Implementation Plan for Healthy Children

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 the State of Victoria, represented by the Hon. David Davis MLC, Minister for Health (known as the Parties to this Implementation Plan).

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

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

7. 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

8. The maximum possible financial contribution to be provided by the Commonwealth as facilitation payments for the Healthy Children initiative is $59.41 million.

9. The maximum possible financial contribution to be provided by the Commonwealth as reward payments for the National Partnership is $37.43 million. Reward payments will be made following the COAG Reform Council's assessment of Victoria'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	$7.83
(ii)	Facilitation payment	June 2012	$10.64
(iii)	Facilitation payment	July 2012	$5.83
(iv)	Facilitation payment	July 2013	$7.02
(v)	Facilitation payment	July 2014	$7.02
(vi)	Facilitation payment	July 2015	$7.02
(vii)	Facilitation payment	July 2016	$7.02
(viii)	Facilitation payment	July 2017	$7.03
Reward Payment for NPAPH		Due date	Amount
(ix)	Reward payment	2016-2017	$18.72
(x)	Reward payment	2017-2018	$18.72

OVERALL BUDGET

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

Table 2: Overall program budget ($ million)

Expenditure item		2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total
(i)	Health promoting early childhood services & schools	0.500	1.250	3.549	3.646	3.814	1.327	1.340	15.426
(ii)	Healthy children and families as part of communities	2.848	7.068	7.886	7.802	6.210	6.080	6.093	43.987
TOTAL		$3.348	$8.318	$11.435	$11.448	$10.024	$7.407	$7.433	$59.413

Notes: A facilitation payment (Healthy Workers and Healthy Children) on the 29 June 2012 of $20 million will be allocated across 2012-18 to matched planned expenditure.

11. 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

12. **Program name:** Healthy children, families and communities

13. The objective in this program is to support health promoting early childhood services, schools and communities to increase fruit and vegetable consumption and physical activity rates in children, adolescents and families.

14. Healthy children, families and communities are inclusive of the following activities. These activities build on and continue the work already commenced and approved under the National Partnership to create a dynamic and integrated preventive health system at a statewide and local level.

Activity 1: Health promoting early childhood services and schools

Activity 2: Healthy children and families as part of communities (Healthy Together Communities - HTC)

15. The senior contact officer for this program is Dr Shelley Bowen, Senior Public Health Advisor, Department of Health Victoria (t: 03 9096 5209 e: shelley.bowen@health.vic.gov.au).

ACTIVITY DETAILS

16. **Activity 1:** Health promoting early childhood services and schools

17. **Overview:** The Department of Health is building a dynamic health and wellbeing system in Victoria to support healthy choices where people live, learn, work and play. A range of statewide initiatives (see below) will be supported through existing statewide policies and strategies including the *Victorian Public Health and Wellbeing Plan 2011 – 2015*, the *Victorian Aboriginal Nutrition and Physical Activity Strategy*, and the *Victorian Healthy Eating Enterprise* (VHEE) which aims to build a vibrant healthy eating culture in Victoria. A Healthy Together Healthy Food Charter aims to ensure consistency of healthy eating messages across VHEE initiatives.

    Further, a new Victorian policy that sets the direction for government and its partners to promote the health of children and young people will support the following statewide initiatives:

    - The **Healthy Together Achievement Program** (Achievement Program) supports early childhood services and schools to create healthy environments for learning and recognises their achievements in promoting health and wellbeing. Benchmarks guide quality health promotion practice in priority areas including healthy eating and oral health, and physical activity. An early childhood service or school will be recognised when benchmarks for a health priority has been achieved.

      Early childhood services and schools will receive guidance to support implementation through 'how to' tools and resources, phone enquiry line and email advice, professional development, online network and website.

