



City of
Whittlesea

Municipal Public Health and Wellbeing Plan

2009 - 2013



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MAYOR'S MESSAGE



The City of Whittlesea is committed to creating environments that support our community's health and wellbeing. To achieve this vision, Council has developed a Municipal Public Health and Wellbeing Plan 2009 – 2013.

The Plan affects everyone within the City of Whittlesea, whether you're 5 or 95; whether you're male or

female; whether you live in the north, south east or west of our municipality; this Plan is about you. It's inclusive of all.

We developed the Plan in partnership with health and community agencies in the municipality and began by looking at local health and wellbeing data that informed us about current issues and trends.

Just as important was what you had told us were your issues through community consultations in 2007 and 2008. Also, the very recent consultations that occurred this year are in line with the strategies proposed throughout the Plan.

The Plan was developed with Federal and State Government priorities in mind, and in accordance with the Victorian Public Health and Wellbeing Act 2008.

We know that our health and wellbeing is influenced by a wide range of issues. It is about the friendships we have, the social networks in our community; whether we have a job and the places we live and most importantly the opportunities we have to live healthy lives.

Through this Plan we will implement strategies that will promote mental health and social wellbeing, we will work to sustain the natural environment and create more liveable and more walkable communities. We will provide opportunities for healthy living and physical activity, creating environments where the healthy choice is the easy choice, and we will work to prevent harm from gambling, alcohol and other drugs.

The City of Whittlesea is among the fastest growing municipalities in Victoria and faces many challenges as a result. We have a high demand for services and infrastructure and areas of social disadvantage. Not least among recent challenges have been the Black Saturday bushfires earlier this year.

Encouraging and enabling people to lead healthy lives and providing the opportunities to help them do so is an immense challenge for all levels of government. The Health and Wellbeing Plan is our way forward. It is Council's commitment to you, that working together, we can achieve maximum health and wellbeing.

Happy reading

Cr Mary Lalios
Mayor

INTRODUCTION

The City of Whittlesea is committed to providing a socially and physically inclusive, safe and sustainable environment that supports the community's health and wellbeing. To achieve this vision, Council has developed a Municipal Public Health and Wellbeing Plan 2009 – 2013.

The Victorian Public Health and Wellbeing Act 2008 requires Councils to prepare a municipal public health and wellbeing plan every four years. The plan must examine health status data and health determinants for the municipality, and respond with goals and strategies for creating a local community in which people can achieve maximum health and wellbeing.

The City of Whittlesea Municipal Public Health and Wellbeing Plan 2009 – 2013 (the Plan) has been developed to improve the health and wellbeing of all who live and work in the municipality. The Plan is underpinned by four principles:

Early in life

Responding early in life to achieve better outcomes for children, young people and their families.

Inclusion

Acting to reduce health inequalities across gender, culture, language and disability; and ensuring equity of access for indigenous, refugee and economically disadvantaged communities.

Sustainability

Building sustainability into programs and planning, and working to ensure economic and social activity is consistent with ecological sustainability.

Partnerships

Working in collaboration and integrating planning across Council, agencies and the community.

The Plan is based on extensive research and consultation, and was developed in partnership with health and community agencies in the local area. It identifies three priority areas for action, and has a strategic focus on knowledge building, gap analysis and coordination, and influencing and advocacy.



POLICY FRAMEWORK

Global context

Health Promotion is the process of enabling people to increase control over, and to improve their health... health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing.

Ottawa Charter 1986

At the first international conference on Health Promotion in 1986, the Ottawa Charter was adopted. It identified the fundamental conditions and resources needed for good health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Five action areas for health promotion action were outlined:

Building healthy public policy

Putting health on the agenda of policy makers in all sectors and at all levels to promote health and foster health equity.

Creating supportive environments

Creating living and working conditions that are safe, stimulating, satisfying and enjoyable. Protecting the natural and built environment and conserving natural resources.

Strengthening community action

Empowering communities to have more ownership and control of their own endeavours and destinies.

Developing personal skills

Providing information, health education and skill development to enable people to take informed action for health.

Reorienting health services

Moving the health sector focus more toward health promotion and prevention, than treatment and cure. The responsibility for health is shared amongst individuals, the community, government, institutions and other organisations.

The World Health Organisation (WHO) defines the social determinants of health as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics. The determinants include socio-economic status, employment, education, housing, social support, access to

health services, transport, food and addiction. The Plan was developed using a Social Determinants of Health approach, addressing these upstream causes of health and wellbeing.

