Initiatives supporting healthy eating and physical activity in East Metropolitan Perth

East Metropolitan Population Health Unit
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GLOSSARY OF TERMS

AHW	Aboriginal Health Worker
BAT	Be Active Together
BHS	Bentley Health Service
CALD	Culturally and Linguistically Diverse Communities
COB	City of Bayswater
COS	City of Swan
DoH	Department of Health
DSR	Department of Sport and Recreation
DYHS	Derbarl Yerrigan Health Service
EMHS	East Metropolitan Health Service
EMPHU	East Metropolitan Population Health Unit
EMPHU EP	East Metropolitan Population Health Unit East Perth site
EPPCHU	Eastern Perth Public and Community Health Unit
EMHS	East Metropolitan Health Service
GDM	Gestational Diabetes Mellitus
GPs	General Practitioners
IFG	Impaired Fasting Glucose
IGT	Impaired Glucose Tolerance
KHS	Kalamunda Health Service
NGOs	Non Government Organisations
NHF	National Heart Foundation
NPHP	National Public Health Partnership
PATF	Physical Activity Taskforce
SHS	Swan Health Service
SNAP	Smoking, Nutrition, Alcohol, Physical Activity
WASCA	Western Australia School Canteen Association

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EXECUTIVE SUMMARY

Historically there have been isolated needs assessments and surveys to inform health promotion planning and initiatives in the East Metropolitan Health Service (EMHS). There is however currently no systematic identification or review of programs and initiatives which support healthy lifestyles in the EMHS. This limits the information available to the East Metropolitan Population Health Unit (EMPHU) to identify strengths and gaps in existing services in order to develop comprehensive operational plans for the region.

Following consultations with staff within EMPHU (East Perth site), it was decided to conduct a healthy lifestyles survey to identify key nutrition and physical activity initiatives and programs within the EMHS. A community audit is a key performance indicator of EMPHU Diabetes and Physical Activity Programs and is listed as the first strategic objective of the Healthy lifestyles strategic framework released by the Department of Health in 2002.

A project officer was designated to coordinate the project. A health promotion framework was used to plan and conduct the survey. Opinion from individuals and organisations experienced in working in nutrition and physical activity was sought to assist in the development of the methodology. Subsequently a Healthy Lifestyles Working Party comprising of relevant EMPHU staff was formed to further guide the project. Limited literature was available to guide the methodology. A questionnaire was developed to gather the data from participating organisations. The organisations invited to participate in the survey were drawn from the public and private sectors, including education, local government, health, transport, the food industry, sport and recreation, corporate, unions/professional associations, welfare and miscellaneous.

The data collected were primarily analysed against EMPHU's population program areas (ie. early years, school, youth, adult and minority groups) to identify gaps in existing programs. Other sub categories were created to analyse the data including secondary prevention, capacity building, general populations, seniors and planned initiatives.

Ninety-three individuals from fifty-six organisations participated in the survey. The response rate within sectors varied considerably with respondents representing disabilities, the corporate sector and the health sector having the highest response rates. The lowest response

rates were seen for unions/professional associations and those organisations categorised as 'miscellaneous'.

A total of 229 initiatives were identified in the survey – of which 60 supported healthy eating, 98 supported physical activity, and 71 supported healthy eating and physical activity. Twenty-nine initiatives were planned for the future.

The greatest number of initiatives were grouped under capacity building, followed by initiatives targeting the general population, adults and seniors and secondary prevention. The groups with the least number of initiatives were those targeting school and youth, early years and minority groups.

RECOMMENDATIONS

1. That there is acknowledgment that the survey findings form one component of evidence of physical activity and nutrition programs of EMHS. Hence it is recommended the data be complemented with additional data sources as required.
2. That EMPHU use the survey findings as a baseline to guide further decision making and planning for nutrition and physical activity programs in the region.
3. New alliances and partnerships be considered to form a “cluster” approach between existing programs to minimise duplication.
4. The working party, in collaboration with executive management, forms a comprehensive dissemination plan that meets the needs of EMPHU.
5. Within future planning, the recognised gaps for aboriginal and culturally and linguistically diverse (CALD) groups and the 0-4 early years programs be considered as the initial focus. Continued emphasis to remain on strengthening the capacity building of communities and organisations within and outside the health sector to implement sustainable initiatives that encompass a population approach and which will ultimately contribute towards positive health outcomes for the EMHS population.

1 INTRODUCTION

There are numerous organisations supporting healthy eating and physical activity in east metropolitan Perth, yet their activities and initiatives may not be known. In an attempt to collate information on existing initiatives that support, or have the potential to influence healthy eating and/or physical activity in the EMHS, EMPHU planned a Healthy Lifestyles Audit in November 2002. This report describes the methodology and the results of this process.

An audit has a range of definitions, but it can essentially be defined as a methodology to 'check 'or 'verify' against an identified measure (Delbridge and Bernard, 1988). Although a range of applications and methods can by employed to achieve this, no published definition of a 'community audit' in the context of health currently exists (Caraher, 1994; Schuermann, 2000; Wood, 1999). The most relevant references to audit methodology, appear in the United Kingdom context, where an audit is a dynamic process, involving reviewing and securing local resources to tackle identified gaps (Hamer, et al., 2003). This full audit cycle may take up to three years to complete.

After consideration of the resource capabilities and needs of EMPHU, a decision was made to conduct a survey to provide the information sought from the community in question. This process was not intended as a comprehensive review. Rather to provide a *snap shot* of some of the organisations that are currently involved in physical activity and/or nutrition related activities in the EMHS. The information was planned to inform EMPHU and its partners of the strengths, gaps and potential opportunities to improve the health and well being of the east metropolitan Perth population. Recommendations designed to aid partnership development, future planning and priority setting for EMPHU and other organisations are included.

2 BACKGROUND & RATIONALE

Non-communicable or chronic diseases such as cardiovascular disease, cancer and diabetes are a cause of enormous human suffering globally, yet the disease toll could be significantly reduced. World Health Organisation experts estimate, for example, that 50% of all

cardiovascular diseases and one-third of cancers are preventable (World Health Organisation, 1998).

While important health gains have been made in the prevention and control of chronic disease, the National Public Health Partnership (NPHP) reports that in Australia:

- the prevalence of heart and vascular disease has increased since 1989/90
- the prevalence of diabetes has almost doubled since the early 1980s, and
- the obesity rates have more than doubled – from less than 8% in 1980 to nearly 20% in 1995 (National Public Health Partnership, 2001).

Between 1997 and 2001, residents within the EMHS were dying at a higher rate than the State rate and the south and north metropolitan area residents (Health Information Centre, 2002a). The death rates were higher for many chronic conditions including ischaemic heart disease, cardiovascular disease (Health Information Centre, 2002f), pneumonia and influenza (Health Information Centre, 2002g) and hereditary and degenerative disease of the central nervous system (Health Information Centre, 2002e). Specific to females, there is a higher rate of mortality for diabetes (Health Information Centre, 2002d), breast cancer (Health Information Centre, 2002c), and alzheimer's disease (Health Information Centre, 2002e). Males, are particularly affected by lung cancer (Health Information Centre 2002c), alzheimer's disease (Health Information Centre, 2002e) and chronic obstructive pulmonary disease (Health Information Centre, 2002g).

In general, the EMHS is most commonly faced with mortality due to diseases of the circulatory system and neoplasms. These diseases account for 69% of all deaths (Health Information Centre, 2002b). The age standardised death rate for males (704.2 per 100,000) is higher than females (446.7 per 100,000) in the EMHS (Health Information Centre, 2002b).

A wide range of initiatives have been undertaken in the past, with some success, however a new approach to chronic disease prevention and control has been designed by the National Public Health Partnership to further impact on health outcomes and reduce the demand on health care services. The National Chronic Disease Prevention Framework is designed to '*inform research, priority setting, service planning and action at all levels of the health system in Australia'* (National Public Health Partnership, 2001: 1).

The National Public Health Partnership focus is on primary prevention (ie. the protection of health by measures which eliminate causes and determinants of departures from good health, and control exposure to risk) and health promotion aimed at the common risk factors and the social determinants of health (National Public Health Partnership, 2001). This is consistent with WHO's Global Strategy for Prevention and Control of Non-Communicable Diseases (National Public Health Partnership, 2001). The global focus is on reducing risk factors common to major chronic diseases (ie. tobacco smoking, poor diet, lack of physical exercise and excessive consumption of alcohol) in the whole population, as well as in high-risk groups – by incorporating health promotion, disease prevention, early detection, treatment and rehabilitation.

The population approach is emphasised in the Western Australian Department of Health's (DoH) Healthy lifestyles strategic framework for primary prevention of diabetes and cardiovascular disease in Western Australia, 2002–2007 (Department of Health, 2002). '*A population approach is based on the knowledge that by far the greatest number of disease cases arises from that majority of the population who are not seen as 'at risk'; and that small changes in this group can produce much greater community benefit than large changes in a small number of high risk individuals*' (Department of Health, 2002: 7). Yet a population focus '*does not exclude consideration of the needs of different populations or provision of intensive interventions for high risk groups*' (Department of Health, 2002: 7).

The first strategic objective of the Healthy Lifestyles strategic framework is to '*generate an information base for action*' (Department of Health, 2002: 12). Community audits have been recommended as a means of establishing '*gaps in local facilities and programs that support healthy lifestyles*' (Department of Health, 2002:14). 'Healthy lifestyles' are difficult to define, but generally encompass health promoting behaviours – regular physical activity, healthy eating, safe alcohol consumption, use of preventive health care, absence of addictive behaviours such as smoking – combined with good mental health and psychosocial support. According to the Healthy lifestyles document, the results from audits can then be analysed '*to identify opportunities for collaboration between health and other sectors and develop formal alliances to implement agreed joint projects*' (Department of Health, 2002:19). Conducting a community audit is also a key performance indicator of the EMPHU Diabetes and Physical Activity Programs.

3 GOAL & OBJECTIVES

3.1 Goal

Through the application of the survey findings develop operational plans, strengthen collaboration and foster new partnerships within and beyond the health sector to enhance the physical activity and nutritional well-being of the EMHS population.

3.2 Objectives

1. Raise awareness and knowledge amongst EMPHU staff of current nutrition and physical activity programs/initiatives available to EMHS populations.

