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About Home Economics Victoria

Home Economics Victoria was established in 1958, as a professional association for teachers, and is the peak home economics organisation in the state of Victoria, Australia. The organisation supports educators in empowering young people to live sustainably and take responsibility for their own physical, mental and social wellbeing.

Opinions expressed in this journal are those of the contributors and do not necessarily represent the views of Home Economics Victoria.

At the time of writing, all internet addresses included in articles were correct. Owing to the dynamic nature of the internet, however, we cannot guarantee their continued validity.

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Cover image: Thank you to Anglican Overseas Aid for providing this image depicting their work in communities of Kolkata, India – empowering women by providing social and financial opportunities.

Foreword

Welcome to issue 2 of the 2015 Victorian Journal of Home Economics. This issue contains contemporary articles of interest for home economics teachers and allied professionals that extend professional learning. Professional reading is an activity that contributes to Victorian Institute of Teaching, professional development requirements.

Dr Bob Mitchell, CEO, Anglican Overseas Aid, received much acclamation at the VCE Health and Human Development student revision lecture in September. The text and slides of this insightful and engaging presentation are published in this issue.

Healthy eating and nutrition education are fundamental elements in food-centred Home Economics courses in schools. The Australian Curriculum and the newly accredited VCE Food Studies emphasise a focus on healthy eating. Ms Stephanie Huggins has written a timely article about the significance of healthy eating and nutrition education in schools. Home Economics Victoria has managed the Victorian Department of Health and Human Services, Healthy Eating and Food Literacy (HEFL) in secondary schools project. The evaluation contains some snapshots of school activities designed to promote healthy eating and food literacy.

We thank all of the contributing authors that have made the Victorian Journal of Home Economics issues diverse in 2015. We welcome input from Home Economics Victoria members. Please contact the editor if you have a topic or issue of interest to your colleagues.

Gail Boddy
Editor

NGO contribution to global health: the experience of AOA

presented by
Dr Bob Mitchell at RMIT
7 September 2015

Good morning students. I do hope that you are having a great Health and Human Development VCE Student Day Out. My topic today is a broad one, the NGO contribution to global health. The role of NGOs is often overlooked or downplayed. NGOs do contribute in powerful and creative ways to global health, and I will be drawing on the experience of my own organisation Anglican Overseas Aid (AOA) to illustrate some of the points I'll be making.

Goals for this talk

Now, I've got several goals for this talk today.

- I want to re-introduce you to the concept of NGOs,
- Show how they contribute to global health, and
- Illustrate the idea of sustainable change.

Throughout I am going to encourage you to think more broadly about health issues, moving beyond a narrow clinical focus to looking at the broader context. When we do that, we see that there are other factors affecting global health, like culture, geo-politics, and even climate change.

What is an NGO?

What are NGOs?

- NGO = Non-Government Organisation
- NGOs are an important part of civil society
- NGOs are not part of government, but sometimes receive government funding
- NGOs provide important services within communities
- These can complement official health services
- NGOs include health promotion charities, mental health and counselling services, and health reform organisations

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The acronym NGO stands for Non-Government Organisation. These are community-based organisations which are a very important part of civil society. NGOs can take on the role of delivering services to community. They are not part of government, but work with governments in the co-ordination and delivery of services. NGOs can include faith-based organisations like church-run hospitals and clinics, international development organisations like World Vision or Oxfam, human rights organisations, like Amnesty.

The size and scale of NGOs in the health sector should not be underestimated. It is commonly claimed that about 40% of health services in Africa are run through faith-based NGOs alone. While it is hard to pin down how this figure has been calculated, it is certain that the contribution made by these organisations is very significant.

We have many NGOs in Australia too. They reflect special-interest groups within the community, and they complement the work of government within the health system. For example, there are health promotion charities, like the Cancer Council or the Heart Foundation, and there are counselling services and clinics. There are groups like Headspace and Beyond Blue creating awareness about mental health issues. And there are groups more interested in public policy issues who lobby for reform of the health system, for example, the Doctors' Reform Society.

How are NGOs funded?

The Australian Government supports the work of some Australian NGOs involved in foreign aid by giving grants to accredited agencies like AOA. This type of funding may be directed to specific places or sectors that meet the government's priorities. AOA has one large program in maternal and child health in Kenya and Ethiopia which is largely supported by the federal government in this way. Of course, Australian NGOs are also supported by the Australian public through donations. So the funding for their work usually comes from a combination of private donors and government grants.

The relationship between NGOs and governments

In a developing country context, there are difficult public policy issues raised by the ongoing presence of NGOs. For example, foreign NGOs, like Oxfam or Care or Save the Children, will generally only want to be present in a community for a limited period of time. The idea is that NGOs should be catalysts for change, not that they should be permanently involved in the delivery of basic community services. The problem is that the provision of services and infrastructure by an NGO may act as a disincentive to governments to accept their proper responsibilities. For example, if an NGO provides a health clinic in a remote area, then why should the government bother? It may decide to save its money or spend it elsewhere. On the other hand, if an NGO pulls out of that community, then there may be no-one at all to deliver those services.

Sustainability

This is a neat segue into the idea of 'sustainability'. Sustainability is one of those buzzwords which gets bandied about. It can mean different things. It can refer to the sustainability of an organisation or the sustainability of the changes it is trying to bring about. For example, if an NGO is providing critically important community services, how is it going to be able to do that on an ongoing basis? Or should it even try? Is it better to figure out ways the community can do that for itself? Or if a program is about bringing about improvements in public health, how are those improvements going to be embedded in a truly lasting way?

Every situation is different, and there are a number of possible strategies. An NGO might start something, and the government might then be persuaded to take it over, and so sustainability is achieved in this way. Or a foreign NGO may build the capacity of local indigenous NGOs which then step up and carry on the work. Or one or more communities may get together and mobilise and start to provide their own services, instead of the NGO doing it. Increasingly popular are so-called 'social enterprise models' of doing development which involve income creation through some kind of local enterprise to ensure that there is a permanent funding stream for important work.

A key strategic concern for foreign NGOs is to avoid long-term dependency. Dependency does not ultimately help communities. In fact, it disempowers them. In the end, true sustainability of social change means that the community itself must become more self-reliant.

Thinking broadly

I want to encourage you to think behind the presenting health issues and look at the broader context. This is sometimes called systems thinking. Too often specific health issues like HIV, or ebola, or malaria are viewed in a more narrow clinical way. Doctors and health professionals can tell you what to do to diagnose and treat these conditions. Organisations involved in development work know that it makes more sense to look at community health in a holistic way. What lies behind the phenomena of the particular disease, and what are the social and environmental factors that contribute to the burden of that disease?

Is ebola simply about a highly dangerous and contagious virus, or is it about poor hygiene and sanitation, overcrowding, social customs during periods of infection, the movement of people across borders, a lack of research, and under-resourced public health systems in some developing countries? It's all of these things.

More generally, material poverty is tightly correlated to poor health outcomes.

The social determinants of health

The Social Determinants of Health

- This important concept is about establishing social and environmental factors which contribute to adverse health outcomes
- These include: physical environment, access to health care, employment and working conditions, social protection and safety nets, distribution of income and power, opportunities for social participation, macro-economic conditions, affordable housing.

