Grampians Region Population Health Plan 2023 - 2029

# Stronger and healthier together

# Acknowledgement of Country

We proudly acknowledge Victoria's First Peoples and their ongoing strength in practising the world's oldest living culture. We acknowledge the Traditional Owners of the lands and waters on which we live and work, and pay our respect to their Elders past and present. We acknowledge that the lands of the Grampians region were never ceded. Always was, always will be, Aboriginal land.

We acknowledge the First Peoples of the Wimmera Southern Mallee, Gariwerd/ Grampians and Central Highlands regions of Victoria, their connections to land, waterways and community, and that we together live and work on *Wotjobalak, Jaadwa, Jadawajali, Wergaia and Jupagalk, Djab Wurrung, Eastern Maar, Dja Dja Wurrung, Wadawurrung and Wurundjeri country.*

Victoria's Aboriginal communities continue to strengthen and grow with the ongoing practice of language, lore and cultural knowledge. We recognise the contribution of Aboriginal people and communities to Victorian life and how this continues to enrich our society more broadly. We acknowledge the contributions of generations of Aboriginal leaders who have come before us, who have fought tirelessly for the rights of their people and communities. We acknowledge Aboriginal self-determination is a human right as enshrined in the *United Nations Declaration on the Rights of Indigenous Peoples*, and we commit to working towards a future of equality, justice and strength.

Finally, we acknowledge that there are long-lasting, far-reaching and intergenerational consequences of colonisation and dispossession. The reality of colonisation involved the establishment of Victoria with the specific intent of excluding Aboriginal people and their lores, culture, customs and traditions. Over time, the development of Victorian laws, policies, systems and structures explicitly excluded Aboriginal Victorians, resulting in and entrenching systemic and structural racism. We acknowledge that the impact and structures of colonisation still exist today. Despite the past and present impacts of colonisation, Aboriginal people, families and communities remain strong and resilient.



***Adapted from***

*Victorian Aboriginal Affairs Framework 2018-2023 (the VAAF)*
https://www.firstpeoplesrelations.vic.gov.au/victorian-aboriginal-affairs-framework-2018-2023

*Korin Korin Balit-Djak: Aboriginal health, wellbeing and safety strategic plan 2017–2027*
https://www.dffh.vic.gov.au/publications/korin-korin-balit-djak

***Cover Photo***

Gariwerd (Grampians National Park)

# Executive Summary

The Grampians Region Population Health Plan (GRPHP) 2023-2029 begins with a vision for the people of our region: that we together achieve the best health and well-being outcomes possible, and that progress towards that goal is made each year.

Health system structural reform 2020-2022 in response to the COVID19 pandemic gave rise to nine local public health units (LPHUs) across Victoria, hosted by major metropolitan and regional health services, and the integration of the former Primary Care Partnerships into those LPHUs. With a permanent place in the health service structure, this means that for the first time resourced LPHU prevention and population health teams can plan medium and longer-term pieces of work, and have the opportunity to extend a local evaluation horizon beyond two or three years. As described in the GRPHP, this both permits a bold and ambitious program of prevention and population interventions, and the capacity to evaluate, scale and sustain where successful.

While the COVID19 pandemic demonstrated that the people and places of the Grampians region have great strength of resilience, social capital and resourcefulness, in general the level of health and well-being experienced by the people of the Grampians is poorer, sometimes far poorer, than in many other parts of Victoria, and when compared with Victorian state averages. Knowing that for many there are structural barriers which prevent or limit people from optimising their health and well-being, the GRPHP has been developed by those in our region with a stake in achieving the collective vision: a diverse range of community members, experts, and agencies who together aim to serve the health and well-being needs of those who live in 11 local government areas extending from the South Australian border to the outskirts of Melbourne.

Through a series of broad and targeted meetings, workshops and iterative processes, more than 200 people have shaped directly the development of the GRPHP by considering various sources of information including

- the epidemiological, sociodemographic, sociocultural and socioeconomic features of our population's health status, strengths and needs, including where these health needs and outcomes differ across the Grampians,
- evidence of successful interventions used locally and elsewhere to address these needs
- information about existing programs underway in parts of our region addressing those and other needs for some groups,
- the voices and lived experience of community members,
- priorities set out in the *Victorian Public Health and Well-being Plan 2019-2023*, and
- contributions from prevention and population health experts, and health and civic leaders about the systemic challenges to improving the region's population health.

Attendees together mapped the complex factors interacting in a system which influence a person's health and well-being status, and then identified feasible, measurable, potentially scalable and potentially sustainable interventions. These were then further considered and programs selected for implementation in the initial years of the plan (with a strategy for repeating the process and broadening the range of programs and priorities in coming years). Accordingly, nine priority streams of work across our three sub-regional hubs are planned, summarised in the figure *The Plan at a Glance* below, spanning health promotion, disease prevention, and (sub-) population health approaches.

Successful implementation of these programs and achieving target outcomes and sustained health improvement can be achieved only through a genuine collaborative effort between all stakeholders characterised by power-sharing, a strengths perspective, equity focus, coalition-building, systems thinking, and a preventive approach, as occurred with success in the region's COVID19 public health response 2020-2022 (Aldrich, Grenfell & Wilson, 2022). The GRPHP notes that the prevention and population health workforce across our region is working on many more initiatives than the focus areas selected as the initial interventions in the GRPHP. We expect there to be many opportunities for future collaborations to undertake a wider suite of preventive actions over time.

Evaluation of the implementation of the GRPHP and programs in priority areas is grounded in the RE-AIM framework which informs the development of collaboratively developed methods and structures for local, timely, iterative and comprehensive data collection. Using quantitative and qualitative methods and including process, impact and outcome measures, we will derive, periodically, the data needed to know whether the programs have the desired reach, are effective, have been adopted as needed, whether implementation is occurring as needed, and that decisions can be made to maintain, scale and sustain based on an assessment of costs and benefits, and value to those using the system. This way our stakeholders can know what is being achieved as we progress, and what and when to tweak our program designs when change is not happening. It is not possible to scale success unless effort has been rigorously evaluated, success documented and lessons learnt. Prioritising the ongoing collection and analysis of data will also underpin the principle of continuous quality improvement and support a culture of learning across our organisation.

