MonashLink
Community Health Service

2009-2012

Health Promotion Strategic Plan

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Definitions

ABS	Australian Bureau of Statistics
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and Linguistically Diverse
CIV	Community Indicators Victoria
DHSV	Dental Health Services Victoria
DHS	Department of Human Services
DPCD	Department of Planning and Community Development
EDVOS	Eastern Domestic Violence Service
EGM	Electronic Gaming Machine
EMR	Eastern Metropolitan Region
GP	General Practitioner
KGFYL	Kids Go For Your Life
LGA	Local Government Authority
MIC	Migrant Information Centre
NR	Neighborhood Renewal
PCP	Primary Care Partnership
SDS	Student Dental Service
SEIFA	Socio-Economic Indexes for Areas
WHE	Women's Health East
WHO	World Health Organisation

Vision Setting

Organisational Vision

MonashLink will be a leader in community health, working collaboratively and responsively to provide the highest quality services that will improve the health and well being of communities within our catchment including the City of Monash.

Health Promotion vision

To work in partnership with people and communities to improve their health and wellbeing, in responsive, innovative and creative ways in order to facilitate social change

Problem Definition

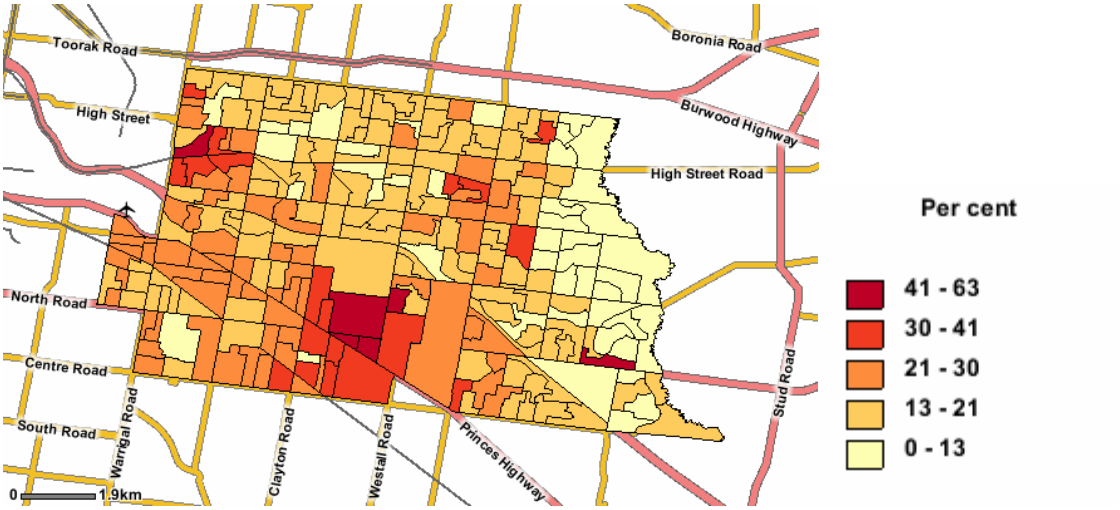
Demographic Profile

ABS data from the 2006 Census indicates that:

- The City of Monash had a population of 161,241 persons, of whom 49.4% were males and 50.6% were females. Of the total population, 0.2% were Indigenous persons, compared with 2.3% Indigenous persons in Australia.
- Monash is culturally diverse, with 40% of its residents coming from more than 30 countries, most commonly China (5.2%), Greece (3.0%), India (2.9%), Malaysia (2.9%) and England (2.7%). Seventy percent (70%) of the population of Clayton and forty-nine percent of the population of Chadstone were born overseas
- English is the only language spoken at home by 56.7% of the population and 38% (61723) speak a language other than English at home. The number of people who do not speak at English at home has risen by 18% (9264) since the ABS Census of 2001.
- One hundred and forty two languages are spoken at home by people residing in the City of Monash. The most common languages are Greek (6.9%), followed by Mandarin (6.1%), Cantonese (4.9%), Italian (3.1%) and Sinhalese (1.5%).
- The number of people speaking Mandarin has increased by 82% (4452) to 9910 since the 2001 ABS Census.
- Other communities where there was a significant increase in population between the 2001 Census and the 2006 Census include Korean 73% (460) to 1091 people, Malay, 197% (236) to 356 people. Conversely, there has been a 7% (807) decrease in the number of Greek speakers from the ABS Census of 2001.
- Population growth is slowing and the profile is aging. In 2006, 15.7% of the population of Monash were children aged between 0-14 years (as compared to 16.1% in 2001); 56.2% of the population were aged 15-54 (57% in 2001); and 28.1% were persons aged 55 years and over (26.4% in 2001).
- The Chinese community in Monash is relatively young. Thirty-three percent (33%) of the Mandarin speaking community are in the 19-29 age group, whereas three percent (3%) of the Mandarin speaking community and four percent (4%) of the Cantonese speaking community are aged 70 years or greater
- The median age of people in Monash in 2006 was 38 years, compared with 37 years for Australia.
- The highest concentration of people aged 15-24 live in Clayton, whilst the highest concentration of people aged over 75 live in Wheeler's Hill, Glen Waverley and parts of Ashwood.
- Whilst single parents with dependent children live throughout the area, there are higher concentrations in the suburbs of Ashwood and Chadstone, Clayton North and Glen Waverley

- In 2006, 58.0% of the population 15 years or older were employed, compared to 62.9% in the Eastern Metro Region (EMR) and the Victorian State average of 60.9% and 5.6% of the population were unemployed, compared to 5.2% nationally.
- Unemployment is highest in the suburbs of Clayton and Ashwood. Of those employed, 27.1% were professionals, 16.7% were Clerical and Administrative Workers, 12.3% were Managers, 11.8% were Technicians and Trades Workers and 10.4% were Sales Workers.
- The most common industries of employment for persons aged 15 years and over were Cafes, Restaurants and Takeaway Food Services (4.4%), School Education (4.4%), Hospitals (3.4%) and Tertiary Education (3.4%).
- In 2006, the Median Gross Weekly Household Income for Monash was $654, compared to $692 in the EMR and the Victorian State average of $600. However, the suburbs of Clayton, Ashwood and Chadstone have high percentages of households with a weekly gross income of less than 500 dollars.

Figure 1: % of low income households with gross weekly income of less than 500 dollars



In the 2007 Community Indicators Victoria (CIV) Survey, 3.7% of persons living in Monash had experienced food insecurity, compared to 4.4% in the EMR and the Victorian State average of 6.0%. In a Department of Victorian Communities (now the Department of Planning and Community Development) survey in 2006, 70.8% of the population of Monash stated they could raise $2,000 in two days in an emergency, compared to 69.9% for the Eastern metropolitan region. From that same survey, 90% stated they could get help from friends, family or neighbors when needed, compared to 92.2% for the EMR (DVC 2007a).

Migrant Settlement Patterns

- Over 10,000 people from 126 countries settled in the City of Monash between July, 2002 and June, 2007, which represents 31% of all people settling in the Eastern Region. The largest number of people entered in 2004/2005 (24% or 2662 people).
- As a percentage of this population, over 50% have settled in the Clayton area. However, the trends for settlement by area of origin provide a more diverse story.
- Whilst people from both north and Southeast Asia have primarily settled in Clayton, Mulgrave or Glen Waverley; people from north and sub-Saharan Africa and the Middle East have settled in many suburbs across Monash including Oakleigh, Ashwood, Chadstone, Wheeler's Hill, Mulgrave and Glen Waverley; and people from southeast Europe have tended to settle in the southern suburbs of Monash.
- The largest communities to settle in the City of Monash comprise people who were born in China (2692) and India (1687). For newer communities 393 people settled from Korea with 72% (283) of these people settling in the last three years.
- Of all the people born in China who settled in Victoria, 14% settled in Monash and of all those born in China who settled in the Eastern Region, 34% settled in Monash.
- Thirty five percent (1687) of all people born in India who settled in the Eastern Region settled in the City of Monash.
- Thirty four percent (8369) of all skilled migrants, 24% (2361) of family stream migrants and 14% (201) of humanitarian entrants settling in the Eastern Region in the five years to June 2007, settled in the City of Monash.
- Seventy seven percent (8369) of all entrants in the City settled under the Skilled Migration program; 22% (2361) settled under the Family Migration Program; and 2% (200) settled under the Humanitarian program.
- Monash has the fourth largest number of Sudanese residents settling under the Refugee and Humanitarian Program in Victoria, after Greater Dandenong, Moonee Valley and Maribynong. It is expected that cities with existing Sudanese populations will continue to attract more Sudanese people in the future (MIC 2003)