In 2008, the WHO Commission on the Social Determinants of Health made three recommendations to address health and health equity:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

National context

National Health Priority Areas

The National Health Priority Areas (NHPA) initiative is a collaborative effort endorsed by the Commonwealth and all State and Territory governments. There are currently seven NHPAs:

- Arthritis and musculoskeletal conditions
- Asthma
- Cancer control
- Cardiovascular health
- Diabetes mellitus
- Injury prevention and control
- Mental health

The seven NHPAs account for almost 80% of the total burden of disease and injury in Australia. The NHPA initiative also focuses on common health risk factors such as tobacco smoking, physical activity, diet and nutrition, excess body weight, high blood pressure and high blood cholesterol.

National Preventative Health Strategy

In 2008, a National Preventative Health Taskforce was established to provide evidence-based advice to governments and health providers on preventative health programs and strategies, focusing on the burden of chronic disease currently caused by obesity, tobacco and the excessive consumption of alcohol. A National Preventative Health Strategy addressing these risk factors is in development.

Victorian context

Public Health and Wellbeing Act 2008

The Victorian Public Health and Wellbeing Act 2008 (the Act) was passed by the Victorian Parliament and was assented to on 2 September 2008. It replaces the Health Act 1958 and is designed to modernise the Victorian public health system and protect the health and wellbeing of the population.

Under section 263 of the Act, a Council must prepare a municipal public health and wellbeing plan that meets new requirements within 12 months of the general election of the Council. Thereafter, Councils will be required to prepare a new plan every four years. A municipal public health and wellbeing plan must:

- (a) include an examination of data about health status and health determinants in the municipal district
- (b) identify goals and strategies based on available evidence for creating a local community in which people can achieve maximum health and wellbeing
- (c) provide for the involvement of people in the local community in the development, implementation and evaluation of the public health and wellbeing plan
- (d) specify how the Council will work in partnership with the Department and other agencies undertaking public health initiatives, projects and programs to accomplish the goals and strategies identified in the public health and wellbeing plan
- (e) be consistent with -
 - (i) the Council Plan prepared under section 125 of the Local Government Act 1989; and
 - (ii) the Municipal Strategic Statement prepared under section 12A of the Planning and Environment Act 1987.

Health promotion priorities for Victoria 2007 - 2012

The Victorian health promotion priorities for 2007-2012 to be considered in health and wellbeing planning are:

1. Promoting physical activity and active communities
2. Promoting accessible and nutritious food
3. Promoting mental health and wellbeing

4. Reducing tobacco-related harm
5. Reducing and minimising harm from alcohol and other drugs
6. Safe environments to prevent unintentional injury
7. Sexual and reproductive health

These priorities are aimed at improving overall health and reducing health inequalities. The Department of Human Services framework to assist Councils in health planning, *Environments for Health and Wellbeing*, considers the impact on health and wellbeing of factors originating in the built, social, economic, and natural environments. It recognises that public health is more than just dealing with illness after it appears or persuading individuals to change attitudes and lifestyles. Public health also deals with the environments in which people live and work.

VicHealth Strategic Priorities 2006-2009

The Victorian Health Promotion Foundation (VicHealth) Strategic Priorities 2006-2009 are:

1. Reducing Harm from Tobacco and Alcohol
 - Reduce smoking
 - Reduce exposure to tobacco smoke
 - Reduce alcohol misuse
2. Creating Active Communities and Promoting Healthy Eating
 - Increase participation in sport and active recreation
 - Improve access to nutritious food
 - Encourage more walking and cycling
 - Promote inclusive and accessible environments
3. Promoting Mental Health and Wellbeing
 - Promote social inclusion
 - Reduce discrimination
 - Prevent violence
 - Increase access to education and employment.

Charter of Human Rights and Responsibilities Act 2006

The Charter of Human Rights and Responsibilities Act 2006 came into effect for public authorities, including local government, on 1 January 2008. The purpose of the Charter is to establish a framework for the protection and promotion of human rights in Victoria. There are 20 civil and political human rights protected by the Charter and Council has ensured that these rights have been taken into account in developing the City of Whittlesea Public Health and Wellbeing Plan 2009 - 2013.

Local context

The City of Whittlesea Municipal Public Health and Wellbeing Plan, Community Plan and Municipal Strategic Statement are statutory planning responsibilities of local government. The Victorian Public Health and Wellbeing Act 2008 determines that health planning should be aligned with these other Council planning processes.