This plan has been developed at a time of planetary urgency. In February 2023 the Intergovernmental Panel on Climate Change (IPCC) reported a "rapidly closing window" for action to keep global warming to 1.5C above pre-industrial levels, warning that to fail to do so risks catastrophic consequences for earth's biosphere (IPCC, 2023). The IPCC outlined that climate change is causing adverse impacts on human physical and mental health. Heat related morbidity and mortality, water-borne, food-borne, and vector-borne diseases and mental health challenges are arising from increasing weather and climate extreme events (IPCC, 2023). Our region has lived experience of dramatic climate events and variability. In light of the need for urgent action, the work described in this plan seeks to incorporate climate and One Health considerations throughout as feasibly as possible. While environmental impact is one aspect of the RE-AIM framework used for evaluation, undertaking broader evaluation of prevention and population health programs' climate impacts is beyond the scope of the GRPHP work at this stage, although may develop in coming years. With no time to waste the GRPHP does include a priority stream of work dedicated to, in the first instance, supporting public health services in the Grampians region to scale efforts for mitigation and adaptation to climate change and its impacts on health.

This plan has been developed at a time of a much wider public conversation about constitutional recognition of Aboriginal and Torres Strait Islander Peoples. This is an opportunity to have policy and legal decisions informed by Aboriginal and Torres Strait Islander ways of knowing, being and doing. As a region, we are committed to ensuring that the voices and experiences of Aboriginal and Torres Strait Islander Peoples living in the Grampians region are represented in ways that the leaders of Goolum Goolum, Budja Budja and Ballarat and District Aboriginal Co-operatives would wish, and we have worked together to achieve this.

The GRPHP in its design, implementation and evaluation recognises the social and structural determinants of health and well-being, and their downstream impacts. The implementation of the GRPHP will apply a lens of inclusion, equity and gender impact across all programs to ensure that any interventions or services

delivered will be accessible, culturally safe and informed by those with lived experience.

The GRPHP sets out a bold shared ambition for the health and well-being of the people of the Grampians region. It has been made possible by and builds upon both the many years of rich working relationships between all who contribute to prevention systems in our region, and the strong bonds forged more recently between the multi-sector community leaders who have worked together to keep our communities safe through the COVID19 pandemic. A great deal of thought and effort and the wisdom of many has come together to produce this document which describes initial programs of action as well as, importantly, a way of working together into the future as all available resources for prevention and population health are mobilised to deliver population health improvement in our region. In public health no-one can work alone; we are and will continue to be stronger and healthier together.

*Endorsement*

The GRPHP fulfills the requirement for Grampians Health to have developed a population health plan. The members of the *Grampians Health Primary Care and Population Health Advisory Committee* (listed in *Appendix 10.1*) have endorsed this plan.

Ms Marie Aitken (Chair)
19 July 2023

The implementation of the GRPHP will be steered by the *Grampians Region Population Health Plan Steering Committee*, members of whom (listed in *Appendix 10.2*) have endorsed this plan.

Dr Rob Grenfell (Chair)
20 July 2023

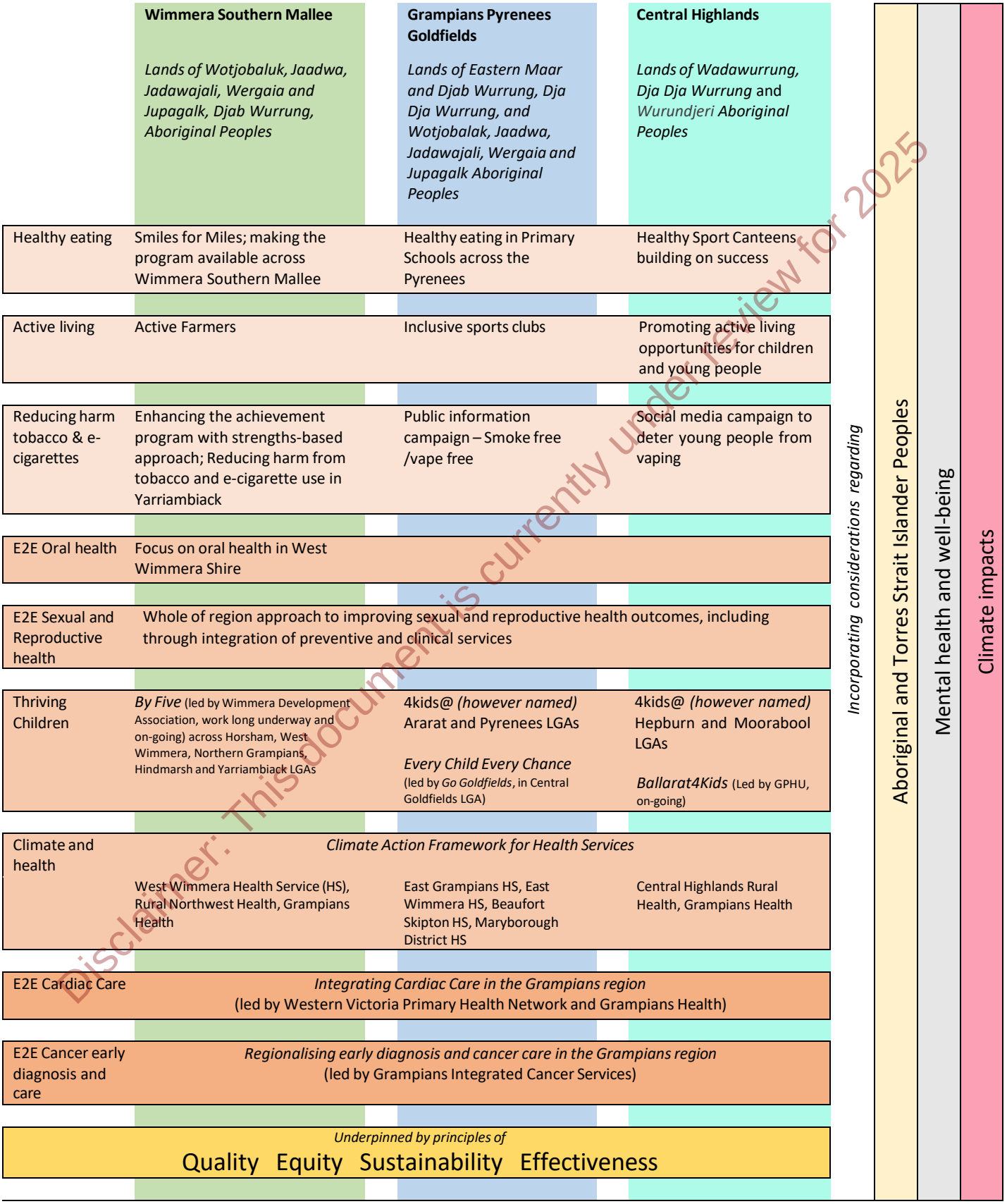
Grampians Health
Grampians Public Health Unit