Health and Wellbeing Profile

Major findings from the Victorian Population Health survey of 2007 for the Eastern Metropolitan region and the Population and Place Profile of 2008 for the Inner East PCP include:

- 85% of all adults rated health as 'excellent', 'very good' or 'good'
- 32% of adults were overweight and 15% were obese, which is similar to results for Victoria.
- 65% of males and 58 % of females met physical activity guidelines. Females are more likely to be sedentary and find insufficient time and opportunities to engage in physical activity than males in the catchment and their Victorian counterparts.
- 56% of females and 41% of males met dietary guidelines for fruit consumption (2 or more serves per day). This is slightly better than results for Victoria

- 9% of females and 5% of males met dietary guidelines for vegetable consumption (5 or more serves per day). This is similar to results for Victorian males, but slightly less than results for Victorian females
- The rates of short-term risky alcohol consumption amongst males and females in the EMR catchment are higher than those for Victoria.
- The rates of long term risk of alcohol related harm amongst males and females are higher in the EMR than they are for Victoria
- Females from the EMR were significantly less likely to be current smokers than females from Victoria (13% EMR, 18% Victoria). Males were also less likely to be smokers, but the difference was less significant (20% EMR, 22% Victoria)
- The Inner East PCP has a higher rate of disability than Victoria. Monash has the highest percentage of its population living with a disability, along with Whitehorse and people with a disability in both LGA's are also most likely to need assistance with core tasks

An analysis of the Burden of Disease Victorian Data for the EMR for 2001 indicates that:

- In general, cardiovascular disease (heart disease and stroke) and cancers accounted for the most years lost to illness and disability, followed by diabetes, chronic obstructive pulmonary disease and diabetes. This is consistent with Victorian data
- Ischaemic heart disease accounted for the most years lost to illness and disability for both males (6605.1 or 10.2%) and females (5159.9 or 8.1%)
- Mental illness i.e. depressions was ranked third for males (2742.7 or 4.2%) and fifth for females (3035 or 4.8%).
- Dementia was the third most significant cause for years lost to ill health and disability for women (3774.6 or 6%)
- Risk factors contributing to the burden of disease are different for men and women in the EMR. For males, tobacco is the leading risk factor, whilst obesity is the leading risk factor amongst females.

Community Indicators and other data reveal that:

- Monash rates higher than the EMR for feeling safe on the street at night and feeling valued by society but rates lower for community connectedness, feeling safe walking alone during the day, self-reported health and subjective wellbeing. In 2007, 50.9% of persons living within Monash reported that their health was either excellent or very good as compared to 53.4% in the Eastern Metro Region and the Victorian State average of 54.3%.
- Monash has the highest rate of robbery and theft of motor vehicles in the EMR.
- The Inner East PCP catchment has higher levels of housing stress amongst two parent families, lone person households and all households than does the EMR; but levels are lower than for Victoria as a whole. Rents for flats and houses are higher in the

Inner East PCP catchment than they are in Victoria but lower than in metropolitan Melbourne as a whole.

- Unemployment amongst 20-24 year olds is higher in the Inner East than in the EMR or Victoria. The Inner East community is also less satisfied with their work-life balance than those in the EMR and Victoria.
- The car (as driver) is the most common form of transport in the EMR. Rates of commuting by train, tram and taxi are proportionally lower in the EMR than for Victoria, although traveling by bus is higher.
- In common with the rest of the EMR, Monash experienced an increase in the number of serious injuries on the roads between 2003 and 2007 and has had the highest reported injuries of this type in the EMR for every year except 2005.
- Between 2004 and 2005, the City of Monash had a greater Net Electronic Gaming Machine (EGM) Expenditure per resident ($945) compared to Metropolitan Melbourne ($678) and Victoria as a whole ($629). In addition, the City of Monash had a significantly greater number of EGM's per resident.

Recently released data on venues shows that Matthew Flinders has customers expending $16-$18M per annum on gaming (electronic gaming machines). This is the highest amount in Monash (and Boroondara). A reduction of machines from 105 to 59 occurred between 2006 and 2008 and expenditure reduced from $18M in 06/07 to $16M in 07/08. Despite this, per machine expenditure increased by $100K to $278,700 per machine (reported in the Age as the highest gaming losses in the State). Most gaming customers at Mathew Flinders apparently come from a 5 kilometer radius (the NR area)

The Neighborhood Renewal Area

The Neighborhood Renewal areas of Ashwood and Chadstone share particular characteristics, which include:

- High levels of public housing
- Higher proportions of single person households than Monash, particularly in public housing
- Relatively high concentrations of older, frail women, who are living alone
- 16.5% of the population aged over 65 years
    - 10% of this age group are female and,
    - 51% are widowed.
- Lower average household sizes, particularly in public housing
- Younger age structure than Monash
- Relatively more residents in the main child bearing age groups of 25 to 44
- Relatively strong increases in population from 2001 to 2006 in the 25 to 44 and 45 to 54 year age groups, but a drop in the number of persons of secondary school age
- More than double the proportion of sole parent families than Monash and roughly triple the proportion of sole parents with children under 15, with the concentration of sole parent families more pronounced in public housing
- Higher rates of unemployment, particularly amongst young females aged 15 to 19
- Relatively more young unemployed (those aged 15 to 19) seeking full time work

- Lower workforce participation rates across all age groups (particularly amongst females), except those aged 15 to 19
- Of those employed, slightly more in full time work, again particularly for females
- Significantly lower rates of employment amongst persons living in public housing
- Only a small number (21%) of older residents of public housing who live alone are accessing local support services even though they would most likely be eligible for them.
- Rates of childhood notifications are 50% higher for the Ashwood/Chadstone area than for the rest of Monash

(ABS 2006: Street Ryan and Associates 2008: Here 2 Help unpublished data 2008)

In the 2007 Neighbourhood Community Survey, the top three reported problems were: poor financial resources; non healthy behaviours; and ageing. In addition:

- 29% of people surveyed reported they had a disability
- 51% reported they had a health condition lasting more than 12 months.
- 32% were finding it hard to manage household income
- 48% reported drug and alcohol use as a one of the top 3 big problems

Index of Disadvantage

The Socio-Economic Indexes for Areas (SEIFA) Index of Relative Socio-economic Disadvantage is created by combining a range of information about the economic and social resources of people and households within an area. The results are standardised across Australia with a mean of 1000. Therefore areas with scores above 1000 are relatively less disadvantaged than the Australian average and those with scores below 1000 are relatively more disadvantaged.

Although Monash LGA ranks 10th in the list of most advantaged LGA's in Victoria, evidence of disadvantage exists throughout the area. Ashwood and Clayton represent two of the five most disadvantaged pockets in the EMR (see Figure One). In fact, seven of the twelve suburbs in Monash have a SEIFA score below the Victorian median of 1030. These suburbs include:

Table 1: Monash SEIFA Scores

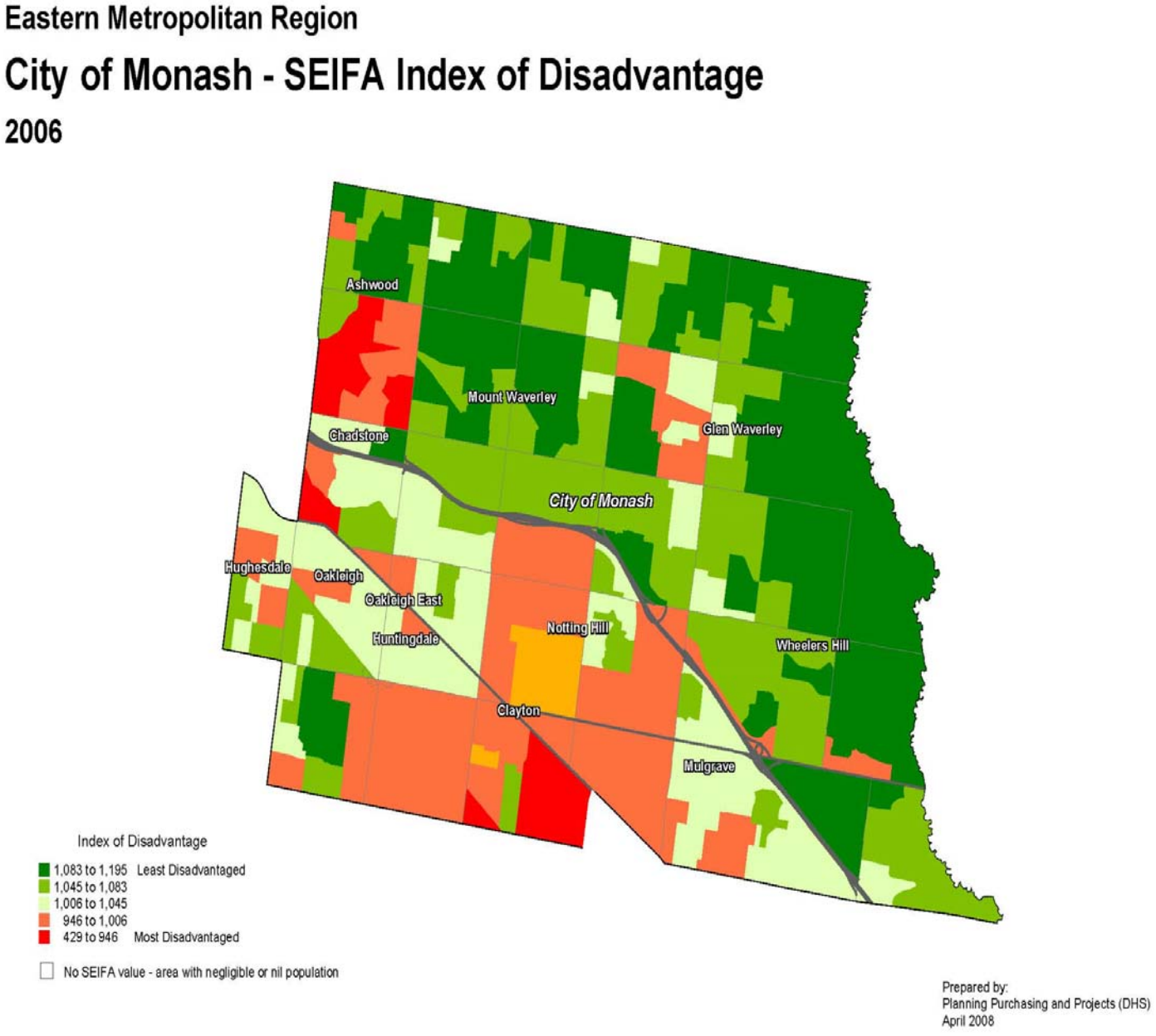
Suburb	SEIFA Score
Clayton	977
Chadstone	996
Ashwood	1012
Oakleigh East	1017
Huntingdale	1022
Oakleigh	1024
Hughesdale	1026

(DHS 2009)

However, it is important to remember that not all households in Ashwood and Clayton will necessarily be disadvantaged. Conversely, disadvantaged households will also be present in the most affluent areas of Monash.

A large body of literature now attests to the direct link between poor health and socioeconomic inequality. This is compounded when this inequality is also associated with place

Figure 2: City of Monash SEIFA Index of Disadvantage



(ABS 2006)

Summary Key Findings

For Monash specifically:

- Monash is culturally diverse with an ageing population
- 14% (201) of all humanitarian entrants settling in the Eastern Region in the five years to June 2007, settled in the City of Monash. Monash has the fourth highest number of South Sudanese people settling under the Refugee and Humanitarian Program in the state
- The largest communities to settle comprise people who were born in China (2692) and India
- Seven of the twelve suburbs in Monash have a SEIFA score below the Victorian median of 1030. Ashwood and Clayton represent two of the five most disadvantaged pockets in the EMR. The most common reported issues by residents of Ashwood are: poor financial resources; non healthy behaviours; and ageing
- Monash has had the highest reported serious injuries on the road in the EMR for every year except 2005
- Monash has the highest rate of robbery and theft of motor vehicles in the EMR.
- Monash has the greatest Net Electronic Gaming Machine (EGM) Expenditure per resident, compared to Metropolitan Melbourne and Victoria as a whole. Gaming losses in the NR area are the highest in the state.
- Monash rates lower for community connectedness, feeling safe walking alone during the day, self-reported health and subjective wellbeing than the EMR
- Monash has the highest percentage of its population living with a disability in the EMR
- Rates of childhood notifications are 50% higher for the Ashwood/Chadstone area than for the rest of Monash
- The suburbs of Clayton, Ashwood and Chadstone have high percentages of households with a weekly gross income of less than 500 dollars

For the EMR:

- Cardiovascular disease (heart disease and stroke) and cancers account for the most years lost to illness and disability
- The rates of both short-term risk of alcohol consumption and long term risk of alcohol related harm amongst males and females in the EMR catchment are higher than those for Victoria

Risk factors contributing to the burden of disease are different for men and women:

- Tobacco smoking is the leading risk factor for males.
- Obesity is the leading risk factor amongst females
- Females are more likely to be sedentary and find insufficient time and opportunities to engage in physical activity

MonashLink Service Usage

A review of referrals to MonashLink recorded on Trakcare for the year 2008 indicates a service profile that does not correlate well with the demographic profile of the area. Although the age profile is consistent with the ageing of the area, the data suggests that MonashLink draws most of its clients from the less disadvantaged suburbs of Glen Waverley and Mount Waverley, with over 80% speaking English only.