2. Identify gaps and opportunities in nutrition and physical activity programs/ initiatives for EMHS populations.

3. Identify suitable partners to improve nutrition and physical activity in EMHS populations.

3.3 Sub-objectives

1. Identify existing nutrition and physical activity programs/initiatives available to EMHS populations.

2. Identify EMHS populations with and without existing/planned nutrition and physical activity programs/initiatives.

3. Assess existing/planned nutrition and physical activity programs/initiatives to determine priority areas for improvement.

4. Identify existing partnerships and collaborations.

5. Identify potential collaborators and partners.

6. Disseminate results in an appropriate format to agencies and organisations supporting healthy eating and/or physical activity.

4 METHODOLOGY

4.1 Consultation and planning process

A project officer was designated to coordinate the project. Staff from EMPHU (East Perth site) formed a Healthy Lifestyles Working Party (working party) to direct the project. The working party was formed following one to one exploratory interviews with staff identified as potential working party members.

Following extensive discussion and negotiation, the group identified the risk factors of poor nutrition and physical inactivity as priority areas for the survey. Poor nutrition and physical inactivity are common risk factors to all six national health priority areas (ie. heart disease and stroke, diabetes, cancers, asthma, mental health, injury) and obesity (National Public Health Partnership, 2001) and comprise core areas addressed by EMPHU. Smoking was excluded as a survey had already been undertaken in 2000 by Eastern Perth Public and Community Health Unit (EPPCHU). In addition the Drug and Alcohol Office were developing regional plans at the time which included investigating priority areas for the development of local strategies for improvement of programs and services that would benefit the community.

The working party acknowledged that the survey had to be broad and encompass a wide range of initiatives and organisations – generally any primary and/or secondary prevention initiative that supported healthy eating or physical activity within the EMHS. Although the Healthy lifestyles strategic framework (Department of Health, 2002) focuses on primary prevention, secondary prevention initiatives were included in the survey because healthy eating and regular physical activity are promoted to people with existing conditions much the same way as they are promoted to the asymptomatic population. To exclude these initiatives may have limited future opportunities to work with organisations which have access to this population. Nationally coordinated programs were also included in the data collection.

Advice was sought from leading organisations working in physical activity and/or nutrition identified by the working party to guide the process. In addition the project officer undertook

a literature review on existing auditing/environmental scan models. However limited literature is published on this topic, and therefore this provided minimal guidance to the process.

4.2 Survey tool

Given the broad nature of the research, and the limited financial resources, a self-completed postal questionnaire (or similar) was considered the most appropriate method. A comprehensive questionnaire containing a combination of open ended and 'tick the box' questions was designed but later simplified by the working party due to its complexity and its estimated completion time (over one hour). The core questions were retained, and a question requesting permission to follow-up at a later date was included. Limited pilot testing occurred (n=3) via telephone (n=1) and face-to-face (n=2) interviews. The final questionnaire contained 26 questions and was expected to take respondents approximately 30 minutes to complete.

Data collection took place in November and December 2002. Each contact person (n=210) (see 4.3 Study cohort) was sent an introductory letter and fax-back form inviting their participation in the survey. The introductory letters outlined the purpose of the survey and acknowledged previous data collection efforts. A recent EMPHU Nutrition Needs Assessment (from October 2002) and a Physical Activity Taskforce (PATF) mapping exercise (from August 2001) were acknowledged in the letter to Physical Activity Taskforce organisations.

Participants were asked to complete and return the fax-back form, choosing between completing the questionnaire electronically, via telephone or via post (Appendix 1). The questionnaire was available from EPPCHU's website as a Word document (for electronic submission) and as a PDF document (for postal submission). Instructions on accessing the questionnaire electronically were stated in the introductory letter, the fax-back form and the questionnaire cover page.

An incentive (ie. to be included in a draw to win a $50 'Angus & Robertson' gift voucher) was offered. A bonus entry was offered to those returning the questionnaire electronically, as this was preferred to reduce data entry time.

All contact with participants was recorded on the spreadsheet of key contacts. This assisted the project officers in making follow-up courtesy calls to the appropriate people with whom

no response was provided. Non-responders were reminded by telephone of the questionnaire and given an extension to the deadline.

4.3 Study cohort

Government and non-government organisations and agencies that were perceived to influence the eating behaviours and/or physical activity levels of Perth populations were identified from a number of sources, including:

- members of the working party
- state and national public health publications (eg. Healthy lifestyle strategic framework (Department of Health, 2002); National Public Health Partnership chronic disease framework (National Public Health Partnership, 2001), Getting Australia active (Bauman, et al., 2002))
- members of the Diabetes representative forum via a brief questionnaire (Appendix 2).

The organisations identified formed the study cohort.

Where there were multiple sites (such as schools), a coordinating body (such as the District Education Office) was listed. Where possible, key contact people were identified for each agency (from existing databases, the working party or by telephoning the organisation). Some agencies, such as EMPHU, local councils and universities, had multiple contact people from different departments.

All returned questionnaires were scanned for suggestions on other organisations or key individuals that could be invited to participate in the survey (snow balling technique). As a result, eighteen additional people were identified, taking the total number of key contacts to 228. A summary of the data collection phase is shown in Table 1.

Table 1: A summary of the data collection phase

Process implemented	**Date 2002**
Introductory letters and fax back form posted	7 November
Fax-back form due back	20 November
Questionnaires disseminated according to preferred method of response.	20 November
Follow-up courtesy telephone call (to non-responders to fax-back). When requested, questionnaire was e-mailed.	18–28 November
Reminder e-mail sent to non-responders who had received the questionnaire via e-mail	29 November
Questionnaires due back	2 December
Prize drawn	3 December
Prize winner notified by telephone and letter	6 December
Thank you letter posted to responders	6 December
Reminder letter posted to non-responders with a copy of the questionnaire and a reply paid envelope	6 December
Final questionnaires due back	12 December
Last questionnaire received	23 December

4.4 Data analysis

The data from completed questionnaires (received by 23 December 2002) were entered into an Excel work sheet (Version 97). In line with the EPPCHU Strategic Plan (2001) and EMPHU program management structure, initiatives were coded and stratified according to:

1. Risk factor (ie. healthy eating, physical activity and/or both).

2. Geographical area. Initiatives implemented outside the EMHS that were not statewide were excluded.

3. Organisational category. These were specified as: government health, non-government health, education, training and research, other government organisations, local government authorities, sports and recreation, unions/professional associations, food industry, corporate and miscellaneous organisations. Respondents from government health organisations were analysed in greater detail to give a breakdown by EMPHU East Perth site, EMPHU other sites, Bentley, Swan and Kalamunda Health Services and other government health organisations.

4. Present or future planned initiatives.

5. Target group. The following target groups were identified:

- General population. Initiatives with no specified target group and/or with three or more target groups were categorised under general population.
- Minority Groups (ie. Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse (CALD) backgrounds and disabled people)
- Early Years (ie. 0-4 years)
- School (5-12 years)
- Youth (13-17 years)
- Adults (18-64 years)
- Seniors (65 years+).

6. Additional categories were created to group data that were not of primary prevention nature:

- Capacity building: Related activities were grouped separately under the following key action areas: workforce development, leadership, organisational development, resource allocation (NSW Health Department, 2001). Research initiatives were included under capacity building.
- Secondary prevention: Referred to those initiatives targeting people with pre-clinical conditions (eg. impaired glucose tolerance) and/or a diagnosed condition (eg. diabetes) (Department of Health, 2002).

Qualitative methods were used to theme open ended question responses in the following categories:

7. Partnerships: These were categorised by organisational sector. In the case of the health sector a more detailed analysis was conducted.

8. Additional programs and facilities needed. These were categorised by the type of strategy evident, outlined by Mackay (1997).

9. Health promotion methods and strategies. These were categorised according to the type of strategies and methods (eg. education policy development, media, structured physical activity program) (Egger, et al., 1990).

5 LIMITATIONS

The main objective of this survey was to raise awareness and knowledge amongst EMPHU staff of current nutrition and physical activity programs available within the EMHS. Not all of the relevant organisations were however identified and not all responded, which in turn, impacted on our ability to achieve this objective. It is thought some organisations may not have realised that their activities influenced the eating habits or physical activity levels of the population and therefore decided not to complete the questionnaire. Some organisations may have decided after reviewing the questionnaire, their work was not relevant to the survey objectives and therefore chose not to participate. Of those who did respond, some provided sufficient information whilst other respondents provided very little which made analysis and categorisation of data difficult.

It was further noted by the working party that the 'health promotion' language used in the survey may have limited responses from some individuals. For example respondents were asked whether any of their initiatives involved working collaboratively with other individuals or organisations. Some respondents did not list any partners even though members of the working party were aware that several partners were involved in the particular program they were referring to. It is therefore likely that the list of partnerships given was not exhaustive and that this question was interpreted in different ways.

Data provided was categorised and reported by counts only. With the design of the survey used, there was no method for quantifying the reach and efficacy of each program and therefore we could only count the numbers of programs/initiatives in each category. It is acknowledged that different programs will have different levels of reach (eg statewide versus local community initiatives) and if a method to weight this could be incorporated in future surveys this would be advantageous.

A detailed analysis of the limitations of the survey tool and methodology can be found in The East Metropolitan Population Health Unit healthy lifestyles audit: an analysis of the process (Watkins and Welch, 2003).

6 RESULTS

6.1 Response rate

Ninety-three individuals (n=93/228, 40.8%) from fifty-six organisations[1] (n=56/116, 48.3%) participated in the survey. The response rate within sectors varied considerably with respondents representing disability services, the corporate sector and the health sector having the highest response rates. The lowest response rates were seen for unions/professional associations and those organisations categorised as 'miscellaneous'.

6.2 Breakdown of respondents by sector

The largest group of individual and organisational respondents came from the health sector (43.0% and 33.9% respectively). Education/research sector and local government followed health in second and third position. Individuals from unions/professional associations did not respond at all to the questionnaire.

A breakdown of individuals and organisations responding by sector is shown in Table 2. The organisations that participated in the survey are listed in Appendix 3.