Suggested Citation:

Aldrich R, Purcell T, Betts J, Burton S, Finnigan G. (2023) *Stronger and healthier together: Grampians Region Population Health Plan 2023-2029*. Ballarat: Grampians Public Health Unit

***Figure 1 The Plan at a Glance**: Grampians Region Population Health Plan priority streams, implementation location, underpinning principles and incorporated considerations*






E2E = end to end prevention and primary care teams integrating with secondary and tertiary teams using value-based healthcare approach

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| | |
|---|---|
| ABC | Australian Broadcasting Corporation |
| ABS | Australian Bureau of Statistics |
| ACCHO | Aboriginal Community Controlled Health Organisation |
| AOD | Alcohol and other drugs |
| ARACY | Australian Research Alliance for Children and Youth |
| B4K | Ballarat for Kids |
| BADAC | Ballarat and District Aboriginal Co-operative |
| BBAC | Budja Budja Aboriginal Co-operative |
| BBV/ STI | Blood borne viruses/ sexually transmissible infections |
| BCH | Ballarat Community Health |
| BNS | Bush Nursing Service |
| BSWPHU | Barwon South West Public Health Unit |
| CAF | Climate Action Framework |
| Cafs | Child and Family Services |
| CEO | Chief Executive Officer |
| CH | Central Highlands |
| CH-HP/IHP | Community Health-Health Promotion/ Integrated Health Promotion |
| CHO | Chief Health Officer |
| CORE | Communities of respect and equality |
| CYPIC | Children and Young People's Improvement Collaborative (Scotland) |
| DH | Department of Health |
| DHSV | Dental Health Services Victoria |
| ECEC | Every Child Every Chance |
| E2E | End to End |
| EM | Emergency Management |
| FMSS | Feasibility, measurability, scalability, sustainability |
| GIA | Gender Impact Assessment |
| GH | Grampians Health |
| GMB | Group Model Building |
| GPG | Grampians Pyrenees Goldfields |
| GPHU | Grampians Public Health Unit |
| GRPHP | Grampians Region Population Health Plan |
| GRPHU | Gippsland Region Public Health Unit |
| Hep A, B, C | Hepatitis A, B, C |

| | |
|---|---|
| HS | Health Service |
| IAP2 | International Association of Public Participation |
| IHD | Ischemic heart disease |
| IPCC | Intergovernmental Panel on Climate Change |
| IUD | Intrauterine device |
| LGA | Local Government Area, Local Government Authority |
| LETTERS | Leadership and governance, Engagement, Training and education, Tools and resources, Evaluation and auditing, Reporting and communication, Sustainability |
| LPHU | Local Public Health Units |
| M&E | Monitoring and evaluation |
| MCRI | Murdoch Children's Research Institute |
| MHWB | Municipal Health and Wellbeing plan |
| MSM | Men who have sex with men |
| NCDs | Non-communicable diseases |
| NFP | Not For Profit |
| PBS | Pharmaceutical Benefits Scheme |
| PCP | Primary Care Partnership |
| PCPHAC | Primary Care and Population Health Advisory Committee |
| PPH | Prevention and population health |
| RE-AIM | Reach, effectiveness, adoption, implementation, maintenance |
| RFDS | Royal Flying Doctor Service |
| RNH | Rural Northwest Health |
| SA4 | Statistical Area 4 |
| SEF | Standard evaluation framework |
| SEWB | Social and emotional well-being |
| SC | Steering Committee |
| SRH | Sexual and reproductive health |
| STICKE | Systems thinking in community knowledge exchange |
| VPHWOF | Victorian Public Health and Wellbeing Outcomes Framework |
| VPHWP | Victorian Public Health and Wellbeing Plan 2019-2023 |
| WHG | Women's Health Grampians |
| WHO | World Health Organisation |
| WSM | Wimmera Southern Mallee |
| WVPHN | Western Victoria Primary Health Network |
| WWHS | West Wimmera Health Service |