Table 2: Referrals by Age, Female

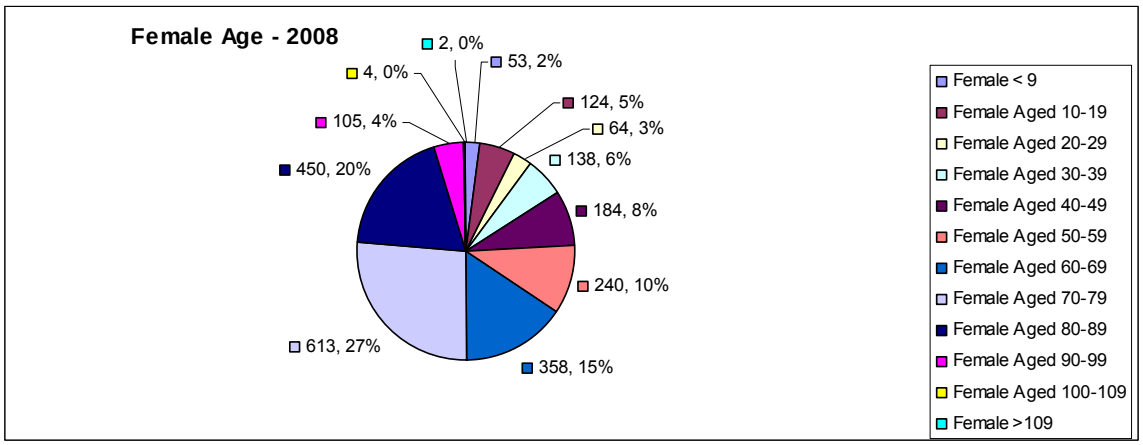


Table 3: Referrals by Age, Male

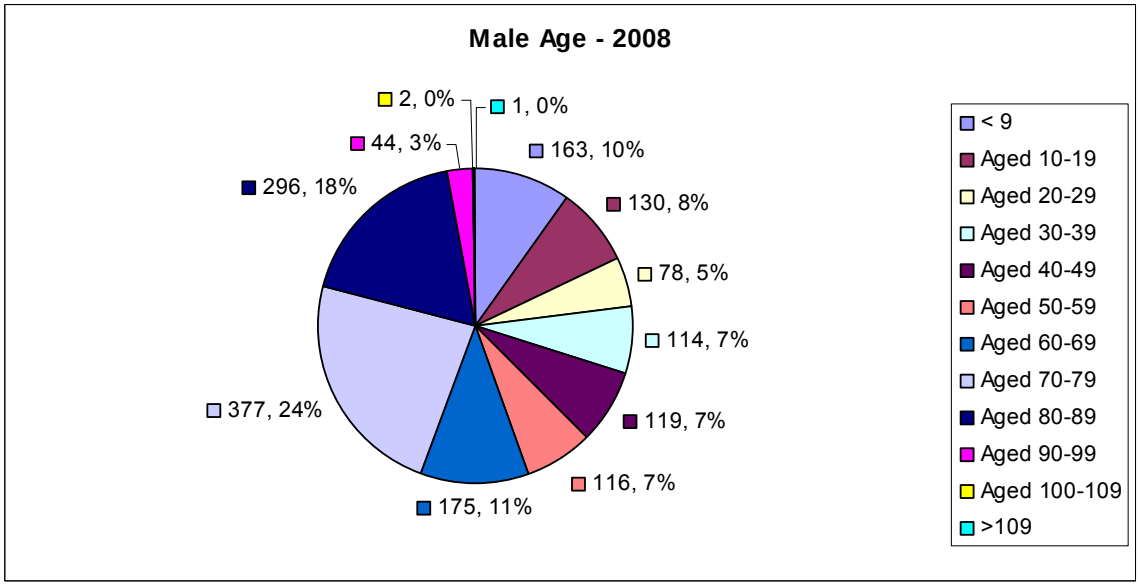


Table 4: Referrals by Suburb

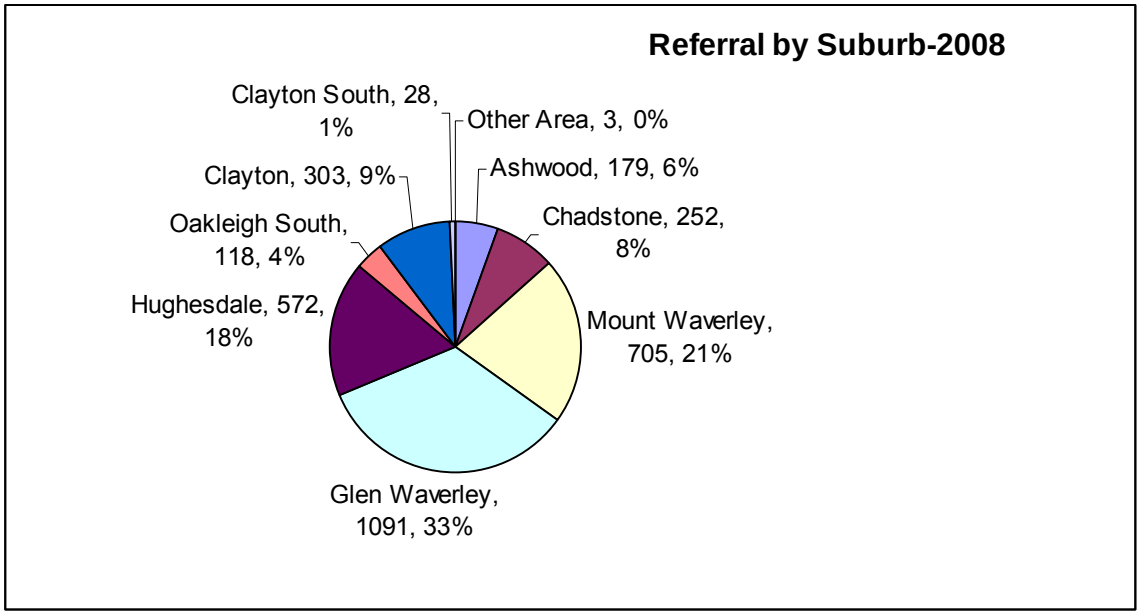
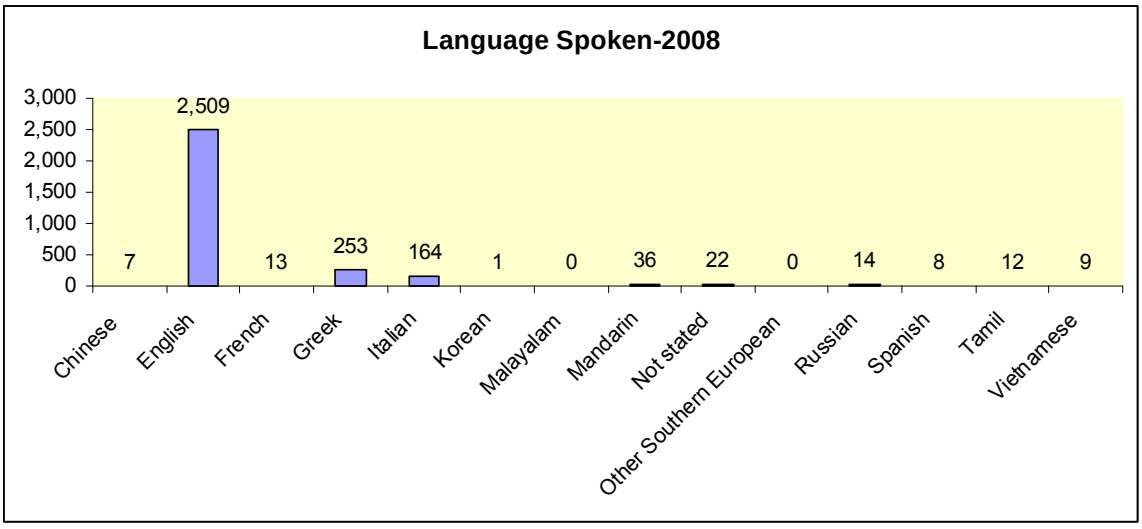


Table 5: Referrals by Language Spoken



Stakeholder Consultations

Local Stakeholders

Recently the City of Monash held a health professional consultation to inform planning for their new Council Plan for 2009-2013 and the following issues were identified by participants:

- Social isolation
- Chronic illness
- Emerging cultural diversity
- Access to health services
- Affordable and public housing
- Community safety
- Gambling/tobacco/drugs
- Food security

The current City of Monash Municipal Public Health Plan 2007-2010 has four health priority areas and four related health goals. These goals are:

1. To enable the community to feel confident that their environment is safe and sustainable
2. To support the community in making healthy lifestyle choices
3. To promote physical and mental health and wellbeing by reducing social isolation, creating strong human and social capital and responding to the needs of Monash's diverse community
4. To enhance the physical and mental health and wellbeing of the Monash community by maximizing choice and facilitating access to universal health services and facilities

MonashLink Staff and the Local Community

A community survey was conducted at two local festivals, the Oakleigh Festival and the Mulgrave Fun Day and with two large Chinese social/support groups in Clayton. The two page survey was translated into three community languages; Greek, Italian and simplified Chinese. One hundred and nineteen surveys were completed. This survey tool is found in **Appendix One**.

An online survey using Survey Monkey was also conducted with MonashLink staff, with over 30 staff responding.

Identified Health Needs

The results of all the surveys indicate the most common identified health needs to be:

- Social isolation/disconnectedness
- Poor mental health

- Gambling & other addictions
- Lack of access to healthy food

State Government Priorities

The current state government health priorities 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

Neighbourhood Renewal sites were also confirmed as one of the priority settings for health promotion practice from 2007.

Determining Priorities

MonashLink is committed to working on integrated health promotion, where the identified health needs of people particularly challenged by health inequality discussed in the last section intersect with MonashLink's mission and values, state and local health promotion priorities, current partnerships and funded health promotion projects. Our values state that we seek to be 'agents of social change'. Our current Strategic Plan expands our commitment to partnerships within our local community.

The following issues are examined for determinants of health, evidence of best practice interventions and current/future opportunities for partnership:

- Family Violence
- Social Inclusion
- Healthy eating and food security
- Oral health
- Problem gambling

Family Violence

In 2007, 45% of Australians aged 16−85 years (or 7.3 million people) had, at some point in their lifetime, experienced at least one of the selected mental disorders (anxiety, mood or substance use disorders) (ABS 2009). Depression and anxiety are the major mental health problems for women in Australia; more than half the women in the Eastern Metropolitan region have a lifetime depression or anxiety disorder (WHE 2009). Three key determinants found in the literature are linked to mental health and well being. These are social inclusion, freedom from discrimination and violence and access to economic resources.

Evidence suggests that intimate partner violence is the leading contributor to death, disease and illness in women aged 15-44, overshadowing even obesity (VicHealth 2004). Conservative estimates suggest a figure of one in five women in Australia suffering some form of physical or sexual violence during their lifetimes. In 2007-08, 44% of all crime in the Eastern Metropolitan was committed against women, with 80% of all rapes and 72% of all sex crimes being against women (WHE 2008).

Women are most at risk of violence in the home and from men they know. Violence against women often is accompanied by violence against children. Young women are at greater risk of violence than older women and women with disabilities are 40% more likely to be the victims of intimate partner violence than women without disabilities (VicHealth 2008). Australian indigenous women are 40 times more likely to be victims of domestic violence; and a quarter of all women seeking services from The Eastern Domestic Violence Service Inc. (EDVOS) in 2007-2008 were from culturally and linguistically diverse backgrounds (WHE 2008).

