

# Implementation Plan for the Healthy Children initiative

## NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

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

### PRELIMINARIES

1. This Implementation Plan is created subject to the provisions of the National Partnership Agreement on Preventive Health and should be read in conjunction with that Agreement (see Attachment A). The objective in the National Partnership is to address the rising prevalence of lifestyle related chronic diseases, by:
  - 1.1 laying the foundations for healthy behaviours in the daily lives of Australians through social marketing efforts and the national roll out of programs supporting healthy lifestyles; and
  - 1.2 supporting these programs and the subsequent evolution of policy with the enabling infrastructure for evidence-based policy design and coordinated implementation.

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

2. The Healthy Children initiative provides funding to support implementation of healthy lifestyle programs in childhood settings across Australia.
3. Under the Healthy Children initiative jurisdictions are responsible for developing programs that may include a range of different activities. Some of these activities may be grouped according to similarities.

### TERMS OF THIS IMPLEMENTATION PLAN

4. This Implementation Plan will commence as soon as it is agreed between the Commonwealth of Australia, represented by the Minister for Health and Ageing, and the State of South Australia, represented by the Minister for Health [or the position of the Minister's authorised delegate] (known as the Parties to this Implementation Plan).
5. This Implementation Plan may be varied by written agreement between authorised delegates.

6. This Implementation Plan will cease on completion of the specified program, including the acceptance of final performance program reporting and processing of final payments against performance benchmarks specified in this Implementation Plan.
7. Either Party may terminate this agreement by providing *30 days* notice in writing. Where this Implementation Plan is terminated, the Commonwealth's liability to make payments to the 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 for the Healthy Children initiative is *[the Commonwealth will insert the maximum possible funding allocated for your jurisdiction]*. Payments will be structured as 50 percent facilitation and 50 percent reward. The reward payments are conditional on achievement against performance benchmarks specified in the National Partnership.
10. Facilitation payments will be payable in accordance with Table 1 from July 2011 to 2014 in accordance with the National Partnership. All payments are exclusive of GST.

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

| <b>Facilitation Payment</b> | <b>Due date</b> | <b>Amount</b> |
|-----------------------------|-----------------|---------------|
| (i) Facilitation payment    | July 2011       | \$2.32        |
| (ii) Facilitation payment   | July 2012       | \$4.63        |
| (iii) Facilitation payment  | July 2013       | \$2.30        |
| (iv) Facilitation payment   | July 2014       | \$2.36        |
| <b>Reward Payment *</b>     | <b>Due date</b> | <b>Amount</b> |
| (i) Reward payment          | 2013-2014       | \$4.65        |
| (ii) Reward payment         | 2014-2015       | \$6.97        |

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

11. Any Commonwealth financial contribution payable will be processed by the Commonwealth Treasury and paid to the 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 (exclusive of GST) is set out in Table 2.

**Table 2: Overall program budget (\$ million)**

| Expenditure item          | Year 1  | Year 2        | Year 3        | Year 4        | Total         |
|---------------------------|---|---------------|---------------|---------------|---------------|
| (i) OPAL IMPLEMENTATION   | \$5.63  | \$6.89        | \$7.00        | \$5.58        | \$25.1        |
| (ii) COPAL IMPLEMENTATION | Budget not included – cost recovered from NT –<br>see NT submission for details |               |               |               |               |
| <b>TOTAL</b>              | <b>\$5.63</b>   | <b>\$6.89</b> | <b>\$7.00</b> | <b>\$5.58</b> | <b>\$25.1</b> |

OPAL is a joint Federal and State funded initiative. The cost of implementing OPAL exceeds the Federal payments under the National Partnership Agreement on Preventive Health for Healthy Children. The differences in funding between the figures in Table 1 (Federal payments) and the figures in Table 2 (Overall program budget) will be made up by the South Australian Government in delivering OPAL over the course of the program.

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

## PROGRAM OVERVIEW AND OBJECTIVE

14. OPAL (Obesity Prevention and Lifestyle)

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

16. OPAL is inclusive of the following activities:

a) OPAL IMPLEMENTATION

b) COPAL IMPLEMENTATION – Please note, as simply an additional OPAL site, this activity is listed but not ‘unpacked’. Northern Territory will provide the detail around this activity and South Australia will liaise to ensure both jurisdictions are able to deliver on OPAL/COPAL. Discussions with Northern Territory are underway to include Palmerston, a ‘satellite city’ of Darwin, in the OPAL program. Should this bid by the Northern Territory be successful as part of the Healthy Children Initiative, it will likely be called COPAL(Children’s Obesity Prevention and Lifestyle).

17. The senior contact officer for this program is Director Health Promotion Branch, Statewide Service Strategy, SA Health. Telephone: (618) 8226 6432; Fax: (618) 8226 6133; Mobile: 0423 029 991; Email: hpb@health.sa.gov.au

## ACTIVITY DETAILS

### OPAL Implementation

- 18. Overview:** OPAL is a community-based, childhood obesity prevention program based on the successful French program EPODE (*Together we can prevent childhood obesity*). OPAL commenced in 2009 and works across multiple sites, sectors, settings and employs a wide range of strategies to bring about healthy lifestyle changes. It will build community capacity, supporting programs and initiatives already working toward increasing healthy weight and developing programs, policy and environments that are supportive of healthy eating and physical activity. It will especially focus on those in greatest need – for example those of lower SES, Indigenous, culturally diverse, regional and remote communities.

Twenty South Australian communities of up to 40,000 residents in each will participate in OPAL from 2009 – 2017. OPAL, through Councils, will support interventions in each community for a period of five years. In the first year (2009) six Councils commenced OPAL which has been followed by four more Councils in 2010. A further ten South Australian Councils will follow in the next two years – five in each of 2011 and 2012. The Northern Territory COPAL community of Palmerston will commence in 2011 and will in effect become the 21<sup>st</sup> ‘OPAL’ community.

OPAL is funded by all three tiers of government and is implemented via a State Coordination Unit and Local Council Teams (a manager and support officer). The State Coordination Unit provides strategic direction, coordinated social marketing and evaluation. The Local Council Teams coordinate community action. Local Council Teams (LCTs) are based within councils which are selected according to community need with a particular focus on demographic characteristics around weight status, number of children and SEIFA score. OPAL LCTs have a dedicated operating budget of \$75,000 per year applied through a range of strategies, to bring about change in the community

At the heart of trying to make a difference to children in OPAL communities are families, with parents and care givers playing a pivotal role in decision making around opportunities for healthy eating and physical activity. OPAL’s innovative social marketing includes a twice yearly thematic approach to promoting healthy behaviours and environments (e.g. promoting water in place of sweet drinks).

OPAL is underpinned by the best available evidence and indeed OPAL’s comprehensive evaluation will significantly contribute to international understanding of how to address overweight and obesity. Providing evaluation advice is the Ministerially appointed OPAL Scientific Advisory Committee (SAC) consisting of 16 leading South Australian academics and chaired by Professor Boyd Swinburn (see Attachment 1). Further and different advice pertaining to the implementation of OPAL is being provided by another Ministerially appointed group, the OPAL Strategic Advisory Committee (see Attachment 2) chaired by Ms Brenda Kuhr.

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

19. **Outputs:** For the outputs and outcomes, please see the attached Logic Model and associated discussion by which OPAL is framing its evaluation. (See Attachments 3, 4 and 5) The following table summarises outputs:

| <b>Year</b> | <b>Output</b>   |
|-------------|---|
| 2011-12     | State level   |
|             | Five additional councils as OPAL sites – staff and contracts in place                                     |
|             | Local plans developed for each site – indicating the range of interventions to be undertaken at each site |
|             | Ten existing councils supported.  |
|             | NT COPAL site commences   |
|             | Comprehensive training sessions for all staff (2x/year minimum)   |
|             | Social marketing – 2 themes developed and conducted in financial year                                     |
|             | Support and take advice from Scientific Advisory Committee  |
|             | Support and take advice from Strategic Advisory Committee   |
|             | Administer OPAL evaluation framework (see OPAL Evaluation Research Design – attachment 5)                 |
|             | Audit new OPAL council regions (HE and PA initiatives/environments)                                       |
|             | Establish local OPAL plans in new Councils  |
|             | Establish local advisory groups in each new OPAL council  |
|             | Commence interventions/implementation of plans including theme use  |
|             | Quarterly reports due for payments  |
| 2012-13     | AS ABOVE  |
| 2013-14     | AS ABOVE but without new OPAL Councils – limit of 20 reached (+NT sites?)                                 |
| 2014-15     | AS ABOVE but without new OPAL Councils – limit of 20 reached  |

20. **Outcomes:** For the outputs and outcomes, please see the attached Logic Model and associated discussion. (See Attachments 3, 4 and 5).

| Year      | Term   | Outcome  |
|-----------|--------|--|
| July 2012 | Short  | Increased awareness of healthy eating and physical activity messages                       |
| July 2013 | Medium | Increased opportunities to participate in a range of physical activities                   |
|           |        | Increased opportunities for children to access healthy meals                               |
|           |        | Improved attitudes to healthy eating and physical activity                                 |
| July 2014 | Long   | Increased intake of fruit and vegetables by children                                       |
|           |        | Increased proportion of children participating in at least 60 minutes of physical activity |
|           |        | Reduced rate of increase in childhood overweight and obesity                               |

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

At the same time overweight and obesity is an issue, so too are low levels of fruit and vegetable consumption and insufficient physical activity (see tables C-E). As weight mediators, these behaviours and the social norms that underpin them must be addressed. These are however complex societal and health issues and as such require solutions that account for the range of challenges surrounding unhealthy weight. And whilst these health risks exist, they are not evenly spread across the population – increased weight, unhealthy eating and less physical activity are skewed to those people experiencing greater disadvantage.

OPAL is a community-based, childhood obesity-prevention initiative that is founded on the best available evidence and based on EPODE. The French model that commenced in the North of France in 1992 as a trial became EPODE in 2004. It has demonstrated promising results, adopting a socio-ecological approach to bringing about weight change in populations. On the world stage, EPODE is one of few community interventions that is scaleable and transferable – being relevant to different sizes and types of populations.

The results of EPODE are encouraging, with the most recent trial of 8 sites demonstrating a significant shift in overweight and obesity, from 20.57% to 18.83% between 2005 and 2009.

In 2007, the Hon John Hill MP, Minister for Health, South Australia, visited France and saw the potential for working with the EPODE international community (now includes: France, Greece, Belgium, Spain, Mexico and South Australia). In 2009 South Australia commenced the implementation of OPAL with full support from Cabinet and with the Hon Nicola Roxon MP, Federal Minister for Health and Ageing committing 'Healthy Children' funding (see Attachment 6). The uptake by Councils in South Australia has resulted in an exciting tri level government partnership focusing on childhood obesity prevention.

The multiple government partnership approach is a good example of 'value add'. Pooled resources applied through the 'hub of communities' – local government – will ensure funding is used effectively, avoiding duplication. The investment across government levels will support an increased dose of existing programs in OPAL areas.

OPAL adopts and adapts the EPODE methodology. The four pillars of EPODE remain central in OPAL application – political support, innovative social marketing, excellent evidence base, and partnerships.