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There is a very important concept that you will come across called the "social determinants of health." This concept is about establishing the social and environmental links which contribute to adverse health outcomes.

Research of the World Health Organisation has identified two broad categories that need to be addressed. The first is daily living conditions. This includes the physical environment in which people live, access to health care, employment and working conditions, social protection and safety nets. A second category concerns distribution of income and power, opportunities for social participation, resource depletion, and macroeconomic conditions.

This is not rocket science. Poor people tend to live in overcrowded or substandard accommodation. Poor people may not have meaningful work. Poor people may not be able to buy good food and may experience periods of food insecurity. Poor people may be homeless, exposed to violence, and may have a higher prevalence of mental health issues. Poor people may not be able to afford health care or medical checks. Poor people may be less well-educated, and may not have a good understanding of their own health and health risks. Poor people may be more vulnerable to exploitation or dangerous work conditions.

The general argument can be made that doing something about material poverty is, generally speaking, very good for people's health. If many health outcomes are, statistically speaking, socially determined, then doing something about the underlying social conditions will improve people's health.

Climate change and global health

Climate change and health

Health impacts include:

- Casualty and injury from extreme weather events
- Loss/damage to public infrastructure necessary for public health
- Desertification, loss of food producing areas
- Prolonged periods of drought with food security risks
- Salination/rising water table affecting food production
- Mosquitoes moving to warming areas

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NGO contribution to global health: the experience of AOA

Another environmental factor, which is starting to have an influence on health, is climate change. The links with health may not be immediately apparent, but this is an area receiving a lot of research. This research shows that climate change is having a disproportionately bad impact on poor communities. Let me give you some examples.

The world is experiencing a growing number of extreme weather events which have been linked to global warming. While it is impossible to say that any particular event is or isn't a consequence of climate change, the overall pattern of increasing extreme events has been established.

In our region we have witnessed very destructive typhoons in places like the Philippines, and cyclones in the Pacific in countries like Vanuatu. Apart from the physical destruction and trauma of these events, there is the risk to food security as crops are destroyed, and to public health as water supply systems and sanitation systems are damaged.

Conversely, in other parts of the world there have been prolonged periods of drought which have caused extreme food shortages.

Another phenomenon is desertification. Parts of Sub-Saharan Africa are becoming more arid as the Sahara desert moves south. This means that land previously used for agriculture is becoming more and more marginal. This, in turn, is placing subsistence farming communities under pressure, and is affecting health and nutrition. On the other hand, as some areas warm up they may become more productive, but the overall picture is that poor communities will be worse off.

In low-lying Pacific Island countries there is a concern about rising sea levels, and in particular, the rising water table which is making some land unusable for agriculture because of salination.

Some impacts are more subtle. In Africa, as average temperatures increase in some areas, they become viable habitats for disease-carrying mosquitoes. As these mosquitoes move into these warmer areas, diseases like malaria can extend their reach. And of course, as temperatures rise, there is the risk to health, especially in the elderly, of heat stress.

Culture and health

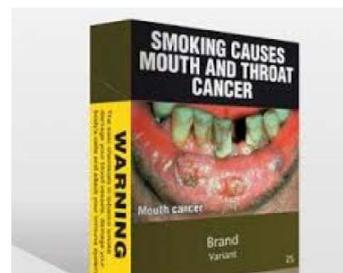
One of the key principles of effective development is that change must be sustainable. Changes need to become embedded in behavioural changes.

From a public policy perspective it is always better to prevent health problems rather than react to them.

Putting these two principles together may mean changing culture, which can be difficult. In Australia, where the funding of our public health system is under pressure, it is vital to try and prevent the onset of disease, especially chronic conditions. A good example in Australia, is the onset of type 2 diabetes, which is linked to rising obesity rates, which is in

turn linked to the increased consumption of sugary foods in our diet and our sedentary lifestyles.

The consequence of type 2 diabetes is the risk of serious sometimes life threatening complications, kidney failure, a life on dialysis. The personal cost is, of course, enormous. The financial cost is also enormous because lifelong treatment and control can be required. Prevention is a far better option. But prevention means changing behaviour.



- Tobacco control in Australia is an example of effective and sustainable change

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In Australia, an example of effective and sustainable change has been tobacco control. Two decades of anti-smoking ads, plain-packaging laws, restrictions on where you can smoke, and increased taxes on tobacco have finally taken effect and rates of smoking are declining. People who smoke are no longer seen as cool, but are more likely to be seen as social pariahs.

I hasten to add that smoking is on the increase in many parts of the developing world. Global tobacco giants have refocused their marketing efforts in other countries with less strict regulation. Tobacco use is a major if not the major health risk in a number of developing countries.

The point I'm making is that better health outcomes are achieved through behavioural change. This is almost always slow and incremental, but it is important to make a start, to give people timely and accurate advice, and to provide a compelling rationale for change.

Health issues do not always present as health issues

To put things back in the context of developing countries there are many health issues which are obvious, and some which really present as other issues. Let me give some examples.

One is girls getting married too early. You may not immediately think of this as a health issue, but it is. While a girl in North Africa may be able to conceive a child at 12 years of age, getting pregnant at that age leads to all sorts of very serious obstetric complications, like fistulas as a result of trauma in childbirth. Girls as young as 12 or 13 are getting married in some countries. Basically, the girl's body is not ready for the stress and strain of delivering a child at such a young age. Sustainability of change comes about by patiently

working with religious and community leaders to discourage the practice of early marriage. This can be difficult, because the practice may have a very long history.

While most people see female genital mutilation or FGM as a matter of human rights – the choice over what happens to your own body – it is also undeniably a health issue too. FGM is a horrendous cultural practice taking place in many parts of northern Africa. This practice is completely anathema to most people living in the West, and is illegal in countries like Australia. While FGM is illegal in a number of African countries, including Kenya and Ethiopia, it is still widely practiced in some communities. The latest countries to ban FGM are Nigeria and Sierra Leone. In other parts of the world, different cultural considerations apply. The practice is generally carried out without proper sterilisation, without proper anaesthetic, and without proper surgical skill. This can lead to botched procedures, serious infection, gynaecological problems, and all sorts of complications. Again, sustainability of change comes about through education and patiently and respectfully working with community leaders.

War and internal conflict as a health issue



War and civil conflict are health issues

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Continuing the theme that health issues often present as other types of issues, I'd like to suggest to you that war and internal civil conflict are also health issues. Undoubtedly they are geopolitical issues, but they also have enormous health consequences.

In the last year AOA has run emergency appeals because of civil conflict in northern Iraq, Syria, Gaza, and South Sudan. Each of these situations has involved risk to large numbers of people because of civil conflict. These situations involve physical and mental trauma, people living without shelter, the overloading and breakdown of health systems, and people moving long distances in very dangerous conditions.

It is difficult to see how sustainable and positive change can occur in some of these contexts, and this is a matter of great sadness.

One incident I remember from a few years ago occurred when I was travelling in the back of a car in Rwanda. Rwanda was a country which had seen one of the world's largest

genocides, when two different groups, Tutsis and Hutus began attacking one another in 1994. About 800,000 people were killed. Anyway, as I looked out the window I saw a shiny new school building and made some innocent comment about it. The driver turned to me and said "You know, that school could be burnt down in civil unrest tomorrow. The biggest developmental challenge in Rwanda is not education, but people learning to live with each other."