Table 2. Individuals and organisations responding by sector

Sectors represented	Number (individual responses)	Percentage of total	Number (organisation responses)	Percentage of total
Health (total)	40	43.0	19	33.9
- Government	*27*	*29.0*	*7*	*12.5*
- Non-Gov't	*13*	*14.0*	*12*	*21.4*
Local Government	13	14.0	9	16.1
Other Government	3	3.2	3	5.4
Sport & Recreation	7	7.5	5	8.9
Education, Training & Research	19	20.4	11	19.6
Disabilities services	3	3.2	1	1.8
Food	3	3.2	3	5.4
Corporate	4	4.4	4	7.1
Miscellaneous	1	1.1	1	1.8
Union/Professions	0	0.0	0	0.0
TOTAL	93	100.0	56	100.0

[1]Organisations with multiple respondents were listed once only to provide a more accurate analysis of the number of participating organisations.

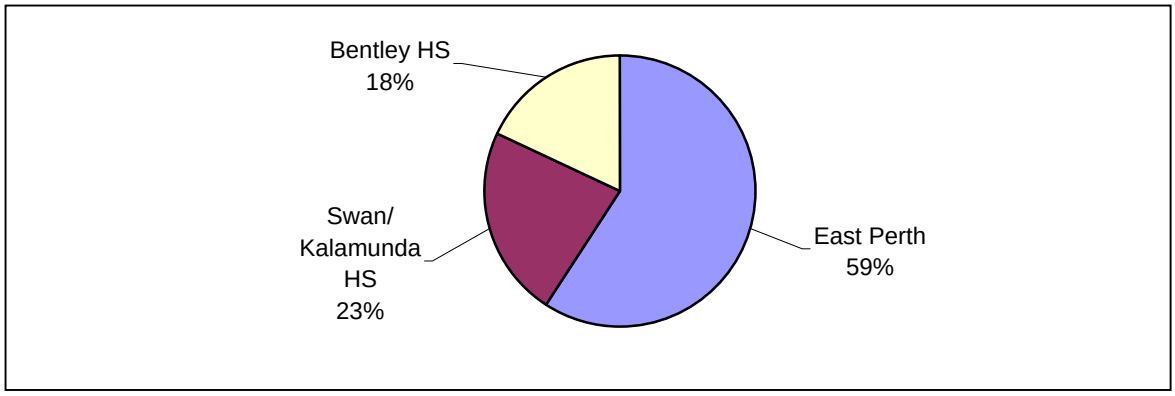
Looking more specifically within the health sector (Table 3), East Metropolitan Health Service (EMHS) staff comprised the largest group of individual respondents (n = 22/40, 55.0%). However, non-government organisations were the largest respondents by organisation (n = 12/19, 63.2%). Other government health organisations comprised the least individual and organisational respondents (12.5% and respectively).

Table 3. Breakdown of respondents within the health sector

Sector	Number (individual responses)	Percentage	Number (organisation responses)	Percentage
EMHS	22	55.0	4	21.1
Other Government	5	12.5	3	12.8
Non-Government	13	32.5	12	66.1
Total	40	100.0	19	100.0

Within EMHS, over half of respondents were based in EMPHU. EMPHU respondents can be categorised to three sites: East Perth, Swan/Kalamunda and Bentley. A breakdown of EMHS respondents is presented in Figure 1.

Figure 1. Representation of individual responses within EMHS



Most (n=67/93, 72.1%) respondents completed the questionnaire electronically, followed by post (n=15/93, 16.1%). A breakdown of methods for questionnaire completion is shown in Table 4.

Table 4. Methods utilised to return completed questionnaire

Method	Number	Percentage
Electronic	67	72.1
Post	15	16.1
Fax	3	3.2
Interview (face to face or telephone)	8	8.6
TOTAL	93	100%

There were 129 individuals who did not complete the questionnaire representing a total of 75 organisations. However, replies were received from other individuals representing 20.0% (n=15/75) of these organisations. Therefore, there was a final total of 60 non-respondent organisations (Appendix 4).

6.3 Organisations involved in healthy lifestyle initiatives

Forty-nine organisations (n=49/56, 87.5%) reported having one or more programs that supported healthy eating or physical activity. The few organisations (n=7/56, 12.5%) that reported not having any programs or initiatives were from the corporate, food and education/research sectors.

6.4 Initiatives reported

A total of 229 initiatives were identified in the survey – of which 60 supported healthy eating, 98 supported physical activity, and 71 supported healthy eating and physical activity. Twenty-nine initiatives were planned in the future.

The greatest number of initiatives were categorised under capacity building (n=104), followed by initiatives targeting the general population (n=53), adults and seniors (n=51) and secondary prevention (n=26). The least number of initiatives were for school and youth (n=18), early years (n=15) and minority groups (n= 10). A summary of initiatives provided for each target group is shown in Table 5.

Table 5. Summary of East Metropolitan and State-wide initiatives provided for each target group

Target Group categories	Number of initiatives			
	Healthy Eating	**Physical Activity**	**Both**	**Total**
General population	17	16	20 (2)	53 (2)
Specific age groups				
Early years	11	1	3	15
School	2	4	3	9
Youth	2	4	3 (1)	9 (1)
Adults	5 (2)	29 (4)	11	45 (6)
Seniors	0	4 (1)	2	6 (1)
Minority groups				
Aboriginal and Torres Strait Islander	2	4	1	7
Disabled	0	1 (2)	0 (1)	1
Culturally and linguistically diverse	1	1	0 (1)	2 (1)
Other				
Secondary prevention	0	7	19 (3)	26 (3)
Capacity building	29 (3)	47 (1)	28 (10)	104 (14)
Total number of initiatives	***69 (5)**	***118 (8)**	***90 (18)**	***277 (31)**

Figures in brackets denote planned initiatives.
**Initiatives that were grouped in two categories (eg. secondary prevention and capacity building) were double-counted. The actual total number of initiatives (single counted) is 229 (ie 60 healthy eating, 98 physical activity, and 71 combined).*

6.5 Target groups and strategies

6.5.1 General population

Fifty-three initiatives identified in the survey were aimed at the general population (17 healthy eating, 16 physical activity and 20 combined). Local government and/or health organisations implemented most of these initiatives.

Common strategies included:

- Conducting public health education seminars and presentations. These were delivered in the context of promoting healthy lifestyle changes in order to prevent certain conditions and diseases. Some of the organisations involved in this type of initiative included the WA Stroke Foundation, Arthritis Foundation of WA, Cancer Foundation and the City of Belmont.
- Implementing awareness raising activities to coincide with specific health weeks (eg. Nutrition Week, Healthy Bones Week, Diabetes Awareness Week) and/or special events (eg. expos). Some of these initiatives involved setting up health displays and disseminating information brochures in community locations (eg. shopping centres, libraries).

- Using mass media and limited reach media (eg. newsletters) to raise public awareness of the benefits of physical activity and healthy eating. Examples of initiatives with a media focus are shown in Figure 2.
- Structured physical activity classes/events. Many of these were organised by local government and ranged from 'special/come and try' events to establishing walking groups. Some of the councils involved included the City of Swan (COS), City of Bayswater (COB), the Town of Bassendean and the City of Belmont. Two organisations (ie the COS and Bentley Health Service) were involved in developing and promoting walk trails to encourage walking in their respective regions.

Some of the nutrition initiatives utilised interactive education methods. For example EMPHU (Swan/Kalamunda Community Nursing and Swan/Nutrition Diabetes Service) and LiveSmart conduct Food Cent$ programs. This food budgeting program demonstrates that healthy eating is affordable and includes organised shopping tours. The latter organisation also conducts vegetarian cooking and nutrition classes, which comprise cooking demonstrations, tastes/samples and nutrition information.

Figure 2. Examples of initiatives with a media focus

- Western Potatoes provide nutritional information and cooking tips on their web-site.
- Curtin University of Technology (Centre for Research into Aged Care Services) have a radio program (100.3FM) that is aimed at encouraging radio listeners to do 'beginner' exercises.
- Be Active Together (BAT) programs in the City of Bayswater and City of Swan disseminate free newsletters via mailing list and bulk distribution. Newsletters outline program activities and events including nutrition related information and recipes.
- Swan/Kalamunda Health Service (Kalamunda Health Promotion) run a radio health program, often with a physical activity or nutrition focus.

6.5.2 Early years

Fifteen Early Years initiatives (ie. 11 healthy eating, one physical activity and three combined) were identified in the survey, most of which were healthy eating focussed. All initiatives in this category targeted parents of 0-4 year olds or expectant mothers as a means of promoting healthy child development in their children. The survey did however identify two initiatives that incorporated some element of health care for mothers. These initiatives were therefore also listed under the 'Adult' programs. All except one initiative were implemented by health organisations (predominantly EMPHU) within a health setting.

The majority of nutrition initiatives were individual or group education programs designed to improve parents' awareness and knowledge of healthy eating in infants/young children.

The only physical activity specific initiative reported was a professional development resource designed for parents. This resource (ie. Building Active Environments) is an initiative of the University of Notre Dame (College of Health) and provides information on how to establish environments that promote physical activity in young children. It was also classified as a capacity building strategy because it was designed for early childhood professionals as well as parents. This resource was in the process of being developed at the time that the survey was conducted.

Costs applied to approximately half of all initiatives. Costs ranged from $15 to $25 for counselling sessions provided to individuals and couples by the Ngala Family Resource Centre. The cost of the Building Active Environments resource was negotiable.

Examples of programs targeting parents of 0-4 years olds are shown in Figure 3.

Figure 3. Examples of initiatives targeting parents of 0-4 year children

- Community Mothers Program provided by EMPHU (Bentley Community Nursing): Nurses and trained volunteers conduct individual home visits to provide new mums with nutrition information and resources.
- First Steps to Solid Program implemented by the Cancer Foundation: This program comprises of five sessions and includes topics such as Introduction to Solids, Food Glorious Food and Tasty Toddler.

The following initiatives were also aimed at promoting wellness amongst mothers:

- New Parents Program implemented by EMPHU (Bentley Community Nursing): Program included a guided pram walk for participants.
- Post Natal Groups implemented by EMPHU (Swan/Kalamunda Community Nursing): Program included an education session (ie. 'Looking After Yourself) which focuses on the importance of diet, rest and exercise for mothers.

6.5.3 School and youth

The survey identified 18 initiatives to improve nutrition and increase physical activity amongst children and youth (ie four healthy eating, eight physical activity and six combined). Most initiatives were implemented in the school setting, delivered by organisations representing health, sport and recreation and local government and were educationally oriented.