The agreement between the South Australian Minister for Health and Proteines Pty Ltd, the parent company administering EPODE, allows for OPAL to expand across South Australia. A progressive roll-out of OPAL will occur between 2009 and 2012, with 20 OPAL communities joining the program in that time. Each Council will receive 5 years of support to implement OPAL. The final year therefore of OPAL will be 2017.

Discussions with Northern Territory are underway to include Palmerston, a ‘satellite city’ of Darwin, in the OPAL program. Should this bid by the Northern Territory be successful as part of the Healthy Children Initiative, it will likely be called COPAL (Children’s Obesity Prevention and Lifestyle). South Australia has the capacity to support COPAL according to preliminary discussions and costings.

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

- a) A systematic, evidence-based, internationally recognised, **best practice model** for children’s obesity prevention with a responsibility to target resources to those in greatest need
- b) A **sensible and flexible framework** for applying existing healthy lifestyle programs, policies and campaigns in communities
- c) **Significant funding** input from the State Government and additional funds contributed by each of 20 local governments to address childhood obesity (plus NT, COPAL investment)
- d) An approach that **unites the agendas** of federal, state and local governments and value adds to existing efforts
- e) A **transferable and scaleable** model that has potential to be administered in a range of sites across Australia
- f) A program designed to **contribute to understanding** – with a multi-million dollar evaluation framework over the length of the program

**NB Should the following data sources be used, potential benchmarks are indicated as a guide only.**

**Table A: BMI categories, children aged 5-17 years**

| BMI categories                          | 2004-05 |      | 2005-06 |      | 2006-07 |      | 2007-08 |      | 2008-09 |      | 2013 | 2015 |
|---|---------|------|---------|------|---------|------|---------|------|---------|------|------|------|
|   | n       | %    | n       | %    | n       | %    | n       | %    | n       | %    | %    | %    |
| Normal                                  | 610     | 70.4 | 726     | 73.5 | 562     | 73.6 | 724     | 73.7 | 857     | 77.5 |      |      |
| Overweight                              | 193     | 22.2 | 162     | 16.4 | 147     | 19.3 | 208     | 21.2 | 199     | 18.0 |      |      |
| Obese                                   | 64      | 7.4  | 100     | 10.1 | 54      | 7.1  | 50      | 5.1  | 50      | 4.5  |      |      |
| Unhealthy weight (overweight and obese) | 257     | 29.6 | 262     | 26.5 | 201     | 26.4 | 258     | 26.3 | 249     | 22.5 | 23.6 | 22.5 |

Data source: SAMSS July 2004 – June 2009. Data are self-reported (CATI),parents report on children’s behalf up to the age of 15, children aged 16+ self-report.

**Table B: Unhealthy weight, children aged 4 years by year**

|   | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2013 | 2015 |
|---|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|
| <b>Unhealthy weight (over-weight and obese) (%)</b> | 11.7 | 13.6 | 15.9 | 18.1 | 19.0 | 18.2 | 17.8 | 19.4 | 20.1 | 20.0 | 19.9 | 19.6 | 18.8 | 19.5 | 20.9 | 19.9 |

Data source: Children, Youth and Women's Health Service.

**Table C: Mean serves of fruit per day, for children aged 5-17 years**

|                    | 2002-03 | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2013 | 2015 |
|--------------------|---------|---------|---------|---------|---------|---------|---------|------|------|
| <b>Mean serves</b> | 1.72    | 1.71    | 1.71    | 1.77    | 1.77    | 1.80    | 1.86    | 2.06 | 2.46 |

Data source: SAMSS July 2004 – June 2009. Data are self-reported (CATI),parents report on children's behalf up to the age of 15, children aged 16+ self-report.

**Table D: Mean serves of vegetables per day, for children aged 5-17 years**

|                    | 2002-03 | 2003-04 | 2004-05 | 2005-06 | 2006-07 | 2007-08 | 2008-09 | 2013 | 2015 |
|--------------------|---------|---------|---------|---------|---------|---------|---------|------|------|
| <b>Mean serves</b> | 1.96    | 2.11    | 2.11    | 2.36    | 2.21    | 2.29    | 2.34    | 2.84 | 3.84 |

Data source: SAMSS July 2004 – June 2009. Data are self-reported (CATI),parents report on children's behalf up to the age of 15, children aged 16+ self-report.

**Table E: The proportion of children aged 5 to 15 years undertaking at least 60 minutes of organised sport per day (South Australian data)**

|                    | 2002-03 |      | 2003-04 |     | 2004-05 |      | 2005-06 |      | 2006-07 |      | 2007-08 |      | 2008-09 |      | 2013 | 2015 |
|--------------------|---------|------|---------|-----|---------|------|---------|------|---------|------|---------|------|---------|------|------|------|
|                    | n       | %    | n       | %   | n       | %    | n       | %    | n       | %    | n       | %    | n       | %    | %    | %    |
| <b>60+ minutes</b> | 92      | 10.3 | 77      | 7.7 | 107     | 10.1 | 144     | 13.7 | 143     | 13.9 | 152     | 14.6 | 182     | 14.9 | 15.6 | 17.1 |

Data source: SAMSS July 2004 – June 2009. Data are self-reported (CATI),parents report on children's behalf up to the age of 15, children aged 16+ self-report.

22. **Contribution to performance benchmarks:** South Australia acknowledges the intention that:  
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 2013** and **31 December 2014**:

- a) *Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state **by 2013**; proportion of children at healthy weight returned to baseline level **by 2015**.*
- 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 2013**; 0.6 for fruits and 1.5 for vegetables **by 2015**.*
- 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 2013**; by 15 per cent **by 2015**.*

OPAL will focus resources within 20 South Australian communities to bring about positive changes in fruit and vegetable consumption and physical activity levels of children. It is anticipated that up to 25% of the South Australian population will be directly affected by OPAL. The impact of OPAL across selected communities will contribute to overall State levels of healthy weight, physical activity and healthy eating. These benchmarks will be addressed through OPAL's community-based and centrally-supported approach to obesity prevention and healthy lifestyles.

23. **Policy consistency:** OPAL will:

1. Do three things – **Promote, Partner and Generate**. It will promote existing quality programs. It will partner with organisations to enhance existing initiatives. And it will generate new initiatives where there is an identified need. At all points, OPAL will ensure consistency with federal and state policy, especially as it relates to the Health Children Initiative.
2. Emphasize the importance of **healthy lifestyles** promoting national and state healthy eating and physical activity guidelines. The State **social marketing** backdrop of “Go for 2 & 5”, breastfeeding and “be active” will be enhanced by 6 monthly OPAL themes focusing on complementary healthy eating and physical activity messages (e.g. promotion of water; decreasing screen time).
3. Support OPAL messages with a wide **range of interventions** that are safe, effective and consistent with and/or are drawn from:

The Eat Well Be Active Healthy Weight Strategy for South Australia 2006-10 (to be reviewed)

Physical Activity Strategy for South Australia

South Australia's Strategic Plan – targets include:

- T2.2 Healthy Weight
- T2.3 Sport & Recreation
- T2.5 Aboriginal Healthy Life Expectancy

4. Through a **settings based** approach, promote existing **key initiatives** within the State including but not limited to: Active travel, Be Active Play Time, Community Foodies, Crunch&Sip, Eat Well Be Active Primary Schools, Healthy Ways, Parenting Eating and Activity for Child Health (PEACH), Start Right Eat Right, Premier's be active Challenge, Right Bite Healthy Food and Drink Supply Strategy for South Australian Schools and

Preschools, Active After School Community Program, Healthy Eating and Physical Activity in the Early Years.

5. Ensure population **groups in greatest need** will be preferentially and appropriately addressed (see target groups below).
  6. Ensure all phases of OPAL are consistent with best practice **body image** policy and protocol.
24. **Target groups:** OPAL aims to improve eating and activity patterns of children, through families and communities in OPAL regions and thereby increase the proportion of 0-18 year olds in the healthy weight range.

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

OPAL target groups fall into several broad categories with a general focus on those in greatest need as reflected in low Socio-Economic-Suburbs (SES):

- Target 1:* Parents and caregivers (i.e. decision makers or gatekeepers for children)
- Target 2:* a) Children 0-5 years; b) children of primary school age; c) adolescents
- Target 3:* Organisations and institutions
- Target 4:* Indigenous
- Target 5:* Cultural groups
- Target 6:* Metro and country

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

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

**Adolescents** are to be addressed independently by OPAL as the most important influence in their lives is peers. As adolescents grow older (12 -18), parents play a progressively less critical role in what they eat and how they spend their leisure time where most physical activity occurs. EPODE concentrates on 5-12 year old children. South Australia will work with adolescents with the view that prevention of adult overweight and obesity requires a life course approach and should not stop short of the adult years.

**Primary aged children** (5-12 years) will be aware of OPAL in their community through positive, non-stigmatising healthy lifestyle messages and the bright and engaging OPAL brand. The detailed information behind the messages is, as has been described, aimed at adults. The healthy eating and physical activity programs and policies supported by OPAL and put in place by adults, will however be enacted by children.

Communities interact with a wide range of **organisations** from food retailers to healthcare providers, from schools to sporting clubs, and from local government to state government. OPAL will promote, partner and generate relevant initiatives with key organisations within OPAL communities. Given OPAL has a five year term in each community and given the quality of the OPAL staff\*, it is anticipated that fruitful partnerships will be formed with key organisations.

High **Indigenous** representation is a key criterion in the selection process for OPAL communities. Port Augusta was selected in part as an OPAL community as a result of a high Aboriginal population. OPAL will develop a tailored approach to addressing healthy weight with Indigenous

people. Similarly, identified *cultural groups* will receive tailored opportunities to engage in activities highlighted by OPAL messages.

OPAL communities will be drawn from the *city and country*. Of the 20 South Australian communities, it is anticipated 12 will be metropolitan based and eight from the country.

Overall numbers of target groups is not yet known as Local Councils enter a competitive tender process each year to be a part of OPAL. Hence half of the OPAL communities are as yet unknown.

\* OPAL staff in communities are employed as strategic operators, not as deliverers of sessions.

### ***Interventions and Social Marketing for Indigenous and Cultural Groups***

#### **State Coordination Unit**

The core social marketing resources are developed centrally by the SCU. The SCU is responsible for setting the strategic directions for the social marketing approach. These resources are developed with advice from SAC, STAC, Local Council Managers and Health Promotion Branch with a view to ensure they are suitable for use with across all population groups. Materials that are developed are focus-group tested with representative samples from the OPAL communities including Aboriginal groups, new arrivals and other cultural groups. The OPAL Strategic and Scientific Advisory Committees responsible for provision of advice on theme selection and implementation have sought representation from the South Australian Aboriginal Health Council which will occur in 2010.

#### **Local interventions and social marketing resources**

Each OPAL community is unique and dynamic. The tailoring of the OPAL approach for Indigenous and cultural groups happens at the local level. Most OPAL communities have developed OPAL Local Advisory Groups with representations from stakeholder groups including migrant and Indigenous groups. The communities guide the local council manager in the selection and delivery of interventions. Interventions are either promoted/partnered or generated by OPAL. Generated activities are designed specifically for the community based on local need and circumstances. SCU provides ongoing support in the generation of new materials.