Family violence has devastating affects on women's health and wellbeing, as well on their families and communities. Depression is one of the most common consequences of sexual and physical violence against women. Women who suffer from violence are also at a higher risk of stress and anxiety disorders, including post-traumatic stress disorder (VicHealth August 2008).

Determinants of Family Violence

Factors underlying and contributing to violence against women lie in a range of environments (such as schools, sports settings, faith-based institutions) and at multiple levels of influence, including individual/relationship (including families), community and organisational, and societal, with the most vulnerable and marginalized groups of women being at greatest risk.

Individual/relationship determinants

- Belief in rigid gender roles and identities, weak support for gender equality
- Masculine orientation/sense of entitlement
- M ale dominance and control of wealth in relationships

Community & organisational determinants

- Culturally-specific norms regarding gender and sexuality
- Masculine peer & organisational cultures

Societal determinants

- Institutional & cultural support for, or weak sanctions against, gender inequality and rigid gender roles

(VicHealth 2007)

Nine broad intervention types have also been shown to reduce or challenge violence and discrimination and are linked to the need to strengthen community action, re-orient health systems and build healthy public policy. These include:

- activities that focus on community education, media, schools and policing
- community education programs
- programs to prevent or reduce work or school-based bullying
- Peer education, school-based and community arts programs for young people

(DHS 2006)

Best Practice Interventions

There is broad consensus internationally that family violence is best addressed in the context of human rights, legal and health frameworks and through the development of coordinated and integrated strategies across sectors (VicHealth 2009)). The Victorian government has introduced a new approach as part of the 'Fairer Victoria' initiative. This 'Risk Assessment and Risk Management Framework' incorporates a consistent, rights-based approach to family violence and ensures that the focus of intervention and support remains firmly on the safety of victims (DVC 2007b).

This rights-based approach to family violence promotes respect, culturally informed and sensitive practice, non-judgmental communication and the promotion of social justice. The framework is underpinned by a common set of principles including the necessity of addressing the power imbalances and gender inequality between those using violence (predominantly men) and those experiencing violence (predominantly women and children). The framework incorporates six components to identify risk and respond to family violence, including:

- A shared understanding of risk and family violence across all service providers
- A standardised approach to assessing risk
- Appropriate referral pathways
- Risk management strategies

(DVC 2007b)

Such a framework sits well within the social model of health and social justice values utilised by MonashLink.

Primary prevention efforts are most likely to be effective when a coordinated range of mutually reinforcing strategies is targeted across multiple levels of influence - individual/relationship (including families), community and organisational, and societal. Some of these interventions include:

- strengthening the capacity of communities, organisations and workforces to take action to prevent the problem
- advocacy to secure community, government and corporate action
- reform of relevant policies and legislation.

(VicHealth 2007)

Opportunity for Partnerships

There is a great opportunity to utilise a range of the interventions and framework described above, in partnership with the Eastern Region Family Violence Network, Women's Health East and with other agencies such as the Eastern Domestic Violence Service Inc. (EDVOS) and Eastern Centre Against Sexual Assault (ECASA), to develop the organisational capacity of MonashLink to respond to the issue of family violence.

There is existing expertise within the organisation, with a small and discreet team of specialized clinicians providing individual and group interventions to women who have or are experiencing violence and to men who are perpetrators of violence. However, there is currently limited capacity outside of this small team to understand and respond to family violence in a coordinated or integrated way. Reforms to family violence risk assessment and management have resulted in the development of a common framework that incorporates a common language and focuses on the rights, needs and safety of people at risk of family violence (DVC 2007). There appears to be scope to build internal capacity for understanding and responding to family violence using this evidence-based framework, within MonashLink in the first instance but subsequently within other service agencies in the City of Monash. This work will be substantially developed in collaboration with the Inner East PCP membership as part of integrated health promotion planning in the region.

Social Inclusion

A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person into the community (VicHealth January 2005).

Determinants of Social Exclusion

Social exclusion appears to result from a combination of linked problems including:

- Living alone
- Low income
- Low rates of literacy and numeracy and therefore poor job skills
- Unemployment,
- Poor housing and transport
- High crime environments,
- Chronic illness
- Family breakdown, family violence and abuse

(VicHealth January 2005; AIFS 2008)

There is also clear evidence to link social exclusion with communities that score poorly on the Australian SEIFA index, where the characteristics of people and families living in these communities interact with the community context itself to create more concentrated disadvantage (AIFS 2008). This underpins the role of place-based interventions such as Neighbourhood Renewal

Research also clearly demonstrates that older people are at risk of isolation due to a range of factors such as depression and mental health, reduced mobility, chronic health conditions, poverty, dementia, lack of extended family living nearby, inadequate transport and others. Taken by themselves each of these issues may be able to be addressed. However where older people suffer from a combination of these factors their potential isolation may be compounded (Inner East PCP 2008).

Best Practice interventions

There is broad consensus that increasing social capital can have benefits for individuals; is an important resource for supporting communities to take action on issues of concern to them; and can contribute to social and economic growth (VicHealth January 2005)

Social capital can be increased by minimizing the risk factors and supporting the protective factors that impact on social inclusion for communities. These factors are usually interrelated but may differ in each community.

Nine categories of interventions have been shown to increase social inclusion. These include:

- Community building and regeneration programs involving multi-agency partnerships
- Community participation and other forms of social contribution
- Workplace mental health promotion and organisational development
- Volunteering
- Physical activity
- Community arts programs.

(DHS 2006)

The Australian government has adopted eleven principles for social inclusion in Australia to guide an inclusive approach to policy, programs and services. These are:

- Reducing disadvantage
- Increasing social and economic participation
- A greater voice and responsibility
- Building on individual and community strengths
- Building partnerships with key stakeholders
- Developing tailored services
- Giving high priority to early intervention and prevention
- Building joined-up services
- Using evidence to inform policy
- Using locational approaches
- Planning for sustainability

(Commonwealth of Australia 2009)

At a more local level, leadership programs have been successful at harnessing diverse skills to assist in addressing a range of community needs including those of socially isolated older people. Members of the Inner East Primary Care Partnership (covering the Cities of Booroondara Manningham, Monash, and Whitehorse) and local community groups, have developed a model based on successful leadership programs that is building capacity within these communities to tackle the growing problem of isolated older people (Inner East PCP 2008). The Leadership for Social Inclusion of Older people Initiative

seeks to assist older residents to remain healthy, independent and socially connected. This will be enabled through:

- the development and support of local leaders who will ensure this issue is given the priority it requires within their communities
- the development of local projects that address issues that lead to social isolation and make a real difference to the lives of older people

(Inner East PCP 2008)

Current Partnerships

MonashLink is currently involved with three social connectedness projects which already involve many of the principles described above. Adding value to some or all of these current projects to sustain the changes long term makes a great deal of sense.

These projects are:

- 'Connecting Us', a local action project
- The Inner East PCP Problem Gambling Initiative. The Problem Gambling Initiative will be discussed under Emerging Issues
- 'Here 2 Help-Pets', in partnership with the AA & C NR & Power Neighborhood House.

Connecting Us

This action project has arisen from the Inner East Primary Care Partnership (PCP) Leadership for Social Inclusion of Older people Initiative. This local project seeks to explore and address the determinants of social isolation in the older Chinese population of Monash. Results of community consultations conducted in Mandarin indicate that social isolation in this population is related to the impact of recent migration from their home country, poor language skills, low financial resources and chronic illness. The strengths of this community include a generally high education level in their country of origin, a willingness to learn and share skills and a strong 'self-help' ethos.

The consultations also indicated that social isolation can be reduced through providing opportunities for community members to share their skills, experience and knowledge with their peers utilising a formal self-help adult education model such as U3A (Choi August 2009 unpublished data)

Here 2 Help – Pets

The Here2Help-Pets Program is piloting a Volunteer pet support program for local residents in the Ashwood, Ashburton & Chadstone (AA & C) Neighbourhood Renewal area. The pilot is funded by Home and Community Care and auspiced by Power Neighborhood House, with MonashLink and the AA & C NR Project as partners. The pilot program has arisen out of a strong partnership between community and government

agencies in the AA & C NR area. The need for such a program was established as a result of surveys conducted in the local area. These variously indicated high rates of self-reported poor health and disability and a high percentage of perceived need for such a program. Supporting research demonstrates the multiple benefits of providing pet support, including better health, better social connections and improved capacity to remain living in the community.