Disclaimer: This document is currently under review for 2025

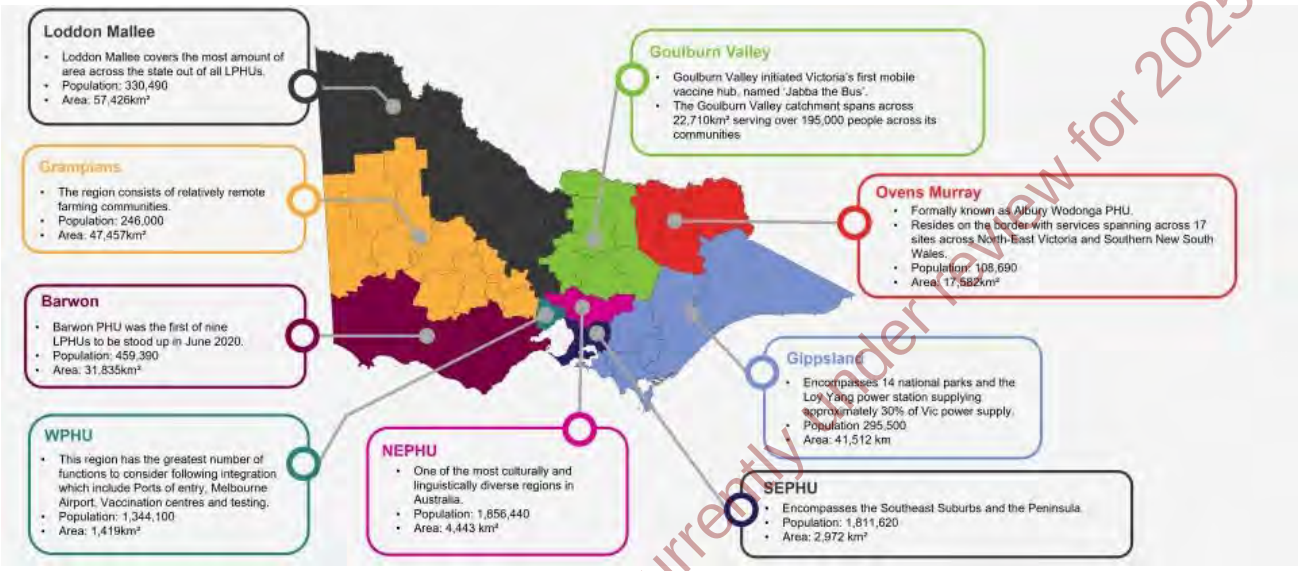
# 1

# Introduction

## 1.1 Establishment of Victorian Local Public Health Units

In response to the COVID-19 pandemic, nine local public health units (LPHUs) were established in late 2020 to support a timely and localised public health response. A map demonstrating the catchment areas of the nine LPHUs in Victoria is provided below (*Figure 2.1*).

*Figure 2.1 Local public health unit map with local government areas (Source: Victorian Department of Health, 2023)*



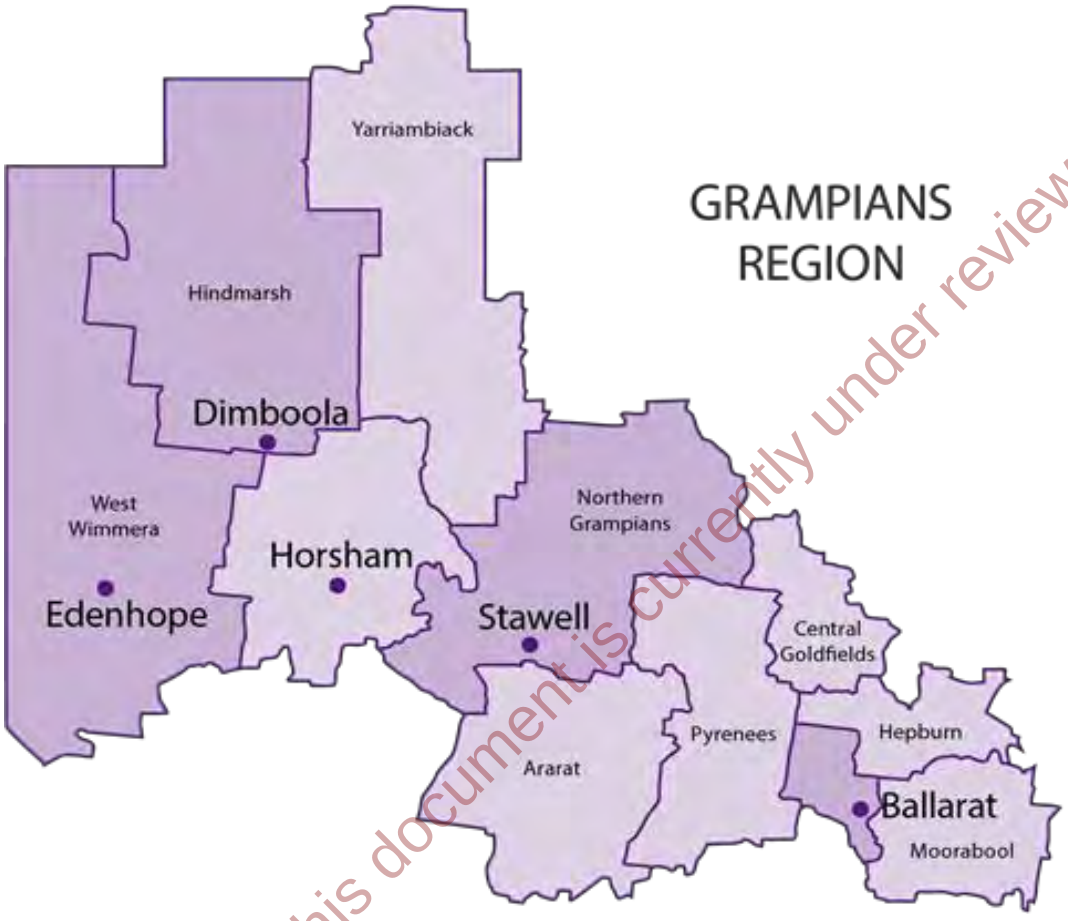

Many agencies contributed to the public health response to the COVID19 pandemic in Victoria. The role of LPHUs included co-ordinating the response, contact tracing, outbreak management and vaccination programs. Localised and targeted communications with the public and other stakeholders, together with an established presence in the community through their local health service, were central elements of this success. In 2022, LPHUs broadened their scope to include the public health management of a range of communicable diseases, and in 2023 this process of transition from centralised to local management continues.

Critically, the value of LPHUs in taking a broader population health approach and responding to the prevention and management of chronic disease has also been recognised, with the integration of local Primary Care Partnership (PCP) teams into LPHUs in June 2022. This new structure for prevention and population health supplements existing prevention agencies and has provided new opportunity for collaboration and alliancing to potentiate the strengths of all.

## 1.2 Introduction to the Grampians Region

The Grampians Public Health Unit (GPHU) covers 11 Local Government Areas (LGAs) in North-Western Victoria and serves a population of more than 250,000 people (see *Figure 2.2*).