#### **A Local Example – A model for future Healthy Children’s interventions**

In Port Augusta a needs analysis has been undertaken for a future theme. The evidence and need identified will inform both the overall OPAL approach to the theme as well as how the OPAL theme will be rolled out in Port Augusta and development of specific resources for the Aboriginal Community. OPAL has worked with the Children’s Centre and funded a cooking group where Aboriginal parents translate recipes into stories using multi-media. Partnership building is core to the OPAL approach and strong connections are being forged with both elders and Aboriginal specific services such as Anangu Bibi Aboriginal Birthing Program and Pika Wiya Health Services, Males in Black, Aboriginal Specific Play groups – these partnerships support the work of the local community members and build their capacity to work in the areas of healthy eating and physical activity. Aboriginal Community Education Officers have been trained in Community Foodies. This will widen their skill-set and provide an informal connection with parents about healthy eating in schools.

Whether it be Indigenous or cultural and linguistically diverse groups OPAL will work strategically at both the state and local levels to provide responsive interventions.

## 25. Stakeholder engagement:

| <b>Stakeholders</b>  | <b>Activity</b>                               | <b>Strategy</b>  |
|--|---|--|
| <b>Local Government</b>  | Becoming an OPAL site                         | <ul style="list-style-type: none"> <li>• A two stage tender process – request of interest (with information sessions) and call for tender.</li> <li>• Selection according to criteria.</li> <li>• Meet with Mayors and CEs to discuss OPAL including working relationships, OPAL region within Council, OPAL Mayors Club.</li> </ul>                   |
|  | Is now an OPAL site                           | <ul style="list-style-type: none"> <li>• Contracting OPAL 5 year initiative</li> <li>• Staff selection and ongoing support</li> <li>• Reporting processes</li> </ul>   |
| <b>Healthy Weight Experts</b>  | Advice on best evidence                       | <ul style="list-style-type: none"> <li>• Create and administer Scientific Advisory Committee (SAC)</li> </ul>  |
|  | Advice on implementation                      | <ul style="list-style-type: none"> <li>• Create and administer Strategic Advisory Committee (STAC)</li> </ul>  |
| <b>Creative Agency / Communication Unit South Australian Health</b>  | OPAL creative, brand and resource development | <ul style="list-style-type: none"> <li>• Develop communication plan</li> <li>• Create brief to describe needs of plan</li> <li>• Select tender to determine agency</li> <li>• Agency creates OPAL brand</li> <li>• Agency (RODEO) creates OPAL themes</li> <li>• Creative and Comms within SA Health contribute to production of resources.</li> </ul> |
| <b>Education Sector (sites and services), Recreation and Sport, Transport, Planning, Retailers, Non-Gov Sector</b> | Advice on strategies to engage                | <ul style="list-style-type: none"> <li>• STAC and Council OPAL advisory groups</li> </ul>  |
|  | Advice on implementation strategies           | <ul style="list-style-type: none"> <li>• STAC and Council OPAL advisory groups and Healthy Weight Taskforce</li> </ul>   |
| <b>Health Sector</b>   | Advice on strategies to engage                | <ul style="list-style-type: none"> <li>• Healthy Weight Coordinating Group at State level.</li> </ul>  |
|  | Advice on implementation strategies           | <ul style="list-style-type: none"> <li>• Council OPAL advisory groups</li> </ul>   |
| <b>Community members</b>   | Advice on implementation strategies           | <ul style="list-style-type: none"> <li>• Council OPAL advisory groups</li> </ul>   |
| <b>Children and Families</b>   | Seeking OPAL message and program advice       | <ul style="list-style-type: none"> <li>• Conduct OPAL focus groups</li> <li>• Conduct OPAL community days</li> </ul>   |

26. **Risk identification and management:**

| <b>Risk</b>  | <b>Level</b> | <b>Mitigation Strategy</b>   |
|--|--------------|--|
| <b>Political support wanes – at National, State or Local level</b> | Medium       | <ul style="list-style-type: none"> <li>• Ensure political leaders are well briefed and understand progress according to goals.</li> <li>• Provide regular positive stories/case studies about communities.</li> <li>• Meet with political advisors where possible to keep informed of OPAL progress</li> <li>• Conduct regular face to face meetings between political figures to share OPAL excellence.</li> <li>• Ensure OPAL application process is relatively simple and positive for potential new OPAL sites.</li> </ul> |
| <b>Staffing recruitment and retention becomes problematic</b>      | Medium       | <ul style="list-style-type: none"> <li>• Recruitment will be enhanced if the position is advertised early and circulated through networks</li> <li>• Retention will be enhanced with good work conditions – ensure management support, PD opportunities, good mentoring.</li> <li>• Set positions at high level (to attract the best candidates and to retain them).</li> </ul>  |
| <b>EPODE/Proteines withdraws support</b>                           | Low          | <ul style="list-style-type: none"> <li>• Maintain regular contact with EPODE colleagues to ensure a clear understanding of international circumstances.</li> <li>• Document all activities to enable continuation in the event Proteines terminates contract.</li> </ul>   |
| <b>Low participation rates of community in OPAL</b>                | Low          | <ul style="list-style-type: none"> <li>• Ensure high quality staff with expertise in community engagement</li> <li>• Ensure sufficient funds are available to engage community members.</li> <li>• Provide mentoring and direction of staff in Councils to ensure they are implementing best evidence and community called for initiatives.</li> <li>• Review communication strategy</li> </ul>  |
| <b>Evaluation is not supported</b>                                 | Medium       | <ul style="list-style-type: none"> <li>• Determine key and likely barriers and develop risk management strategy (this is complete – see Attachment 7)</li> </ul>   |
| <b>OPAL brand is compromised</b>                                   | Low          | <ul style="list-style-type: none"> <li>• Ensure integrity of OPAL brand by association with evidence based activity</li> <li>• Maintain quality control via regularly monitored systems and processes</li> </ul>   |

See Attachment 7 for further risk management evaluation

27. **Evaluation:** OPAL has a comprehensive evaluation planned. It will occur over eight years – 2010-2018. The evaluation framework has been developed by the OPAL evaluation manager, Dr Michelle Jones with guidance from the OPAL Scientific Advisory Committee chaired by Professor Boyd Swinburn.

The evaluation of OPAL will determine the impact of OPAL on children, families, organisations, communities and environments using a mixed methods approach. This approach will see the meshing of complementary quantitative and qualitative data. Triangulation research design is widely accepted as best practice in ensuring a rigorous, information rich evaluation. Varying forms of data will be gathered on OPAL and brought together to better understand the complexities of the impact of OPAL on individuals and communities.

An independent evaluator has been sought with a tender going to market in May 2010. The tender document is attached to provide full detail about the planned evaluation (see Attachment 8).

Evaluation results will be used to inform the OPAL program, each participating community, and the State and Federal Governments of progress. Evaluation results are integral to continuous quality improvement of OPAL.

OPAL will use the following indicators to determine success:

***Outcome indicators:***

- Positively influences healthy weight by increasing healthy weight in children (0-18 years)

***Impact indicators:***

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

***Process indicators:***

- Extent of vertical and horizontal collaborations arising from OPAL
- Increased partnerships at State and Local levels
- Level of engagement and participation in OPAL program
- Equity and cultural inclusiveness in the delivery of OPAL within communities

28. **Infrastructure:** Integral to delivering OPAL is constantly developing infrastructure which falls into two broad categories – hard and soft infrastructure. Soft infrastructure refers to the people, knowledge, concepts and capacity building that constitute OPAL. Hard infrastructure refers to the tangible, touchable objects that are required to make OPAL function. As a third consideration, OPAL’s Social Marketing combines both soft and hard infrastructure.

| <b>Soft Infrastructure</b>          | <b>Activity / Description</b>   |
|-------------------------------------|---|
| OPAL State Coordination Unit staff  | State Manager, Social Marketing Manager, Evaluation Manager, Project Officer x 2, Admin officer.  |
| OPAL Local Council Teams (LCT)      | 20 Local Council Managers, 20 OPAL Project Support Officers.  |
| OPAL by EPODE – a concept           | EPODE methodology is applied in a South Australian context – adopted and adapted to suit. Licence agreement defines requirements.   |
| Staff training                      | Enhancing understanding of the EPODE community-development approach to childhood-obesity prevention via training - occurs with whole team at least twice per year.<br>Additional staff training linked to performance development schedules for all staff.<br>EPODE international training occurs twice per year. |
| Community training                  | OPAL LCT will develop community capacity via training around HE and PA – through settings (e.g. Community Neighbourhood Houses, schools etc).   |
| <b>Hard Infrastructure</b>          |   |
| Theme specific local infrastructure | Every 6 months a new theme will provide a multitude of opportunities to work with communities to establish healthy eating and physical activity infrastructure – e.g. <i>Water theme</i> : water fountains in schools and local communities, graffiti art water tanks promoting message                           |
| Non-theme specific infrastructure   | As a backdrop to the theme specific work of OPAL, local OPAL teams will establish hard infrastructure to support HE and PA (eg. One metre <sup>2</sup> gardens, OPAL community spaces etc) in council areas via funding appropriate initiatives.  |
| Offices and equipment and transport | OPAL State Coordination Unit staff will draw from State and Federal funds to establish and maintain office space and equipment and for travel expenses.’<br><br>NB OPAL LCT will draw upon local government contributions to cover these costs.   |
| <b>Social Marketing</b>             |   |
| Theme development                   | From evidence base to concept development, the knowledge of experts in various fields is used to establish an OPAL theme designed to focus attention on HE and PA in OPAL communities.  |
| Theme interventions                 | Each theme will be supported by a range of evidence-based interventions that target settings and population groups and work to change behaviours and environments.<br>OPAL LCT will contribute to interventions through their community experience.   |
| Theme merchandise                   | A common message across all OPAL sites will be conveyed through a range of materials/resources including posters, pamphlets, instructional engagement action sheets etc.  |
| Theme training                      | Social marketing staff will conduct regular theme based training with all OPAL staff to ensure consistent application of theme messages.  |

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

| <b>Deliverable and milestone</b>   | <b>Due date</b>                       |
|--|---------------------------------------|
| (i) Five OPAL sites (Councils) commence each year (with staff, budgets etc)                | July 2011 and 2012                    |
| (ii) NT COPAL site (Palmerston) commences  | July 2011                             |
| (iii) Orientation and set up training completed for new OPAL sites                         | July 2011 and 2012                    |
| (iv) Data collection occurs year one for new OPAL sites                                    | July 2011 and 2012                    |
| (v) Local steering committees formed   | Sept. 2011 and 2012                   |
| (vi) Social marketing themes implemented   | Sept and March 2012, 2013, 2014, 2015 |
| (vii) Data collection occurs year three for new OPAL sites & year five for original sites. | July 2014 and 2015                    |
| (viii) Annual activity reports completed   | August 2012, 2013, 2014, 2015         |

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

State Manager, OPAL (Obesity Prevention and Lifestyle)  
Statewide Service Strategy, SA Health

Ph: +61 8 8226 6068

Em: hpb@health.sa.gov.au

Mail: 11 Hindmarsh Square

Fax: +61 8 8226 6133

ADELAIDE SA 5000

31. **Activity budget:** A detailed budget is provided (see attachment 9 for budget details) that indicates the combination of federal and state funding contributing to the implementation of OPAL.

Attributing cost/payment of specific activities to federal or state money has not been performed as OPAL is an integrated and 'seamless' initiative that does not lend itself to segregation of funds.