The program directly targets residents who own pets and have been identified as requiring considerable support to engage in mainstream services and/or community activities in the Ashwood & Chadstone Communities, such as those over the age of 65 and/or who have a disability. Low cost pet care such as grooming, walking, feeding and fostering is being provided by volunteers from the local community who are over the age of 18 years of age and interested in volunteering opportunities that involve pet support.

The Here2Help Project is being used as a vehicle to build community connections and community capacity (and may lead to other Here2Help programs as a response to local needs). The program will be used as an engagement tool to informally monitor the well being of disengaed residents and inform local organisations about what services and access may be required in the area.

Here2Help-Pets will increase the opportunities for volunteering to those community members that may be socially, economically and/or culturally isolated or disadvantaged. It will also help to facilitate pathways to future training and or employment opportuities for interested volunteers in a local and supportive environment.

Outcomes for frail, isolated older and disabled residents will include increased social connections, increased monitoring of their needs and the capacity to link them into other services if required. For pet owners, outcomes will also include the positive results from having a companion animal such as improved health, companionship and more engagement in their local communities.

A further outcome will be to improve the capacity building of Power Neighbourhood House as it works with more volunteers and local residents.

(Nabben, unpublished data 2009)

Healthy Eating

Healthy eating is important across the lifespan to enhance quality of life, contribute to health and to a general sense of wellbeing. The costs of poor nutrition in Australia are significant. Poor nutrition accounts for up to 10% of the burden of disease when considering collectively the burden of obesity, inadequate consumption of vegetables and fruit and high blood cholesterol. Poor nutrition is estimated to account for more than $1.5 billion in direct costs to the health care system (KGFYL)

Diets high in fruits, vegetables and legumes provide fibre, vitamins and minerals and are associated with a decreased risk of obesity, diabetes, cardiovascular diseases and some cancers. They are also associated with a decreased consumption of foods high in saturated fats, salt and sugar and can play a role in weight management by reducing energy intake (KGFYL)

Healthy eating is not only about the consumption of nutritious foods but also about the integral and enjoyable part of daily life that food offers. Access to adequate food is a basic human right and upholds dignity. Dignity does not come from being fed (eg soup kitchens, welfare food vouchers etc), but from providing for oneself and one's family. It's about having an informed choice over what foods you want to eat.

However, food choices are determined not only by individual taste preferences, but also by an interaction of individual, social, cultural, economic and environmental influences. Individual characteristics such as income, education, cooking ability, age, and ethnicity will affect food choice. Broader economic, social, and environmental factors such as globalisation, food production, trade agreements, taxes levied on food, and transport policy may determine the availability, quality and price of food and subsequently influence food choice (VicHealth 2005)

Thirty-seven percent of a child's daily energy intake is consumed at school, and the majority of children bring their lunch to school from home. Twenty percent of Victorian students have high fat, salt or sugar packaged snack one or more times per day, with 65% having them once per week. Therefore children's lunchboxes provide significant nutritional influence and should be considered as an essential means to improve children's overall diet (KGFYL)

Many newly arrived families from many CALD backgrounds who settle in Monash, but particularly in Clayton and surrounding suburbs have spent 10 years or more in Refugee Camps. They have a range of complex health needs arising from poor health care in their countries of origin, lack of understanding of basic health and safety issues and poor nutrition due to reliance on meagre food rations in camps. Having survived challenges in war torn countries, the trauma experienced by these people contribute to poor health and well being.

In Australia, communities are confronted with a wide range of choices for food. Many families struggle with cooking healthy meals for their children, have limited knowledge

of nutritious snacks, healthy lunch boxes and are unfamiliar with using kitchen equipment.

Food Security

Food security exists when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food which meets their dietary needs and food preferences for an active and healthy life. Household food security is the application of this concept to the family level, with individuals within households as the focus of concern. Food insecurity exists when people do not have adequate physical, social or economic access to food as defined above (FAO 2003)

Determinants of Food Insecurity

Food supply (or availability) and access are pre-requisites for both food security and the consumption of a healthy diet. Food supply is influenced by a wide range of factors, including demand, transport and storage, taxes levied on foods, shop management, urban development and food policies (Davis 2009).

Vulnerability to food security is influenced by many factors including:

- Low income (particularly amongst women of child-bearing age, children and adolescents, and single parents with young dependent children).
- Unemployment or limited formal education,
- Chronic illness and disability
- ATSI, CALD and refugee status
- Social isolation
- Poor physical access to food supply or poor cooking skills
- Alcohol and/or substance abuse
- Homelessness (particularly amongst youths, women of child-bearing age and the elderly)

(Vic Health August 2005)

Fifty three of Victoria's 79 local government areas have reported that one in 20 of their residents ran out of food in the last 12 months and could not afford to buy more. Based on these figures, several hundred thousand Victorians are at risk of food insecurity (VicHealth July 2008)

Best Practice Interventions

Interventions in **nutrition, healthy weight and healthy body image** promotion, that appear to be effective on the basis of available literature include:

- Using the community health centre as an organisational role model
- Creating local policies in public and private settings that support good nutrition and healthy weight,

- Using schools as settings for health promotion including organisational change efforts, advocacy and policy development, such as supporting schools and pre-schools to work towards achieving a 'Go For Your Life' award.
- Advocacy for local food and nutrition policies and improvements to existing policies.
- Identifying, training and supporting volunteer opinion leaders to act as role models and sources of advice on nutrition.
- Using print media and direct mail for nutrition education with older adults.
- In-service training of primary and secondary school teachers
- Group education for preschool and primary children
- primary prevention interventions with young children and adolescents about the importance of healthy bodies and self-esteem and the possible consequences of negative body images on their health, at pre-school, school and in the community (such as Girl Guides)
- separate programs run for adolescent boys and girls
- secondary interventions at university, to address both body image and eating issues
- primary and secondary interventions for adults in the community to de-emphasise weight/fat loss and dieting and increase emphasis on health, well-being and enjoyment of physical activity

  (Tsianakas & Rice 2005; Paxton 2002; DHS 1998; Deakin University 2005; KGFYL)

In order to be effective, strategies addressing **food insecurity** need to focus on the socio – cultural, built and natural environments and economic determinants of healthy eating, with specific target groups being:

- People on low incomes,
- People living with a disability or chronic illness
- Single parent with dependent children,
- Kooris,
- New arrivals (refugees or asylum seekers) from culturally and linguistically diverse groups.
- People living in low socio-economic index areas in Victoria.

(Vic Health August 2005)

Successful approaches to address food insecurity also need to focus on multiple strategies and partners at the local level. The role of local councils is of paramount importance in addressing physical and infrastructure barriers, particularly to the development of community gardens.

Current Partnerships

MonashLink is currently involved with two food security and healthy eating projects involving partnerships with local agencies, working with the target groups and strategies discussed above. Adding value to current projects to sustain the changes long term makes a great deal of sense. These projects are:

- ‘Community Leadership for Healthy Outcomes’, in partnership with Anglicare/Dixon House and New Hope
- ‘Advancing Food Security and Community Gardens’ in partnership with the Ashburton, Ashwood and Chadstone Neighborhood Renewal Project (AA & C NR) and Inner East Community Health Service and funded by the Department of human Services

Advancing Food Security and Community Gardens Project
The Advancing Food Security and Community Gardens Project aims to develop a strategic approach to supporting community garden initiatives and improving community food security with particular attention to the needs of low income households. It’s objectives include to:

- Increase the coordination of activities and develop a strategic approach that addresses food security and community gardens initiatives.
- Increase participation of community members in food security and community garden activities.

Based on extensive interviews as part of the project, local barriers to food security and community gardening have been identified (see **Appendix Two**)

Ideas for improving food access in the short term include:

- Increased Access to fruit and vegetables
- Community lunches
- School meals, healthy snacks and breakfast clubs
- Education around cooking skills and healthy eating
- Transport and town planning
- Policy support & funding opportunities
- Beautifying neighborhoods to instill public pride
- Community Gardens
- Income generating activities

A more comprehensive list of strategies generated by the project can be found in the full project report titled ‘FOOD SECURITY &COMMUNITY GARDENING in the Ashburton, Ashwood &Chadstone Neighbourhood Renewal Area PROJECT REPORT’.