The survey findings revealed that some initiatives utilised innovative strategies whilst others used more traditional education methods (eg. disseminating health pamphlets/information resources, health education sessions).

Some of the physical activity initiatives included special walk to school events and exercise programs implemented during the school holidays.

Less than half of the initiatives targeting this group incurred a fee ranging between $2 to $200.

Examples of school and youth programs are shown in Figure 4.

Figure 4. Examples of school and youth programs

- Inspector Pickles Makes a Fresh Start: A theatre and music production implemented by Pickles Production that encourages young children to eat more fruit and vegetables. The initiative won the National Heart Foundation (NHF) Local Government Award in 2001 for the Best Nutrition project in WA.
- Medical Access Centre: This is a mobile service specifically for 'at risk'/fringed youth. The Medical Access Centre is implemented by the Perth Hills Division of General Practice and appeared to be the only initiative which provided education on a one to one basis.
- School Health Promotion: Bentley community nursing staff are frequently involved in promoting special health events at high schools (eg. setting up poster displays and handouts during Fruit and Veg week).
- Food Cent$: A course delivered by Real Life and Happiness that combines raising awareness about food affordability and physical activity. The program is a modified version of the adult Food Cent$ program.
- Be Active Extreme Series: This program, which is delivered by the City of Belmont focuses on participation rather than competition. It is run during summer and aims to attract participants of various school ages and skill levels.
- School Mountain Bike Program: A school mountain bike program for recalcitrant school children that was implemented by EMPHU (School Youth Program).

6.5.4 Adults and seniors

A total of 51 initiatives (ie five healthy eating, 33 physical activity and 13 combined) targeting adults and seniors were identified in the survey. A range of organisations including local government, government and non-government health organisations, universities and government departments implemented these.

Walking groups were the most common type of physical activity class offered to both groups. Local councils were the main organisers of walking groups. Overall there appeared to be more

physical activity options available to adults, in comparison to seniors (eg. football, golf, dancing, swimming, walking).

Some of the physical activity initiatives targeting adults were implemented in the workplace setting. These organisations utilised motivational strategies to encourage staff participation. Some work-site programs were competitive, requiring workplaces to nominate staff in teams (eg. National Heart Foundation's Climb to the Top Challenge).

The survey identified five adult initiatives which targeted women only. These initiatives focussed on providing busy or new mums the opportunity to participate in physical activity. One example is the multi-generational pram walking group established by the Swan Health Service (Health Promotion). This program focuses on enhancing social support networks between young women and older women in the Chidlow community. Mothers with more than one child are provided with additional strollers to support their participation in the program.

The survey revealed some healthy lifestyle education programs designed to improve the target group's awareness and knowledge of the importance of physical activity and/or good nutrition. Most of these were implemented by health organisations.

The survey revealed some examples of high profile media campaigns implemented by the DoH. The Find Thirty campaign for example incorporates television advertisements, outdoor media (taxi tops, billboards), an interactive web-site and various educational brochures and merchandise. This campaign was also categorised as a Capacity Building strategy because resources are disseminated to health professionals. The DoH's Injury Prevention General Awareness Raising Program utilises similar mass media strategies to increase knowledge among older people of the primary risk factors of falls.

Overall the survey identified few examples of initiatives which utilised broader approaches, other than educational methods or organising structured physical activity classes. One example is the Swan Health Service's Healthy Choices Program which aims to create healthy environments by increasing the availability of healthy foods for staff. Another is the healthy lifestyle policy that was developed as part of Curtin University's Healthy Lifestyle Program to allow staff to participate in healthy activities during working hours. They also have established a walking group whereby regular walkers walk and work collectively to improve

the environment (eg. reduce litter, request more water fountains, and fund raise for more seating).

About a fifth of initiatives incurred costs for participants, ranging from a gold coin to $500. All walking group initiatives were free.

Examples of programs targeting adults and seniors are shown in Figure 5.

Figure 5. Examples of programs targeting adults and seniors

- Positive Ageing Program: This twelve month program, also implemented by the S/KHS Kalamunda Health Promotion, targets working aged and older adults and promotes regular physical activity and good nutrition as ways of maximising good health and maintaining independence. The program includes physical activity upskilling for senior group leaders, walk days and education sessions.
- The Cancer Foundation's Healthy Blokes Program: This was the only initiative which specifically targeted men, in this case, blue collar men aged 30-65 years. The program educates about healthy eating, physical activity and health service utilisation.

Work-based programs:

- Derbarl Yerrigan Health Service (DYHS): Have set up walking groups for staff. Participants are registered and given a free cap, t-shirt and drink bottle.
- Eastern Metropolitan Regional Council: Staff have subsidised entry to a swimming pool facility
- Woodside Energy Ltd. (Perth office only): Gymnasia are available on all Woodside operational facilities. Woodside provides subsidised gym membership to Perth office based staff.
- Department of Local Government and Regional Development: Offer lunch time sporting activities for staff.

6.5.5 Minority groups

Overall there were few nutrition and physical activity programs targeting this group (three healthy eating, six physical activity and one combined). Most initiatives were delivered by health organisations and appeared to be set mainly within the workplace and community locations.

The survey revealed that all the healthy eating and the combined initiatives (ie healthy eating and physical activity) were education focussed and involved working with Aboriginal health workers and interpreters. For example as part of the Midvale Support Group, Aboriginal health workers (AHW) demonstrate to a group of Aboriginal women how to cook traditional meals. This is a Swan/Kalamunda Community Nursing initiative. Similarly AHWs and interpreters are employed to assist community nurses to deliver one to one nutrition and other health related information during home visits to their respective communities. This initiative

is called the Refugee and Aboriginal Families Program and is implemented by EMPHU (Bentley Community Nursing). This latter initiative involves staff making referrals to other agencies to address welfare matters if required (eg. Centrelink, migrant resource centres, accommodation services).

All of the physical activity initiatives were structured activities (ie. aqua-aerobic classes, dancing, yoga), most of which were implemented by the DYHS. DYHS provides activities and classes for staff, although aqua-aerobic classes are specifically organised for the community. The City of Bayswater have swimming classes for culturally and linguistically diverse residents as part of their Be Active Together program.

Only one initiative targeted people with disabilities, that is, a recreational service implemented by Eastern Metropolitan Regional Council. The service assists people with disability in the East metropolitan region to access community based sport, recreation and leisure activities in their local area.

All initiatives targeting this group were free or low cost, ranging from $2-$5.

6.5.6 Secondary prevention

The survey identified 26 secondary prevention initiatives (ie seven physical activity and 19 combined). Initiatives for secondary prevention were either implemented at the pre-clinical stage of a disease (eg impaired fasting glucose (IFG) or impaired glucose tolerance (IGT)[1] programs) and/or at the clinical stage to prevent future complications (eg Living with diabetes program).

These initiatives were mostly:

- Implemented by health organisations. Only two initiatives were implemented by organisations outside the health sector (ie. one local government and a recreation organisation).
- Aimed at adults and/or seniors. The survey only identified one initiative which targeted children, that is the 'Why Weight?' Program. This program comprises healthy lifestyle sessions for overweight/obese children and is implemented by the Women's and Children's Health Service.

[1] *People with IFG/IGT have identified signs and symptoms that make them at high risk of developing Type 2 diabetes eg. overweight, have high blood pressure, high cholesterol.*

- For a variety of pre-clinical or existing conditions including Type 2 diabetes, post-natal depression, arthritis and cardiac events.
- Educationally oriented. Most of the educational initiatives utilised individual (ie. one to one consultations in health settings) and/or group methods. Furthermore many initiatives appeared to involve a multi-disciplinary team approach (eg. dietitians, nurses, physiotherapist etc).

The programs targeting people with an existing diagnosed condition (predominantly Type 2 diabetes) were aimed at improving their capacity to self manage their condition in order to avoid developing complications. For example in the 'Living with diabetes' program, participants are taught how to eat well and are encouraged to exercise for glucose control. This standardised program is conducted by the Bentley Health Service, EMPHU (Swan Nutrition/Diabetes Service) and the Perth and Hills Division of General Practice. Another example is the program for Italian and Vietnamese people with diabetes. As part of the program, Italian and Vietnamese diabetes support officers have been trained to provide diabetes information and support services to their respective communities. This program is implemented by EMPHU (Swan Nutrition/Diabetes Service and East Perth Diabetes Team).

Five education programs for people with pre-clinical conditions who have a greater risk than the general population of developing chronic diseases were identified. The 'Risk reduction program for women who have a history of gestational diabetes mellitus (GDM) program, for example, aims to provide women with a history of GDM with relevant information about what preventive measures they need to take to reduce their risk of developing Type 2 diabetes. This program is implemented by the BHS and EMPHU (Swan Community Nursing and Nutrition/Diabetes Service) and includes regular screening for Type 2 diabetes by their GP and promoting the importance of healthy eating and regular physical activity.

Interestingly, some programs appeared to cater for similar population groups (Figure 6), however were implemented independently from each other and varied in their approach.

The initiatives implemented outside the health sector focussed on promoting opportunities for people with existing conditions to participate in physical activity (eg. classes for people with arthritis) whilst those implemented by health organisations were educationally oriented.

Figure 6. Examples of secondary prevention programs

- Perth Hills Division of General Practice has an IFG/IGT program: Program is comprised of two education sessions and normally run on demand. Participants are placed onto an electronic recall system to visit their GP for periodic support and follow up.
- Canning Division of General Practice's Community Cardiac Care Program: Seven-week education and ten-week exercise program. This program primarily targets adults who are at risk of or have had a cardiac event. A support group also meets on a monthly basis.
- Swan Nutrition/Diabetes Service's Healthy Lifestyle Program: Program comprises three sessions and covers behaviour change in addition to providing information on physical activity and nutrition. People who have been referred by their GP for weight reduction, high cholesterol, high blood pressure and/or people with type 2 diabetes requiring an education update attend this latter program.
- The Fighting Fit and Fabulous in Your Forties and Fifties Program implemented by the Swan/Kalamunda Health Service Health Promotion: Program encourages participants to make healthy lifestyle changes that will decrease their risk of developing chronic diseases. Although it is a primary prevention program, it attracts people with pre-existing or existing conditions such as IGF/IGT and diabetes.

6.5.7 Capacity building

One hundred and four initiatives were grouped under capacity building thus representing the greatest number of initiatives (ie. 29 healthy eating, 47 physical activity and 28 combined).