Please note year 4 where there is both a facilitation and reward payment that totals \$9,303,100. This exceeds the total planned cost of OPAL delivery of \$5,581,442. Should South Australia actually achieve a full reward payment, negotiation would occur with the Commonwealth to determine best allocation of funds – e.g. additional sites, extension of existing sites.

**Table 4: Activity project budget (\$ million)**

| <b>Expenditure item</b> | <b>Year 1</b> | <b>Year 2</b> | <b>Year 3</b> | <b>Year 4</b> | <b>Total</b>   |
|-------------------------|---------------|---------------|---------------|---------------|----------------|
| (i) OPAL implementation | \$2.32        | \$4.63        | \$2.30        | \$2.36        | \$11.61        |
| <b>TOTAL</b>            | <b>\$2.32</b> | <b>\$4.63</b> | <b>\$2.3</b>  | <b>\$2.36</b> | <b>\$11.61</b> |

Notes: Full breakdown of combined Federal/State funding of OPAL – see Attachment 9

## 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 2013 and 31 December 2014:
- a) Increase in proportion of children at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of children at healthy weight returned to baseline level by 2015.
  - 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 2013; 0.6 for fruits and 1.5 for vegetables by 2015.
  - 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 2013; by 15 per cent by 2015.
  - d) Increase in proportion of adults at unhealthy weight held at less than five per cent from baseline for each state by 2013; proportion of adults at healthy weight returned to baseline level by 2015.
  - 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 2013; 0.6 for fruits and 1.5 for vegetables from baseline by 2015.

- 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 2013; 15 per cent from baseline by 2015.
  - 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.

## National Partnership Agreement on Preventive Health

### HEALTHY CHILDREN

#### *Scoping Statement and Guiding Policy Principles*

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## **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:

- a) 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;
- b) social marketing for adults aimed at reducing obesity and tobacco use; and
- c) 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.<sup>1</sup> 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).<sup>2</sup>

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:

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<sup>1</sup> Australian Bureau of Statistics (2009); National Health Survey 2007-08 – Summary of results, Canberra

<sup>2</sup> Australian National University (2007); Children's Nutrition and Physical Activity Survey – Fact Sheet – Key Findings 2007, Canberra

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

**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)<sup>4</sup> 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.

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<sup>3</sup> [www.socialinclusion.gov.au/Documents/SIToolKit.pdf](http://www.socialinclusion.gov.au/Documents/SIToolKit.pdf)

<sup>4</sup> 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*

- 2.3.1 Programs under the initiative should be focused on primary and secondary prevention.
- 2.3.2 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).

- 2.3.3 Programs should reflect the requirements of the Australian Government's *Social Inclusion Toolkit*.
- 2.3.4 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.
- 2.3.5 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).
- 2.3.6 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.
- 2.3.7 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.
- 2.3.8 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.
- 2.3.9 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).
- 2.3.10 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.
- 2.3.11 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.
- 2.3.12 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).
- 2.3.13 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.
- 2.3.14 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***

- 2.3.15 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.

- 2.3.16 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.
- 2.3.17 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.
- 2.3.18 Programs should complement existing effective programs and policies for children and young people.
- 2.3.19 Programs should explicitly support breastfeeding where relevant.
- 2.3.20 Programs should comply with requirements for working with children and young people in each state and territory.
- 2.3.21 Programs must be safe and appropriate for children and young people and their parents and families.

**List of attachments**

- Attachment 1 Scientific Advisory Committee (SAC) and Terms of Reference
- Attachment 2 Strategic Advisory Committee (STAC) and Terms of Reference
- Attachment 3 OPAL Logic Model
- Attachment 4 Discussion – how OPAL is framing its evaluation
- Attachment 5 OPAL Evaluation Framework
- Attachment 6 Letter of support from Hon Nicola Roxon, Federal Minister for Health  
Committing ‘healthy children’ funding
- Attachment 7 Evaluation risk management matrix
- Attachment 8 Evaluation tender documents
  
- Attachment 9 OPAL Budget

## Scientific Advisory Committee Membership and Terms of Reference

Attachment 1

|              | Title       | First Name     | Surname          | Department  | Institution                                  |
|--------------|-------------|----------------|------------------|---|--|
| Chair        | Professor   | <b>Boyd</b>    | <b>Swinburn</b>  | Professor of Population Health, and Director, WHO Collaborating Center for Obesity Prevention | Deakin University                            |
| Deputy Chair | Professor   | <b>Tim</b>     | <b>Olds</b>      | Division of Health Sciences, School of Health Sciences  | University of South Australia                |
|              | Dr          | <b>Anthea</b>  | <b>Magarey</b>   | Flinders Clinical and Molecular Medicine, Nutrition and Dietetics                             | Flinders University                          |
|              | Professor   | <b>John</b>    | <b>Lynch</b>     | Division of Health Sciences, Health Sciences Divisional Office                                | University of South Australia                |
|              | Professor   | <b>Mark</b>    | <b>Daniel</b>    | Research Chair for Social Epidemiology Division of Health Sciences                            | University of South Australia                |
|              | Professor   | <b>Robyn</b>   | <b>McDermott</b> | Sansom Institute for Health Research  | University of South Australia                |
|              | Professor   | <b>Kerin</b>   | <b>O'Dea</b>     | Division of Health Sciences, Health Sciences Divisional Office                                | University of South Australia                |
|              | Professor   | <b>Gary</b>    | <b>Wittert</b>   | Head, School of Medicine  | The University of Adelaide                   |
|              | Professor   | <b>Peter</b>   | <b>Clifton</b>   | Laboratory head , Nutritional Interventions   | Baker IDI Heart and Diabetes Institute       |
|              | A/Professor | <b>Manny</b>   | <b>Noakes</b>    | CSIRO Human Nutrition   | CSIRO Human Nutrition and Health Sciences    |
|              | A/Professor | <b>Jon</b>     | <b>Karnon</b>    | Public Health   | The University of Adelaide                   |
|              | Professor   | <b>Pascale</b> | <b>Quester</b>   | Professions, Faculty of The   | The University of Adelaide                   |
|              | A/Professor | <b>Fiona</b>   | <b>Verity</b>    | Faculty of Social Sciences, School of Social Work   | Flinders University                          |
|              | Professor   | <b>Marika</b>  | <b>Tiggeman</b>  | School of Psychology  | Flinders University                          |
|              | Ms          | <b>Leah</b>    | <b>Cassidy</b>   | Project Manager, Healthy Eating and Physical Activity   | Department of Education and Children Service |

|  | <b>Title</b> | <b>First Name</b> | <b>Surname</b>  | <b>Department</b>                                | <b>Institution</b>                                  |
|--|--------------|-------------------|-----------------|--|---|
|  | A/Professor  | <b>Nicola</b>     | <b>Spurrier</b> | Consultant Paediatrician                         | Child Health Clinical Network Nominee and SA Health |
|  | Mr           | <b>Andrew</b>     | <b>Stanley</b>  | Director Strategic Planning, Policy and Research | SA Health   |
|  | Mr           | <b>Mark</b>       | <b>Williams</b> | OPAL Manager                                     | SA Health   |
|  | Dr           | <b>Michelle</b>   | <b>Jones</b>    | OPAL Evaluation Manager                          | SA Health   |

## **OPAL (OBESITY PREVENTION AND LIFESTYLE) SCIENTIFIC ADVISORY COMMITTEE**

### **TERMS OF REFERENCE**

#### **OPAL Scientific Advisory Committee (SAC) Membership and Composition**

1. The SAC is an advisory committee to SA Health through the OPAL State Coordination Unit.
2. The SAC is responsible for advising the OPAL State Coordination Unit on issues impacting upon the implementation, evaluation and monitoring of OPAL locally and across the State.
3. The committee is comprised of a Chair, Deputy Chair and relevant academic experts in a range of relevant areas (including nutrition, physical activity, obesity prevention and community development).
4. Members will be appointed to the SAC for an initial term of two years.
5. The SAC may invite individuals who are not members of the SAC to participate in meetings in order to provide relevant information to the SAC.

#### **Role of the OPAL Scientific Advisory Committee**

The Scientific Advisory Committee will:

- Provide expert advice in-line with the best available evidence to inform the overall development and implementation of the OPAL initiative and related programs.
- Consider best practice in the evaluation of community-based obesity prevention programs both in Australia and internationally and provide advice as it relates to OPAL.
- Ensure the development and implementation of a comprehensive, rigorous and scientifically sound OPAL evaluation framework.
- Provide expertise and advice on the development and implementation of evaluation infrastructure.
- Provide expertise and linkages with relevant related research, evaluation and monitoring including that undertaken by EPODE internationally.
- Provide a public profile for the technical and evaluation related components of OPAL and assist with positive media coverage on issues relating to the OPAL content and evaluation.
- Provide a forum for the exchange of information, ideas and strategies on healthy eating and physical activity.
- Declare any anticipated conflicts of interest

#### **Administration**

- The OPAL Evaluation Manager will act as the Executive Officer to the SAC.
- The staff from the OPAL State Coordination Unit will attend meetings, provide support to the SAC and report on OPAL.
- Meetings will be conducted at a minimum twice yearly. Some out of session activity and input may be required from time to time.

## Strategic Advisory Committee Membership and Terms of Reference

| Strategic Advisory Committee | Title | First Name   | Surname   | Position           | Unit                                      | Organisation  |
|------------------------------|-------|--------------|-----------|--------------------|---|---|
| Chair                        | Ms    | Brenda       | Kuhr      |                    |   | Oz Train  |
| Deputy Chair                 | Ms    | Rachael      | Sporn     |                    |   |   |
|                              | Ms    | Caroline     | Miller    | General Manager    | Cancer Control Programs                   | Cancer Council South Australia                      |
|                              | Ms    | Felicity-ann | Lewis     | Mayor              |   | City of Marion                                      |
|                              | Mr    | Greg         | Perkin    | City Manager       |   | City of Port Augusta                                |
|                              | Mr    | Ross         | Womersley | Executive Director |   | South Australian Council of Social Services         |
|                              | Mr    | Russell      | Markham   | Chief Executive    |   | Foodland  |
|                              | Ms    | Stephanie    | Vasileff  | Chef               |   |   |
|                              | Dr    | Cathy        | Sanders   |                    |   | Parkside Family Practice                            |
|                              | Ms    | Catherine    | Winter    | Director           | Healthy Children, Healthy Workers Section | Department of Health and Ageing                     |
|                              | Ms    | Jenice       | Zerna     | President          |   | South Australian Association of School Parent Clubs |
|                              | Mr    | Steve        | Portlock  | President          |   | South Australian Primary Principals Association     |
|                              | Ms    | Wendy        | Keech     | Director           | Cardiovascular Health Programs            | Heart Foundation                                    |

# **OPAL (OBESITY PREVENTION AND LIFESTYLE) STRATEGIC ADVISORY COMMITTEE**

## **TERMS OF REFERENCE (DRAFT)**

### **OPAL Strategic Advisory Committee (STAC) Membership and Composition**

- The STAC is an advisory committee to SA Health through the OPAL State Coordination Unit.
- The STAC is responsible for advising the Government of South Australia through SA Health on the strategic implementation of OPAL in South Australia and contributing to its success.
- The STAC includes a Chair and Deputy Chair who will be appointed for an initial term of two years.
- The committee will be comprised of representatives from key areas related to healthy eating, physical activity, healthy weight, communities, business and government who are committed to the aims of OPAL.
- The STAC may invite experts to participate in particular meetings in order to provide relevant information to the STAC.
- The staff from the OPAL State Coordination Unit will attend meetings, provide support to the STAC, report on the OPAL initiative and make use of STAC advice.