The Principle, Objectives and Strategies of the Municipal Public Health and Wellbeing Plan 2009–2013 are consistent with the objectives of the City of Whittlesea Community Plan and the vision and objectives of the Municipal Strategic Statement.

City of Whittlesea Community Plan 2008 - 2012

The Community Plan is a four-year plan that identifies community needs, priorities and strategies for achieving community identified outcomes. It lays out the actions for new and improved community services, facilities and programs that Council will implement over the next four years. The Community Plan is the Council Plan for the purposes of complying with Section 125 of the Local Government Act 1989.

In 2008, over 200 residents participated in the annual review of the Plan. The six most frequently raised issues were transport; environment; facilities and infrastructure; youth; community services; sporting and leisure facilities.

The Community Plan has identified five Key Strategic Objectives for 2008 – 2012:

1. Leadership: Council to provide valued community leadership
2. Environment: Protect and enhance the natural and built environment
3. Community: Community involvement, growth and diversity
4. Sustainable growth: Balance of diverse growth opportunities
5. Service: Community satisfaction with Council services and facilities.

Municipal Strategic Statement

The City of Whittlesea Municipal Strategic Statement is prepared under section 12A of the Planning and Environment Act 1987. The Municipal Strategic Statement vision states:

The City of Whittlesea recognises the need for strong leadership and is accepting of the challenges that a growth area on the metropolitan fringe brings. By necessity the City of Whittlesea will adopt a long-term outlook in working toward sustainable outcomes in housing provision, employment generation and preservation and enhancement of rural areas and features of environmental significance.

The strategic vision for the municipality is summarised into twelve key land use planning objectives which address:

1. Residential Growth Areas
2. Managing Urban Growth
3. Housing Provision
4. Employment and Economic Development
5. Transport and Accessibility
6. Activity Centres
7. Infrastructure Provision
8. Leisure Recreation and Tourism
9. Heritage and Culture
10. Environmental Assets
11. Rural Land Use and Development
12. Image and Appearance

HEALTH AND WELLBEING PROFILE

The *City of Whittlesea Health and Wellbeing Profile 2008* (the Profile) provides an overview of public health and wellbeing issues in the municipality. The Profile has been developed as a research document to provide information for the development of the Plan and is intended as a resource for Council and health and community agencies in the City of Whittlesea.

The City of Whittlesea is located 20km north of Melbourne. It is a large municipality covering an area of 490 km² of both urban and rural land. It has a population of around 130,000 and includes the suburbs of Bundoora, Donnybrook, Doreen, Eden Park, Epping, Humevale, Kinglake West, Lalor, Mernda, Mill Park, South Morang, Thomastown and Whittlesea.

Demographics

The City of Whittlesea is among the fastest growing municipalities in Victoria. Over the past decade, the City has grown by an average of more than six people per day. This strong growth is expected to accelerate over the next two decades with an increase of nearly 30,000 persons over the next ten years.

Significant growth is anticipated in all age cohorts, together with greater diversity in household structures: it is expected that there will be an increase in the proportion of childless-couples, one-parent families and single occupant dwellings. While the City of Whittlesea has a higher proportion of families with dependent children than Melbourne and Victoria, the average household size is getting smaller. While the municipality retains a relatively young age profile, with a higher proportion of children and a lower proportion of older residents than metropolitan Melbourne or Victoria, the strongest growth between 2001 and 2006 occurred in the older age groups.

The City is also one of the most culturally and economically diverse areas in the Melbourne metropolitan area. The proportion of residents from non-English speaking backgrounds is about 48%, which is double the Victorian average. 32.8% of the Whittlesea population were born overseas and 43.1% of residents normally speak a language other than English at home. Since 2001 there have been increases in people born in India, Sri Lanka, the Philippines and Lebanon, whilst Iraq represents one of the fastest growing community groups. The number of people identifying as Aboriginal or Torres Strait Islander has increased by 21% between 2001 and 2006.

Health status

In the City of Whittlesea, the top three specific diseases that affect men and women are heart disease, depression and diabetes. The incidence of diabetes is increasing throughout Australia and in the City of Whittlesea the number of people with diabetes almost doubled between 2001 and 2006. It has been found that more overseas-born people than Australian-born report having diabetes, with the highest diabetes prevalence among people from the Middle East and North Africa. These are two emerging communities in the municipality.

