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 (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 Tasmania, represented by the Minister for Health and Human Services (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 Tasmania for the Healthy Children initiative is $5.70 million.

10. The maximum possible financial contribution to be provided by the Commonwealth as reward payments to Tasmania for the National Partnership is $3.56 million. Reward payments will be made following the COAG Reform Council's assessment of Tasmania's achievement against the seven performance benchmarks specified in the National Partnership. Facilitation and reward payments will be payable in accordance with Table 1 from July 2011 to 2018 in accordance with the National Partnership. All payments are exclusive of GST.

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

Facilitation Payment for Healthy Children initiative		Due date	Amount
(i)	Facilitation payment	July 2011	$0.79
(ii)	Facilitation payment	June 2012	$1.02
(iii)	Facilitation payment	July 2012	$0.54
(iv)	Facilitation payment	July 2013	$0.67
(v)	Facilitation payment	July 2014	$0.67
(vi)	Facilitation payment	July 2015	$0.67
(vii)	Facilitation payment	July 2016	$0.67
(viii)	Facilitation payment	July 2017	$0.67
Reward Payment for NPAPH		Due date	Amount
(ix)	Reward payment	2016-2017	$1.78
(x)	Reward payment	2017-2018	$1.78

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

OVERALL BUDGET

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

Table 2: Overall program budget ($ million)

Expenditure item	Year 1 11/12	Year 2 12/13	Year 3 13/14	Year 4 14/15	Year 5 15/16	Year 6 16/17	Year7 17/18	TOTAL
Move Well Eat Well Tasmania	1.81	0.54	0.67	0.67	0.67	0.67	0.67	5.70
TOTAL	**1.81**	**0.54**	**0.67**	**0.67**	**0.67**	**0.67**	**0.67**	**5.70**

Note: Figures are rounded to 2 decimal points. Accordingly, individual years may not sum perfectly to the total shown.

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. **Move Well Eat Well Tasmania**

15. The objective in this program is to use a structured evidence based approach to facilitate the development of environments and settings for children and youth that promote, facilitate and support healthy eating and physical activity through policy and practice.

Tasmanian Context

The development of the activities under the Healthy Children's Initiative has been designed to align with; extend and provide complementary activities to the programs and strategic directions of the Tasmanian Government and the Department of Health and Human Services (DHHS). This initiative will build on work that is underway to address chronic disease prevention and the reduction of risk factors.

16. **Move Well Eat Well Tasmania** is inclusive of the following sub-activities:

a) Move Well Eat Well Early Childhood (MWEW EC)

b) Move Well Eat Well Primary Schools (MWEW PS)

c) CoolCAP School Canteen Accreditation Primary School Program

d) Food Patch (FP) peer education and influence in early childhood settings

e) Healthy Young People (HYP) program

17. **Contact Officer**

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ACTIVITY DETAILS

18. **Activity: MOVE WELL EAT WELL TASMANIA**

19. **Overview:** Move Well Eat Well (MWEW) is an existing primary school program that focuses on building policies, curricula, teaching and learning environments, school support, and physical environments that support health and well-being. Under the Healthy Children's Program, MWEW will be expanded to early childhood settings targeting 0 to 5-year-olds. The existing Primary Schools program will be expanded to new schools, and current participating schools will receive ongoing support. In addition, the existing award-based school canteen accreditation program (CoolCAP Program**)** will be expanded. There will also be an expansion of the Food Patch program into early childhood settings. Food Patch uses a peer education approach to children's nutrition and physical activity promotion throughout Tasmania.

    MWEW has not yet been applied to secondary schools and evidence suggests that a different approach from the existing Awards program will need to be applied. A new program, Healthy Young People (HYP), will be piloted that aims to give young people greater access to and opportunities for physical activity and healthy food choices. The pilot program will use a whole-school approach to explore and build on 'critical success factors' within the school environment. It will support young people to identify strengths within their schools and the changes needed to create a supportive and healthy school environment. If successful, it will be expanded.

20. **Outputs**

Output	*Quantity*	*Quality*	*Timeframe*
MWEW Primary Schools	Number of primary schools participating in MWEW PS Double the number of primary schools achieving Award (baseline July 2010)	See evaluation, outcomes and performance benchmarks	2017/18 Final report
MWEW Early Childhood	Number of childcare and other early childhood settings participating in MWEW EC 20% of Early Childhood Services are MWEW members		
CoolCAP program	Number of primary school canteens working towards accreditation Number of primary school canteens achieving accreditation 9 accreditations per school year.		
Food Patch program	Number of trained and active Food Patch Educators (FPEs) At least 6 new FPEs per year undergoing initial training.	See evaluation, outcomes and performance benchmarks	
Healthy Young People	Development/adaptation of tools, guides and resources for schools 2 schools to be involved in the pilot program		