This is one of the greatest challenges for any kind of sustainable change. We do need to work for a peaceful world.

Health aspects of AOA programs

In the next part of my lecture I am going to look at a segment of our programs and how they address health issues in particular contexts. You will see how different the issues are in each place. It is impossible to look at all of AOA's programs in 45 minutes, so I've decided to showcase a subset of programs that affect women's health.

The Gaza Strip



Gaza

- In Gaza AOA funds free breast screening at an Anglican hospital for poor Palestinian women
- We also address cultural attitudes through community outreach work

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Our program in the Gaza Strip is about free breast screening for Palestinian women. The context there is 1.8 million people in a strip of land about 35 km long and 10k wide. There are high rates of unemployment, large numbers of refugees, and degraded public infrastructure because of successive military interventions. In the midst of this very challenging environment, the Anglican Church has owned and operated a public hospital for over a century.

The work we fund at that hospital is about offering a free public breast screening clinic for poor Palestinian women. We do mammography and fine tissue biopsy to diagnose breast cancer. That's the clinical description of what we do. But there is a lot more to it than that when you look behind the diagnosis.

The hospital has a range of community outreach programs that go along with the clinical service.

For example, there is work done to teach women about breast self-examination for early detection. This is so important in a conservative culture where this is not a topic that can be easily raised.

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We all know the importance of women being supported through breast cancer. Family and social support is critical to get the best outcomes. For this reason, attitudes of men are challenged, for example, the practice of sometimes divorcing women who are diagnosed with the disease, or taking an additional wife which then disrupts the family order.

Another cultural belief which is encountered, is that daughters may no longer be considered marriageable if their mother has been diagnosed with breast cancer.

Then there is the practice of first cousins marrying. This exacerbates a genetic predisposition in some Arab women to get breast cancer. So the hospital warns about this.

So you can see it's not just about a disease. For a health outcome to be permanently and sustainably improved, it is necessary to address surrounding cultural beliefs and practices, what you might call behaviours, which can make the situation far worse.

Another issue in Gaza is actually getting women out of Gaza for more sophisticated treatment when that is necessary. Radiography and chemotherapy are severely limited in Gaza, but it is extremely difficult to get permission for anyone to leave. It is a complex geopolitical situation that directly affects women's health. Israel has very strict border controls, and Hamas, the local government, is not too keen on people leaving either because it can look like an admission of failure for the Palestinian health system. In the midst of all this complexity, ordinary everyday women can die.

In reality, the most likely treatment option is surgical excision of the cancer or radical mastectomy. That's politics for you. So we can add yet another factor that can determine health outcomes.

Kenya and Ethiopia



Ethiopia and Kenya

- Semi-nomadic pastoral communities
- Maternal and child health issues
- Training up traditional birth attendants

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The main work we do in Kenya and Ethiopia is in the area of maternal and child health. The particular communities we work with are semi-nomadic pastoralist communities. These are cattle-grazing tribal groups, like the Masai and Samburu. They move from place to place to graze their cattle. The type of country is very rough. Logically enough, the more fertile, better quality land has been taken and permanently settled. So these tribes are left to roam very marginal countryside with their cattle. This takes them into remote less-populated areas.

There are particular health issues associated with that, especially for pregnant women. It may be that when it comes time for a woman to give birth, they are a long way from any type of clinical setting. They may be in the middle of nowhere.

Our work involves helping communities to find ways for women to attend health facilities to give birth managed by a skilled health professional. They are accompanied by traditional birth attendants as a friend who reassures and guides the woman through the hospital environment. We also train traditional birth attendants and health volunteers to help safely deliver the baby in circumstances where the woman cannot reach a clinic. The ideal, of course, would be to get women to attend a hospital or a clinic, and this is the direction the government in Kenya would like to go. However, this clinical model of care is unrealistic for nomadic communities, and so there is a valuable role to be played by traditional birth attendants.

An important part of the training is to try and identify when there are likely to be complications so that arrangements can be made for those women to attend clinics. We also supply solar-powered birthing kits so that there can be adequate light when women give birth at night in remote places.

Again, there are cultural practices that are challenged. One is the practice by some groups of restricting the diet of women in their third trimester of pregnancy. This is done to try and reduce the birth weight of the child, in the belief that this will lead to an easier birth. Starvation diets are not good for the mother or the child.

Another problem is the difficulty in getting good baseline data about infant mortality rates. There are no reliable figures. The reason for this is that children who die at birth or in early infancy are not registered. The cultural belief is to not mention people who have died; they are not spoken of again. And so it is very hard to determine a reliable statistical baseline.

You can see once again that it is impossible to separate culture from health care. What makes change sustainable is empowering the community itself through training, and respectful challenging of detrimental behaviours.

South Africa



South Africa

- High levels of domestic violence
- Safe Persons' Network
- Getting abuse taken seriously

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You would be well aware of the focus on domestic violence in Australia at the moment. The importance of this issue has been highlighted by the appointment of Rosie Batty as Australian of the Year. You might think it is odd to be talking about domestic violence in a talk about health and NGOs. Let me assure you that domestic violence is a major health issue here in Australia as well as overseas. One woman in Australia is killed by her partner or ex-partner every week in Australia. And for every woman killed, there are countless numbers of assaults and injuries resulting in physical and mental trauma.

The position is even worse in other countries. Our work in South Africa is really based around responding to gender-based violence. There are alarmingly high rates of domestic violence in South Africa. It is traditionally a male dominated society, and the rights of women are frequently ignored.

The basis of our program is about behavioural change. First, we work with local communities to create what we call 'safe persons networks'. These are networks of people to whom women can go when they experience domestic violence. They will be believed, supported, and cared for. We also work very closely with people in the justice system, like police and magistrates and village elders to ensure that the complaints of women are taken seriously and followed up.

Finally, we are working through churches in South Africa to appeal for change on the basis of their religious convictions. Religious faith is taken very seriously in South Africa, so working with clergy to train them about gender-based violence ('GBV') is very useful. Churches are an authoritative voice in their communities and they are well-positioned to influence their communities in a positive way to prevent GBV.

Again, culture and an important health issue are inextricably linked. The way to deal with a difficult issue sustainably is by using cultural levers to bring about behavioural change.

I also need to say something about HIV which has affected many women in Africa. Death rates from HIV are stabilising now due to the availability of anti-retroviral drugs. Culturally, there have been very concerted efforts to try and educate men and women about sexual health and preventative measures. This can be difficult in conservative cultures where this kind of discussion is often taboo. The education of men is especially important. For AOA, HIV has been a major part of our programs in Africa for two decades. The challenge has been to move beyond simply awareness-raising and into changing behaviour. One approach has been to work with young men especially, teaching about HIV during initiation practices upon entering manhood. This is an especially formative time for young adult men, and a good opportunity to instil important learnings.

India



India

- Empowerment for women living in slums
- Alternative income streams
- Educating children of sex workers

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Our work in India focuses on women living in slum communities in Kolkata. These are often very poor, semi-literate, migrant women, and some sex workers. Our partner there tries to do two things. They try and convince the women to enrol their children in school. And they try and get them to join women's co-operatives which provide both social support and additional income through goods that they make and sell.