Disability affects 7% of the population according to the 2006 Household Survey. Most people who suffered disability were 55 years and over (59%) but it is also an affliction of people aged 25-54 years (29.6%). Since the population of the City of Whittlesea is ageing, it may be anticipated that the incidence of disability will increase. Into the future it is forecast that the greatest impact will be felt in the older age groups, which will steadily increase.

In the City of Whittlesea, the average breastfeeding rates have declined rapidly between the years 2002 and 2006. Only 37.6% of children at 3 months of age are being breastfed, compared with 51.8% for Victoria. However, immunisation rates have improved, especially for children aged between 72 and 75 months where almost 5% more children were immunised in 2007 than were immunised in 2004.

Education and employment

The City of Whittlesea has, in comparison with Melbourne and Victoria, more than twice the proportion of people who have not gone to school; more people who have left school at Year 8 or below; a lower percentage of people who have completed year twelve and a significantly lower proportion of people with university level qualifications.

In the City of Whittlesea there is a smaller proportion of people employed in highly skilled jobs than in the Northern and Western Metropolitan area, Melbourne or Victoria. The three most common types of occupation are technician and trades worker, clerical and administrative, and labourers. At September 2007, the municipal unemployment rate was 5%, as compared to 4.5% for Melbourne. This represents around 3,300 residents who were classified as unemployed, which is 200 fewer than at September 2006.

Socio-economic status

The municipality of Whittlesea's SEIFA Index of Relative Socio-economic Disadvantage is 978 which ranks it 27th most disadvantaged among the 79 Municipalities of Victoria. Social exclusion, caused by relative poverty, is potentially experienced by 29% of families in the City of Whittlesea as 10,000 families are earning 60% less than the national median weekly income. The majority of low-income households are in the older suburbs of the municipality. Households paying more than 30% of income toward housing costs are more likely to be found in the newer suburbs.

Risk factors

Good food and exercise, important for promoting health and wellbeing, are being incorporated into the lifestyles of many people in the North and West Region of Melbourne, including City of Whittlesea. In 2007, females were more likely to meet recommended fruit consumption than males (52% female vs 38% male). Both males and females had low vegetable consumption with only 6% meeting recommended guidelines of 5 or more daily serves. 65% of males and 62% of females meet recommended physical activity guidelines.

In 2007, 6.9% of people in the City of Whittlesea ran out of food in the previous twelve months and could not afford to buy more. This was higher than the Victorian rate of 6.0%.

Whittlesea has one of the lowest rates in the State for tobacco-related hospitalisations. Similar to tobacco, alcohol related hospital admissions and bed-day rates for the City of Whittlesea residents were among the lowest in Melbourne and Victoria. Whittlesea's lower alcohol related harm rates are also evident in the government funded treatment sector data. Treatment utilisation rates for alcohol as the primary drug of concern are lower among Whittlesea residents compared to Melbourne, and Victoria. That Whittlesea residents have lower rates may be caused by residents having more barriers to accessing services.

In the City of Whittlesea, more money is spent per adult on gaming than in Melbourne or Victoria. During the financial year 2007-08, adults in the City of Whittlesea lost \$87 million on Electronic Gaming Machines, which equates to \$883 net expenditure per adult, ranking the municipality seventh highest across the State. The number of Electronic Gaming Machines has remained steady at 616 since 2000



and the number of venues at nine. In comparison, the net expenditure in metropolitan Melbourne was \$697 per adult and in Victoria it was \$657.

Conclusion

The Profile identifies areas of good health and wellbeing, and areas where the City can build upon existing strengths. The Profile also identifies areas of health inequality among particular population groups within the municipality, and areas that require special attention.

Encouraging people to lead healthy lives and providing the resources to help them do so is an immense challenge for all levels of government. The challenge in the municipality of the City of Whittlesea is amplified because of the diversity of a population that is spread over a large geographical area, but concentrated in the south. The City faces the distinctive challenge of balancing the dynamics of urban areas, rural areas, rapid growth, social disadvantage and high demand for services.

DEVELOPING THE HEALTH AND WELLBEING PLAN

Evaluation of Municipal Public Health Plan 2004 – 2007

In preparation for the development of the Plan, an evaluation of the Municipal Public Health Plan 2004 – 2007 was conducted comprising an audit of actions, and interviews with Steering Committee members.