### **Role of the OPAL Strategic Advisory Committee**

The Strategic Advisory Committee will:

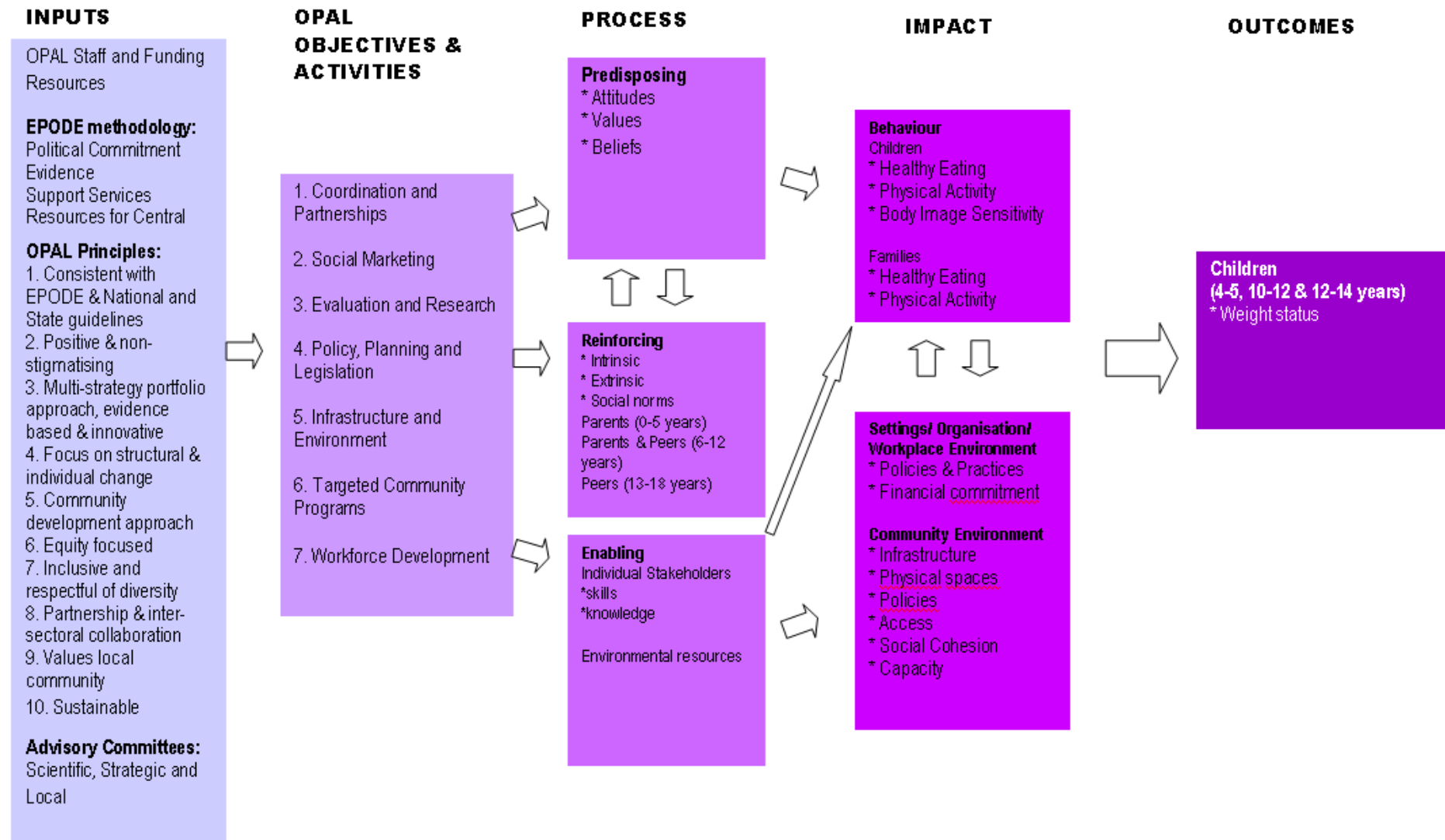
- Offer strategic advice to ensure the successful implementation of OPAL in South Australia.
- Ensure a high public profile for OPAL, assist with positive media coverage and act as an advocate for the OPAL initiative and the importance of obesity prevention.
- Provide opportunities to link OPAL with other healthy eating and physical activity programs and opportunities.
- Provide a forum for sharing information on planning, implementation and evaluation issues as they relate to OPAL.
- Assist with advice and support for any future partnerships with the private and non-government sectors.

### **Administration**

- The OPAL Social Marketing Manager will act as the Executive Officer to the STAC.
- Meetings will be conducted regularly (every 4 months proposed) and will be held at a mutually agreeable and central location.

**OPAL LOGIC MODEL**

Figure 1: Precede Proceed Model of Health Promotion Planning applied to OPAL (Obesity Prevention and Lifestyle)



## **Discussion – how OPAL is framing its evaluation**

OPAL will be considered successful if it achieves the following when compared with the comparison communities, these are summarised in the OPAL Logic Model (Appendix 1):

### ***Outcome indicators:***

- positively influences healthy weight by either 1) slowing the rate of increase in overweight and obesity or 2) levelling overweight and obesity or 3) increasing healthy weight in children (0-18 years);

### ***Impact indicators:***

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

### ***Process indicators:***

- extent of vertical and horizontal collaborations arising from OPAL;
- increased partnerships at State and Local levels;
- level of engagement and participation in OPAL program;
- equity and cultural inclusiveness in the delivery of OPAL within communities.

The evaluation of OPAL will determine the impact of OPAL on children, families, organisations, communities and environments using a mixed methods approach. A triangulation research design will bring together both quantitative and qualitative data. The value of a mixed methods design is to supplement the strengths and weaknesses of both approaches<sup>5</sup>. Different but complementary data will be gathered on OPAL and brought together to better understand the complexities of the impact of OPAL on individuals and communities. The qualitative and quantitative data sets will be collected concurrently and will be given equal value and the results will be merged during interpretation (Fig 1: the two data sets will be analysed separately in a results section and then merged together during interpretation and discussion phase).

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<sup>5</sup> Creswell, J. W. and V. L. Plano Clark (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, Sage Publications.

## OPAL Evaluation Research Design

*Please note: The OPAL evaluation research provided below reflects the position held in early 2010. Considerable refinement has occurred since. Upon finalization of contracts with external evaluators, a final research design will be submitted to the Commonwealth for information.*

The OPAL initiative is a multi-setting, multi-sectoral community-based program aiming to increase the number of 0-18year olds who are of a healthy weight. The program is modelled on a successful intervention EPODE from France<sup>6</sup>. The OPAL program is defined as having three key components:

- EPODE methodology which is made up of political commitment, scientific base, social marketing and public/private partners;
- community development approach and
- principles of primary health care (including a focus on sustainability, equity, positive and non-stigmatising approach to healthy weight etc).

The purpose of this evaluation is to determine the success of the OPAL initiative. This evaluation will first and foremost determine whether OPAL has brought about change in population weight; this will be reliant upon increasing healthy eating and physical activity. The underpinning social ecological theory that relates the OPAL program to changes within individuals, families, organisations, communities and environments will be used to explore how and why changes have occurred. The primary components of social ecological theory underpinning OPAL include the notions of:

- *interdependence* between individuals and their environments and the interconnections between multiple settings and life domains and
- *cycles of mutual influence* where physical and social settings directly and indirectly influence the occupant's health and where occupants in turn, modify the health of their surroundings through their individual and collective action.

OPAL communities are defined as those communities with contracted political buy-in from Local, State and Federal governments. They have two staff employed through SA Health located in local government acting in a defined, bounded region (part of an LGA). The OPAL program will run for a period of eight years, commencing in 2009/2010. Each year, a number of communities will commence the intervention (Table 1) and will be supported for a 5 year term in each region to implement the initiative. These communities are matched with comparison communities to facilitate evaluation of effectiveness of OPAL.

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<sup>6</sup> Romon, M., et al., *Downward trends in the prevalence of childhood overweight in the setting of 12-year school- and community-based programmes*. Public Health Nutrition, 2008. **First View Article**(doi: 10.1017/S1368980008004278, Published online by Cambridge University Press 23 Dec 2008

**Table 1: Start dates of 20 OPAL communities over 4 years**

|                               | 2009-10 | 2010-11 | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 |
|-------------------------------|---------|---------|---------|---------|---------|---------|---------|---------|
| Phase 1<br>(6<br>Communities) |         |         |         |         |         |         |         |         |
| Phase 2<br>(4<br>Communities) |         |         |         |         |         |         |         |         |
| Phase 3<br>(5<br>Communities) |         |         |         |         |         |         |         |         |
| Phase 4<br>(5<br>Communities) |         |         |         |         |         |         |         |         |

OPAL will be considered successful if it achieves the following when compared with the comparison communities, these are summarised in the OPAL Logic Model (Appendix 1):

***Outcome indicators:***

- positively influences healthy weight by either 1) slowing the rate of increase in overweight and obesity or 2) levelling overweight and obesity or 3) increasing healthy weight in children (0-18 years);

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- change in community/social norms toward healthy eating and physical activity.

***Process indicators:***

- extent of vertical and horizontal collaborations arising from OPAL;
- increased partnerships at State and Local levels;
- level of engagement and participation in OPAL program;
- equity and cultural inclusiveness in the delivery of OPAL within communities.

The evaluation of OPAL will determine the impact of OPAL on children, families, organisations, communities and environments using a mixed methods approach. A triangulation research design will bring together both quantitative and qualitative data. The value of a mixed methods design is to supplement the strengths and weaknesses of both approaches<sup>7</sup>. Different but complementary data will be gathered on OPAL and brought together to better understand the complexities of the impact of OPAL on

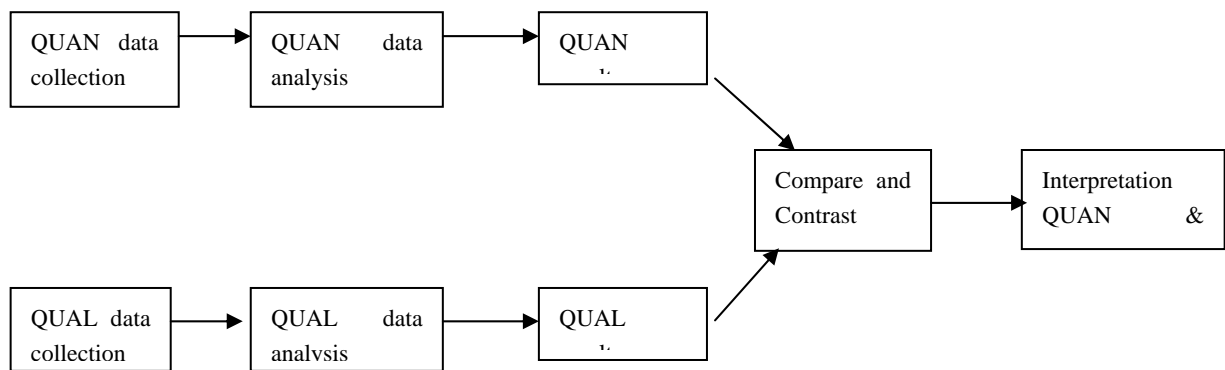
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<sup>7</sup> Creswell, J. W. and V. L. Plano Clark (2007). Designing and Conducting Mixed Methods Research. Thousand Oaks, Sage Publications.