*Figure 2.2 Map of the local government areas which form the catchment area of the Grampians Public Health Unit (Source: Grampians Health, 2023)*






The region is diverse in terms of socio-demographics, industry and geography, incorporating the large regional city of Ballarat (approximate population: 116, 000) in the eastern end of the region, and remote farming communities along the South Australian border to the west. It includes a number of sites of cultural, historical and natural significance including the Grampians (Gariwerd) National Park, Lake Bolac, Mount Arapiles (Dyurrite) and Little Desert National Park.

There is a wide network of health services providing care and support to people living in the Grampians region, as outlined below in *Table 1.*

*Table 1 Health services providing care in the Grampians region*

| Region | Hospital | Urgent care centre | General practice | Aboriginal Community Controlled Organisation | Community health services | Bush nursing centres | Aged care facilities | Pharmacies | Maternal and child health |
|---|---|---|---|---|---|---|---|---|---|
| Central Highlands | 5 | 4 | 28 | 1 | 12 | 0 | 32 | 37 | 15 |
| Grampians Pyrenees Goldfields | 8 | 6 | 15 | 1 | 14 | 2 | 18 | 13 | 8 |
| Wimmera Southern Mallee | 8 | 8 | 21 | 1 | 19 | 2 | 16 | 14 | 18 |
| Grampians region | 21 | 18 | 64 | 3 | 45 | 4 | 66 | 64 | 41 |

Over the past two years, the Grampians region has experienced significant organisational change in health agency structures with the establishment of Grampians Health and the transition of PCP functions.

In November 2021, Edenhope and District Memorial Hospital, Stawell Regional Health, Wimmera Health Care Group and Ballarat Health Services amalgamated to become Grampians Health. It is important to acknowledge that while the GPHU is hosted by Grampians Health (GH), GPHU is responsible for serving communities across the breadth of the above mentioned LGAs.

In Victoria, placed-based PCP teams worked collaboratively across communities to enhance health and wellbeing outcomes for over 20 years. With integration the PCPs brought with them strong partnerships and significant local knowledge and experience in health promotion and disease prevention. The three PCPs - Grampians Pyrenees, Central Highlands and Wimmera Southern Mallee which transitioned to join the GPHU in mid-2022, have formed place-based GPHU prevention and population health (PPH) teams. The PCP functions covering Central Goldfields LGA also transitioned into the GPHU to create the Grampians Pyrenees Goldfields PPH team; the PCP functions covering Golden Plains LGA moved from the Central Highlands PPH team to Barwon South West PHU (BSWPHU).

## 1.3 Creating a catchment population health plan

A regional population health plan is a key 2022-2023 deliverable for LPHUs. LPHUs have been required to create a population health plan for their catchment in partnership with stakeholders. The resulting Grampians Region Population Health Plan 2023-2029 (GRPHP) reports an assessment of health, strengths and priorities of local communities which then informed a series of population health interventions to transform health and wellbeing outcomes.

## 1.4 Guiding principles and values for the Grampians Region Population Health Plan

Population health can be defined in a number of ways. For the purpose of this plan, a population health approach can be defined as different from health promotion actions where health promotion interventions start with a *risk factor* or *disease* and interventions seek to target groups of people who may share that risk factor or disease diagnosis to stop their progression. A population health approach on the other hand might start with a *sub-population* or *group,* members of which share a common sociodemographic, sociocultural or socioeconomic characteristic which makes them particularly susceptible to social and commercial determinants of health. Interventions may seek to support members of the group to strengthen their capacity to attenuate the impacts of those social or commercial determinants of health (Aldrich, 2022), and improve their health outcomes.

Importantly, a population health approach has improved health outcomes as the end goal (as opposed to process evaluation measures) and should be conceived of as a conceptual framework for considering the root causes of health disparities and the subsequent policies, interventions and resources required to address these disparities (Health Canada, 1998; Young, 1998).

Accordingly, a population health plan for the Grampians region presents a unique opportunity to focus on the specific health needs of our region, and an opportunity to develop a suite of interventions with the key goal of achieving measurable population health improvement. This will be achieved through a stakeholder-driven process of exploration of systemic barriers to health gains and targeted interventions, recognising the importance of diversity and intersectionality, and seeking to understand and address the common factors influencing population health outcomes. By aligning activities across the region, leveraging existing programs and actions, and adapting initiatives to places and the people of our region the GPHU has a key role in

- facilitating implementation of state-wide programs, priorities, and policy at a local level while ensuring these inform and are informed by local priorities and responses
- strengthening local prevention capacity and networks to drive coordinated and collective impact with sufficient scale and reach, and
- promoting health and wellbeing outcomes that matter to people, communities, and the environment.

*Local Public Health Unit Population Health Catchment Planning Framework, June 2023*

As such the overarching aim of the GRPHP is to work in partnership with our local stakeholders and communities to transform health and wellbeing outcomes for all people living in the Grampians region. This will be achieved through:

- strengthening partnerships with health, social and other community stakeholders,
- adopting a stakeholder-driven approach to developing, implementing and evaluating the GRPHP,
- drawing on the principles of systems science to conceptualise contributing factors to health outcomes and identify key leverage points for targeted public health interventions, and
- the development of robust governance, implementation and evaluation systems.

The approach to developing the GRPHP is underpinned by the following guiding values and principles:

- Stakeholder-driven
- Power-sharing
- Coalition building
- Strengths perspective
- Equity-focused (including regarding gender)
- Quality
- Effectiveness
- Sustainability

Guided by leaders in local Aboriginal communities, community members with lived experience and content experts, our plan seeks to incorporate considerations regarding Aboriginal and Torres Strait Islander people, mental health and wellbeing, and climate impacts into all activities.