The audit found that of the 89 actions in the Health Plan, 84 actions were achieved or partly achieved. Recommendations from the interviews were that the Health Plan should operate at a more strategic level, addressing the upstream determinants of health. The Health Plan and the Steering Committee should address population health concerns, rather than focus on micro-outcomes of projects. The Committee should have a monitoring and evaluation role that determines whether the Health Plan is meeting its objectives.

Partnership approach

A partnership of health and community agencies was established to oversee development of the Plan. This group comprised the City of Whittlesea, and health and community agencies in the municipality. Agencies represented were Department of Human Services (North & West Metropolitan Region), Latrobe University Public Health, Neami – Whittlesea, North Central Metro Primary Care Partnership, Northern Area Mental Health Service, Northern Division of General Practice, Northern Health, Plenty Valley Community Health, The Northern Hospital, Whittlesea Community Connections and Women's Health in the North.

The framework for the Plan was developed through a series of facilitated workshops held with senior staff from Council and these agencies. The partnership considered the global, national, state and local policy context; and population health data from the *Health and Wellbeing Profile 2008*. Community consultation also informed the development of the Plan. These included the 2007 and 2008 Mayoral Forums; consultations for the Community Plan, Disability Action Plan, Multicultural Plan and Youth Plan; and the Epping Central Community Engagement Program.

Three priority areas were identified which had a strategic focus on knowledge building; gap analysis and coordination; influencing and advocacy. They were consistent with community concerns, Federal and State Government directions and addressed key issues drawn from the population health data. The priority areas are:

Priority Area One: People

Goal : Promoting mental health and social wellbeing to achieve a resilient and inclusive community.

Priority Area Two: Spaces and Places

Goal: Sustaining natural environments, creating built environments and providing community infrastructure to support health and wellbeing.

Priority Area Three: People and Place - Making it Happen

Goal: Improve capacity for health and wellbeing.

Community consultation

A capable and or viable community is one in which its residents work together to influence various aspects of the local social order in which residents set goals for collective life and in which they have the ability to carry out work to accomplish these goals. - Schoenberg 1979¹

The priority areas were distributed widely for community comment for six weeks in 2009. The aim of this consultation process was to inform the community about the priority areas and seek comments and feedback about how Council and agencies should respond to these priorities.

¹ cited in Henderson, P. and Thomas, D.N. 2001, *Skills in Neighbourhood Work*, Routledge, p.20





Some themes to emerge from the consultation included:

Priority Area One: People

- Building links across groups, across cultures and across generations promotes mental health and social wellbeing. Intergenerational and multicultural meeting spaces are required to support this.
- Promoting street barbeques and ‘getting to know your neighbour’ days, and providing opportunities for different groups who use Council facilities to come together increases links within the community.

Priority Area Two: Spaces and Places

- Built environments should be created where services are located near public transport, where affordable housing is available, and where housing for vulnerable groups is prioritised.
- Creating a supportive environment for health and wellbeing could be achieved with walking and cycling infrastructure, bike racks, walking

and cycling maps, and programs for sustainable transport to school and work.

- Providing incentives for home owners and businesses who reduce energy use.

Priority Area Three: People and Place - Making it Happen

- Healthy living could be promoted by providing access to affordable recreation and leisure opportunities and facilitating access to the natural environment.
- Healthy eating could be improved through programs that address food access and availability, and programs that support nutrition awareness.
- Reducing harm from gambling, alcohol and other drugs could be achieved by promoting low cost activities for vulnerable groups and providing tobacco and alcohol free facilities and events.

The community consultation reaffirmed the priority areas for action, and provided detail for the implementation of specific strategies.

HEALTH AND WELLBEING ACTION PLAN

A two-year Action Plan 2009 – 2011 has been developed to address the three priorities. The Action Plan consists of 20 strategies. During the second year of implementation an Action Plan for 2011 – 2013 will be developed, responding to changing Federal and State policy frameworks, updated health and wellbeing data, and outcomes from strategies in the first two-year Action Plan.

A Steering Committee will provide strategic advice and support in the implementation and evaluation of the City of Whittlesea Municipal Public Health and Wellbeing Plan 2009 – 2013. The Committee will be chaired by a Councillor and will comprise representatives from Council, Department of Human Services, agencies and the community. The Committee will ensure compliance with the Act regarding implementation and evaluation of the Plan.