      The Healthy Together Healthy Eating Advisory Service (HEAS) provides healthy eating and nutrition advice and menu assessment services to schools, early childhood services, workplaces and hospitals. The service assists schools in meeting the *School Canteens and Other School Food Services Policy* and supports settings to work towards achieving the healthy eating and oral health benchmarks of the Achievement Program. It will also support Victorian hospitals in implementing the *Healthy Choices: food and drink guidelines for Victorian public hospitals.*

    - The provision of **Healthy Living Programs and Strategies** designed for young people and families such as healthy living web 2.0, for example online tools and advice to support healthy living through the Better Health Channel and Jamie's Ministry of Food (fixed kitchen).

    - A statewide **social marketing campaign** focused on increasing the fruit and vegetable consumption and physical activity of families.

18. **Outputs:**

Output	**Quantity**	**Quality**	**Timeframe**
Number of early childhood services and schools participating in the Achievement Program	75% of all primary schools 30% of all secondary schools 75% of eligible early childhood education and care services	See evaluation, outcomes & performance benchmark measurement.	2017-18

19. **Outcomes:**

Activity	**Long term outcomes (2017/18) ***
Activity 1: Health promoting early childhood services and schools	• Proportion of children at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by children to meet targets • Increase in proportion of children participating in moderate physical activity each day by 15 per cent

* see NPAPH Performance Benchmarks for details

20. **Rationale:** Victoria is taking an innovative systems-building approach to prevention. It is utilising systems theory to establish the building blocks of a preventive health system and design comprehensive initiatives that target all levels of the system.

A social ecological systems model lies at the heart of Victoria's prevention strategy, supporting a range of complementary health promoting initiatives which are supported by appropriate policies and programs delivered at different levels within the system: statewide, settings and communities.

The initiatives detailed are evidence based and shift effort from less effective approaches (fragmented short-term projects) to those that have the potential for greater population impact. The Achievement Program is based on the World Health Organization's Health Promoting Schools model. It shows how schools can take a whole school approach to working towards meeting benchmarks for health priority areas such as healthy eating and oral health, physical activity, tobacco control and alcohol and other drug use.

The Health Promoting Schools model (www.iuhpe.org) recognises that schools are complex organisations and encourages schools to take a whole-of-school approach to implement changes in the curriculum, teaching and learning environment; support school organisation, culture and policy and physical environment; and through partnership activities with parents and the community.

There is strong evidence that the health promoting schools approach is effective in improving health and educational outcomes. The health promoting schools approach can impact on health and wellbeing especially in the areas of nutrition and physical activity, contributes to the development of individual skills and factors in the school environment such as healthy policies and school culture, and enhances parental participation in the school community (Stewart-Brown, 2006).

Evaluation of school programs in Victoria such as Kids Go For Your Life (Prosse et al, 2009), Romp n Chomp (de Silva-Sangorski et al, 2010), Fun N Healthy in Moreland (unpublished) indicate the effectiveness of the health promoting schools model. Rather than a number of disparate programs, the Achievement Program creates a streamlined program that maximises the synergies and minimises cost of these activities.

The current Victorian government funded HEAS has been identified as essential to support the implementation of the Achievement Program. A review of the advisory service model and its work in supporting the Department of Education and Early Childhood Development (DEECD) healthy canteens policy showed it had facilitated significant improvements in healthy food provision in primary schools (unpublished). The review concluded that this advisory service model could be applied to other nutrition programs and healthy food supply strategies such as expansion to early childhood services and secondary schools. As a result, a comprehensive

advisory service, the Healthy Together Healthy Eating Advisory Service (HEAS), was established.

References:

de Silva-Sanigorski A, Bell AC, Kremer P, Nichols M, Crellin M, Simth M, Sharp S, de Groot F, Carpenter L, Boak R, Robertson N, Swimburne B. Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. American Journal of Clinical Nutrition 2010; 91: 831-840.

Prosse L, de Silva-Sanigorski A, Carpenter L, Hoinsett S, Gibbs L, Swinburne B, Waters E. Evaluation of the Kids – 'Go for your life' intervention in Australia primary schools. 2009. Report to the Department of Health.