## **SOUTH AUSTRALIA, OPAL (OBESITY PREVENTION AND LIFESTYLE)**

individuals and communities. The qualitative and quantitative data sets will be collected concurrently and will be given equal value and the results will be merged during interpretation (Fig 1: the two data sets will be analysed separately in a results section and then merged together during interpretation and discussion phase).

**Figure 1: Triangulation Design: Convergence Model**



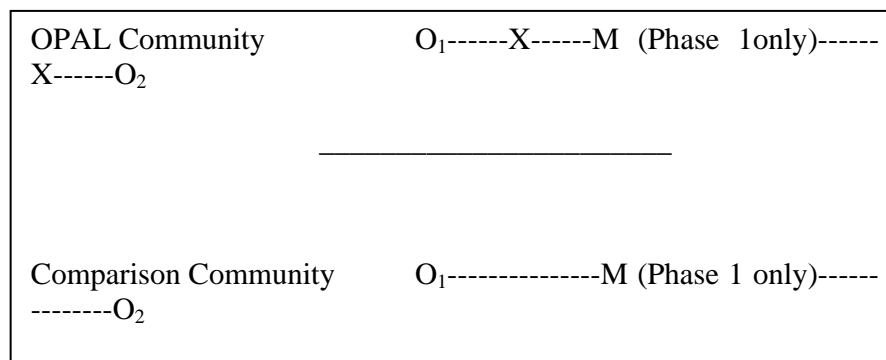
Source: Creswell & Plano Clark (2007) *Designing and Conducting Mixed Methods Research*

### Quasi-Experimental Design

The research design is quasi-experimental. It is anticipated that the data collection will allow both repeated cross-sectional and longitudinal analysis. A repeated cross-section design provides a series of ‘snapshots’ of the frequency and characteristics in a population at a particular point in time (Figure 2). The ‘snapshots’ would occur at the following three time points for the first Phase of OPAL communities: beginning (year 1), midpoint – questionnaires only (year 3) and conclusion (year 5) and differences between the intervention and comparison communities would be analysed at each time point. A baseline and final report will be prepared and the mid-point data will be used to:

- a. meet State and Federal reporting requirements,
- b. provide progress feedback to communities and generate momentum in OPAL communities and;
- c. provide formative feedback to OPAL staff about the progress of OPAL within communities to refine and re-shape OPAL to improve outcomes.

**Figure 2: Repeated Cross-Section Design**

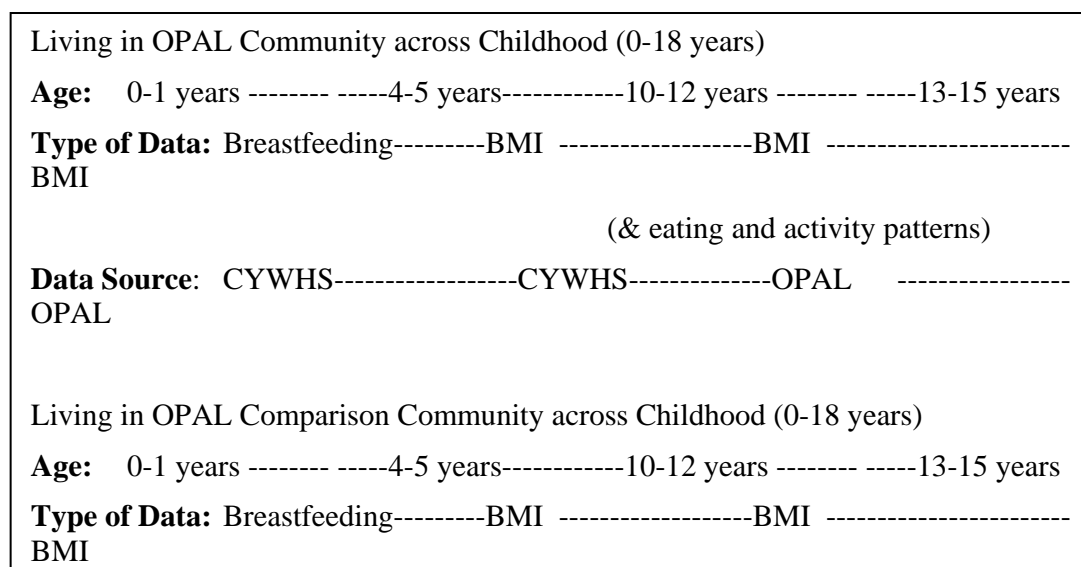


**SOUTH AUSTRALIA, OPAL (OBESITY PREVENTION AND LIFESTYLE)**

It is anticipated that over time communities that were initially defined as comparison groups may elect to take up the OPAL initiative and thus become intervention communities. To account for this occurrence, a grouped comparison design will be used. This means for example that in the first year, each metropolitan OPAL community will have three comparison communities and each rural OPAL community will have four comparison communities. This will result in at least one comparison site for each OPAL community remaining after five years of intervention. If this occurs the remaining comparison community will be over-sampled (more schools invited to be involved to ensure comparison sample size remains consistent).

Longitudinal studies involve repeated observations of the same individuals over time. The nature of OPAL spanning 0-18 year olds within defined communities over an extended period of time (5 years) allows for the tracking of individuals. In the case of changes in body weight, longitudinal data provides excellent information about the impact of interventions. In South Australia we are fortunate to have one of the most comprehensive health data sets for children 4-5 years. This data is collected annually and provides accurate weight and height (used to derive BMI). Paired with their 4-5 year old data set, OPAL proposes adding height and weight measurements at 10-12 years and 13-15 years (see Figure 3). Tracking of children’s weight status therefore becomes possible. In this OPAL evaluation, parents will be asked to consent to their child being tracked over the course of OPAL and linked to other data sets (such as CYWHS, DECS (NAPLAN) data, SADS data). Therefore a consenting 10-12 year old child will have their eating and activity patterns and weight status linked with their 4-5 year old weight status and their breastfeeding patterns. This will allow examination of persistence of healthy/unhealthy weight status over time. This data will also be linked with their 13-15 year old weight status and eating and activity patterns. Data linkage and tracking of children within OPAL communities over time will allow for a more in-depth analysis of the health and social effects of healthy weight. It will also allow greater interpretation and linking of the health outcomes to the OPAL intervention. The ability to link OPAL data with representative data collected by other state authorities provides a unique opportunity to draw associations between lifestyle behaviours and health outcomes across the childhood period.

**Figure 3: Longitudinal Tracking**



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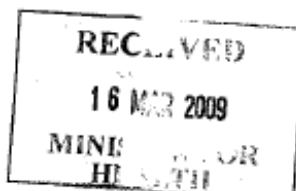


**THE HON NICOLA ROXON MP  
MINISTER FOR HEALTH AND AGEING**

Department of Health

26 MAR 2009

Office of the Chief Executive



The Hon John Hill MHA  
Minister for Health  
Minister for the Southern Suburbs  
Minister Assisting the Premier in the Arts  
GPO Box 2555  
ADELAIDE SA 5001

Dear Minister

Thank you for your letter of 22 January 2009 regarding the use of funds under the National Partnership Agreement on Preventive Health (the National Partnership) for the implementation of the EPODE program in South Australia.

EPODE has demonstrated an impressive capacity to reverse trends in childhood overweight and obesity in France and its extension into Spain and Belgium, and imminently into Greece, reflects the growing level of international confidence in the program. South Australia's intent to localise the program in an Australian context, and on the scale of some 20 sites, marks an important development in our efforts to curb childhood overweight and obesity, and one which I am sure all jurisdictions will be watching with interest.

Having regard to the compelling evidence for EPODE's effectiveness, the cost efficiency with which you will be implementing it, its contribution to national reform of our approach to childhood overweight and obesity, and the potential sustainability of the project, I am pleased to approve your application of funds under the National Partnership to this program. I understand the funds to be applied to EPODE are around \$11 million.

As you have already announced the program will be made available in 20 sites across South Australia, I seek your assurance that National Partnership funds will not be applied to activities already funded by your government.

I look forward to hearing more about your experiences in implementing the program.

Yours sincerely

**NICOLA ROXON**

10 MAR 2009

## Evaluation risk management matrix

| SPU Areas   | Cause/ Risk Factors  | Risk Quantification |                 |                | Controls/ Mitigating Factors  |
|-------------|--|---------------------|-----------------|----------------|---|
|             |  | Likely<br>(1-5)     | Impact<br>(1-5) | Total<br>(L+C) |   |
| Procurement | Perceived advantage to SAC members                                   | 3                   | 3               | 6              | Ask all SAC members to declare possible conflicts of interest. All South Australian Universities are represented on SAC.<br><br>Any bid must include representation from at least one South Australian University. All information from SAC about OPAL evaluation will be distributed to all respondents. Further, an information session will be held in the first week of the RFT information sharing and fielding questions. |
|             | Procurement process criticised from external sources                 | 2                   | 3               | 5              | Ensure open, transparent and accountable processes.   |
|             | Unable to appoint before timeline to begin baseline data collection. | 5                   | 3               | 8              | Will begin evaluation Term 3 rather than 2.   |
|             | EOI fails to attract tenders   | 1                   | 5               | 6              | Interest in the OPAL evaluation has been high demonstrated by the high interest in being on SAC. It is also a high value evaluation.  |
|             | Late tender documents  | 3                   | 2               | 5              | The RFT documents will specify that late tenders will not be accepted.  |

|          |  |   |   |   |   |
|----------|--|---|---|---|---|
|          | The successful tenderer (ST) is unable to deliver evaluation for 5+3 years as per service agreement.               | 3 | 4 | 7 | Will be closely managed through the service agreement ie ensure deadline are met.   |
|          | The ST is unable to successfully engage settings and stakeholders in evaluation intervention and comparison sites. | 3 | 2 | 5 | OPAL State Coordination Unit will work closely with Education sector (DECS, Independent and Catholic Schools) to ensure their needs are met through the evaluation and that the evaluation value adds to their needs. |
|          | Timelines are unable to be met by the ST.  | 3 | 4 | 7 | Will be closely managed through the service agreement. The course of action if this occurs will be detailed in the service agreement.   |
|          | Unable to collect data for evaluation in regional/remote areas.  | 3 | 3 | 6 | as above  |
|          | Lack of continuity of staff over extended period of time for OPAL evaluation.                                      | 3 | 3 | 6 | as above  |
| Business | Unfair or unethical practice.  | 2 | 2 | 4 | Ethics approvals for the evaluation have been sought from SA Health ethics and will be sought from Aboriginal Health Ethics Committee, DECS research committee and the ST institutional ethics committee              |
|          | Conflict of Interest.  | 2 | 3 | 5 | All SAC members and members of the evaluation team will be asked to declare any conflicts of interest.  |