These were mostly:

- State-wide initiatives.
- Implemented by the health sector (government and non-government), however other sectors also involved included education/research, sport and recreation, and, to a lesser extent, the food industry.
- Multi-strategic, from the point of view that they comprised of more than one capacity building strategy.

Most initiatives could be grouped according to the headings of the capacity building model, including leadership, workforce development, resources, organisational development and partnerships. Some initiatives were difficult to categorise because of insufficient information.

Leadership

Many of the capacity building initiatives could be classified as demonstrating leadership. Leadership initiatives included developing and/or overseeing the coordination of new and

creative initiatives, setting priorities for action and developing quality improvement systems to inform and support best health promotion practice within other organisations.

Some organisations offered accreditation and/or reward systems in order to acknowledge the achievements of organisations undertaking quality health promotion work (Figure 7). Many healthy eating initiatives offered accreditation programs and award systems to promote access to quality healthy foods in restaurants and other food outlets. These initiatives were implemented within the school and food outlet settings (eg. restaurants).

Many of the physical activity leadership initiatives were research oriented. Research initiatives were also included under this heading because it was presumed their results would be disseminated and used to inform best practice interventions. Research and/or university institutions implemented most of the research projects which targeted children, adolescents and adults. In addition some of the physical activity initiatives appeared to have a strong emphasis on advocacy for partnership initiatives across sectors to implement sustainable programs (Figure 7).

Figure 7. Examples of leadership initiatives

- Physical Activity Taskforce: The Physical Activity Taskforce was established to oversee the development and implementation of a 'whole of community' physical activity plan for Western Australia. The Department of Premier and Cabinet established the Physical Activity Taskforce.
- Meals on Wheels Nutrition Project: This project looks at the development of a code of practice for Meals on Wheels services in light of the Food Safety Standards and new dietary guidelines for older adults. This initiative is implemented by the DoH.
- Healthy Choices Award: The Healthy Choices Awards are designed to meet the demands of Australians who are health conscious when eating out. The Award promotes restaurants and other food outlets that provide healthy eating environments including healthy foods, hygiene, outside smoke fee areas and alcohol service practices. It is a DoH (Nutrition and Physical Activity branch) initiative administered through local government and public health units.
- National Heart Foundation Kellogg Local Government Awards: This is a national award program that recognises sustainable structural changes and community action that reaches local communities with a health message (ie good nutrition and regular physical activity). This initiative is implemented by the NHF.
- Overweight and Leisure Time Pursuits: This is a pilot study being conducted by the University of Western Australia (Department of Population Health) which examines preventing weight gain in children by reducing sedentary leisure time activities.

Resources

Many of the resource oriented initiatives were either financial (eg. seeding grants), human (eg. establishing positions) and information (eg. specialist advise/consultancy) (Figure 8).

Figure 8. Examples of resource initiatives

- Nutrition Australia responds to electronic and post nutrition questions from students and the general community, thus working within a resource information capacity.
- The EMPHU (East Perth Nutrition Team) has commenced developing some nutrition resources as part of the Good Food for New Arrivals program. The resources are intended for health workers and English as a second language teachers to disseminate to parents who are newly arrived humanitarian entrants to Western Australia with children aged 0-12 years.
- The EMPHU physical activity team provide physical activity seeding grants to community organisations.

Workforce development

Many of the workforce development initiatives could be classified as mentoring schemes, seminars, training workshops, development and dissemination of planning guides/manuals, university courses, training programs, course development (ie. incorporating competency based standards into courses) (Figure 9).

Figure 9. Examples of workforce development initiatives

- EMPHU Physical Activity Team (East Perth site) offer professional mentoring and training to health professionals and other appropriate professionals.
- Marr Mooditj Training Course for Aboriginal students. All students in Certificate 3 & 4 program receive nutrition training.
- Department of Sport and Recreation supports high schools to train high school students to coach and mentor primary school children in sport and physical activity.
- Sports Medicine Australia education program targets coaches, players, teachers and parents to ensure community participants are aware of how to prevent injury or limit effects of injury from sport.
- Nutrition Australia has a quarterly newsletter which is sent out to members highlighting/informing them of current nutrition issues.
- The Arthritis Foundation of WA, through their Tai Chi and Tai Chi for Arthritis program, offers training for instructors. This program is also listed as a secondary prevention initiative because of the tai chi classes to people with arthritis.

Organisational development

The majority of capacity building initiatives involved organisations assisting other organisations to implement physical activity and/or nutrition initiatives. The initiatives listed under organisational development however referred to those implemented internally – for the benefit of the organisation. The survey identified only three initiatives listed under this heading (Figure 10).

Figure 10. Examples of organisational development initiatives

- Healthy Lifestyle Policy implemented by Curtin University to enable its staff to participate in healthy activities during working hours.
- City of Swan have developed a health strategy designed to promote and improve health within their area.
- EMPHU (East Perth Physical Activity Team) have developed a strategic/operational physical activity plan for the Unit.

6.5.8 Planned Initiatives

Thirty-one initiatives (ie six healthy eating, eight physical activity and 15 combined) had been planned by different organisations (Figure 11). Given the time frame between the collection and analysis of data, it is likely that some of these initiatives may already be in progress. Additionally those with finite time-lines may have been completed. Some initiatives appeared to be an expansion of existing programs.

Figure 11. Examples of planned initiatives.

- The WA Canteen Association is developing a WASCA Website that is intended to provide information about the organisation and its programs; foster opportunities for communities to access existing programs and increase support by food companies.
- The DoH has adapted their Food Cent$ program for use in secondary schools. Home economic teachers will be trained by the Home Economics Institute in 2003 (month not specified).
- The City of Bayswater plan to increase access to varied user groups of the Riverside Gardens including seniors and aged. This initiative builds on improvements made to the area over the past two years.
- The National Heart Foundation is developing a secondary prevention guide, patient discharge guidelines and health kit for patients at discharge.
- The DoH is planning to increase awareness and knowledge of health professionals to facilitate the provision of accurate and consistent physical activity messages to clients. For example integrated SNAP (Smoking, Nutrition, Alcohol and Physical Activity Program) for general practice.
- The EMPHU East Perth Diabetes Team is planning to broaden their existing program for Italian and Vietnamese people with diabetes to all Vietnamese and Italian people living in the EMHS. Community consultations are planned to identify appropriate healthy lifestyle interventions (eg. establish walking groups).

6.6 Partnerships

Respondents were asked whether any of their initiatives involved working collaboratively with other individuals or organisations. The majority of respondents indicated that they were working in collaboration with other organisations and individuals.

Responses received from EMPHU at East Perth site (EMPHU EP) indicated that considerable collaboration with a range of partners was occurring. This included partnerships with other government health organisations (eg DoH, Derbarl Yerrigan Health Service) and non-government health organisations (eg. National Heart Foundation, Division of GPs). Several respondents mentioned collaborating with other government departments (eg. Department of Planning and Infrastructure) and local government authorities. Where appropriate collaboration also involved community groups such as those in the Italian and Vietnamese community, schools and the media. For most projects EMPHU EP was the key coordinating organisation. Respondents also identified other organisations and individuals they would like to become involved with. These included community and allied health professionals, GPs, community groups, organisations representing aboriginal and CALD interests and the private sector.

Respondents from EMPHU, based in locations other than East Perth, also reported collaborating with a selection of organisations and individuals. However, the number and range of partnerships was not as extensive as that reported by EMPHU EP. Allied health professionals such as dietitians, child health nurses, physiotherapists and midwives were identified as partners in several projects. In addition, partnerships existed with the DoH, the Department of Education, local government authorities, schools and tertiary education, social workers, clinical psychologists and supermarkets.

The Health Services at Swan, Bentley and Kalamunda all reported collaborating with other organisations and individuals on projects. Several respondents mentioned EMPHU as a partner. Allied health professionals such as dietitians, child health workers, midwives, physiotherapists, podiatrists and health promotion officers were commonly mentioned. There were also partnerships with non-government health organisations (eg. Diabetes Australia WA, Cancer Foundation, Asthma WA) and with community organisations, local government authorities, commercial organisations and supermarkets. Kalamunda Health Service reported collaborating with a wider range of partners than Swan Health Service or Bentley Health Service.

Other government health organisations including the DoH, Women's and Children's Health Service and Derbarl Yerrigan Health Service (DYHS) reported collaborating with a range of partners. These included other government and non-government health organisations, allied health professionals, local government authorities, community groups, and the food industry. They were usually the key coordinating organisation. Population health units, Aboriginal communities, health centres, TAFE and training providers and the Office for Aboriginal Health were mentioned by respondents as organisations they would like to develop partnerships with. Government departments in areas other than health tended to collaborate mostly with other government departments, the DoH, non-government organisations and local government authorities.

Organisations in education, training and research cited many partnerships. These included partnerships with universities, TAFE, schools and other organisations in this sector such as the Catholic Education Office and Department of Education. Other partnerships included government departments in health and other areas, non-government health organisations, local government authorities, the media and food companies and supermarkets. In most cases the responding organisation was the key coordinating organisation. Other organisations, which were perceived as potential partners, included walking groups, seniors' organisations, DoH, Centrelink, supermarkets, schools and workplaces.

Local government authorities collaborated with a range of partners on initiatives including government departments, health organisations, resident associations, community groups and other local government authorities.

Organisations in sport and recreation reported collaborating with other organisations in sports and recreation, universities, non-government health organisations such as Healthway and community and women's groups.

Organisations in the food industry and corporate respondents mentioned comparatively few partnerships. Food industry respondents mentioned collaboration with other food organisations, the DoH and the media. One corporate respondent mentioned collaboration with the National Heart Foundation.

Summary

In summary, government health organisations cited partnerships most frequently and described the widest range of partnerships. Within government health organisations, respondents from EMPHU EP had the most extensive partnerships. Respondents from non-government health organisations, other government departments, local government authorities, education, training and research and sports and recreation liaised with a range of partners but not to the same extent as government health organisations. Corporate and food industry organisations cited fewer partnerships than other organisational groups.

6.7 Additional programs and facilities

Respondents were asked what additional programs and facilities were needed to support healthy eating and physical activity within the EMHS. Responses could be classified as:

Educational

- More comprehensive and consistent nutrition training for teachers/educators
- Integration of nutrition into curriculum framework learning outcomes
- A comprehensive and well-promoted web-site that brings together all elements of a healthy lifestyle
- Programs on food selection and preparation with access for people with physical and intellectual disabilities.