## 1.5 Language and data used in this plan

### 1.5.1 Language used in this plan

In this report we have sought the advice of the leaders of Goolum Goolum, Budja Budja and Ballarat and District Aboriginal Co-operatives regarding their preferences of words used to describe those they serve in their catchments. Accordingly, the terms *Aboriginal* and *Aboriginal and Torres Strait Islander Peoples* are used as wished when referring to residents of various parts of our region. The GPHU PPH teams work in three sub-regional hubs. The Traditional Owners of the lands served by those hubs are named.

### 1.5.2 Data used in this plan

Numbers tell stories and the way we tell stories matters. While there may be plentiful data about sub-populations in our community, how decisions are made regarding what and how data are collected in the first instance cannot be separated from deeply held beliefs about the strengths or deficits of communities. For this reason, care has been taken to ensure that strengths as well as gaps are reported, and to ensure no location or group is singled out in ways that may communicate differently than what the outcomes may mean for them. Health outcome data can illuminate the need to close an equity gap resulting from structures of society beyond the control of an individual.

## 1.6 Structure of the Grampians Region Population Health Plan 2023-2029

The GRPHP is presented in a further six sections.

*Section 2* sets out the methods used to gather and collate crucial evidence of programs and outcomes locally and elsewhere, how partnerships were built during the consultation phase of the development, how decisions have been made to determine the priorities selected, and the process or developing the GRPHP evaluation framework. *Appendices 1.1 to 1.4* comprise additional information about the methods used to develop the plan.

*Section 3* describes the results of data synthesis and the outcomes of the stakeholder process to determine priorities and programs for focus. Demographic and outcome evidence for our region is briefly described, as are the results of having mapped current prevention system activities (with data further detailed in *Appendices 2 to 4*). Contributions written by the Ballarat and District Aboriginal Co-operative, Budja Budja Aboriginal Co-operative, and Goolum Goolum Aboriginal Co-operative comprise *Section 3.2 "In our own words".* Informed by voices, priorities and capacities of community, agencies and experts, the programs across the priority areas of *Healthy eating, Active living*, and *Reducing harm from tobacco and e-cigarettes* for our region (including outcome targets) are set out in Table 3 (found in *Section 3.4*). Further detail around rationale and implementation for all priority areas is reported in *Appendices 6.1 to 6.9*. Structures and work to support the implementation of the GRPHP are described in *Section 3.6,* and tools and resources for implementation are further elaborated in *Appendix 7*.

*Section 4* presents the evaluation framework for the GRPHP formed through discussion with stakeholders. *Section 5* concludes the GRPHP by discussing readiness to take advantage of opportunities as they arise and strategies to build adaptive capacity in order to both manage risks and respond to future threats to health. Figure 4 illustrates steps in an iterative program process of scoping, implementing, evaluating, scaling success and sustaining the gains (demonstrated through further evaluation) up to 10 years into the future.

*Section 6* lists references cited in the GRPHP, and a series of Appendices comprise *Section 7*, containing most of the explanatory detail in support of the GRPHP.

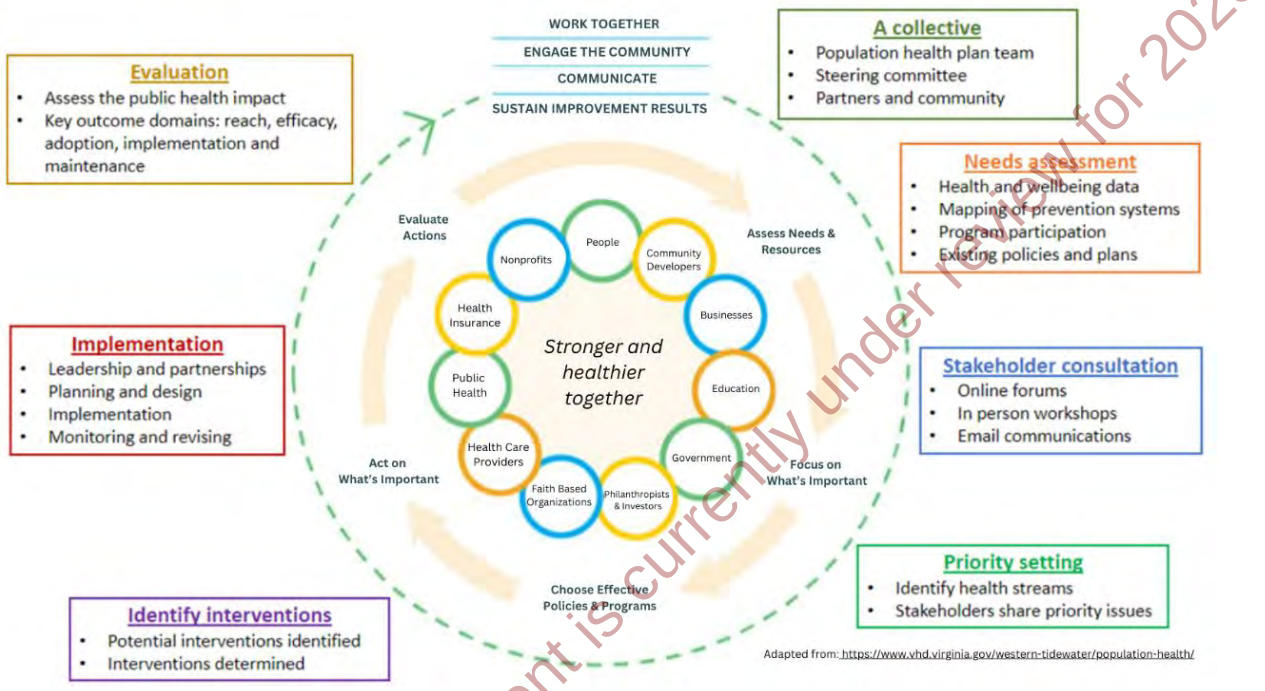

Disclaimer: This document is currently under review for 2025

# 2

# Methods

To achieve the aim of transforming health and wellbeing outcomes for all people in the Grampians region, a systematic and robust methodology was adopted to develop the GRPHP. This chapter provides an overview of the methods that were used during each step of the development process. A summary of this stepwise approach is outlined in *Figure 3*. Additional supporting information is contained in *Appendices 1.1 to 1.3.*

*Figure 3 GPHU approach to developing a population health plan*






## 2.1 Establishment of the GRPHP Steering Committee

To oversee the development of the GRCPHP and its subsequent implementation and evaluation, the GRPHP Steering Committee (SC) was convened. Diverse representation of professionals and communities across the Grampians region has been embedded into the SC membership. *Appendix 10* provides further details about the SC membership.