Again, there are health implications of this work, which are not immediately obvious. For children, once they are enrolled at school, they will be subject to regular basic health checks, including height, weight, and dental health. Being at school is a safer environment than being on the streets, or getting trapped into child labour.

For the women themselves, the co-operatives provide social support and opportunities to interact with other women, and can provide an additional stream of income that takes pressure off the family budget. Again, there are cultural considerations which impact the work. Some women from Muslim backgrounds are restricted in their mobility. They may be restricted to the home environment, and it takes careful work with the family to achieve their participation.

South Pacific



Solomon Islands and Vanuatu

- Replacing kerosene
- Freeing up income
- Environmentally friendly approach
- Business model helps fund women's initiatives

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Finally, I want to tell you about our work in Pacific Island countries like the Solomon Islands and Vanuatu. These are groups of islands spread out over the Pacific Ocean. There is very limited physical infrastructure in these countries. The

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geography of scattered island communities means there is no reticulated electricity. These island communities have typically relied on the burning of kerosene lamps in their village huts for lighting.

There are major health issues associated with this. The burning of kerosene in a confined space, like a hut, has about the same impact on your respiratory system as smoking a packet of cigarettes a day. It is also dangerous, and there are burns and fire-risk from the exposed flames. We try and encourage families to replace kerosene with solar lighting.

This has major impacts on households. An immediate benefit is improved respiratory health. But there are other benefits too. Because solar lighting is inexhaustible and free, it means children can study at night. It literally means that the day does not end when the sun goes down.

Another benefit is that the solar systems tend to pay for themselves in about 8 weeks. In other words, the amount that would have been spent on kerosene will pay for the solar equipment in 8 weeks. After that, there is a permanent saving that can be diverted to children's education, books, uniforms, or healthcare. Obviously, too, solar is much kinder to the environment than burning fossil fuels.

The sustainability of this work comes from the fact that we use a business model to implement the program. We train up people to install and distribute the solar products, which are themselves affordable and easily maintained. This model provides opportunities for employment, and this helps to make education affordable. In some cases the distributor is a women's group called the Mothers' Union. This is a form of appropriate empowerment and ensures gender equity. They divert their profits to fund their own programs combating GBV. So this particular program is a win, win, win.

Closing remarks



- NGOs have critical role
- Sustainability is vital
- Social, cultural, and environmental factors affect health outcomes
- 'Social determinants of health' a key concept
- An integrated 'systems approach' desirable
- Think broadly!

My time is nearly up, so I want to recap on some of the main points from this session.

NGOs are very important contributors to human health both here in Australia and overseas. Their contribution is often overlooked.

The most effective NGOs are those that develop strategies to make their work sustainable.

Sustainability usually involves looking at a problem more broadly, and considering the bigger picture. Only then can the full range of relevant factors be considered.

There are many different strategies to achieve sustainability: community education, empowering and mobilising local communities, behavioural change programs, working with women, building the capacity of local NGOs, and working with local leaders to challenge harmful practices. There are also social enterprise models of doing development by which communities can generate their own funding.

Another thing we've learned is that it is the way cultural and environmental factors are deeply entangled with many health issues. The term 'social determinants of health' refers to some of these background factors which can impact health outcomes.

Many health issues present as some other kind of issue. This just goes to show that health and development responses needs to be looked at in a highly integrated way. Every context is different, and it can be a mistake to 'roll-out' one-size-fits-all answers.

Even topics like climate change have important health implications. The take away message from this talk is to think broadly and look at whole systems.

Thanks so much for your attention today, and I hope that this talk has given you some food for thought.

Author Biography

(Rev.) **Dr Bob Mitchell**. LLB, MPhil, GradDipTax, GradDipTheol, MThSt, GradCertMin, PhD

Dr Bob Mitchell is the CEO of Anglican Overseas Aid. He has a passion for aid and development as a ministry of the church. Before AOA he was a senior executive at World Vision Australia serving in both strategic and operational roles. He is currently a director of Western Health, and is a member of the international advisory board of the Christian Journal for Global Health. Dr Mitchell holds post-graduate qualifications and has extensive experience in public policy, theology, and taxation law, and is an ordained Anglican minister.

Benefits of Healthy Eating and Nutrition Education in schools

Ms Stephanie Huggins
Deakin University

Schools are powerful settings for the delivery of health promotion messages ⁽¹⁾. Targeting student behaviour during the early, influential stages of life can establish healthy habits that continue into adulthood ⁽²⁾. In February 2015, there were 915,159 students enrolled in schools across Victoria alone ⁽³⁾. There is potential in the school setting to not only reach a large number of students, but also staff, families and the greater school community ⁽¹⁾.

The positive effects of healthy eating on disease outcomes, mental health and behaviour, cognitive function, growth and other aspects of human development are well known. Given the high rates of diet-related disease in Australia, schools are an opportune setting for the implementation of nutrition promotion activities ⁽⁴⁻⁷⁾.

Being Overweight and Obesity

According to the 2011–13 Australian Health Survey, approximately 62.8% of Australian adults and 25.7% of children are overweight or obese ⁽⁴⁾. Poor nutrition is a leading cause of weight gain and obesity ⁽⁵⁾. Being overweight or obese increases the risk of numerous diseases including type 2 diabetes, cardiovascular disease, a number of cancers and osteoporosis ⁽⁵⁾. Carrying excess weight also contributes to low self-confidence and self-esteem, poor relationships and academic performance, discrimination and depression ⁽⁶⁾.

Mental Health and Behaviour

Links have been found between nutrition, mental health and behaviour ⁽⁷⁾. Diets comprised of highly processed, low-nutrient foods are associated with depressive symptoms and delinquent behaviour ⁽⁷⁾. Conversely, diets high in fruit and green leafy vegetables are related to improved behaviour ⁽⁷⁾. Low intakes of B-group vitamins in particular have been linked with reduced psychological wellbeing, aggressive tendencies, poor mood moderation and anxiety and depression in adolescents ^(7, 8).

Growth and Development

A nutritious diet is important for growth and development ⁽⁹⁾. Dairy in particular is essential for bone health and linear growth ⁽¹⁰⁾. Sufficient dairy intake is also inversely associated with dental caries, hypertension and adiposity ⁽¹⁰⁾. It is important to consume enough calcium in younger years in order to achieve full bone mass potential ⁽⁹⁾. Peak bone mass is reached at around ages 25 to 30, after which bone density does not continue to build ⁽⁹⁾. From approximately age 40, bone mass will slowly decrease and too much loss of bone strength can result in fractures and osteoporosis ⁽⁹⁾.

Cognitive Function

Sufficient nutrient intake is essential for optimal brain function ^(10, 11). Healthy diets have been linked to superior concentration, cognition, energy levels and academic performance ⁽¹¹⁾. Contrastingly, a lack of essential nutrients and high intakes of saturated and trans fats are associated with reduced memory and learning ability ⁽²⁾. Increased susceptibility to illness is also related to poor nutrition, with studies indicating more absences from school when students have deficient diets ⁽¹²⁾.