Stewart-Brown S. 2006. What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promotion schools approach? Copenhagen, WHO Regional Office for Europe (Health Evidence Network report; wwww.euro.who.int/document/e88185.pdf).

21. **Contribution to performance benchmarks:** See logic map attached (attachment A).

22. **Policy consistency:** *NPAPH and Healthy Children Scoping Statement and Guiding Policy Principles (Attachment B).*

    Health promoting early childhood services and schools is consistent with the objectives of the NPAPH to improve nutrition and increase levels of physical activity in children. It is also consistent with the outputs, scope and policy principles of the Healthy Children initiative as detailed in the Healthy Children Scoping Statement and Guiding Policy Principles.

    This activity is consistent with broader Victorian preventive health reforms, preventive health policies and specific directions in healthy children.

23. **Target group(s):** 2525 eligible early childhood services and 2238 primary and secondary schools across the state (as at July 2012).

24. **Stakeholder engagement:** The initiatives build on and continue the work already commenced and approved under the National Partnership.

    A Steering Group jointly chaired by Department of Education and Early Childhood Development (DEECD) and Department of Health (DH), with membership involving Department of Human Services (DHS), Department of Planning and Community Development (DPCD), non-government and independent schools and the Municipal Association of Victoria guides the work under the Healthy Children initiative of the National Partnership.

    A broad range of stakeholders were consulted and engaged in the development of the initiatives.

    A Partnership and Engagement Strategy has been developed to ensure a stronger engagement and collaboration with partners and key stakeholders to align policy and programs and deliver shared goals to shape the prevention system in Victoria and deliver better health outcomes.

25. **Risk identification and management:**

Risk	**Level**	**Mitigation strategy**	**Responsibility/timeline**
The engagement of early childhood services and schools in the Achievement Program	L-M	DH staff position that jointly sits with DEECD. The Achievement Program developed to support and align with the National Quality Standards and school strategic planning. External agency contracted to undertake communication and engagement and support schools and services to implement the Achievement Program (website, e-newsletters, networks, forums etc). Communication and engagement strategy developed and updated regularly. Secondary schools are a new initiative and will be piloted prior to statewide roll-out.	Prevention and Population Health Branch (PPHB)
NGOs continuing to work in a traditional programmatic approach	M	Whole system methods established to support statewide NGOs as part of a system (eg meeting differently). Ongoing feedback and assessment at state and local level (eg system inventory and assessment).	PPHB and the Centre of Excellence in Intervention and Prevention Science (CEIPS)

26. **Evaluation:**

Activity	**Methodology**	**Timeframe**
Activity 1: Health promoting early childhood services and schools As Healthy Children's activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Children Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it.	Modelled National Health Survey and enhanced Victorian Population Health Survey (VPHS). Process review and discrete program level evaluation in the Healthy Together Communities (HTC) areas have been designed to provide lessons learnt/ insights. Supplementary school and service-based Achievement Program data is being investigated.	The modelled Victorian baseline from the 07/08 NHS and enhanced VPHS 2016 and 2017 will provide statewide outcomes data for children specifically. Supplementary school and service-based Achievement Program evaluation data collected in HTC areas and statewide.

27. **Infrastructure:** Not applicable. Infrastructure funded under the NPAPH has been detailed under each activity.

28. **Implementation schedule:**

Table 3: Implementation schedule

Deliverables and milestones	**Due Date**
(i) Engagement and support of early childhood services and schools in the Achievement Program including provision of resources, advice and network	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(ii) Healthy Living Programs and Strategies provided	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(iii) Social marketing campaign delivered	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018

29. **Responsible officer and contact details:** Dr Shelley Bowen, Senior Public Health Advisor, Department of Health Victoria (t: 03 9096 5209 e: shelley.bowen@health.vic.gov.au).