**SOUTH AUSTRALIA, OPAL (OBESITY PREVENTION AND LIFESTYLE)**

|             |   |   |   |   |  |
|-------------|---|---|---|---|--|
|             | Legal challenge from unsuccessful bidder.   | 3 | 3 | 6 | <p>Potential danger that one bidder perceives that another has been favoured.</p> <p>Some SAC members actively lobby the Minister on service provision and research issues.</p> <p>Potential for appeals from unsuccessful tenderer. This can be mitigated through strict adherence to procurement processes and liaison with SPU.</p> |
|             | Business operational issues (eg financial management, internal risk management, staff changes). | 3 | 3 | 6 | Tenderers will be asked at the RFT stage to submit financial and operational information.  |
| OHS&W       | Inadequate OHS&W awareness by the ST.   | 1 | 2 | 3 | To be addressed in service agreement.  |
|             | Inadequate OHS&W risk assessment identification and modification by the ST.                     | 2 | 2 | 4 | OHS&W will be mandatory within the service agreement. Details of risk management to be specified within the service agreement.   |
|             | Schools involved in OPAL evaluation have inadequate OHS&W policies in place                     | 2 | 2 | 4 | Processes for managing this situation will developed in conjunction with the ST, school and DECS.  |
|             | Schools involved in OPAL evaluation have poor adherence to OHS&W policies (if in existence).    | 3 | 2 | 5 | Case by case basis. See notes above.   |
| Environment | The ST business operations have a significantly negative environmental impact.                  | 1 | 1 | 2 | Highly unlikely, information on environmental impact and sustainability will be included in the service agreement.   |
|             | The OPAL evaluation has a significantly negative environmental impact.                          | 1 | 1 | 2 | as above   |

|                               |   |   |   |   |  |
|-------------------------------|---|---|---|---|--|
| Public Safety                 | The OPAL evaluation puts children at risk of unhealthy body image or eating disorders.        | 1 | 5 | 6 | <p>OPAL body image protocol to be implemented at all times. OPAL evaluation manager to monitor implementation of protocol.</p> <p>ST to provide body image training to all staff.</p> <p>Any identified negative consequences of evaluation to be reported to OPAL Evaluation Manager.</p> |
|                               | The OPAL evaluation puts children at risk of abuse.   | 1 | 5 | 6 | <p>ST to ensure that all staff going into schools have police check, mandatory reporting training and approvals equivalent to teachers.</p> <p>Staff member the same gender as child undertakes measuring. Measuring in private but within earshot of other measurers.</p>                 |
| Political Risk or Sensitivity | Inter-sectoral collaborations with DECS become strained.                                      | 3 | 5 | 8 | <p>Engagement with DECS in the planning of the OPAL evaluation.</p> <p>Ethics approvals from DECS sought.</p> <p>OPAL and its evaluation have the support of Cabinet.</p> <p>Detailed briefings sent to Minister for Health and Minister for Education to ensure consistent response.</p>  |
|                               | State election called during procurement process – possible change of Government or Minister. | 5 | 1 | 6 | <p>Should Opposition take government then way forward would be negotiated.</p>   |
|                               | Risk that the Minister/CE etc are criticised publicly by an unsuccessful tenderer             | 3 | 3 | 6 | <p>Adherence to the procurement processes will ensure that any criticism is unwarranted.</p> <p>Briefing can be sent to the Minister explaining reason for selection of ST.</p>  |

## **Evaluation tender documents – key sections**

### ***OPAL Evaluation Aims and Objectives***

The OPAL Evaluation aims to determine the effectiveness of the OPAL initiative and advance the promotion of healthy weight, physical activity and healthy eating, consistent with South Australia's Strategic Plan Target 2.2, Healthy Weight through the achievement of broad objectives.

In order to determine the effectiveness of OPAL, a quasi-experimental research design combining qualitative and quantitative methods, including outcome, impact and process indicators will be undertaken. The contractor will be responsible for contributing to the development of OPAL through the evaluation by:

1. Contributing to the research design of a rigorous OPAL Evaluation Framework based on best practice principles.
2. Undertaking collection, management, linkage and storage of data.
3. Undertaking analysis to determine effectiveness of OPAL.
4. Providing reports to OPAL on the progress of the OPAL Evaluation and the effectiveness of OPAL.
5. Providing evaluation and research advice to OPAL.
6. Working through existing OPAL governance structures.
7. Development of appropriate infrastructure to support the conduct of the OPAL Evaluation.

### ***OPAL Evaluation Budget***

The OPAL Evaluation has a budget with an upper limit of \$4.554m (incl GST) over the eight year life of the program. Please refer to OPAL Evaluation Research Design document for a more detailed description of what is required to be completed within the proposed budget.

### ***Evaluation***

Evaluation of your Offer will include, but not be limited to, assessment of the following evaluation criteria (see table below). These evaluation criteria are indicative only and may be amended at the Customers discretion.

Please only respond to the Evaluation Criteria (below). However, please also consider the following:

1. Item 7: Specific Requirements (in Part B: Requirements and Specification); and
2. Attachment 1: OPAL Evaluation Research Design (much of the design of the OPAL Evaluation has been considered by OPAL SAC. The respondents must use this basic design in their proposal.)

**1. Any bid must\* include representation from at least one South Australian University.** Agencies other than South Australian Universities tendering for the OPAL evaluation must\* clearly define:

- a) with which university they will have an affiliation for the period of the evaluation at least 5 years hence.
- b) with which faculty and staff member they will have an affiliation (must be related to nutrition, physical activity, healthy weight and/or be specifically a member of the OPAL Scientific Advisory Committee – listed in Attachment 2 ).

**2. Provide a budget for OPAL Evaluation (including whole of life costings) and value for money for the required activities.** The respondent must provide detail of all costs associated with the contract including.

- a) Detailed budget for each component of the evaluation over the full life of the evaluation.
- b) Evidence of the ability to undertake the required evaluation within the allocated budget.
- c) Evidence of previous experience in completing research within budget and of managing significant budgets over extended timeframes.
- d) Budget allocations for value-added components.

**3. Development of a rigorous evaluation plan for OPAL must be provided with demonstrated value for money given the proposed OPAL research design (provided in Part B of the RFT). The respondent must include:**

- a) A clear description of the methodology to be employed over the 5-8 year evaluation.
- b) Identification of critical variables and corresponding indicators.
- c) Summary budget allocations given the proposed overall budget.
- d) Timelines.
- e) Measurement tools (including rationale for selection, reliability and validity testing ie whether the testing has occurred or not, if not include costings).
- f) Plan for statistical analysis (including cross-section, longitudinal and cost benefit).
- g) Value added research/benefits.
- h) Reporting timelines and possible publications (proposed titles and number).

**4. Demonstrated knowledge, qualifications, experience and research track record of evaluation team. The respondent must demonstrate:**

- a) High level knowledge in all of the following areas:
  - i. Epidemiology of South Australian population
  - ii. Child nutrition
  - iii. Child physical activity
  - iv. South Australian communities and community development
  - v. Economic analysis
  - vi. Aboriginal Health.
- b) Experience in large scale evaluations of community based childhood obesity prevention programs or similar using qualitative and quantitative approaches.
- c) Experience in management of large data sets including data collection, coding, entry and storage.
- d) Experience in longitudinal tracking and data linkage.
- e) Extensive experience in the collection of anthropometric data from children ensuring adherence to appropriate body image protocol.
- f) Experience in data analysis and reporting (including software use, statistical analysis and interpretation) in the following areas:
  - i. child healthy weight
  - ii. child physical activity attitudes, behaviour and knowledge
  - iii. child healthy eating attitudes, behaviour and knowledge
  - iv. body image sensitivities
  - v. community capacity
  - vi. health literacy
  - vii. environments supportive of healthy weight, healthy eating and physical activity (infrastructure, policies and practices etc).

**5. Demonstrated understanding of the OPAL initiative, EPODE methodology and evaluations of similar childhood obesity prevention programs. The respondent must demonstrate:**

- a) They understand and can articulate the scope and approach of the OPAL initiative in South Australia;
- b) They understand and can articulate the four pillars of the EPODE methodology and apply them to OPAL and the evaluation;
- c) An ability to link other relevant research opportunities into OPAL evaluation to expand rigour, scope and add value to OPAL evaluation.

**6. Availability of appropriate resources and a demonstrated ability to deliver in the timeframes required. The respondent must demonstrate:**

- a) They will provide staff with high level communication, conflict management, negotiation and planning skills to work with OPAL communities.
- b) They have experience coordinating a workforce responsible for data collection, analysis and reporting.
- c) They have experience in facilitating high levels of participation in evaluation and repeated entry into communities.
- d) They have experience in negotiating multiple ethics approval processes.
- e) They have capacity to evaluate the program for the next 5-8 years as OPAL grows to 20 communities including ‘matched’ comparisons communities (including infrastructure/staffing arrangements etc).
- f) They have experience in the preparation of high quality reports (able to withstand peer review) and their delivery within tight timeframes.

**7. Sustainability of the Respondent’s approach. The respondent must demonstrate:**

- a) An ability to work within the principles guiding OPAL and the values of the public sector
- b) Knowledge of and experience complying with OHW&S regulations and other legislative requirements
- c) High level experience, success and flexibility in balancing stakeholder expectations and constraints
- d) An ability to identify, manage and appropriately respond to risk.

**8. Identification of Conflict of Interest**

**9. Provide referee reports which describe where the Respondent has:**

- a) Undertaken similar evaluations previously.
- b) Have capacity to meet the requirements of a multi-year, multi-site, complex evaluation.
- c) Have capacity to manage resources (financial, human and intellectual) of a project of this magnitude.

\*Respondents should note that the meaning of the words ‘Must’, ‘Will’ or ‘Shall’ implies that a requirement is mandatory and failure to meet the requirement may result in an Offer being considered non-compliant. The word ‘Should’ implies that a requirement is only desirable and an offer will not be excluded from consideration if the requirement is not met.

***Specific Requirements***

The following requirements will be factored into the final service agreement between the Minister and the contractor. More detail is provided in this section than in the preceding evaluation criteria. The respondent should consider the following information whilst responding to section 6.

In order to determine the effectiveness of OPAL, a quasi-experimental research design combining qualitative and quantitative methods, including outcome, impact and process indicators will be undertaken. The contractor will be responsible for contributing to the development of OPAL through the evaluation by:

**7.1 Contributing to the research design of a rigorous OPAL Evaluation Framework based on best practice principles. The contractor will:**

7.1.1 Use the OPAL Research Design as a basis and provide a clear description of the methodology to be employed over the 5-8 year evaluation.

7.1.2 Identify critical variables and corresponding indicators.

7.1.3 Seek and receive ethics approvals from SA Health, DECS, Aboriginal Health Research Ethics committee and relevant University ethics committee

7.1.4 Maintain a budget providing regular reports.

7.1.5 Develop a work plan including timelines and reporting requirements.

7.1.6 Identify measurement tools (including rationale for selection, reliability and validity testing ie whether the testing has occurred or not, if not include costings).

7.1.8 Identify value added components to core OPAL Evaluation.

7.1.9 Provide a plan for reporting timelines and possible publications (proposed titles and number).

7.1.10 Develop a risk management plan for OPAL Evaluation including contingency planning.

**7.2 Undertaking collection, management, linkage and storage of data. The contractor will:**

7.2.1 Undertake data collection within the specified protocol and guidelines of approved ethics applications which includes consideration of the protection of privacy of participants and body image sensitivities.

7.2.2 Develop and use printed materials that comply with OPAL Communications Strategy (including use of OPAL graphic device on some materials used in the evaluation and the use of acknowledgements in the publication of reports).