Breakfast in particular is important for student learning ⁽¹³⁾. School breakfast programs are being implemented around the world in response to research that shows the positive effect of nutritious breakfasts on reduced school absenteeism and behaviour, concentration and academic performance ⁽¹²⁾. These programs not only give students access to breakfast, but assist time-poor parents in ensuring their child has a meal before they start their school day ⁽⁵⁾. It is clearly important that the breakfasts offered by schools are balanced and nutritious ^(12, 13).

Dietary Recommendations

It is recommended that school-aged children eat approximately two serves of fruit and five serves of vegetables per day ⁽¹⁴⁾. Fruit and vegetables are essential for adequate nutrient and fibre intake, and reduce the risk of developing a number of chronic diseases ⁽¹⁵⁾. These include cardiovascular disease, diabetes, obesity and multiple cancers such as colorectal and stomach ⁽¹⁵⁾. In 2011–12 only

5.5% of Australians met the recommended guidelines for fruit and vegetable intake ⁽¹⁶⁾.

It is also important to ensure the recommended daily intake for each food group is met, and that discretionary foods are limited ⁽¹⁶⁾. Discretionary items are those high in saturated fats, added salt and added sugars, for example chips, pastries and lollies. ⁽¹⁶⁾

Recommended average daily number of serves from each of the five food groups*					Additional serves for more active, taller or older children and adolescents	
	Vegetables & Legumes/beans	Fruit	Grain (cereal) foods, mostly wholegrain	Lean meat and poultry, fish, eggs, nuts and seeds, and legumes/beans	Milk, yoghurt, cheese and/or alternative (mostly reduced fat)	Approx. number of additional serves from the five food groups or discretionary choices
Toddlers**						
1–2	2–3	½	4	1	1–1½	
Boys						
2–3	2½	1	4	1	1½	0–1
4–8	4½	1½	4	1½	2	0–2½
9–11	5	2	5	2½	2½	0–3
12–13	5½	2	6	2½	3½	0–3
14–18	5½	2	7	2½	3½	0–5
Girls						
2–3	2½	1	4	1	1½	0–1
4–8	4½	1½	4	1½	1½	0–1
9–11	5	2	4	2½	3	0–3
12–13	5	2	5	2½	3½	0–2½
14–18	5	2	7	2½	3½	0–2½

Nutrition Education

Children become more independent and in control of their own decisions as they grow older and decision-making behaviour established at this time can track into adulthood ⁽¹⁾. Resources available to children influence the establishment of this behaviour, providing a powerful window of opportunity in the school setting for influencing long-term healthy decision making ⁽¹⁾. In terms of nutrition behaviour, the resources available to children can include access to nutritious food as well as skills and knowledge ⁽¹⁷⁾.



Australian Government
National Health and Medical Research Council
Department of Health and Ageing

www.eatforhealth.gov.au

Australian Guide to Healthy Eating

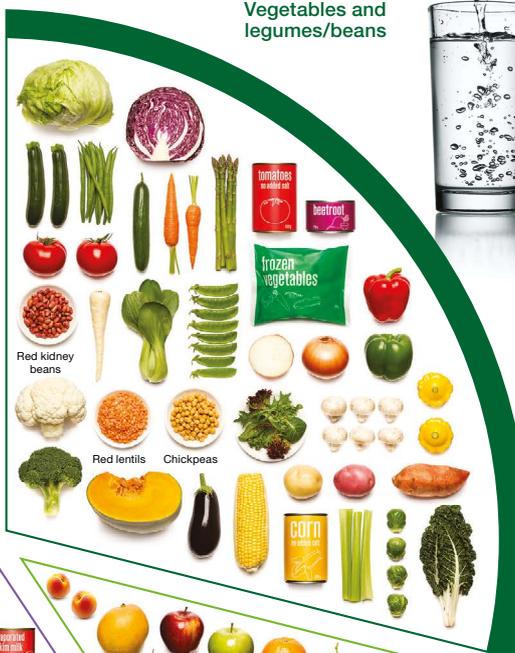
Enjoy a wide variety of nutritious foods from these five food groups every day.

Drink plenty of water.

Grain (cereal) foods, mostly wholegrain and/or high cereal fibre varieties



Vegetables and legumes/beans



Lean meats and poultry, fish, eggs, tofu, nuts and seeds and legumes/beans



Fruit



Milk, yoghurt, cheese and/or alternatives, mostly reduced fat



Use small amounts



Only sometimes and in small amounts



Source: National Health and Medical Research Council, Australian Dietary Guidelines, eatforhealth.gov.au

Benefits of Healthy Eating and Nutrition Education in schools

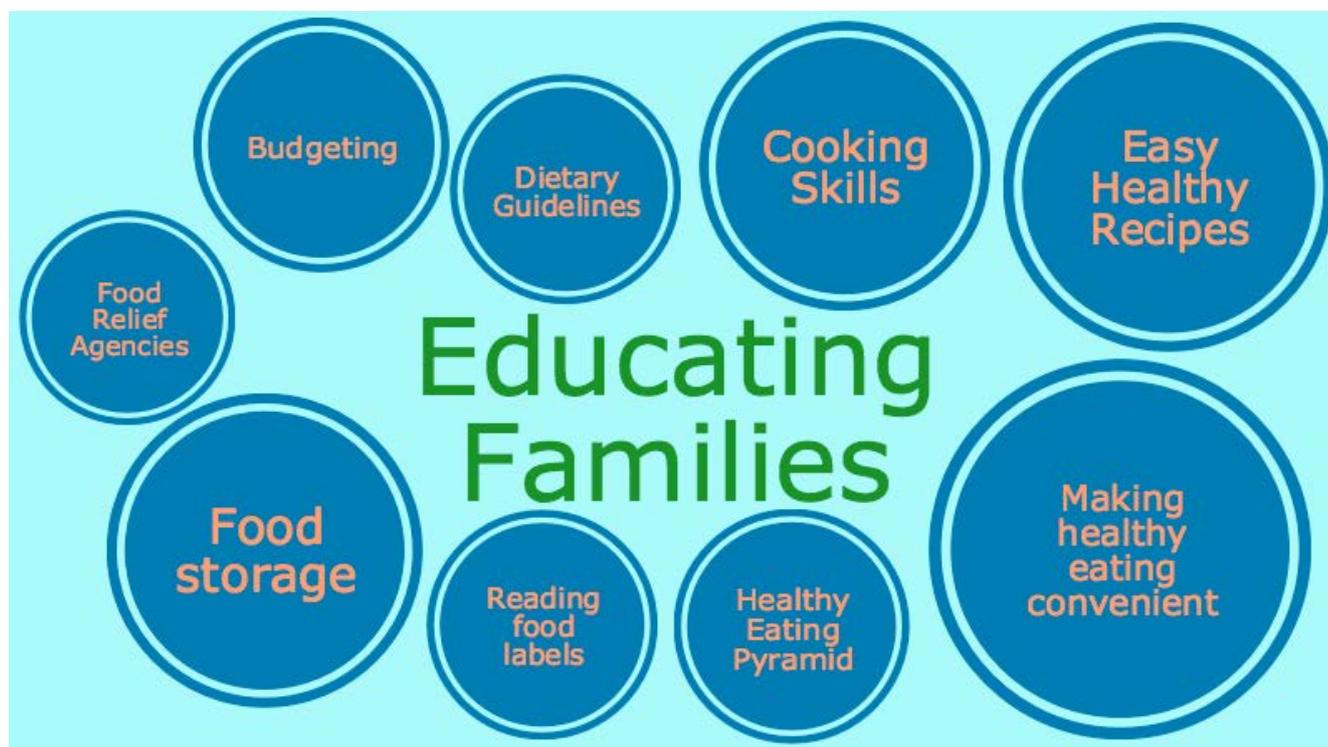
In order for students to make informed nutrition decisions, it is important to equip them with knowledge about what constitutes a healthy diet ⁽¹⁸⁾. The Australian Guide to Healthy Eating provides teachers with the latest recommendations on eating for good health ⁽¹⁴⁾.