30. **Activity budget:**

Table 4: Activity project budget ($ million)

Expenditure item	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total
(iv) Healthy Together Achievement Program								
(v) Healthy Living Programs and Strategies								
(vi) Social marketing campaign								
(vii) Evaluation								
TOTAL	0.500	1.250	3.549	3.646	3.814	1.327	1.340	15.426

31. **Activity 2:** Healthy children and families as part of communities (Healthy Together Communities - HTC). Note: HTC was previously delivered under the Prevention Community Model banner.

32. **Overview:** The HTC strategy is defined as a whole of community and complex community-level system building effort to raise the profile of and demand for good health. Its business is to create multiple health promoting environments. The HTC strategy is surrounded and supported by a multi-level prevention system building effort across Victoria.

The HTC strategy brings together local stakeholders and communities to develop local solutions to promote health and wellbeing by using local partnerships and a skilled health promotion workforce to design and deliver tailored programs and initiatives. This involves working with local communities, schools and workplaces to take action on health, that is, improving people's health where they live, learn, work and play.

The HTC builds on existing health promotion efforts in a select number of communities through the provision of:

- A new prevention workforce and leadership and workforce development strategy.
- Tailored interventions at the community level, including healthy living programs that encourage community participation in prevention, as well as strategies that create environments that encourage and support healthy living such as Healthy Together Health Champions, Jamie's Ministry of Food mobile kitchen, Healthy Food Connect, Healthy Food Recovery, Healthy Eating and Food Literacy in Secondary Schools and Healthy by Design.
- Innovative local community engagement and social marketing (healthy eating and physical activity messages)
- Statewide initiatives and social marketing to support healthy lifestyles such as Healthy Together Achievement Program and Healthy Together Healthy Eating Advisory Service.
- Research and evaluation support via the Centre of Excellence in Intervention and Prevention Science (CEIPS)

The *Working together towards healthier communities: Joint statement of commitment to prevention* (www.health.vic.gov.au/prevention) articulates the agreement between all levels of government to participate in the implementation of the HTC strategy.

Operating across the municipalities of: Hume, Wyndham, Whittlesea, Knox, Greater Dandenong, Cardinia Shire, Mildura, Greater Bendigo, Wodonga, Latrobe, Greater Geelong, Ararat, Pyrenees and Central Goldfields, Healthy Together Communities will reach approximately 1.3 million Victorians, 520 schools, 938 early childhood services and 4,409 medium to large workplaces.

33. **Outputs:**

Output	**Quantity**	**Quality**	**Timeframe**
Activity 2: Healthy children and families as part of communities (HTC)	12 prevention areas (across 14 local government areas).	See evaluation, outcomes & performance benchmark measurement.	2017/18

34. **Outcomes:**

Activity	**Long term outcomes (2017/18) ***
Activity 2: Healthy children and families as part of communities (HTC)	• Proportion of children at healthy weight returned to 2008 baseline. • Increase in daily serves of fruits and vegetables consumed by children to meet targets • Increase in proportion of children participating in moderate physical activity each day by 15 per cent

* see NPAPH Performance Benchmarks for details

35. **Rationale:** Victoria is taking an innovative systems-building approach to prevention. It is utilising systems theory to establish the building blocks of a preventive health system and design comprehensive initiatives that target all levels of the system: statewide, settings and communities.

The HTC approach is a whole of community and complex community level system building effort. This approach recognises that early childhood services and schools are one setting within a community to improve children's health and action within an early childhood service or school must be replicated across the community. It acknowledges that children are part of a family and the broader community and reinforcing health promoting approaches across a range of settings and in the community will have greater effect.

Birch and Ventura (2009) found that school-only based interventions had little success and in those that did show significant effects, the effect sizes are small compared to relative population level increases in obesity. A social ecological model highlights that a child's weight status is influenced by a range of factors and schools are only one of several contexts for change. This model highlights that preventive health interventions should be implemented across the multiple contexts that can influence a child's eating, activity and weight. In addition to schools, other contexts include home, family and community.