7.2.3 Employ and train a workforce to undertake data collection.

7.2.4 Liaise with intervention and comparison communities to maximise data collections and ongoing partnerships with settings in communities.

7.2.5 Code data including development of coding systems, data management protocol and data dictionary.

7.2.6 Develop data linkage protocol and systems in conjunction with South Australia/North Territory DataLink and data custodians.

7.2.7 Undertake data linkage.

7.2.8 Secure data storage (of electronic and paper-based data) compliant with ethics requirements.

**7.3 Undertaking analysis to determine effectiveness of OPAL. The contractor will:**

7.3.1 Develop applied research questions in consultation with OPAL and stakeholders and a plan for statistical analysis (including cross-section, longitudinal and cost benefit).

7.3.2 Undertake a power analysis to assist with sample size calculations for each phase of OPAL Evaluation.

7.3.3 Consult with statisticians to undertake appropriate analysis and assist in the interpretation of outcomes.

7.3.4 Undertake analysis of data to meet reporting requirements including cross-sectional, longitudinal and economic analyses.

7.3.5 Maintain an 'analysis journal' including tests undertaken and the provision of syntax files.

**7.4 Providing reports to OPAL on the progress of the OPAL Evaluation and the effectiveness of OPAL. The contractor will:**

7.4.1 Prepare and provide quarterly reports on the progress of the OPAL Evaluation.

7.4.2 Prepare and provide baseline reports for each phase of the OPAL Evaluation (including interim-reports for stakeholders including Education and Local Government).

7.4.3 Prepare and provide final reports for each phase of the OPAL Evaluation (including interim-reports for stakeholders including Education and Local Government).

7.4.4 Prepare and provide final reports and associated publications including outcomes from the longitudinal and cost benefit analyses.

**7.5 Providing evaluation and research advice to OPAL. The contractor will:**

7.5.1 Keep OPAL abreast of literature regarding community-based childhood obesity prevention programs, settings-based interventions and literature relevant to OPAL social marketing themes.

7.5.2 Advise if evaluation findings are consistent with evidence-based approaches to physical activity, nutrition and obesity prevention at Statewide and Local Government levels and coordinated with and complementary to National policies.

7.5.3 Provide research-based economic effectiveness advice regarding 'best investments' to inform priority setting and efficiency across OPAL, relating physical activity, nutrition and obesity prevention promotion.

7.5.4 Contribute to OPAL staff training where necessary and provide reflective practice opportunities for OPAL staff.

7.5.5 Provide advice on consent, measurement, intervention priorities, evidence-based actions, evidence gaps and policy to OPAL State Coordination Unit, SAC and other relevant SA Health and government committees.

7.5.6 Identify research opportunities that link to OPAL to support and strengthen the OPAL evaluation.

7.5.7 Provide evidence-based strategic advice and briefings on physical activity, nutrition and obesity prevention issues to OPAL, SA Health, other government agencies, NGOs and industry stakeholders.

**7.6 Working through existing OPAL governance structures. The contractor will:**

7.6.1 Report to the OPAL Evaluation Manager.

7.6.2 Engage with the Scientific Advisory Committee (SAC) mediated through OPAL Evaluation Manager. This may include the provision of updates, preparation of documents for SAC and responding to questions from SAC.

7.6.3 Ensure that contact with OPAL intervention communities is mediated through OPAL Local Council Team.

7.6.4 Ensure that contact with OPAL intervention and comparison communities is respectful and in accordance with OPAL principles, public sector values and protocol developed by OPAL.

7.6.5 Ensure that contact with EPODE and EEN Research streams and Scientific Committees will be mediated through OPAL State Coordination Unit or SAC Chair.

7.6.6 Where requested work closely with other relevant research bodies or groups, including interdisciplinary groups (ie intra-state, interstate or international collaborations) to progress the OPAL research agenda such as Eat Well Be Active Research and Evaluation Centre and Collaboration of Community-Based Obesity Prevention Sites (CO-OPS).

**7.7 The development of appropriate infrastructure to support the conduct of the OPAL Evaluation. The contractor will:**

7.7.1 Source, develop and/or purchase tools including questionnaires for use by OPAL.

7.7.2 Purchase all required equipment to undertake the evaluation including printed materials, scales, stadiometers and measurement equipment, software, computers.

7.7.3 Employ and train suitably qualified staff to conduct data collection, analysis and report writing.

**Deliverables or outputs:**

1. Annual and overall OPAL Evaluation work plan.
2. Risk management matrix and contingency plan.
3. Ethics proposals for SA Health, DECS, Aboriginal Health and regular updates.
4. Quarterly meetings held with the OPAL Evaluation Manager to review progress against the annual work program.
5. Quarterly reports sent to the OPAL Evaluation Manager against deliverables in the annual work program.
6. Production of information sheet, consent forms, questionnaires, or web-based interface for OPAL Evaluation.
7. Develop and provide evaluation methods protocol, data management systems protocol, syntax files for analysis.
8. Regular reports to Scientific Advisory Committee – may include presentations or written briefings.
9. Training for OPAL staff.
10. Identify and provide relevant reports, documents and information to assist in planning OPAL themes, interventions and evaluation.
11. Contribute to and or produce peer reviewed journal publications and conference papers on physical activity, nutrition, weight status and community based obesity prevention programs in collaboration with relevant OPAL staff and SAC members.

12. Where requested contribute to the preparation of reports against the nominated obesity prevention targets of the National Partnership Agreement on Preventive Health (annually).
13. Annual presentations to OPAL Mayoral Club, Health Promotion Branch, etc
14. Provide regular briefings to OPAL State Coordination Unit, HPB and Minister for Health.
15. Provide updates, evaluation progress and baseline and final reports on physical activity, nutrition and weight status for South Australian children in OPAL intervention and comparison communities (linked to SASP Targets and NP targets for incentive payments) according to the following schedule:

| <b>Report</b>  | <b>Due date</b> |
|--|-----------------|
| Baseline Report Phase 1                                | Dec 2010        |
| Baseline Report Phase 2                                | Dec 2011        |
| Phase 1 – Interim Impact Measure Report                | Dec 2012        |
| Baseline Report Phase 3                                | Dec 2012        |
| Baseline Report Phase 4                                | Dec 2013        |
| Progress Reports                                       | Quarterly       |
| Final report Phase 1                                   | Jan 2014        |
| Final report Phase 2                                   | Jan 2015        |
| Final Report Phase 3                                   | Jan 2016        |
| Final Report Phase 4                                   | Jan 2017        |
| OPAL Final Evaluation Report                           | April 2018      |
| Copies of yearly ethics review reports to be submitted | 2010 - 2017     |

**See attached spreadsheet**

OPAL COMMITTED COSTS

|   | 2011-12          | 2012-13          | 2013-14          | 2014-15          | Total             |
|---|------------------|------------------|------------------|------------------|-------------------|
| New OPAL sites                            | 5                | 5                | 0                | 0                |                   |
| <b>Number of proposed OPAL sites</b>      | <b>15</b>        | <b>20</b>        | <b>20</b>        | <b>14</b>        |                   |
| <b>Local Council Team</b>                 |                  |                  |                  |                  |                   |
| <b>Required FTEs</b>                      |                  |                  |                  |                  |                   |
| ASO7 Coordinators                         | 14               | 19               | 19               | 13               |                   |
| ASO5 Coordinator                          | 1                | 1                | 1                | 1                |                   |
| ASO2 Support Officers                     | 15               | 20               | 20               | 14               |                   |
| <b>Total - FTEs</b>                       | <b>30</b>        | <b>40</b>        | <b>40</b>        | <b>28</b>        |                   |
| <b>Total - Salaries &amp; oncosts</b>     | <b>2,463,874</b> | <b>3,535,872</b> | <b>3,649,285</b> | <b>2,551,488</b> | <b>12,200,519</b> |
| <b>Goods and Services</b>                 |                  |                  |                  |                  |                   |
| Grants to Local Government                | 720,481          | 1,006,000        | 1,071,959        | 743,973          | 3,542,412         |
| <b>Total Goods and Services</b>           | <b>720,481</b>   | <b>1,006,000</b> | <b>1,071,959</b> | <b>743,973</b>   | <b>3,542,412</b>  |
| <b>Total Expenses - Local Govt Sites</b>  | <b>3,184,355</b> | <b>4,541,872</b> | <b>4,721,244</b> | <b>3,295,460</b> | <b>15,742,932</b> |
| <b>State Coordination Unit</b>            |                  |                  |                  |                  |                   |
| <b>Required FTEs</b>                      |                  |                  |                  |                  |                   |
| ASO8 Manager                              | 1                | 1                | 1                | 1                |                   |
| ASO7 Eval. Coord.                         | 1                | 1                | 1                | 1                |                   |
| ASO7 Social Mktg                          | 1                | 1                | 1                | 1                |                   |
| ASO5 Additional Program Staff             | 1                | 1                | 1                | 1                |                   |
| Additional Comms Staff                    | 1                | 1                | 1                | 1                |                   |
| ASO2 Admin Support                        | 1                | 1                | 1                | 1                |                   |
| <b>Total - FTEs</b>                       | <b>6</b>         | <b>6</b>         | <b>6</b>         | <b>6</b>         |                   |
| <b>Total - Salaries &amp; oncosts</b>     | <b>610,467</b>   | <b>624,435</b>   | <b>636,924</b>   | <b>649,662</b>   | <b>2,521,488</b>  |
| <b>Goods and Services</b>                 |                  |                  |                  |                  |                   |
| Social marketing materials                | 463,500          | 477,500          | 412,000          | 344,000          | 1,697,000         |
| Staff training and development            | 116,304          | 119,212          | 122,192          | 125,247          | 482,955           |
| Evaluation Costs                          | 918,000          | 900,000          | 908,600          | 935,125          | 3,661,725         |
| Committees                                | 25,500           | 26,010           | 26,530           | 27,061           | 105,101           |
| Goods and Services                        | 316,518          | 255,711          | 282,941          | 304,888          | 1,160,058         |
| <b>Total Goods and Services</b>           | <b>1,839,823</b> | <b>1,778,433</b> | <b>1,752,263</b> | <b>1,736,321</b> | <b>7,106,839</b>  |
| <b>Total Expenses - Central Resources</b> | <b>2,450,290</b> | <b>2,402,867</b> | <b>2,389,187</b> | <b>2,385,983</b> | <b>9,628,327</b>  |
| <b>Total Cost of Statewide Delivery</b>   | <b>5,634,645</b> | <b>6,944,740</b> | <b>7,110,431</b> | <b>5,681,443</b> | <b>25,371,258</b> |
| <b>NPP Funding</b>                        |                  |                  |                  |                  |                   |
| Healthy Children Facilitation             | 2,320,000        | 4,630,000        | 2,300,000        | 2,360,000        | 11,610,000        |
| Healthy Children Rewards                  | -                | -                | 4,650,000        | 6,970,000        | 11,620,000        |
| <b>Total NPP funding</b>                  | <b>2,320,000</b> | <b>4,630,000</b> | <b>6,950,000</b> | <b>9,330,000</b> | <b>23,230,000</b> |
| <b>State funding</b>                      | <b>3,314,645</b> | <b>2,314,740</b> | <b>4,810,431</b> | <b>3,321,443</b> | <b>28,135,553</b> |