Priority Area One: People

Goal : Promoting mental health and social wellbeing to achieve a resilient and inclusive community

Objective 1.1: To increase community connectedness

No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
1.1.1	<p>Conduct an asset audit of social capital to inform strategic and program development. Council will work with agencies and with the community to determine:</p> <ul style="list-style-type: none"> • what level of connectedness currently exists within groups, between groups and with institutions of power and influence. • who are our vulnerable groups. • whether current projects and initiatives are improving social capital. • what is the benchmark we want to achieve. 	<p>Increased understanding about community connectedness in the municipality.</p> <p>Increased knowledge about the impact existing projects and initiatives have had on community connectedness.</p> <p>Measurement framework for social capital in the municipality.</p> <p>Strategies for implementation in 2011-12 Action Plan.</p>	<p>Knowledge building</p> <p>Gap analysis and coordination</p> <p>Links with strategies</p> <p>1.2.1, 1.2.2</p> <p>2.1.1, 2.1.2</p>

Objective 1.2: To increase access to education, employment and transport for vulnerable groups

No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
1.2.1	<p>Facilitate cross-sector coordination for improved access to education, employment and transport services for vulnerable groups:</p> <ul style="list-style-type: none"> • Identify existing initiatives • Identify strategic gaps • Build links between initiatives • Identify opportunities for further work. 	<p>A map of current employment and education pathways and opportunities for vulnerable groups in the municipality.</p> <p>Coordinated action across existing projects and networks.</p>	<p>Knowledge building</p> <p>Gap analysis and coordination</p> <p>Links with 1.1.1</p>
1.2.2	<p>Identify opportunities for creating employment pathways for vulnerable communities by linking with existing local industry and establishing employers in the municipality.</p>	<p>Employment pathways and opportunities established for vulnerable groups.</p>	

Objective 1.3: To build the capacity of individuals and the community for the prevention of family violence, particularly against women and children

No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
1.3.1	<p>Develop local social marketing strategies to raise awareness of family violence with a focus on building the knowledge, understanding and skills of individuals in the community.</p>	<p>Increased awareness and understanding of family violence in the community.</p> <p>Increased knowledge and skill to take action against family violence by community members.</p>	<p>Knowledge building</p> <p>Influencing and advocacy</p>

Priority Area Two: Spaces and Places

Goal: Sustaining natural environments, creating built environments and providing community infrastructure to support health and wellbeing

Objective 2.1: To ensure the provision of appropriate facilities and infrastructure that promote and support health and wellbeing			
No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
2.1.1	Identify gaps in community meeting spaces and advocate for community spaces, schools as hubs and community hubs.	Increased access to community meeting spaces.	Knowledge building Gap analysis and coordination Influencing and advocacy
2.1.2	Plan for future health infrastructure including services at local level by: <ul style="list-style-type: none"> • Informing the Planning for a Healthier North process with research on the needs of the municipality • Advocating to Planning for a Healthier North for action at the local level 	Advocacy and action for improved access to health services.	Links with 1.1.1
2.1.3	Identify housing needs in the municipality for vulnerable communities.	Housing need documented, and opportunities for further action identified.	
Objective 2.2: Create walkable and liveable communities in the natural and built environments			
No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
2.2.1	Identify strategic priorities for filling the gaps in the walking and cycling network at the local level, including to public transport nodes, schools, activity centres, along creek corridors and open space areas.	Increased walkability in the municipality. Reduction in the use of cars for small trips.	Gap analysis and coordination Influencing and advocacy
2.2.2	Build workforce capacity within Council and with developers for healthy design incorporating walkability, accessibility, community safety and provision of shade.	Improved coordination and capacity for healthy design. Improved perceptions of safety in local areas.	Knowledge building Gap analysis and coordination
Objective 2.3: Reduce impact of climate change on vulnerable groups			
No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
2.3.1	Identify local impacts of climate change on the health and wellbeing of vulnerable groups and the role of local government in addressing these impacts.	Heat Wave Strategy developed. Strategies for implementation in 2011-13 Action Plan.	Knowledge building

Priority Area Three: People and Place - Making it happen

Goal: Improve capacity for health and wellbeing

Objective 3.1: To promote healthy living and physical activity			
No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
3.1.1	Increase accessibility and affordability of recreation options for people on low incomes.	<p>Increased number of accessible and affordable active and passive recreation options available.</p> <p>Increased understanding of barriers and enablers to participation in active recreation.</p>	<p>Knowledge building</p> <p>Gap analysis and coordination</p> <p>Influencing and advocacy</p>
3.1.2	Work in partnership with mental health and primary care service providers to provide opportunities for increasing levels of physical activity and recreation among vulnerable groups, particularly those with a mental illness.	<p>Partnerships for addressing health inequality through active recreation established.</p> <p>Increased number of people from vulnerable groups participating in sustainable physical activity and active recreation programs, and at a range of levels including coaching, officiating, administration and management.</p>	<p>Gap analysis and coordination</p>
3.1.3	Research local level data on diabetes, identifying prevalence across age and ethnicity.	<p>Increased knowledge and understanding of the prevalence of diabetes in population groups in the municipality.</p> <p>Strategies identified for the 2011-13 Action Plan.</p>	<p>Knowledge building</p>