The UK Foresight report on obesity defined school based only interventions as failing to address the systemic drivers of chronic disease in a concerted and coordinated manner and what is needed is a 'whole of systems' approach (Foresight, 2007). For example, action in one part of the system

(eg encouraging school children to have a healthy lunch) can be undermined by the actions in other parts of the system (eg price of fast food located close to the school).

The HTC strategy builds on community-level interventions in preventive health across Australia and internationally such as *Colac Be Active Eat Well in Victoria* (Sanigorski et al, 2008), *EPODE* in France (Roman et al, 2009), *OPAL* (Obesity Prevention and Lifestyle) in South Australia, *Healthy Weight, Healthy Lives* in the UK and *Communities Putting Prevention to Work* in the USA.

The Victorian Department of Health (Centre for Allied Health, 2009) commissioned a rapid review of the research evidence on community level interventions to reduce obesity which supports their effectiveness when based on the following core elements: integrated and comprehensive program, across multiple settings; using multiple interventions, targeting change at the individual, group and organisation levels; involves the community in planning, implementation and evaluation, and; uses multiple individual-level intervention strategies.

The HTC strategy has been developed in recognition that local governments have a legislated responsibility for the health and wellbeing of their community and are ideally placed to lead local policies that influence the many determinants of health. Further, experience that has shown that spreading resources too thinly over too short a period of time has little impact (Hawe et al, 2009; Foresight, 2007). Victoria's prevention effort is therefore focused on providing a concentrated, well-resourced prevention effort in selected communities to build a preventive health system at the local level.

References:

Birch LL, Ventura AK. Preventing childhood obesity: what works? International Journal of Obesity 2009; 33: 74-81.

Cross-Government Obesity Unit, Department of Health and Department of Children, Schools and Families. 2008. Healthy Weight, Healthy Lives: a Cross –Government Strategy for England. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_084024.pdf

Foresight. 2007. Tackling obesities: future choices-project report. London: The Stationery Office. http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities/reports-and-publications

Hawe P, Shiell A, Riley T. Theorising interventions as events in the systems. American Journal of Community Psychology 2009; 43: 267-276.

Romon M, Lommez A, Tafflet M, Basdevant A, Oppert JM, Bresson JL, Ducimetière P, Charles MA, Borys JM. Downward trends in the prevalence of childhood overweight in the setting of 12-year school- and community-based programmes. Public Health Nutrition 2009; 12(10): 1735-42.

Sanigorski AM, Bell AC, Kremer PF, Cuttler R, Swinburn BA. Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. International Journal of Obesity. 2008; 79: 1-8.

The Centre for Allied Health Evidence. 2009. Community-based interventions: A rapid review. A technical report prepared for Department of Health, Victoria. http://www.health.vic.gov.au/healthpromotion/downloads/cbi_full_report_final.pdf

US Department of Health and Human Services. 2010. Communities Putting Prevention to Work. www.cdc.gov/chronicdisease/recovery/

36. **Contribution to performance benchmarks:** See logic map attached (attachment A).

37. **Policy consistency:** *NPAPH and Healthy Children Scoping Statement and Guiding Policy Principles (Attachment B).*

    Health promoting early childhood services and schools is consistent with the objectives of the NPAPH to improve nutrition and increase levels of physical activity in children. It is also consistent with the outputs, scope and policy principles of the Healthy Children initiative as detailed in the Healthy Children Scoping Statement and Guiding Policy Principles.

    This activity is consistent with broader Victorian preventive health reforms, preventive health policies and specific directions in healthy children.

38. **Target group(s):** The HTC strategy funds 14 Local Government Areas (or 12 Prevention Areas) and reaches approximately 1.3 million Victorians, comprising approximately 520 schools, 938 early childhood services, and 4,409 medium-large workplaces/businesses (20 plus employees).

39. **Stakeholder engagement:** The initiatives build on and continue the work already commenced and approved under the National Partnership. Extensive engagement and consultation of key stakeholders was undertaken in the development of the HTC strategy.