Hands-on school cooking programs have shown increased student cooking ability and willingness to try new foods ⁽¹⁷⁾. Behaviour at home has also been influenced by school cooking programs, with families cooking more meals at home and students asking parents to make the meals prepared at school ⁽¹⁷⁾. This news is promising for reinforcing behaviour encouraged in the classroom. Targeting families with nutrition messages can also increase student access to healthy food, as they acquire the majority of their food from home ⁽¹⁹⁾.

Barriers to providing healthy food at home for families include lack of nutrition knowledge, access to food outlets and supermarkets, limited budgets and lack of cooking skills ^(17, 19, 20). Teaching parents about the effects of a nutritious diet on student learning and overall wellbeing can be valuable for encouraging healthy eating at home ⁽¹⁹⁾. Providing information about how to prepare meals on a budget, how to store food

and make healthy eating more convenient and highlighting food relief agencies can also increase the provision of healthy food by families. Some ideas for influencing the provision of nutritious food and parent behaviour through schools include:

- School newsletter articles and tips
- Homework involving parents, for example making or planning a low-cost, easy, healthy meal
- Take-home healthy recipes made in class
- Nutrition posters and displays around the school
- Opportunities for parents to volunteer with healthy eating activities
- Information sessions and parent nights/mornings
- Use incentives, eg. food and giveaways for attending information sessions
- Facilitate and allow time for socialising at parent events
- Highlight links between nutrition, learning and student wellbeing
- Consider different family backgrounds and availabilities ^(18, 21, 22)



The opportunity for influencing the healthy eating habits of young Australians, presented by the school setting, is exciting. With alarming rates of diet-related disease in Australia, and abundant positive effects of a nutritious diet, the need to deliver nutrition education to school students and their families is clear.

Benefits of Healthy Eating and Nutrition Education in schools

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Author Biography

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HEFL evaluation

Abstract

Home Economics Victoria led the Healthy Eating and Food Literacy (HEFL) Secondary Schools, funded by the State Government of Victoria and the Australian Government as part of the statewide health effort Healthy Together Victoria (HTV).

The HEFL project was part of a systems approach to chronic disease prevention targeting 14 Healthy Together Communities (HTCs) in the local government areas of Hume, Wyndham, Whittlesea, Knox, Cardinia, Greater Dandenong, Greater Geelong, Mildura, Latrobe, Wodonga, Greater Bendigo and Ararat, Central Goldfields and Pyrenees.

The goal of HEFL was that children, young people and families demonstrate behaviours that support healthy eating. This report provides narrative of the project using qualitative data collected from schools.

“Being food literate means having the knowledge, skills and the capacity to source, prepare, cook and share food in a sustainable manner to promote a healthy and balanced lifestyle. Food literacy is also about individuals understanding the role that food plays in communities and cultures.”

Home Economics Victoria 2013

Introduction

The HEFL project started with a rapid review and extensive consultation to examine successful primary prevention and health promotion initiatives; those that had been associated with improved healthy eating and/or food literacy among adolescents in schools. The research highlighted the importance and influence of a supportive environment (school, students' families and local community) to encourage healthy eating behavioural change. It also suggested that both knowledge and skill development are needed to effect change in eating behaviours.

Informed by consultation findings, schools were provided with information about improving food literacy via food literacy webinars and face-to-face professional development workshops. This was followed up in 2015 with newsletters, topic specific webinars and needs-based individual support for teachers.

Home Economics Victoria had consistent, ongoing communication with schools through direct contact with key stakeholders, those who were most likely to be the drivers of change. These people are generally Home Economics teachers, but can include Health and Physical Education teachers, Student Welfare Coordinators, School Nurses and School Leadership staff.

Tailored, targeted, diverse and responsive strategies were identified to support schools, they included:

- Direct school contact and support in the form of phone calls, emails and face-to-face meetings.
- Interactive and action-focussed workshops.
- A teachers' resource package which offered activity ideas, tips and resources to assist in the delivery of food literacy education and healthy eating initiatives in schools.
- Webinars that delivered direct, topical information to teachers and stakeholders.
- An online portal that provided an asynchronous space to share a wide range of resources, case studies and research.
- Newsletters to share school stories, research, resources and tips among teachers and school leadership.

Goals and objectives

Objective 1

To improve food literacy and increase the capacity of whole school staff to embed healthy eating into the school environment.

Evidence of whole school approaches aimed at improving healthy eating behaviours is well documented (Jourdan, Mannix McNamara, Simar, Geary, & Pommier, 2010; St Leger & Young, 2009; Townsend et al., 2011). It has been found that implementing sustainable change in schools requires the leadership skills of teachers as well as the Principal team (Drysdale & Gurr, 2011). Supportive leadership is essential for the achievement of whole school health promotion (Rana & Alvaro, 2010) in secondary schools, by directing organisational change and encouraging positive responses from teachers and students (Mathews et al., 2010).

Our findings support these research findings. Teachers consistently report that the success of any program they implement is dependent on the support and encouragement of school leadership.

Teaching and Learning, is one of the three major components of the Australian Health Promoting Schools Framework (AHPSA, 1997). All teachers we spoke to include a healthy eating focus in the curriculum, generally in Home Economics and Health classes.

HEFL Key Findings:

- A whole school approach is the goal of many schools. However, individual schools are at very different stages in the process.
- A few schools demonstrated healthy eating values across all domains, some were conducting smaller programs and initiatives across the school, and still others were confined to a classroom.
- Healthy eating is almost always taught in Home Economics classes. Having the ability to directly contact and support Home Economics teachers meant that these key stakeholders received the resources and curriculum support required to make progress.
- Many schools had already improved their school canteen. Others were in the process of doing so, however, in many cases teachers still felt the canteen should be healthier.
- Very few schools we spoke to sold sugary drinks, although, some still allow these drinks on school grounds.
- The school wellbeing team generally does not focus on healthy eating and tends to be more involved with student welfare issues such as mental health, family-specific concerns, school transition adjustment, alcohol and illicit drugs.
- The majority of schools teach food literacy in Home Economics or Health classes. Formal cross-curriculum activities are not common in secondary schools which tend to teach prescribed, mandated curriculum in subject specific areas.