Community Leadership for Healthy Outcomes
The Community Leadership for Healthy Outcomes Project is seeking to create a supportive environment in which newly arrived refugees and migrants can improve their knowledge, skills and confidence in developing healthier eating patterns and life styles for their families, through an innovative peer to peer train the trainer model. The train the trainer approach is providing the Sudanese and other targeted communities in Clayton South with much needed information on healthy eating in a culturally appropriate way. It is also developing the capacity of community leaders to run

effective information sessions for their communities in conjunction with relevant mainstream organisations.

The emerging needs of the Sudanese community as this project progresses include immediate individual aspirations to acquire qualifications and work in order to provide for families. Early contacts with three Sudanese women's organisations also indicate that a long-term collective aim of the members is to build the skill level within the Sudanese community of Clayton South and surrounding areas to enable continued growth and collective resilience. These partnerships will be further developed in the coming months.

Oral Health

Oral health is a significant public health issue in this country. DHSV data from 2006 for children attending a School Dental Service indicate that:

- 57% of children entering primary school have experienced dental decay in their baby teeth 82%, of which had previously been untreated.
- By 12 years of age just on 50% of children will have already experienced decay in their • permanent teeth.

The National Survey of Adult Oral Health revealed that of the 14,000 people interviewed who also underwent an examination:

- 15.1% had experienced toothache in the preceding 12 months
- 17.4% had avoided some foods due to problems with their mouth, teeth or dentures
- More than one quarter had evidence of untreated decay
- 20.6% said cost prevented them from having the treatment recommended
- 6.4% had lost all their natural teeth and 11.4% had an inadequate dentition (compared to 14.4% in the 1987-88 survey)
- 20.5% had evidence of moderate gum disease and another 19.7% had signs of gum inflammation, which is a precursor to gum disease

(DHSV 2008)

Dental disease is particularly prevalent among immigrant and refugee populations in Australia, with significant incidence of dental decay, gum disease, dento-facial trauma and non-functional malocclusions (Marino et al 2001). In Victoria there is a consistent trend of increasing levels of decay with increasing level of disadvantage; statistics demonstrate 97% more decay in children from the highest disadvantage group. The incidence of dental caries in the age group 5-14 years in the City of Monash is over double that (2.17 times higher) of cities such as Stonington, which lie on the opposite end of the socio-economic gradient (Schibeci & Haramis 2009).

The World Health Organisation (WHO) has identified oral health as one of its most essential target areas (Schibeci & Haramis 2009). Links between oral health and a number of common diseases are recognised:

- Oral health status is linked closely with healthy eating, with poor diet increasing the risk for many chronic diseases. The WHO is focusing on dietary counseling to reduce the incidence of poor oral health.
- There is consistent evidence that associates dental caries and periodontal disease with an increased risk for cardiovascular disease
- Oral disease may be a contributing factor to the thickening of arteries (atherosclerosis)
- There is also a suggested association between dental plaque, poor oral health and lung disease, mainly in elderly people in residential care and in people with chronic obstructive pulmonary disease
- People with diabetes have been shown to have twice the risk of developing periodontal disease which then further complicates the management of their diabetes.

(DHSV 2008)

Determinants of Oral Health

The behavioral determinants of oral health include diet and hygiene, smoking, alcohol and risk behaviours causing injuries and stress which are shared with a number of other chronic diseases such as obesity, diabetes, heart disease, cancer, and stroke. The social determinants of oral health include age, gender, urbanization, socio-economic level and social network (Do et al 2008: DHSV 2008). Disadvantaged and migrant populations are at greatest risk of oral disease (Schibeci & Haramis 2009). Determinants specific to immigrant and refugee populations include malnutrition, fear of authority, cultural isolation, communication barriers and exposure to a different diet on arrival (Kingsford Smith & Szuster 2000: Marino et al 2001).

Best Practice Interventions

There is little awareness in the community of how to prevent oral disease. Management of oral disease has typically focused on the treatment of symptoms and not on addressing the underlying causes (Schibeci & Haramis 2009). The National Oral Health Plan for 2004-2013 describes a need for community-based oral health promotion programs alongside timely access to dental assessment and treatment for new arrivals to Australia (National Advisory Committee on Oral Health 2004).

'Smiles 4 Miles' is an initiative of Dental Health Services Victoria (DHSV) that aims to improve oral health for preschool aged children. The program uses a multi-faceted approach including curriculum, policy, parent engagement and community links, but has been operating for only one year and is still very much in the development stage. It is therefore difficult to judge whether the program measures will have an impact, and how they will impact on vulnerable groups.

Current partnerships

The 'Keeping Kids Smiling' pilot project has been developed by MonashLink to establish sustainable partnerships between primary schools in the City of Monash and the Student Dental Service (SDS) based at MonashLink (Clayton). Its aims are to:

- Increase the number of dental visits
- Increase oral health literacy (in particular, related to nutrition) of children and parents
- Create a referral system between the SDS and Dietetics department

(Schibeci & Haramis 2009).

The results of screening and surveys undertaken at Clarinda Primary School indicate that:

- Less than 40% of children were reported to brush the recommended two or more times per day
- An average of 37% of children reported to have never been to a dentist- nearly 3 times more children than reported Victorian averages

- Only 5% of children have visited a SDS for dental care, and 77% of surveyed participants stated they would like more information on how to find a SDS
- 48% of parents expressed concerns about taking their child for a dental check up
- Children of overseas born and health care card holder parents showed significantly poorer dental health and behaviours than their respective counterparts.

Reach and impacts of the program include:

- 85% of targeted children attended the SDS visit program (n=51)
- 23% of students who attended were considered to be in the 'high risk' category following the dental check up component of the program
- There were significant increases in overall oral health/nutrition knowledge in students following the education component of the program. Significant increases were observed (above 50%) in previously not well identified decay causing foods including juice, jam and dried fruit.

(Schibeci & Haramis 2009)

The findings of the 'Keeping Kids Smiling' pilot project support the need for multi-faceted community-based oral health promotion programs.

Work with Clarinda Primary School will continue and hopefully expand to two other primary schools in the City of Monash over the next few years.

Problem Gambling

The reported data for the Monash area on net electronic gaming machine expenditure and gambling losses are alarming. Research studies indicate that:

- there is a relationship between gambling expenditure and problem gambling
- gambling related issues identified by GPs in Victoria include physical/emotional problems due to excessive gambling, stress, problems at work and relationship issues
- problem gambling is principally related to socio-economic environment
- the vast majority of people who present with gambling issues in Victoria are women (83 per cent)
- convenience gambling venues tend to be concentrated in those local communities that suffer the highest degree of socio-economic disadvantage;
- many costs arising from excessive and problem gambling are felt within local communities, the family and extended family members;

(SA Centre for Economic Studies 2005)

Current partnerships

The Department of Justice has provided three year funding (to June 2011) to the Inner East Primary Care Partnership (IEPCP) to employ a part-time project officer to strengthen prevention and early intervention approaches to problem gambling, using a health promotion approach and with a view to long-term sustainability.

Initial research was undertaken to identify at risk areas to focus on, with the result that the Neighbourhood Renewal area of Ashwood/Chadstone was the first such area. The decision was based on three factors:

- The presence of a large electronic gaming machine venue – Matthew Flinders Hotel, on Warrigal Road
- The association between disadvantage and risk of problem gambling
- The network of local residents and service providers that is present in the NR area.

The project seeks to:

- Work collaboratively with Gamblers Help Eastern to support community action, which reduces risk factors and builds protective factors associated with problem gambling.
- Provide support to organisations and services such as training (eg about problem gambling, health promotion); assistance with funding applications etc.
- Use a strengths based approach when working with organisations to use existing structures and activities.

Goal Setting

Goal One: To Promote Mental health and Wellbeing

This goal has been confirmed as the Inner East PCP Integrated Health Promotion catchment goal, with two major determinants for action:

1. To promote social connectedness

Rationale: Local data and results of surveys and consultations indicate that social isolation is an issue of concern for the Monash community. Current project work demonstrates effective partnership development and amenability to intervention with the following target groups:

- The older Chinese community in Monash
- Older and/or disabled, isolated residents of public housing in the Ashwood/Chadstone community

2. To prevent or reduce family violence

Rationale: MonashLink is committed to working with communities most vulnerable to family violence, in collaboration with the Inner East PCP membership as part of integrated health promotion planning in the region.