Objective 3.2: To improve healthy eating, accessibility and affordability of food

No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
3.2.1	Increase healthy food options in the municipality by working with local food businesses to introduce a recognition program.	Increased availability of healthy foods in restaurants and cafes. Increased organisational capacity for providing healthy environments and settings.	Gap analysis and coordination
3.2.2	Improve access to healthy food for refugees and new arrivals.	Increased understanding and knowledge about healthy foods available in the municipality. Increased access to food and increased acceptability of healthy food by newly arrived communities.	Knowledge building Gap analysis and coordination
3.2.3	Investigate opportunities to improve food access and affordability with the relocation of the Wholesale Fruit and Vegetable market to Epping.	Strategies identified for the 2011-13 Action Plan.	Knowledge building Gap analysis and coordination Links with Strategy 1.1.1
3.2.4	Develop a community garden policy to support the development of gardens in public and private open space, aged care facilities, residential developments, schools and community spaces.	Council policy support for community gardens. Increased number and range of community gardens.	Gap analysis and coordination Influencing and advocacy

Objective 3.3: To prevent harm from gambling, alcohol and other drugs

No.	Strategies 2009 - 2011	Expected outcomes	Type of strategy
3.3.1	Develop a Drug and Alcohol Profile for the municipality.	Increased knowledge about drug and alcohol use and harm in the municipality.	Knowledge building
3.3.2	Reduce and minimise alcohol related harm through the reduction of early age uptake and frequent adolescent alcohol use.	Increased capacity within Council and the community for reducing harm from alcohol among young people and their families. Improved coordination among agencies for preventing harm from alcohol.	Gap analysis and coordination Influencing and advocacy
3.3.3	Work in partnership with agencies on reducing the impact of gambling at the local level.	Improved coordination among agencies for reducing the incidence of gambling.	Gap analysis and coordination

GLOSSARY

Climate Change: impact on health

'Global climate change is progressing and health impacts have been observed in a number of countries, including Australia. The main health impacts will be due to direct heat exposure, extreme weather, air pollution, reduced local food production, food and vector-borne infectious diseases and mental stress. The issue is one of major public health importance. Adaptation to reduce the effects of climate change involves many different sectors to minimise negative health outcomes. Wide-scale mitigation is also required, in order to reduce the effects of climate change. In addition, future urban design must be modified to mitigate and adapt to the effects of climate change.'

(Source: Kjellstrom T, Weaver HJ. Climate change and health: impacts, vulnerability, adaptation and mitigation. *New South Wales Public Health Bulletin* 2009; 20: 5–9.)

Disability Adjusted Life Years (DALY)

The DALY is a measure of the disease burden in a population combining the loss of years of life due to premature mortality and the loss of healthy years of life due to disease or injury. One DALY can be thought of as one lost year of healthy life. The DALY is a so-called health gap measure. This means that the burden of disease is measured as the gap between the current health status of the population and an ideal situation where everyone lives into old age, free of disease or injury. The term disability is used quite broadly, in this sense, to include all departures from complete health due to disease or injury.

(Source: health.vic.gov.au)

Health inequality

There are marked inequalities in health between different groups of people in Victoria, including differences in rates and patterns of death and disease, life expectancy and in how people rate their own health. Victorians who have particularly poor health include people from lower socio-economic groups, Indigenous people, people from refugee backgrounds and those with disabilities. People who live in low-income areas also have poorer health. Many of these inequalities are preventable as they are not due to genetic or biological factors. Instead, they are related to inequalities in access to the things we all need for good health, such as income, education, and good living and working conditions. Poverty and inequality can also affect community networks and lifestyles which in turn influence health.