    A Partnership and Engagement Strategy has been developed to ensure a stronger engagement and collaboration with partners and key stakeholders to align policy and programs and deliver shared goals to shape the prevention system in Victoria and deliver better health outcomes.

40. **Risk identification and management:**

Risk	**Level**	**Mitigation strategy**	**Responsibility/timeline**
Staff turnover and knowledge retention	L	Knowledge retained in prevention team. Documented knowledge in system inventory and assessments, event logs and case studies.	PPHB, CEIPS and HTCs
Continuing to work in a traditional programmatic approach	M	Whole system methods established to support HTC workforce to think and act systems (eg networks of practice, workforce development, leadership for prevention initiative). DH participating on all HTC governance groups to ensure integrity. Ongoing feedback and assessment at state and local level (eg system inventory and assessment).	PPHB, CEIPS and HTCs

41. **Evaluation:**

Activity	Methodology	Timeframe
Activity 2: Healthy children and families as part of communities (HTC) As Healthy Children activities are collectively intended to contribute to outcomes shared by all other NPAPH initiatives, the evaluation of Healthy Children Victoria will necessarily be a component of a broader Victorian evaluation strategy and will contribute to it.	In addition to the existing 2008 and 2011 VPHS-LGA behavioural measures of adults and parents, a baseline survey in 2012 (CATI), will cover key behavioural mediator variables (not currently measured) such as attitudes, self-efficacy and intentions. These measures will be taken in HTCs, and selected comparison communities to create a quasi-experimental design, to allow for assessment of both between area and within area effects between 2012 and 2015. Process review and discrete program level evaluation in the HTCs have been designed to provide lessons learnt/ insights. Supplementary school and service-based Achievement Program data is being investigated.	2018 parent baseline using VPHS-LGA (HTC areas). 2011, 2014 and 2017 post-test using VPHS-LGA 2012 baseline mediator CATI survey in HTC areas and comparison areas. 2015 post-test mediator CATI survey in HTC areas and comparison areas. 2011-2017 qualitative process review and case studies (a component of a community-wide evaluation to be undertaken with HTC areas) Supplementary school and service-based Achievement Program evaluation data collected in HTC areas and statewide. 2016/2017 evaluation report and peer-reviewed publications

42. **Infrastructure:** Not applicable. Infrastructure funded under the NPAPH has been detailed under each activity.

43. **Implementation schedule:**

Table 3: Implementation schedule

Deliverables and milestones	Due Date
(i) Prevention workforce engaged and maintained	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(ii) Leadership and workforce development strategy delivered	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(iii) Healthy Living Programs and Strategies provided	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018
(iv) Local community engagement and social marketing delivered	Annual reporting by 31 August 2012, 2013, 2014, 2015, 2016, 2017 and 2018

44. **Responsible officer and contact details:** Dr Shelley Bowen, Senior Public Health Advisor, Department of Health Victoria (t: 03 9096 5209 e: shelley.bowen@health.vic.gov.au).

45. **Activity budget:**

Table 4: Activity project budget ($ million)

Expenditure item	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	Total
(i) Prevention workforce								
(ii) Leadership and workforce development								
(iii) Healthy Living Programs and Strategies								
(iv) Community engagement and social marketing								
(v) Evaluation								
TOTAL	2.848	7.068	7.886	7.802	6.210	6.080	6.093	43.987

NA = Funded from NPAPH Social Marketing and Enabling Infrastructure programs

ROLES AND RESPONSIBILITIES

Role of the Commonwealth

46. 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

47. 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.

48. The State agrees to participate in the Implementation Working Group and 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

49. 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.