## 2.2 Methods to assess health outcomes, strengths and needs

A health needs assessment was undertaken to systematically assess the state of health and wellbeing among people living in the Grampians region, enabling for the identification of major risk factors and causes of ill health and identify opportunities to address these (World Health Organization, 2001). The *Local Public Health Unit Population Health Catchment Planning Framework* outlined the information that should be incorporated into the health needs assessment. This included data on the health status and wider determinants impacting the health and well-being of individuals, existing prevention systems and program participation across the catchment. In addition to these three streams, the GRPHP also includes a synthesis

of the health priorities among health promoting agencies to better understand the key issues that local stakeholders are targeting. Therefore, the following four streams of data were collected and analysed:

1. Epidemiological health and social information for the region,
2. Mapping of prevention systems,
3. Program participation,
4. Existing health priorities among health promoting agencies.

To our knowledge, this is the first report in the Grampians region that has collated and analysed local level data to better understand health outcomes, strengths and needs across the region and, for some outcomes, over time. *Appendix 1.1* provides detailed description of the methods used to perform the health needs assessment.

## 2.3 Identifying health promotion priority interventions

While the Victorian Health and Well-being Plan 2019-2023 sets out 10 priorities, Department of Health prevention and population health funding requires that, given the level of morbidity and mortality for which they are risk factors, increasingly greater than 70% of funding is dedicated to the priorities of Healthy eating, Active living and Reducing harm from tobacco and e-cigarettes. Accordingly, these three priorities were initially selected for particular prevention attention in the GRPHP.

## 2.4 Additional streams of priority

As well as the extensive work undertaken to identify priorities in the areas of *Healthy eating, Active living* and *Reducing harm from tobacco and e-cigarettes*, further priority streams of work were identified informed by health outcome data, local knowledge, and expert assessment of climate change and its impact on health. These additional streams include *Strengthening oral health, Sexual and reproductive health and viral hepatitis, Thriving children, Tackling climate change and its impacts on health, Enhancing cardiac care* and *Regionalising cancer care across our community*. *Section 3.4* Plan of actions and interventions describes these streams and the evidence supporting their inclusion as a priority.

## 2.5 Methods to engage stakeholders

A stakeholder-driven approach to developing the GRPHP was adopted to ensure population health priorities and place-based solutions were identified and considered implementable by local communities. To achieve this, a plan to meaningfully engage with a diverse range of stakeholders was created. Informed by the International Association of Public Participation (IAP2) engagement design methodology (IAP2, 2020), a stakeholder engagement plan was iteratively developed. The engagement plan sought the participation of many stakeholders including representatives from the Victorian Department of Health, local government, community health, Women's Health Grampians, Aboriginal co-operatives, multicultural councils, community organisations, the Western Victoria Primary Healthcare Network (WVPHN), peak bodies, not-for-profit (NFP) organisations and research institutes. The expertise, lived experience and perspectives on gender, diversity,

ability and intersectionality provided by stakeholders, enabled inclusivity to be embedded within the GRPHP. *Appendix 1.2* outlines the stepwise approach from initial conceptual ideas through to the identification of a series of potential place-based interventions for *Healthy eating, Active living* and *Reducing harm from tobacco and e-cigarettes* streams according to local priorities.

For the additional priority streams of *Strengthening oral health, Sexual and reproductive health and viral hepatitis, Thriving children, Tackling climate change and its impacts on health, Enhancing cardiac care* and *Regionalising cancer care across our community,* targeted stakeholder engagement was undertaken to develop the initial actions in these priority streams. Details about the initial actions within these priority streams are described in *Appendices 6.4-6.9.*

## 2.6 The contribution of Aboriginal Co-operatives to the GRPHP

To ensure that the GRPHP reflected information about the communities served by Goolum Goolum, Budja Budja and Ballarat and District Aboriginal Co-operatives as the organisations would choose to communicate that information, the leaders of each Aboriginal co-operative were approached to discuss whether each organisation would wish to provide their own report to the GRPHP. This idea was keenly embraced, and the resulting reports comprise *Section 3.2* "In our own words".

## 2.7 Methods to determine preventive interventions

Following the engagement workshops for the *Healthy eating, Active living* and *Reducing harm from tobacco and e-cigarettes* streams, data collected during the workshops on the stakeholder identified interventions were synthesised and reviewed to assess their feasibility, measurability, scalability and sustainability (*as set out in Appendix 1.3*). A short list of preventive health activities was shared with stakeholders, and stakeholders were invited to nominate interventions to which their organisation could contribute. The interventions that had the highest number of organisations that could support the initiative have been included for attention in the first year of the GRPHP. For interventions that were equally supported, readiness for implementation and the strength of local stakeholder support were considered by GPHU to determine the intervention included.

For each for the one-community stakeholder selected interventions, potential target outcome and impact measures were identified. The potential measures were identified by GPHU using the Victorian Public Health and Wellbeing Plan Outcomes Framework (VPHWOF). These measures will be revised with relevant stakeholders during the implementation planning phase to determine an agreed set of targets.

## 2.8 Methods to develop an implementation plan for the GRPHP

To successfully enact the prevention interventions included in the GRPHP, a clear and comprehensive plan for implementation is critical. The LETTERS framework for implementation, as described by Aldrich and Ford (2012), will be used to develop an implementation plan for each of the interventions. The LETTERS framework is a model for program implementation, which outlines the key steps that are required to operationalise an initiative. These elements include:

- **L**eadership and governance
- **E**ngaging with people and processes
- **T**raining and education
- **T**ools and resources
- **E**valuation and audit
- **R**eporting and communication, and
- **S**ustainability

The implementation plan that will be used to enact the GRPHP is described in *Section 3.6*. Literature pertaining to priority areas has been reviewed and will further inform the implementation plans.