(Source: vichealth.vic.gov.au)

Liveability

Liveability encompasses the many characteristics that influence people to live in a place. These characteristics include:

- Participation - political and democratic processes that allow people to participate in decisions that affect them
- Economic strength – efficient markets that promote and encourage economic prosperity, employment opportunities, and the wellbeing of all residents
- Social inclusion - all have the opportunity to participate fully in society and to gain a sense of belonging and fulfilment
- Built infrastructure (such as hospitals, education facilities, leisure facilities, libraries, and telecommunications & transport networks) – adequately provided and maintained
- Social infrastructure (such as community organisations, clubs, support services, art and culture) - to assist people to achieve their full potential
- Environment – sustainable practices to preserve the natural environment for current and future generations
- Transport – mobility of population and distribution of goods facilitated by transport choices that are environmentally sustainable
- Amenity - urban planning which meets local needs within the context of broader planning needs.

Places which embody these characteristics develop both an effective and competitive market place and the social capital necessary for all members of society, no matter their initial circumstances, to choose the degree and manner in which they access and participate in society, and to sustain a strong economy.

(Source: vcec.vic.gov.au)

Planning for a Healthier North

Planning for a Healthier North is working toward a regional, integrated health planning model. The agencies represented are from the seven northern local government areas and include local government, community health, three Divisions of General Practice, three Primary Care Partnerships, seven Metropolitan Health Services, Royal District Nursing Service, Victorian Aboriginal Health Service.

Population health approach

A population health approach emphasises a view of the community as a whole, addressing the key determinants of health and wellbeing of the population and reducing health inequities, in addition to treating and supporting individuals. Population health activity encompasses organised responses to promote and protect health, to prevent illness, injury and disability, to decrease the burden of illness and to restore and rehabilitate those with chronic disease. It also encompasses an understanding of the social and economic determinants of health. Individual care and a community focus complement each other and lead to better health and wellbeing outcomes by addressing health and community support issues from different perspectives.

(Source: health.vic.gov.au)

Social capital

The Australian Bureau of Statistics has adopted the Organisation for Economic Cooperation and Development (OECD) definition of social capital. This OECD definition is emerging as a common basis for international comparability: "Networks, together with shared norms, values and understandings which facilitate cooperation within or among groups."

(Source: abs.gov.au)

Violence prevention

Primary prevention interventions are those that seek to prevent violence before it occurs. Interventions can be targeted to the whole population or to particular groups that may be at higher risk of being the perpetrators or victims of violence. Some primary prevention interventions (such as social marketing campaigns) focus on changing behaviour or building the knowledge and skills of individuals. However, primary prevention can also focus on changing environments so that they are safer for women. Interventions that do not have a particular focus on violence, but address its underlying causes (such as gender inequality and poverty), are also primary prevention interventions.

(Source: vichealth.vic.gov.au)

Vulnerable groups

The definition of vulnerable groups varies between countries, but amongst the most important defining characteristics are age, sex, ethnicity and location. But also important are people with disabilities and stigmatised illnesses, such as mental ill-health. In areas facing war or civil conflicts displaced people and refugees form an important vulnerable group.

(Source: Institute of Development Studies, www.eldis.org)

Walkability

Walkable communities, or locations, make footpath-based travel as easy as possible for all members of the community including children, people with prams/shopping carts and people using mobility aids. Walkability encompasses issues of safety (traffic and personal), attractive surroundings, distance between destinations, gradients, appropriate surfaces and physical barriers to access such as steps and gutters.

(Source: dse.vic.gov.au/melbourne2030online)

ACKNOWLEDGMENTS

The City of Whittlesea would like to acknowledge the contribution of the following organisations to the development of the plan:

CITY OF WHITTLESEA

Cr Kris Pavlidis
Ruth Spielman
Neville Kurth
Maureen Murphy
Jessica Bailey
Mairead O'Sullivan

DEPARTMENT OF HUMAN SERVICES

Stephanie McAdam

PLENTY VALLEY COMMUNITY HEALTH SERVICE

Gabrielle MacTiernan
Maarten Post

NORTH CENTRAL METRO PRIMARY CARE PARTNERSHIP

Kath O'Donnell

NORTHERN AREA MENTAL HEALTH SERVICE

Robyn Humphries

NORTHERN HEALTH

Eileesh Diviney

NORTHERN DIVISION OF GENERAL PRACTICE

Phillip Bain

THE NORTHERN HOSPITAL

Mary Marcon

NEAMI - WHITTLESEA

Kirra Yates

WHITTLESEA COMMUNITY CONNECTIONS

Jemal Ahmet

WOMEN'S HEALTH IN THE NORTH

Angela Nesci