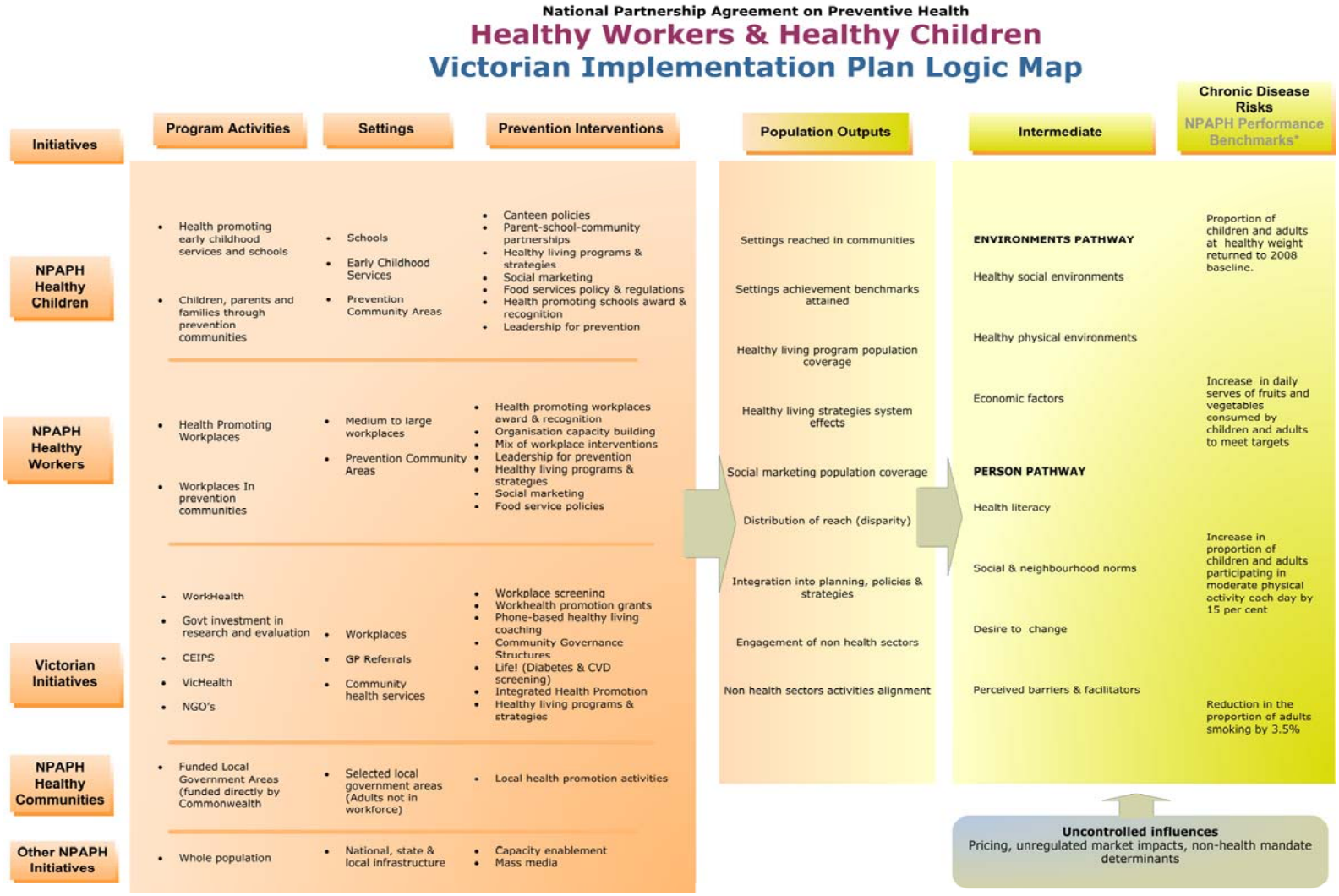
    f) Increase in proportion of adults participating in at least 30 minutes of moderate physical activity on five or more days of the week of 5 per cent from baseline for each state by 2016; 15 per cent from baseline by 2018.

    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.

50. The requirements of performance reports will be mutually agreed following confirmation of the specifications for measuring performance benchmarks by the Standing Council on Health.

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

ATTACHMENT A: LOGIC MAP



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 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;

[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 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.

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

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

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.