Community organisation and community development

- Cheaper self-run alternatives to 'Weight Watchers' for Senior Citizens under the guidance of a dietitian
- Post-natal support groups for mothers who experienced gestational diabetes
- After school physical activity programs that are affordable and enjoyable and give parents the opportunity to become involved.

Mass media strategies

- Raise awareness of healthy eating in primary schools through 'Eat Healthy' week
- Ongoing media campaigns to support community initiatives.

Motivational

- Discounted entry to swimming pools for seniors

- Develop strategies that encourage parents to get their children to walk/cycle to school rather than drive them.

Environmental

- Appropriate public space for young people to be active in
- Improved environmental supports and end of trip facilities (eg. bike racks, showers and cycle paths).

Organisational interventions

- Employers to encourage time out for staff and realistic workloads.

Healthy public policy

- School canteens being more rigorously controlled in what can be sold at school
- Better initiatives and incentives to encourage alternative travel (eg. car pool car parks in central Perth rather than outskirts)
- All councils should have a recreation team supporting physical activity programs in their locality
- Development of programs that target childhood obesity
- Planned walks and improved footpaths
- More Liveable Neighbourhood initiatives.

Legislation

- Limitations on the number of fast food outlets in communities.

Economic incentives (or disincentives)

- State government not increasing public transport costs.

Reorientating health services

- Ensure hospital-based dietitians carry out more community work.

Many respondents requested additional (unspecified) programs for particular target groups (eg. families and children, Aboriginal and Torres Strait Islander (ATSI), seniors). Several respondents emphasised the need for greater collaboration between agencies. Several respondents requested further research in the areas of physical activity or healthy eating.

7 DISCUSSION

A total of 229 initiatives were identified in the survey – of which 60 supported healthy eating, 98 supported physical activity, and 71 supported healthy eating and physical activity. Twenty-nine initiatives were planned for the future.

The survey achieved a response rate of 40.8%. The survey provides a *snap shot* of some of the current and planned primary and secondary prevention physical activity and nutrition activities in the EMHS. The project officer and the working party members understand that the survey findings represent only 'part of the picture'. It is intended the results will be complemented with existing and additional data sources to stimulate further discussion to assist EMPHU identify existing gaps in services, set priorities and inform future directions.

Analysis of the results has led to the development of the following discussion categories:

- Best practice
- Location of programs
- Providers of programs
- Risk factor focus
- Identified gaps and opportunities
    - Aboriginal and minority groups
    - Early Years
    - School and youth
    - Partnerships.

7.1 Best practice

Information regarding how rigorously programs have been evaluated, if at all, was not sought from this survey. It is therefore difficult to comment on the effectiveness of programs and initiatives and/or to know which programs represent a 'best practice'[2] approach. In a recent study into the effectiveness of programs supported and/or implemented by EMPHU it was concluded '*With the rising costs of health care, decisions about purchasing and provision in the health care system should be based, where possible, on interventions proven to work. In addition, with public spending of all kinds under intense scrutiny, investment of the available*

[2] Best practice refers to initiatives that have demonstrated their effectiveness and suitability for enhancing the health of populations.

resources allocated to health care should be directed at those interventions that have been shown to be most cost-effective in addressing the community's priority health needs' (Hendrie, et al., 2003: 28). The difficulty remains however that there are limited data available in published literature on effectiveness, including cost effectiveness of specific programs and interventions. However, within population health there are acknowledged approaches, recognised as 'best practice', which when applied assist in achieving programs that are more likely to be effective.

A population health approach is aimed at the whole population. It recognises, that to succeed, programs and initiatives require the following characteristics: population wide programming, acting on root causes, using multiple strategies, long term planning, collaborating with other sectors and basing decisions on evidence (Lilley, 2000). In particular the use of multiple strategies to achieve health outcomes is an agreed focus of the public health workforce. Strategies for promoting population health include: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorientating health services (World Health Organisation, 1986). Yet a population focus does not exclude interventions to particular sub groups of the population who require targeted assistance, particularly in the area of determinants of health (Department of Health, 2002).

The survey findings revealed a small number of programs directly targeting the community that utilised broader approaches other than educational methods and/or establishing structured physical activity opportunities. Most notably is Curtin University's Healthy Lifestyle Program. This program incorporates various strategies including policy development to enable staff time off work to participate in healthy lifestyle activities. Other examples included Swan Health Service Healthy Choices program designed to provide a variety of healthy food choices at their Black Duck Cafe and which was combined with awareness raising strategies. The City of Bayswater and City of Swan through their Be Active Together programs have implemented walk trail initiatives that provide opportunities for incidental walking.

Less attention was generally given to sustainable approaches other than capacity building. Capacity building initiatives were mostly implemented by organisations that did not have direct contact with the community. Rather they focussed on building the capacity of other organisations to deliver services and facilitate healthy lifestyle with the community through a range of strategies (eg. resource allocation, workforce development). In particular many

capacity building initiatives could be were classified as ‘leadership’. These initiatives appeared to be comprehensive and more encompassing of a population health approach. Those with a healthy eating focus used accreditation systems to promote access to quality foods in restaurants. Some of the physical activity leadership initiatives on the other hand were advocacy oriented, promoting the importance of partnerships and sustainable physical activity opportunities. The current trend towards implementing sustainable initiatives is likely to continue as creating physical environments supportive of physical activity is a key recommended action area put forward by the Evaluation and Monitoring Working Group of the Physical Activity Task Force[3] (Bull, 2003). This includes initiatives such as maintaining safety of footpaths and the creation of attractive public places through the involvement of a wide range of sectors (Bull, 2003).

Within this survey, the majority (105/276: 38.0%) of programs and initiatives came under the category of capacity building. This demonstrates a considerable commitment to this health promotion approach within the EMHS.

The findings of this survey revealed that many of the initiatives in the region are educational in nature, primarily focussing on improving the knowledge and skills of individuals and small groups. Common education methods included one to one consultations, workshops, presentations and seminars which appeared to be either ‘one off’ events or part of ‘healthy lifestyle’ programs delivered over a series of weeks/lessons. Health organisations working directly with early years, adults, and minority groups used educational approaches most often. Educational approaches were also most commonly used in secondary prevention initiatives.

According to Basch (cited in Egger, Spark and Lawson, 1990) group methods have been used by health educators to help individuals adopt and maintain health behaviours and provide a supportive environment for individuals facing similar health issues. Despite some of the benefits of behavioural modification approaches to health, research has shown that focusing on increasing an individual’s knowledge and skills alone is ineffective in increasing the physical activity levels and improving nutrition at the population level (Baum, 2002; Egger, Spark and Lawson, 1990; Lilley, 2000). Furthermore education methods are less likely to impact upon the structural and/or root causes of illness (Baum, 2002). Hence it could be said that solely educational approaches do not constitute ' best practice'.

[3] The Physical Activity Task Force was established to oversee the development and implementation of a whole of community physical activity strategy for Western Australia and comprises representation from the Department of Premier and Cabinet, Education, Planning and Infrastructure, Health etc.

Summary

The majority of programs and initiatives in the EMHS use capacity building. Overall it would seem that few initiatives implemented by organisations *targeting the community directly* were multi-strategic and/or encompassed a population health approach. Generally, most physical activity initiatives were structured classes (eg. dancing, tai chi, yoga) and nutritional initiatives were predominantly isolated to educational approaches.

7.2 Location of programs

Within the EMHS there is a vast number of potential settings (or locations) in which initiatives and programs can be implemented. These include schools, health services, workplaces and the home. The data gathered from this survey do not allow in-depth analysis and discussion of the programs within settings. However, the trends related to the locality of programs in some of the target groups can be discussed.

Not surprisingly, the vast majority of school and youth programs are set within the school environment. There is good rationale for using schools as a setting to increase opportunities for physical activity and nutrition. According to Bauman, et al. (2002), all school age children spend considerable time in this environment (ie. six hours per day for 40 weeks a year, between the age of 5 to 17 years). Equally, however there are limitations of using school settings. School based programs generally focus on competitive sport and less on recreational activities. Not all children enjoy school and may therefore demonstrate little enthusiasm when participating in related activities. There are some limitations to teachers' availability or skill in recreational and nutritional activity curricula (Bauman, et al., 2002). Although the school setting provides an avenue for parents to be involved in physical activity and healthy lifestyle initiatives, only a few initiatives identified in the survey appeared to engage the wider family and/or community.

Some adult programs identified in the survey were set within the workplace. Providing health opportunities in a work place is favourable, as there is the potential of a captive audience. A large proportion of waking hours is spent at work. Furthermore, programs at work are opportunistic from the point of economies of scale and being able to target hard to reach population such as males and CALD populations (Bauman, et al., 2002). This is exemplified in the program provided at Derbarl Yerrigan Health Service targeting aboriginal staff.

The general finding was that most workplaces, which promoted healthy lifestyles at work, did so within a general worksite 'wellness' program. Common features of these programs included organised structured physical activity classes and motivational incentives for participation and health seminars. In some cases subsidised access to facilities was provided (eg. gymnasium, swimming pool). The capacity for these programs to effectively influence all staff within the workplace is however, questionable. According to (Bauman, et al., 2002), work site initiatives can at best be described as ad hoc. Furthermore there is insufficient evidence that supports their effectiveness in increasing physical activity levels across the population. However, the workplace has potential as a setting if programs are more comprehensive and rigorously evaluated.

Summary

The main settings identified for programs targeting children, youth and adults were schools and workplaces. The benefits and limitations of using these settings to promote physical activity were identified. More research is needed to determine the effectiveness of programs in these settings in promoting healthy lifestyle behaviours across the population.

7.3 Providers of programs

The health sector was responsible for most of the primary, secondary and capacity building initiatives. This is not surprising given that health is their core business. Key organisations included EMPHU, DoH, Swan Health Service, Bentley Health Service and Kalamunda Health Service and the National Heart Foundation.

Other key leading sectors included local government, education/research, sport and recreation, and education/research. The initiatives implemented by these organisations were mostly physical activity oriented (particularly walking) targeting general populations and/or adults. It is interesting to note that such sectors were actively involved in delivering health services even though it is not their core business. This may reflect a growing trend towards working in partnership across sectors particularly in the area of physical activity.

