<ul style="list-style-type: none"> • Ongoing support to NT COPAL site • Establish & maintain local advisory groups in each new OPAL council 	
Policy & Planning: <ul style="list-style-type: none"> • Local plans developed for each site – indicating the range of interventions to be undertaken at each site 	Annually at 30 June 2012, 2013, 2014, 2015, 2016, 2017, 2018
Social marketing & Awareness: <ul style="list-style-type: none"> • One theme developed and conducted in financial year 	Annually at 30 June 2012, 2013, 2014, 2015, 2016, 2017, 2018

31. **Responsible officer and contact details:** Health Promotion Branch, Public Health and Clinical Systems, SA Health. Phone: Telephone: (618) 8226 6329; Fax: (618) 8226 6133; Level 4 11 Hindmarsh Square, Adelaide 5000

32. Activity budget:

Table 4: Activity project budget – NPAPH Healthy Children’s contribution only (\$ million)

	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	
Expenditure item	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Salaries	0.74	3.26	2.73	1.86	1.2	0.45	0.49	10.73
Grants (e.g. Councils, Evaluation)	0.22	1.7	0.9	0.68	0.46	0.2	0.03	4.19
Goods & Services (e.g. Social Marketing, Training,)	0.1	0.94	0.62	0.31	0.31	0.18	0.23	2.69
TOTAL	1.06	5.9	4.25	2.85	1.97	0.83	0.75	17.61

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

33. 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

34. The State is responsible for all aspects of program implementation, including:

- fully funding the program, after accounting for financial contributions from the Commonwealth and any third party;
- 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.
35. 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

36. 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:
- a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2016; proportion of children at healthy weight returned to baseline level by 2018.
 - b) Increase in mean number of daily serves of fruits and vegetables consumed by children by at least 0.2 for fruits and 0.5 for vegetables from baseline for each State by 2016; 0.6 for fruits and 1.5 for vegetables by 2018.
 - c) Increase in proportion of children participating in at least 60 minutes of moderate physical activity every day from baseline for each State by five per cent by 2016; by 15 per cent by 2018.
 - d) 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.
 - e) Increase in mean number of daily serves of fruits and vegetables consumed by adults by at least 0.2 for fruits and 0.5 for vegetables from baseline for each state by 2016; 0.6 for fruits and 1.5 for vegetables from baseline by 2018.
 - f) Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline for each state by 2016; 15 per cent from baseline by 2018.
 - g) 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.
37. 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.
38. The performance reports are due within two months of the end of the relevant period.

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.
- *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

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

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;
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.

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

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