21. **Outcomes:**

Refer Attachment A: Tasmanian Implementation Plan Logic Map

22. **Rationale:**

Healthy eating and physical activity promote children's physical, social and emotional wellbeing and provide opportunities for optimal learning and development. While many children enjoy a healthy lifestyle, there are a significant number of Tasmanian children who are missing out on the benefits of healthy eating and physical activity. The prevalence of overweight and obesity is on the rise with a recent national survey indicating just over one in five Australian children are either overweight or obese. Between 1985 and 1995 the prevalence of overweight Australian children aged seven to 15 years nearly doubled and the rates of obesity almost tripled. Obesity in children is associated with:

- poor body image and low self esteem
- social isolation
- risk taking behaviour, depression and development of disordered eating practices in adolescents and adulthood
- high cholesterol, blood pressure, glucose intolerance and insulin resistance.

Supporting the development of healthy eating and physical activity habits is an important way childhood settings can contribute to the prevention of obesity in Tasmanian children. Childcare and schools can play a key role in the prevention of both childhood obesity and disordered eating and body dissatisfaction by promoting healthy eating, physical activity and positive body image.

Prevention programs that are limited to short-term, education-based strategies without addressing the social and environmental factors do not achieve sustained positive changes. A more effective strategy is using a whole school approach rather than focusing on the individual and individual behaviours. Move Well Eat Well encourages schools to promote healthy eating, physical activity and positive body image to ALL students, irrespective of body shape and size. It takes into account the social and physical environment, develops links with parents and the wider community and – importantly - helps to normalise healthy eating and physical activity and make these an integral part of the school culture. Becoming a Move Well Eat Well Award School means creating a healthy school environment that makes healthy choices positive, normal and easy for students.

The Move Well Eat Well Award is based on The World Health Organisation's Health Promoting Schools model which encourages healthy eating and physical activity to be incorporated in the day-to-day activities of schools. This model outlines essential elements across three key areas – supportive environments, teaching and learning, and working in partnerships. The Move Well Eat Well Award School provides consistent and evidence-based information for schools and can be adapted to meet the needs of different socio-economic, geographical and cultural environments.

Move Well Eat Well – Early Childhood (MWEW EC) will extend the existing Move Well Eat Well – Primary Schools (MWEW PS) program into the early childhood setting. Extending this program to early childhood settings will facilitate consistency in health promoting approaches for children and their families.

Multiple interventions targeting children in early childhood settings have been implemented nationally and internationally. The results from these interventions have highlighted early childhood settings as efficacious in achieving positive changes in physical activity, weight status and healthy eating. By engaging the Tasmanian early childhood sector in MWEW EC a large

proportion of Tasmanian children and families will be exposed to healthy messages and practices which may encourage the adoption of more healthy behaviours.

The Tasmanian School Canteen Association Inc. (TSCA) has established the School Canteen Accreditation Program, Cool CAP, and has delivered this program effectively and efficiently with a small amount of grant funding ($50,000 per annum) from DHHS and the Department of Education (DoE) since 2003. To date funding levels have restricted the capacity of the TSCA to identify and target schools with greater need, to provide additional support in rural and disadvantaged settings, and to work with secondary schools. Increased funding to the TSCA will increase its capacity to undertake this work.

Evaluation of the Food Patch program has shown that the Food Patch Educators (peer educators) are able to transfer important nutrition and physical activity information and practices in ways that are relevant to the culture and socio-demographic make up of the communities in which they live. They do this through the provision of information, resources, experiences and role modeling in a variety of settings, including new mothers groups, playgroups, childcare settings, and school settings. Evaluation shows the program has a good reach into disadvantaged communities and is a well accepted method to engage parents using early childhood services.

There is very little evidence on the effectiveness of health promotion strategies in relation to young people and physical activity and there is even less research with a focus on socially excluded young people. However, one of the critical factors identified is the importance of involving young people in the development and implementation of programs that target them. Research also indicates there is a range of structural and environmental barriers impacting on young people being physically active and that settings-based interventions in high schools can be successful in increasing physical activity amongst adolescents. Whole school approaches involving staff, parents and students have had some success as have interventions that allow young people to be involved in decision-making and planning.

There is considerable literature that supports the use of schools as a setting for the promotion of healthy eating and physical activity in adolescents. Advantages of using schools include the captive audience of students; the ability to modify the school environment to promote healthy eating and physical activity; adolescents are able to influence their peers; the opportunities for role modelling; and the presence of existing partnerships and ability to develop new partnerships.

To date little work has been undertaken to encourage young people to adopt healthy lifestyles outside of the school and family settings. This project will use the lessons from the Sentinel Site for Obesity Prevention and will use the principles and best practice guidelines developed by CO-OPS in community-based obesity prevention with adolescents.