Our discussions with schools and teachers revealed a range of strategies are being utilised to support and promote healthy eating across the whole-school including:

Domain	Reported examples healthy eating and food literacy
Healthy policies	<ul style="list-style-type: none"> • Establishing a committee or team that has a focus on healthy eating. • Reviewing policies that support healthy eating. • Banning high sugar content drinks and confectionary in the school. • Formally reviewing the school canteen in line with the School Canteens and Other School Food Services Policy, some schools have used the Healthy Eating Advisory Service.
Healthy physical environment	<ul style="list-style-type: none"> • Ensuring healthy options are offered at the school canteen. • Running breakfast clubs for students. • Establishing kitchen gardens, which can be used in practical Home Economics classes. • Providing welcoming spaces for students to eat together.
Healthy social environment	<ul style="list-style-type: none"> • Having expectations that students bring healthy foods to school. • Using non-food based rewards with students. • Having healthy fundraisers and celebrations. • Displaying healthy eating posters around the school. • Providing free fruit to staff and students. • Encouraging students to eat together in Home Economics classes.
Learning and skills	<ul style="list-style-type: none"> • Food literacy and healthy eating is actively taught, generally in Home Economics and Health, but also occasionally, in other subjects across the curriculum. • Students are taught knowledge and skills to source, prepare, cook and share healthy foods. • Practical cooking classes are enjoyed by students and provide them with the opportunity to try new foods and learn valuable skills. • The impact of food marketing and sponsorship on young peoples' food choice is explored.
Engaging students, staff and families	<ul style="list-style-type: none"> • Supporting student led programs (including VCAL) that promote healthy eating. • Providing healthy options at parent events. • Allowing students to take food and recipes home to share with their family. • Encouraging staff to eat healthy through staff events, programs and the provision of healthy food in the staff room. • Hosting school community events to promote health and wellbeing.
Community partnerships	<ul style="list-style-type: none"> • Linking with food charities and/or local businesses to run breakfast programs. • Exploring local data to support food literacy programs. • Utilising community grants and services to promote food literacy in the school. • Working with local business and Healthy Together Victoria staff to promote healthy eating in the school community.

Spotlight – Red Cliffs Secondary College

Red Cliffs Secondary College identified healthy eating as a priority area in their 2014/15 Health Promotion Plan. They signed up for the Achievement Program and have implemented initiatives to increase the capacity of whole-school staff to embed healthy eating into the school environment including:

- A Healthy Eating Committee, which is chaired by the Assistant Principal and includes student, parent and staff representation.
- An assessment of the school canteen menu by the Healthy Eating Advisory Service.
- Food literacy and healthy eating is taught in Food Technology classes.
- A Student Breakfast Club established in response to concerns about the number of students arriving at school without having eaten breakfast.
- The staff salad club, building on the successful staff soup club, where staff provide a salad lunch for other participating colleagues.

Objective 2

To increase students' and families' food literacy

In a systematic review of teaching approaches that promote healthy eating in primary school children, Dudley et al (2015) identified enhanced curricula (speciality nutrition education programs), cross-curricular (nutritional education delivered across two or more subjects) and experiential learning (food preparation, community gardens) as the most effective strategies for facilitating healthy eating.

Hartmen et al., (2013) also summarised that “cooking skills may help people to meet nutrition guidelines in their daily nutrition supply. They allow people to make healthier food choices. It is, therefore, important to teach children and teenagers how to cook and to encourage them to develop their cooking skills”.

Nutritional knowledge and particularly the effort and skills required in the process of cooking and meal provision are recognised as important considerations (Holsten et al., 2012; D. Pendergast, Garvis, & Kanasa, 2011). A New Zealand study of 11–14 year olds, found that having the knowledge and ability to use different cooking techniques is important in making food decisions (Utter et al., 2013).

The Healthy Together Victoria Achievement Program provide evidence based benchmarks tailored to secondary schools for health priority areas. The Healthy Eating and Oral Health Benchmarks recognise learning and skills as a key driver in increasing students' food literacy. Knowledge about healthy eating along with planning, budgeting and cooking skills are central to Home Economics classes (Healthy Together Victoria, 2015). Many schools also had a specific nutrition or cultural focus. A small number had formalised cross-curriculum projects that were underway.

Increasing food literacy in families

Parent involvement in schooling benefits students, teachers, parents and ultimately, the wider community. Department of Education & Training reports into parent partnerships found a decline in parent involvement between primary and secondary school. They also found that parents of older students tend to be most interested in school initiatives that relate directly to health and wellbeing, academic outcomes, their child's future and the maintenance of a positive relationship with their child. (Department of Education and Training, Victoria 2006 & 2015)

One of the determinants of diet quality among young adults is the level of cooking skills practised in the home (N. I. Larson, Perry, Story, & Neumark-Sztainer, 2006). Implementing healthy eating policy through an engaging secondary school-based curriculum that targets home food and cooking skills, is more likely to have sustained impact on dietary quality in adulthood (Fulkerson et al., 2010; N. Larson, Fulkerson, Story, & Neumark-Sztainer, 2013; M. N. Laska et al., 2012; Thorpe et al., 2013). Determinants of healthy home cooking are varied food budgets, cooking equipment, cooking confidence, family functioning and food preferences (Foley, Spurr, Lenoy, De Jong, & Fichera, 2011).

In secondary schools, where getting parent involvement is more challenging, food and cooking is an instrument for family and community engagement and cohesion. Dudley et al., (2015) also identified parental involvement (active participation within or outside the school) as an effective teaching strategy for facilitating healthy eating in primary school children. This strategy was used with many of the teachers we spoke to who consistently found it to be a useful way to engage parents.

Our discussions with teachers revealed food literacy in the home is supported by students trying new foods at school then bringing new food tastes and recipes home to share with their families. Parent feedback and engagement is generally very positive.

HEFL Key Findings

- Students enjoy and are highly engaged in practical Home Economics classes.
- Students employ the skills learnt in class at home in formal and informal ways.
- Home Economics classes are places where students are exposed to and have opportunities to try new foods.
- While cross-curriculum activities are not the norm, some schools are beginning to teach food literacy across subjects.
- Many schools are using vegetable or herb gardens to teach students where their food comes from and to use the produce in practical classes, to enhance knowledge and skill development.
- Many teachers reported positive parent feedback and requests for recipes.

Spotlight – Sacred Heart College

Year 8 students undertake an interdisciplinary curriculum unit, where students prepare a two-course meal at home. The unit requires students to follow through a design cycle to design, prepare and evaluate their meal including:

- Meeting with their family to discuss the proposed menu
- Consideration of tastes, preferences, food intolerances and allergies, cultural practices and cost
- What ingredients are needed? What is in the pantry? What purchases are required?
- Writing up and costing the food purchasing order
- The full process of preparing the meal, including cooking and cleaning up
- Documenting this process via photographs
- Receiving parent comments about the meal.

The unit allows parents to have first-hand demonstrations of their children's capabilities in the kitchen. Many parents are pleasantly surprised at the skill level their children have, and that they also cleaned up. Many report that they intend to have their children cook for the family more often. “Parents generally love the unit and provide positive feedback on the meals.” Maree Wade, Sacred Heart College

Objective 3

To increase the capacity of schools to participate in locally driven healthy eating and food literacy health promotion activities

“Forming effective partnerships between early childhood services, schools, training providers and the wider community helps to improve the learning and development of children and young people.” (Department of Education and Training 2015)

A key feature of the face-to-face workshops was that they were held in the local government area with Healthy Together Community (HTC) staff. It provided an opportunity for teachers to learn about and participate in locally driven initiatives. This was a successful model as it increased teachers’ knowledge of what is available locally, while making community contacts.