Whilst MonashLink will collaborate with other member agencies on shared strategies, a specific aim for our organisation is to build internal capacity for understanding and responding to family violence using evidence-based frameworks. Therefore our suggested initial target group in relation to this key determinant is:

- The MonashLink clinical workforce

Goal Two: To Promote Access to nutritious, affordable and culturally appropriate food

Rationale: Results of surveys and consultations indicate that healthy eating and food security are issues of concern for the Monash community. Data indicates high prevalence rates for cardiovascular disease and obesity in the EMR and significant socioeconomic disadvantage in local populations. Current project work demonstrates effective partnership development and amenability to intervention with the following target groups:

- The South Sudanese community of South Clayton
- The Ashwood/Chadstone community within the Neighborhood Renewal area

Promoting Oral Health

The main recommendation from the results of the 'Keeping Kids Smiling' pilot project is that MonashLink continues to develop oral health as an emerging issue, in order to work towards a broader goal for Monash, using the pilot project model as a guide for future implementation.

The School Dental Service and other Oral Health staff will further develop and expand implementation of this model. It is hoped that this will generate more compelling data to support a funding application for a multi-faceted community-based oral health promotion program in the future.

Addressing Problem Gambling

It is recommended that addressing problem gambling be adopted as an emerging issue within the timelines of the 2009-2012 Plan, with a view to building on partnerships developed as a result of the Problem Gambling initiative, in preparation for adopting the issue as a major priority in the 2012-2015 Plan

The completion of the new community hub at Batesford Reserve offers an opportunity to begin building these partnerships within this local setting. Monash Council will have a youth and family service at this facility and MonashLink is also considering this option with their Eastern Drug and Alcohol Service.

The recent creation of the AA&C Healthy Living Network, which comprises former partners from the 'Festival for Healthy Living' (FHL) and 'Healthy Kids in Monash' (HKIM) also creates possibilities to link local schools gardens to the arts, mental health promotion and the problem gambling initiative.

Table 6: Health Promotion Plan at a Glance

The following table provides an overall view of MonashLink's Health Promotion Strategic Plan for 2009-2012. An annual budget, as well as three year Action and Evaluation Plans for each specific health promotion priority will be developed to ensure that the strategic goals are comprehensively planned, implemented and evaluated

Goal	Objectives	Target population(s)	Settings and Partners (Actual and Potential)	Links to state, Regional local priority areas
To Promote Mental health and Wellbeing by promoting social connectedness	I. Initiate and sustain effective involvement of community organisations identified as possible partners, in the development of project 2. Improve capacity of the older Chinese community to take collective action to meet identified needs 3. Improve capacity of MonashLink to respond to the health needs of the older Chinese community and increase the uptake of services by the older Chinese community	**The older Chinese community in Monash**	1. Chinese Seniors Clubs Waverley U3A Migrant Information Centre, Box Hill Monash Council Monash Volunteer Centre Chinese Community Social Service Xin Jing Shan Association AMES 2. Chinese Seniors Clubs, Mt Waverley & Glen Waverley 3. MonashLink	State Government Priority **IEPCP IHP Priority**

To Promote Mental health and Wellbeing by preventing or reducing family violence	Draft Objectives 1. Work with Inner East PCP partner agencies to develop a PCP-wide policy on working with people affected by family violence. 2. Develop an integrated approach to the prevention, assessment of risk and early identification of family violence across MonashLink Community Health teams and programs. 3. Build workforce capacity within MonashLink to utilise this integrated approach to respond to family violence 4. Enhance current collaborative work with existing agencies and networks working with people affected by family violence	**The MonashLink clinical workforce**	PCP partner agencies	State government Priority **IEPCP IHP Priority**
To Promote Access to culturally appropriate and nutritious food	1. Enable the continued delivery of the 'healthy eating' course to South Sudanese women and the broader dissemination of information about culturally appropriate and healthy eating 2. Develop the leadership capacity of the management committees of South Sudanese women's organisations to effectively address the needs of the South Sudanese community and meet the needs of each individual organisation and its members. 3. Improve the capacity of the South Sudanese community to take collective action to meet identified needs 4. Improve the capacity of MonashLink to respond to the health needs of the South Sudanese	**The South Sudanese community in Clayton and surrounding areas**	Anglicare-Dixon House Baai-Bor Women in Australia Inc., The South Sudanese Women's Network South Sudanese Fellows Foundation Box Hill and Chisholm TAFE institutes Holistic African Society Local churches Migrant Information Centre, Box Hill	State Government Priority Local priority

	community and increase the uptake of services by the South Sudanese community			
To Promote Access to affordable and nutritious food	1. Increase *supply and local availability* of affordable, nutritious and culturally appropriate food. 2. Support activities that increase *access* to affordable and nutritious food, including knowledge and skills relating to healthy eating and physical access to food outlets. 3. Build MonashLink capacity to identify, provide services to, and appropriately refer clients facing food insecurity. 4. Build external capacity to address and support food security	**Residents at most socioeconomic disadvantage in the Ashwood/Chadstone community**	Ashburton, Ashwood & Chadstone Neighborhood Renewal (AA & C NR) Plant the Seed for Healthy Life Inner East CHS Damper Creek Co-op City of Monash City of Booroondara	State Government Priority Local priority
Flexible Component	**Emerging Issues:** • **Oral Health** • **Problem Gambling**	• **Primary school-aged children in Clarinda, Clayton and Westall** • **The Ashwood/Chadstone community within the Neighborhood Renewal area**	Clarinda, Clayton and Westall Primary Schools AA&C Healthy Living Network (former partners from the 'Festival for Healthy Living' (FHL) and 'Healthy Kids in Monash' (HKIM) projects)	Local priorities Oral Health is also an aspect of promoting accessible and nutritious food

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Appendix One

Health Survey

The suburb where you live or work: _____

Your age:
(Please tick)

- ☐ **Under 18**
- ☐ **18-25**
- ☐ **26-35**
- ☐ **36-50**
- ☐ **51-65**
- ☐ **66-80**
- ☐ **Over 80**

A recent report has shown that the following problems (over page) commonly lead to people experiencing poorer health in the Monash area

Please tick the two (2) problems that you are most concerned about.

☐ **Inability to buy or cook healthy food**

What needs to happen in your community to improve this problem?

_____

☐ **Depression/Mental health problems**

What needs to happen in your community to improve this problem?

_____

☐ **Poor public transport**

What needs to happen in your community to improve this problem?

_____

☐ **Social isolation/Loneliness**

What needs to happen in your community to improve this problem?

_____

☐ **Alcohol/tobacco/other drug addiction**

What needs to happen in your community to improve this problem?

_____

☐ **Any others? _____**

What needs to happen in your community to improve these problems?

_____

Thank you for your time!

Appendix Two

Barriers to food security in the Ashburton, Ashwood and Chadstone area

NATURAL	BUILT	ECONOMIC	SOCIO-CULTURAL
Further support for community gardens: policy support around water and keeping animals. in-kind support (mulch, topsoil, land). funding support. Policy and funding support for programs encouraging edible planting in public areas. Programs supporting growing & sharing of food from home gardens (water policy, grey-water and water restrictions, gardening clubs, gardening workshops, low-cost mulch and composting bins).	Ensure that outlets of affordable basic food needs (milk, bread, fruit etc) are within reasonable distance for all residents. Review of public transport routes – if insufficient then add new route, revise routes or supplement with community bus to affordable food outlets. Where needed, upgrade facilities within and around public housing, including public spaces, to promote public pride, increase safety and promote a healthy lifestyle.	Support for cheap community meals and or community kitchens open to all (including kids) and where feasible, for dinners as well as lunches. Support for school breakfast clubs and healthy snacks that aim to improve the diet of the most vulnerable students. Support for affordable food outlets. e.g. Support for food co-op or affordable food market. Delivery of accessible financial skills workshop (need to be readily accessible by residents). Support for emergency relief and strategies to increase fresh produce in emergency relief packages. Promotion of affordable home delivery options for nutritious foods. Wherever possible, support local employment opportunities.	Support for activities that promote healthy eating (e.g. healthy lunchbox workshops for parents, school breakfasts/snacks, community healthy eating workshops). Support for activities that teach cooking skills and motivate participants to eat well. Support for other social and food connectedness activities, including community lunches and community gardening. Ongoing support for efforts to engage most disadvantaged with basic services. Engagement of local businesses in community activities.

(Davis 2009)