23. **Contribution to performance benchmarks:**

This activity will contribute to achieving:

- Increased proportion of children and young people across Tasmania within the healthy weight range
- Increased participation in physical activity
- Increased consumption of fruit and vegetables

24. **Policy consistency:**

The Move Well Eat Well program is consistent with the NPAPH Healthy Children Scoping Statement and Guiding Policy Principles (Attachment B) in that uses a primary prevention

approach to addressing risk factors of poor nutrition and physical inactivity. The program will be implemented in settings including child care, schools, and children and family centres, with the primary target being children and young people. It combines using new and innovative approaches (e.g. HYP) with expanding and adapting existing programs (MWEW PS, FFP, CoolCAP).

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

- MWEW EC: Tasmanian children aged 0-5 years
- MWEW PS: Tasmanian children aged 4-12 years
- CoolCAP: Tasmanian children aged 4-18 years
- Family Food Patch**:** Tasmanian children aged 0-12 years
- Healthy Young People: Tasmanian young people aged 12-18 years

NB. Overlap in age ranges is due to the fact that in Tasmania kindergarten at age 4 is provided within primary schools, while childcare settings also cater for 4-5 year olds.

26. **Stakeholder engagement:**

A range of stakeholders will be engaged using a variety of strategies as appropriate.

Stakeholders	**Engagement strategies**

• Child care providers
• Child and Family Centres
• Department of Education
• Catholic Education Office
• Association of Independent Schools Tasmania
• Tasmanian School Canteen Association
• School Parents and Friends
• National Quality Framework
• Childcare licensing bodies
• Community Nutrition Unit
• Premier's Physical Activity Council
• Physical activity/active play experts
• DHHS Child, Youth and Family Services
• DHHS staff specialising in health promotion, oral health
• Non government health and community workers
• Local government health and community workers
• Family Food Educators
• Community Houses
• The Link Youth Health Service
• Menzies Centre, University of Tasmania
• Eat Well Tasmania and other relevant NGOs
• Local Government
• Families
	• Formal committees:
	  ○ Move Well Eat Well (MWEW) Steering Committee
	  ○ MWEW Reference group
	  ○ Young Peoples' Health and Wellbeing (YPHWB) Steering Committee
	  ○ YPHWB Reference Groups
	  ○ Cool Cap Governance group
	  ○ Food Patch steering committee and reference group
	  ○ Stakeholder-specific working groups
	• Use of existing networks
	• Food Patch promotional resources and web content
	• Move Well Eat Well promotional resources and web content
	• Formal and informal meetings
	• Letters of Agreement / contracts
	• Orientation sessions
	• Presentations
	• Contributions to existing newsletters
	• Invitations to provide input to resources
	• Provision of targeted information as appropriate
	• Evaluation interviews (random sample)
	• Information sessions at school assemblies
	• DHHS Intranet
	• Targeted information for stakeholders as appropriate.

27. **Risk identification and management:**

Component	Risk	Level	Mitigation strategy
MWEW Early Childhood Settings	Early childhood settings fail to engage with MWEW-EC strategy	Medium	Communication and marketing strategy Identify champions
MWEW Primary Schools	Non-member schools become progressively more difficult to engage School communities do not have resources to achieve/ maintain award status	Medium Medium	Targeted Promotion Maintain regular engagement with existing stakeholders Provide additional support to schools to apply for award status
CoolCAP	Non-member schools become progressively more difficult to engage Schools do not have resources to achieve or maintain accreditation status.	Medium Medium	Provide additional support in rural and disadvantaged settings and to work with secondary schools Maintain regular engagement with existing stakeholders
Food Patch	Retaining existing Food Patch Educators in program Engaging new recruits to training program	Medium Low	Maintain regular engagement with existing educators, expect turnover, and maintain a recruitment program. Recruit through existing networks (for example community houses, schools etc). Existing educators promote and champion program
Healthy Young People (HYP)	Limited evidence on efficacy of health promotion programs for adolescents. Adolescents and school communities fail to engage with HYP	Medium Medium	Program will be informed by local research Identify peer leaders/ teachers to champion program. Peer led program development and implementation in schools

28. **Evaluation:**

Activity	**Methodology**	**Timeframe**
Move Well Eat Well (MWEW) • MWEW Early Childhood Settings (MWEW-EC) • MWEW Primary Schools (MWEW-PS) • CoolCAP • Food Patch	Process evaluation and discrete program level evaluation of MWEW and Food Patch in primary school and early childhood settings and CoolCAP in primary and secondary school settings (eg numbers participating, accreditation status, achievement/maintenance of awards). Qualitative evaluation of impact of MWEW through annual Member surveys, evidence of changes to policy and practice in Member schools and services, reassessment of Award schools, key informant interviews in selected school/ early childhood settings with a focus on changes to nutrition and physical activity policy.	Ongoing program activity data collection with annual reporting. Ongoing- scheduled interviews with award status schools and services
• Healthy Young People (HYP)	Qualitative evaluation of HYP impact on school culture/norms/ environment/ policy and practice – key informant interviews Action research on school environmental and policy barriers/enablers to healthy eating and physical activity ASSAD survey will provide supplementary data on Physical Activity and Healthy Eating	Annual interviews with key informants Ongoing with annual reporting Next ASSAD due in 2011, results available 2013