Some organisations that responded indicated they were not involved in any activities that may enhance the health of the catchment population. These were organisations outside the health sector (ie. education, miscellaneous and corporate).

Summary

Most initiatives were delivered by the health sector. Local government, sport and recreation government departments and other government departments however delivered many physical activity programs.

7.4 Risk factor focus

The survey respondents indicated that in the EMHS there is a larger number of programs focused on physical activity, than healthy eating. It is not possible to say whether this is an issue within the context of this survey. They both represent important factors within a healthy lifestyle, but there are many other factors that will also influence the number of programs in the region. These include workforce capacity, facilities, access, publicity and reach of this survey.

It is worth noting also there was a significant proportion of initiatives that combined both (or more) risk factors. Clustering of risk factors represents an effective use of resources and is discussed further under Identified gaps and opportunities (section 7.5).

There is an identified emphasis on walking within the physical activity programs of the regions. This is warranted and in line with the results of the 2002 Adult Physical Activity Survey (Department of Health, Department of Sport and Recreation and The University of Western Australia, 2003) which showed that walking for recreation was the most popular type of activity undertaken by respondents (ie. 55% for men and 70% for women).

Summary

The survey results highlighted that there were more physical activity programs compared to healthy eating initiatives in the EMHS. Most of the physical activity programs promoted walking. A significant number of programs addressed both risk factors (ie physical activity and healthy eating).

7.5 Identified gaps and opportunities

Aboriginal and minority groups

According to the National Framework for Preventing Chronic Disease (National Public Health Partnership, 2001), socio-economic disparities between health and illness rates are significant in Australia. The social determinants of health research provides an established

evidence base for refocussing efforts on health inequalities. Many disadvantaged groups face a series of interconnected problems, including poor health, which may be compounded by social disadvantage. Furthermore, unemployment may lead to stress and poverty, with health problems exacerbated by poor transport and lack of access to affordable fresh food (National Public Health Partnership, 2001). Therefore, health improvement strategies need to take into account local circumstances and context, and social and environmental barriers to change. Effective prevention requires the collaboration of many parts of the health system with other sectors (National Public Health Partnership, 2001). Local government, State and Commonwealth government departments, schools, communities, transport, housing, recreation and voluntary organisations all have an important role to play with disadvantaged groups.

The programs identified from the survey for Aboriginal and CALD communities generally did not address health inequalities. The majority of initiatives tended to be provided solely by health organisations with very few linkages and connections to other organisations. Furthermore, the number of initiatives indicate the general lack of resources allocated to making a difference in health outcomes for minority groups.

EMPHU and other organisations seeking to address these issues, need to be mindful of the required infrastructure and organisational capacity of community organisations to implement healthy oriented programs and initiatives. A number of potential barriers that may impede an organisation's capacity to conduct and sustain healthy lifestyle initiatives include lack of management support, transient staff, inadequate access to equipment and resources and conflicting priorities within the organisation.

Early years

The majority (n= 14) of initiatives for the early years age group related to parenting and/ or nutrition and were provided in the health setting. It seems that the overall response to initiatives targeting early years is low for both nutrition and physical activity. EMHS supports the State focus for new vision in child health for 0-2 years (Marshall and Craft, 2000). There is extensive evidence that investing in the early years will reap health benefits in later life (Marshall and Craft, 2000).

School and youth

The National Health and Medical Research Council (NHMRC) Australian Dietary Guidelines

for Children and Adolescents (National Health and Medical Research Council, 2003), include physical activity as important for all children for bone density and growth and development. With the escalating and alarming increase in childhood obesity, people and organisations must support and commit to a shift in attitude and awareness of the benefits of good food and increased physical activity to combat the crisis of childhood obesity (VicHealth, 2003). The Citizen's Summit in Victoria (VicHealth, 2003) identified that by school age many of the behaviours that hasten children onto the path of obesity have already been set in place. Therefore attitudes about promotion of physical activity and healthy eating need to start with the parents, the community, local government, Department of Transport, the media, the community and health care providers to increase awareness and knowledge about prevention of obesity from early years.

Partnerships

Many initiatives concentrated on inviting community people to participate in activities established and largely controlled by health agencies and/or other agencies. Evidence of community development, whereby a significant proportion of decision-making and control was vested within the community itself, was difficult to ascertain from the available data (Egger, Spark and Lawson, 1990). According to Baum (2000: 501), '*There are many health roles played by community groups that are largely invisible, yet contribute significantly to health. They could do this more systematically in partnership with health agencies. Underlying this approach is the recognition that a healthy society is one with high levels of civic engagement, providing cohesiveness and trust'*. Working within a community development capacity presents a potential opportunity for EMPHU to work more closely with community groups (eg. women's groups, youth groups) to implement programs that seek to increase community participation and reduce social isolation. The community development approach is thought to be most effective particularly when working with the 'hardest to reach' communities and populations.

The current framework in which population health within the EMHS is organised (based on vertical, single issues programs) offers potential strengths, but leads to the potential for duplication of services for some populations. Analysis of the results shows a trend towards various programs being run by different organisations but targeting essentially the same health issues and populations. Healthy lifestyles play an important role not only in the prevention of the onset of disease, but also in the management of existing conditions. Within secondary prevention, the preventing chronic disease framework (National Public Health

Partnership, 2001) identifies that a number of conditions can be grouped together based on commonalities in their risk factors and pathogenesis. Clustering together a range of health conditions within one program could form the basis for integrated planning and partnerships between and within organisations in the EMHS. This would lead to a planned approach and better use of existing resources. The strengths of each organisation could add value to existing programs in order to prevent duplication. It is worth noting that since the survey was undertaken, a significant restructuring of EMPHU has occurred which has facilitated a shift towards clustering of risk factors in some program areas, notably those in the Adult Program. This will ensure greater inter-sectoral program integration and synergy.

Structures such as bi-lateral agreements, national health priority funding cycles and primary health partnerships can add value to resources to improve health outcomes of communities. New initiatives, to increase the capacity of primary health care providers, have been identified as key output areas for DoH. These provide an opportunity to work in partnership with general practitioners to implement new initiatives such as the Smoking, Nutrition, Alcohol and Physical Activity (SNAP) framework into primary health care settings (Department of Health, 2003). Promoting physical activity through general practice is also one of the recommended program action areas made by the Physical Activity Task Force to be implemented over the next four years (Bull, 2003). This provides a window of opportunity to influence stronger alliances between primary care providers and EMPHU. New opportunities are now emerging for EMPHU to review partnerships and alliances that will facilitate the sharing of resources and whole of region planning cycles.

Summary

It appears that there were fewer programs for populations with the least capacity. A total of ten initiatives for all groups including Aboriginal and Torres Strait Islanders, the disabled community and CALD were reported. These were provided by the health sector. EMPHU identifies Aboriginal and CALD communities as priority areas of action. This area is particularly relevant to EMPHU as the EMHS has the highest percentage of Aboriginal and CALD communities (Australian Bureau of Statistics, 2002). Similarly the survey results identified few initiatives which targeted early years and school children. This is despite the evidence showing that investing in the early years will reap health benefits in later life and the alarming increase in childhood obesity.

There is a need for EMPHU to increasingly work with the community and with organisations

across sectors to jointly plan and implement programs that will address identified gaps. This combined with clustering risk factors would help to prevent duplication of programs and enable resources and planning cycles to be integrated.

8 CONCLUSION

The conclusions of the report are based on the information received from participating individuals and organisations. Inevitably, a limitation of this is that not all organisations completed the questionnaire and therefore not all initiatives in the region were captured. Nevertheless the data collected have provided considerable information to assist EMPHU plan for future strategies and set priorities in order to improve the health of the population based within the EMHS.

Overall it appears that most initiatives implemented by organisations working at the coalface used single approaches, the most common being educational in nutrition and provision of structured classes in physical activity. Capacity building strategies comprised the largest number of initiatives. These activities were generally more comprehensive and broad ranging. A population approach is required that encompasses population wide programming, acting on root causes, using multiple strategies, long term planning, collaborating with other sectors and basing decisions on evidence.

Several gaps and opportunities were identified. It is evident that more resources and support are required for minority and disadvantaged groups. Complex health issues such as addressing health inequalities require a multi-faceted approach that cannot be achieved by the health sector alone. Opportunities for new partnerships include collaboration with transport, local government and the sport and recreation sectors. Moving towards clustering risk factors is recommended to enhance program integration and avoid potential duplication.

9 RECOMMENDATIONS

1. That there is acknowledgment that the survey findings form one component of evidence of physical activity and nutrition programs of EMHS. Hence it is recommended the data be complemented with additional data sources as required.
2. That EMPHU use the survey findings as a baseline to guide further decision making and planning for nutrition and physical activity programs in the region.
3. New alliances and partnerships be considered to form a “cluster” approach between existing programs to minimise duplication.
4. The working party, in collaboration with executive management, forms a comprehensive dissemination plan that meets the needs of EMPHU.
5. Within future planning, the recognised gaps for Aboriginal and CALD groups and the 0-4 early years programs be considered as the initial focus. Continued emphasis to remain on strengthening the capacity building of communities and organisations within and outside the health sector to implement sustainable initiatives that encompass a population approach and which will ultimately contribute towards positive health outcomes for the EMHS population.

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APPENDIX 1

SURVEY OF INITIATIVES SUPPORTING HEALTHY LIFESTYLES

ID _ _ _

The East Metropolitan Population Health Unit is conducting a survey with organisations that support healthy eating and/or physical activity in east metropolitan Perth populations.

Your organisation has been identified as one that influences the health behaviours of people living and working in east metropolitan Perth. The Director of the East Metropolitan Population Health Unit recently sent you a letter inviting you to participate in the survey. The survey will help us to develop partnerships and set priorities in order to improve the health of the east metro population. We plan to disseminate summary data to all participating organisations, which may assist your own planning and development. The survey takes about 30 minutes to complete.