HEFL Key Findings

- The face-to-face workshops were instrumental in connecting teachers with Healthy Together Victoria staff.
- These connections allowed HTCs and schools to be aware of and linked to complementary initiatives and programs, increasing school capacity to participate in local initiatives.
- The range of local partnerships is vast, with some schools having very formalised partnerships while others take part in one-off or smaller initiatives.

Spotlight – Maryborough Education Centre

Maryborough Education Centre has productive community relationships, which they continue to build upon. The school’s breakfast program provides fruit donated by Street Harvest (the fruit is also made available freely around the school for students to eat throughout the day). A local Coles and bakery donate bread, and other food items are donated by Bendigo FoodShare.

The school has recently worked with the Jamie’s Ministry of Food Mobile Kitchen. The Home Economics teacher volunteered to help run the sessions and the school referred parents to the program.

Objective 4

To increase schools’ achievement of the healthy eating and oral health benchmarks in the Achievement Program.

The September 2015 Achievement Program statistics show that 132 secondary schools across the state were registered with 70 of those coming from HTCs. This figure accounts for 57% of total Achievement Program registrations, while the schools in the HTCs make up only 30% of secondary schools across the state. This data indicates that secondary schools in HTCs have registered for the Achievement Program at a higher rate.

Total Secondary Schools	Total Registered for AP	HTC Secondary Schools	HTC Registered for AP
574	132	173	70
100%	24% of total schools	30% of total schools	57% of AP registrations

Figures from: Achievement Program data – Registrations until end September 2015. Department of Education and Training Summary Statistics Victorian Schools, July 2015 www.education.vic.gov.au/about/department/pages/factsandfigures.aspx

HEFL Key Findings

- A greater percentage of schools in HTC areas registered for the Achievement Program.
- Schools’ progress through the Achievement Program has been slow, with many teachers identifying the time required to undertake the work and attend meetings as barriers.
- Schools who are succeeding with the Achievement Program have a dedicated team with clear goals, have ensured it is part of the whole school plan and have utilised the HTC.
- Teachers reported the face-to-face workshops run by Home Economics Victoria provided the resources and support they needed to get their school registered and progressing with the Program

Spotlight – Mount Ridley College

Mount Ridley College’s Health and Wellbeing Committee was established long before the school registered for the Achievement Program. The first task of the committee was to research local data and develop a plan to show how the Achievement Program could support existing school initiatives and the whole school community; a solid case presented to the school leadership team would ensure their support. The committee’s preparation supported the program’s implementation while ensuring that the work was viewed in a whole school context.

“Support of leadership is critical, you need to show how it fits with school direction and not be an add-on. We had to show that we are doing this anyway so let’s make it official.” Kate Stevonovic, teacher.

Objective 5

To assist schools to develop and deliver initiatives consistent with the five principles of the healthy food charter.

“The Healthy Food Charter is a guide for those working in partnership with the Victorian Government to improve the health of Victorians through food.” (Department of Health, 2013)

The five principals of the Healthy Food Charter are:

1	Easy	<ul style="list-style-type: none"> • Showcase recipes that use easily accessible ingredients and equipment • Showcase recipes that are easy to prepare • Promote the same meals for children and adults • Promote healthy options for purchase
2	Fresh	<ul style="list-style-type: none"> • Use seasonal fresh produce whenever possible • Include at least one serve of fruit or vegetables in every breakfast • Include at least two serves of vegetables in every lunch and dinner • Include fruit or vegetables in every snack or dessert • Understand how to store and handle fresh produce safely
3	Balanced	<ul style="list-style-type: none"> • To promote variety, create meals with at least three food groups • Add fruits and vegetables to every snack and meal • Promote wholemeal and wholegrains • Promote use of legumes • Promote dairy foods – mostly reduced fat • Use lean meat and poultry • Promote use of oily fish
4	Healthy	<ul style="list-style-type: none"> • Always offer water • Limit sugar-sweetened drinks • Practise portion control • Promote poly- and monounsaturated fats and reduce foods containing saturated fat • Reduce salt (sodium) • Reduce added sugars • Choose healthy cooking methods • Follow policies and guidelines
5	Connected	<ul style="list-style-type: none"> • Enjoy and share food • Understand how food is grown • Use seasonal ingredients • Enjoy local produce • Promote healthy food that is accessible to all • Connect to diverse communities and cultures • Reduce food waste

The Healthy Food Charter was one of the sources used to develop the Home Economics Victoria definition of Food Literacy. It also informed the content presented to teachers in all workshops and the teacher resource kit. Home Economics Victoria consistently refers to current Government guidelines and advice when preparing materials and advice for teachers.

These principles, along with advice from the Australian Dietary Guidelines, are central to the Home Economics curriculum and this was consistently shown through our discussions with teachers.

These principles are also seen in other whole school initiatives such as the school canteen or school gardens. Many schools are embracing edible gardens to teach students where food comes from and to provide healthy ingredients to use in the classroom.

HEFL Key Findings

- The principles of the healthy food charter, along with advice from the Australian Dietary Guidelines, are central to the Home Economics curriculum being taught in schools.
- Schools are also reviewing their school canteens and developing school gardens to further support these principles.

Spotlight – Kurnai College

Kurnai College (Churchill) students have opportunities to develop and apply knowledge that enhances healthy eating. For example, they evaluate food consumption patterns and habits throughout the lifespan with a focus on the time between adolescence and adulthood. In practical lessons they analyse and discuss topical issues such as the consumption of sugary drinks and why water is the preferred beverage choice.

Students also have opportunities to learn budgeting through cost analysis activities around various foods available in the local community. Practical cooking skills are learned and practised through the planning and preparation of healthy meals at school. Regular tasting plates are offered to encourage students to taste new foods. These new food experiences are a source of encouragement for parents to increase the food variety available at home by trying what has been used or tasted at school.

Find out more: Home Economics Victoria online portal <http://homeeconomicsvictoria.ning.com/healthy-eating-and-food-literacy>

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Gail has taught Home Economics, Health and Textiles in Victorian Secondary Schools. Gail has held project management roles for national and state mental health, healthy eating and food literacy projects.

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Mission statement

Our purpose is to promote skills for life to achieve optimal and sustainable wellbeing for individuals, families and communities. By promoting wellbeing, encompassing health, we aim to prevent and/or control disease such as obesity and type 2 diabetes by providing teachers, students, parents and wider school communities with education and information.

Objectives

- Promote skills for life, including home economics, to achieve optimal and sustainable wellbeing for individuals, families and communities.
- Promote health and wellbeing, aimed at preventing diseases, specifically obesity and type 2 diabetes.
- Provide education and information about health and wellbeing through education programs, resources, publications, advocacy and consultancy.
- Support research into health and wellbeing including the provision of awards and scholarships.
- Work in partnership with relevant health and education bodies, government departments, organisations and industry.

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