29. **Infrastructure:**

The Tasmanian State government is providing a variety of infrastructure to encourage the successful completion of the Healthy Children's initiative. The Healthy Children's Initiative will extend the successful pilot of the Move Well Eat program in Primary Schools, which was adapted from the Kids Go For Your Life (KGFYL) program in Victoria and funded by the Tasmanian State Government. Under the Move Well Eat Well Early Childhood program, the adapted Victorian KGFYL resources will form the base for the framework and resources in Tasmania, and be complemented and supported by existing resources relevant to Healthy Children activities developed and funded in Tasmania through Population Health.

The Healthy Children's initiative also provides the opportunity to build on existing services provided by non-government organisations and funded by state government - this includes the Cool Canteen Program and the Food Patch program. To date both have received short term and limited funding that has impacted on capacity and forward strategic planning.

The Healthy Young People Project (HYP) has used formative research to assist in the development of a framework for secondary schools that will be trialled and evaluated in pilot schools before further development or rollout more broadly.

30. **Implementation schedule:**

Table 3: Implementation schedule

Deliverable and milestone	Due date
• Communication strategy and materials developed for HC Initiative	July 2011
• HC Initiative Advisory Group/s convened	July 2011
• Workplans developed for all sub-activities	September 2011
• Funding agreements with NGO's in place to expand capacity of their projects	September 2011
• Development and pilot of the MWEW- Early Childhood Framework and resources	December 2011
• Development and Pilot of the Healthy Young Peoples project framework	December 2012
• Workplan of rollout of interventions developed	Jan 2012
• Business plans developed for each initiative with key milestones and performance indicators identified	July 2013
• Annual review and reporting against business plan milestones and performance indicators for each initiative	Ongoing for life of NPAPH

Notes:

31. **Activity budget:**

Table 4: Activity project budget ($ million)

Notes: DHHS has also agreed to cash-flow the funds from the Commonwealth more evenly across the period of the agreement, to enable better planning and implementation of programs.

Expenditure item	Yr 1 11/12	Yr 2 12/13	Yr 3 13/14	Yr 4 14/15	Yr 5 15/16	Yr 6 16/17	Yr 7 17/18	TOTAL
MWEW - EC	0.376	0.28	0.29	0.31	0.31	0.32	0.32	2.206
MWEW - PS	0.15	0.28	0.29	0.3	0.31	0.32	0.32	1.97
CoolCAP	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.35
Food Patch	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Healthy Young People (HYP)	0.06	0.06	0.06	0.061	0.065	0.08	0.09	0.476
TOTAL	0.736	0.77	0.79	0.821	0.835	0.87	0.88	**5.702**

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

32. 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

33. 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.

34. 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

35. 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.

36. 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.

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

Attachment A: Tasmanian Implementation Plan Logic Map

Initiative	Activity	Sub activities	Settings	Interventions	Short Term Outcomes	Medium Term Outcomes	Long Term Outcomes (NPA benchmarks)
NPAPH Healthy Children	**MWEW Tasmania**	**MWEW (ECS)** **MWEW (PS)** **Food Patch (FP)** **Cool CAP (CC)**	Early Childhood Settings (ECS) Primary Schools (PS)	MWEW Award system implemented FP Training for peer educators and health community workers CC accreditation system implemented (PS only)	Engagement of ECS with MWEW_ ECS program Proportion of PS attaining MWEW Award status Proportion of PS *maintaining* MWEW Award status Proportion of PS with CC accreditation Proportion of PS *maintaining* CC accreditation Number of FP Educators trained	MWEW framework informs nutrition and physical activity policy and practice in PS and ECS Increase in number of MWEW ECS/PS Increase in number of ECS/PS attaining MWEW award status Increase in number of ECS/PS maintaining MWEW award statutes Increase in number of PS with CC accreditations	**Changes in eating and activity behaviours as measured by the NPAPH Benchmarks** Proportion of children and young people achieving: Healthy weight benchmark Physical Activity benchmark Consuming fruit and vegetable benchmark
		Healthy Young People (HYP) Program	Secondary Schools (SS)	Training/workshops for students/teachers School action plan developed (AP)	Audit of school policies completed Database of good practices established 4 schools engaged in Pilot program Student leaders trained	Changes in policy/planning /environment in Secondary Schools to support healthy eating and physical activity	

ATTACHMENT B

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

[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

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;
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.