To complete this survey electronically:

1. **Save this Word document to your home drive**
2. **Type your responses in the boxes provided**

Note: The boxes will enlarge as needed, so there is no need to re-format the document

3. **Return the saved document via e-mail to Krista.Williams@health.wa.gov.au by 2 December 2002**

	Please type your contact details below. When typing, boxes will enlarge as needed.
1. Name	
2. Position	
3. Organisation	
4. Address	
5. Postcode	
6. Telephone	
7. Fax	
8. E-mail	
9. Website	

10. Do you, or your organisation/group, potentially have any influence on the eating habits and/or physical activity levels of populations in Perth?
(delete inappropriate answer)

Yes→ continue

No➔ continue

11. **Do you, or your organisation, currently have any initiatives or programs that support healthy eating and/or physical activity? E.g. awareness raising activities, education or skill development activities, research initiatives, environments and policies promoting walking, partnerships and committee membership.**
(delete inappropriate answer)

Yes➔ go to Q13
No➔ go to Q12

12. **Do you have any initiatives or programs that support healthy eating and/or physical activity planned for the next three years?**
(delete inappropriate answer)

Yes➔ continue
No➔ go to Q21

13. **Please describe your existing and planned initiatives/ programs that support healthy eating and/or physical activity in the 'well' population. Please provide the title (if there is one) and a brief description of each initiative and program.**
(please complete the table below. When typing, boxes will enlarge as needed)

ID	Title	Description
	e.g. Food Cent$	Food budgeting program that shows that healthy eating is affordable. Consists of three sessions – budgeting, cooking and shopping – to increase knowledge and skills. Health professionals and community volunteers are trained by Nutritionists to conduct small group sessions. Resource materials are supplied.
a.		
b.		
c.		
d.		
e.		

14. For each initiative and program, who is your target group? Please provide all details.

(please complete the table below listing each initiative/ program in the same order as you did in the table above)

ID	Target Group
	e.g. year 6 primary school students in Kalamunda, their parents and school staff
a.	
b.	
c.	
d.	
e.	

15. How much does it cost the target group to participate in each initiative/ program?

(please complete the table below using the same order as you did in the table above. If Nil please state 'Nil')

ID	Cost
a.	
b.	
c.	
d.	
e.	

Continue…

16. What is the geographical area covered by each initiative/program?
(place an X in the appropriate box/es using the same order as you did in the table above)

ID	State-wide	Metropolitan Perth	Other, please specify E.g. specific suburb(s), local government area, health district etc
a.			
b.			
c.			
d.			
e.			

17. For each initiative/program, what has been achieved to date? What have been the lessons learnt/recommendations for the future?
(please complete table below using the same order as you did in the table above)

ID	Achievements	Lessons Learnt/Recommendations
	e.g. developed brochures promoting pram walking groups; child health nurses distribute brochures to new Mums; pram walking group established	e.g. ensure adequate facilities like shade, drinking fountains and toilets are on the walking routes
a.		
b.		
c.		
d.		
e.		

Continue…

18. Do any of these initiatives/programs involve working collaboratively with other individuals or organisations?
(please complete the table below using the same order as you did in the table above. If Nil please state 'Nil')

ID	Other individuals or organisation involved	Coordinating (Key) Organisation	Other organisations you would like to see become partners
a.			
b.			
c.			
d.			
e.			

19. For each initiative/program, please state if it is ongoing, a one-off, or limited to a specific time. If limited to a specific time, please provide details.
(place an X in the appropriate box/es using the same order as you did in the table above)

ID	Ongoing	One-off	Specific Time*	*If limited to a specific time, please provide details
a.				
b.				
c.				
d.				
e.				

20. Have any reports or documents been produced on your initiatives/programs that I could obtain a copy of at a later date?
(delete inappropriate answer)

Yes→ continue
No→ continue

21. Are you aware of other initiatives/programs that support healthy eating and/or physical activity in Perth populations?
(delete inappropriate answer)

Yes→ Please list in the box below
No→ go to Q22

22. In your opinion, what additional programs and facilities are needed to support healthy eating and physical activity in Perth?
(please list in the box below)

23. Can you provide us with contacts for other healthy eating and/or physical activity initiatives/ programs for Perth populations?
(please list below)

Name	
Organisation	
Position	
Initiative/ Program	
Telephone	

Name	
Organisation	
Position	
Initiative/ Program	
Telephone	

Name	
Organisation	
Position	
Initiative/ Program	
Telephone	

Continue…

Name	
Organisation	
Position	
Initiative/ Program	
Telephone	

24. Does your organisation have any initiatives or programs that support healthy lifestyles that are NOT focussed on eating habits or physical activity?
(delete inappropriate answer)

Yes➔ Please describe in the box below
No➔ go to Q25

25. Do you give us permission to share the information about your initiatives and programs with other organisations that support healthy lifestyles?
(delete inappropriate answers)

Yes, including all contact details supplied ➔ Continue
Yes, including contact details for the organisation ➔ Continue
No ➔ Continue

26. Are we able to contact you again should we need further clarification about your initiatives/programs?
(delete inappropriate answer)

Yes ➔ Continue
No ➔ Continue

END: That completes the survey. Thank you for your assistance with this project, it is much appreciated.

Please save the completed survey and forward it via e-mail to Krista.Williams@health.wa.gov.au by 2 December 2002.

You will go in the draw to win a $50 Angus and Robertson book voucher. If you submit your survey via e-mail you will get a bonus entry – doubling your chances of winning!
For further information contact Krista Williams, Public Health Officer, East Metropolitan Population Health Unit, on phone 9224 2029 or fax 9224 1612.

APPENDIX 2

CONSUMERS' PERSPECTIVES ON HEALTHY EATING

This survey will help guide a review of existing nutrition initiatives and programs in the east metropolitan area. There are no right or wrong answers, just your opinions. The survey results will remain anonymous and confidential, and used only by staff at the East Metropolitan Population Health Unit. PLEASE PRINT CLEARLY.

1. **What makes it easier for you and other Perth citizens to eat a healthy diet?**

2. **What more can be done to make healthy food choices the easy choices?**

3. **What organisations, agencies and individuals are, or should be, involved in making healthy food choices the easy choices for Perth citizens?**

Please write additional comments below and on the back of the page

CONSUMERS' PERSPECTIVES PHYSICAL ACTIVITY

This survey will help guide a review of existing physical activity initiatives and programs in the east metropolitan area. There are no right or wrong answers, just your opinions. The survey results will remain anonymous and confidential, and used only by staff at the East Metropolitan Population Health Unit. PLEASE PRINT CLEARLY.

1. **What makes it easier for you and other Perth citizens to be physically active?**

2. **What more can be done to make the physically active choice the easy choice?**

3. **What organisations, agencies and individuals are, or should be, involved in making the physically active choice the easy choice for Perth citizens? (Exclude those already listed for the nutrition survey)**

Please write additional comments below and on the back of the page

APPENDIX 3

ORGANISATIONS WHICH RESPONDED

HEALTH

(i) Government (7)

East Metropolitan Population Health Unit
Bentley Health Service
Swan Health Service
Kalamunda Health Service
Dept of Health
Derbarl Yerrigan Health Service
Women and Children's Health Service

(ii) Non Government (12)

Diabetes WA
National Heart Foundation
Cancer Foundation
Canning Division of General Practice
Perth and Hills Division of General Practice
Women's Health Care House
Stroke Foundation
AMA
RACGP
Arthritis Foundation
Nutrition Australia
Ngala Family Resource Centre

EDUCATION, TRAINING & RESEARCH (11)

Department of Education
UWA
Curtin University
University of Notre Dame
Marr Mooditj Foundation
Meerilinga Training College
Pickles Productions
ReaLife Health and Happiness
Live Smart
WA School Road Safety Project
WA School Canteen Assoc.

LOCAL GOVERNMENT (9)

Town of Bassendean

City of Bayswater
City of Belmont
City of South Perth
City of Swan
Town of Victoria Park
Town of Vincent
Dept of Local Government & Regional Development
East Metropolitan Regional Council

OTHER GOVERNMENT (3)

Department of Environmental Protection
Department of Planning & Infrastructure
Premier's Physical Activity Taskforce

SPORTS & RECREATION (5)

Dept of Sport and Recreation
Bibbulmum Track Foundation
Seniors Recreation Council WA
Sports Medicine Australia
Womensport West

FOOD INDUSTRY (3)

Fresh Finesse
Western Potatoes
WA Vegetable Growers Assoc

CORPORATE (4)

Alinta Gas
StateWest Credit Union
Woodside Petroleum
HBF

DISABILITIES (1)

Disabilities Services Commission

MISCELLANEOUS (1)

Streets Alive

APPENDIX 4

NON-RESPONDENT ORGANISATIONS

HEALTH

(i) Government (1)

Department of Health & Aged Care (WA Office)

(ii) Non-Government (8)

Healthway
Asthma Foundation
Australian Breastfeeding Assoc
Health Consumer's Council
WA Aboriginal Controlled Health Organisation
Asetts
Lady Gowrie Centre
Silver Chain

EDUCATION, TRAINING & RESEARCH (8)

Edith Cowan University
Commission of Catholic Education
SE Metro College of TAFE
WA Council of State Schools Organisations
State Training Councils Division
Parents & Friends Federation of WA
Australian School of Tourism and Hotel Management
Telethon Institute of Child Health Research

OTHER GOVERNMENT (7)

Department of Community Development
Department of Conservation & Land Management
Conservation Council of WA
Department of Veteran's Affairs
Department of Industry & Technology
Police Service WA
Transperth

LOCAL GOVERNMENT (7)

City of Canning
City of Perth
Shire of Kalamunda
Shire of Mundaring
City of Stirling
Local Government Association

Roadwise

SPORTS & RECREATION (6)

Surf Lifesaving WA
Bicycle Transportation Alliance Inc
WA Sports Federation
Lotteries Commission
Tourism Council of WA
North East Region Youth Council

UNIONS/PROFESSIONAL ASSOCIATIONS (9)

Australian Liquor, Hospitality & Miscellaneous Workers Union WA
Australian Nursing Federation
Health Services Union of Australia, WA
Community & Public Sector Union
National Union of Workers
Australian Manufacturing Workers Union
Australian Services Union WA
Dietitians Association Australia (WA)
Public Health Association (WA)

FOOD (5)

Chamber of Fruit & Vegetable Industries
WA Fruit Growers Assoc
Foodbank
Australian Bananas
Catering Institute of Australia (WA)

CORPORATE (2)

Rio Tinto Inc
Water Corporation

MISCELLANEOUS (7)

Health & Medicine (The West Australian)
Community Newspaper Group
Neighbourhood Watch
Keep Australia Beautiful
Retirees WA
Celebrate WA
WA Council of Social Service (WACOSS)