## 2.9 Evaluation framework

Historically, a variety of frameworks have been used to structure the evaluation of public health programs and their interventions. Some of these have been specific to the intervention, for example the Standard Evaluation Framework (SEF) for physical activity interventions (Hanson and Jones, 2017) while others have adopted generic approaches to guide the evaluation, such as the Framework for Evaluation in Public Health (Koplan et al., 1999). Irrespective of the type or nature of approach applied, the objective of using an evaluation framework is to provide a scientifically robust and systematic approach to evaluation to ensure that the local process, impact and outcome measured are captured through local evaluation.

For the purpose of the GRPHP, the term evaluation is defined as 'the systematic evaluation and assessment of the features of an initiative and its effects in order to produce information that can be used by those who have an interest in its improvement or effectiveness' (WHO, 1998, p.3). Whereas the expression 'evaluation framework' refers to the 'structured guidance which facilitates the systematic evaluation of the implementation or outcomes of an intervention' (Fynn et al., 2020, p.2).

Following a careful review of existing evaluation frameworks used to evaluate public health interventions, the approach best matched to manage the complexity and diversity of the priority streams contained within the catchment plan is RE-AIM. The RE-AIM framework (Table 2) is a planning and evaluation model designed to assess the public health impact of interventions using five outcome dimensions: reach, efficacy, adoption, implementation, and maintenance (Glasgow et al., 2019). The framework was designed over 20 years ago and been applied extensively in all facets of public health program evaluation in diverse fields of chronic disease, cancer, health promotion, screening, physical activity and dietary patterns, to name a few, with over 700 publication citations in peer-reviewed literature (Glasglow and Estabrooks, 2018; Kwan et al., 2019).

*Table 2 Explanation of RE-AIM domains (Adapted from Glasgow and Estabrooks, 2018)*

| RE-AIM Domain | Explanation - Definition |
|---|---|
| **Reach** | WHO is (was) intended to benefit and who actually participates or is exposed to the intervention? Measured by number and similarity of participants to your target group. |
| **Effectiveness** | WHAT are (were) the most important benefits you are trying to achieve and what is (was) the likelihood of negative outcomes? Measured by change on key outcome(s) and consistency across subgroups. |
| **Adoption** | WHERE is (was) the program or policy applied and WHO applied it? Measured by what settings and staff take up the intervention and which do not. |
| **Implementation** | HOW consistently is (was) the program or policy delivered, HOW will it be (was it) adapted, HOW much will (did) it cost, and WHY will (did) the results come about? |
| **Maintenance** | WHEN will (was) the initiative become operational; how long will (was) it be sustained (setting level); and how long are the results sustained (individual level)? Measured by longevity of effects (individual level) and program sustainability (setting level). |

There are many strengths to using the RE-AIM framework to test the effect, translatability and wider public health impact of stakeholder selected interventions in the GRPHP. Firstly, the framework can be applied systematically across all diverse priority streams of the catchment plan, with extensive practical guidance and resources from both theoretical and published real-world contexts available to support the design. Similarly, the outcome dimensions are equally pertinent for those interventions with short or longer lead times and program timeframes required to achieve change in the target population.

Importantly, the framework structure and process required to capture each dimension, enable all the program stakeholders to quickly develop a shared understanding of the different roles, responsibilities, and processes needed to evaluate the intervention. Equally significant is the opportunity to test different interventions applied in the same stream but implemented in different catchment areas. Similarly, RE- AIM provides a robust approach to compare and contrast the effect and impact of different interventions and determine the comparative cost/impact ratio between them.

An evaluation schema, using RE-AIM as the guiding framework is set out in *Appendix 8*. Evaluation plans will be developed for each priority stream intervention during the implementation planning phase.

A detailed assessment of cultural safety will also be performed to ensure all GRPHP interventions are planned, implemented and evaluated in accordance to cultural safety standards. GPHU will work in close partnership with local Aboriginal leaders and communities, health organisations and health staff to identify or develop appropriate cultural safety assessment tools that can be used across every aspect of the development and implementation of the GRPHP.

# 3

# Evidence and Action

## 3.1 Using data to inform action

The results from the health needs assessment provide a comprehensive understanding of the health and wellbeing status of people living in the Grampians region. *Table 3.1* below presents an overview of the key findings. Please refer to *Appendix 2* for more detailed demographic, social and health data for each of the local government area (LGA) in the Grampians region.

*Table 3.1 Key findings: strengths, community profile, health risk and protective factors, health outcomes and prevention systems, Grampians Region, 2023*

**Key strengths**

- People in the Grampians region are more likely to belong to an organised group, compared with the Victorian average
- People in the Grampians are more likely have someone outside their household that they can rely on to care for them or their children in an emergency, when compared with the Victorian average
- Several LGAs demonstrated a higher proportion of people participating in organised sport than the Victorian average
- There are generally high rate of childhood immunisation coverage across the region (approaching 100% in several areas)
- There is a strong network of prevention and population health activities across the region *(Appendix 4.1)*

**Community profile**

Compared with the Victorian average, the Grampians region generally reflects:

- An ageing population
- Lower educational attainment levels
- A lower median weekly household income
- Fewer adults participating in the labour force
- A relatively high proportion of the population living with a disability

**Health risk factors and protective factors**

Compared with the Victorian average, the Grampians region generally reflects:

- Higher rates of smoking
- Higher rates of obesity
- Higher rates of physical inactivity
- Higher rates of sugar sweetened beverage consumption
- Higher participation rates in bowel and breast cancer screening
- Lower participation rates in cervical cancer screening

**Health outcomes**

Compared with the Victorian average, the Grampians region generally reflects:

- Lower life expectancy for both men and women and over the past decade there has been a widening of the inequity gap

- Higher rates of premature death
- Higher rates of chronic diseases including cardiovascular disease, diabetes, respiratory diseases and cancer

**Prevention systems**

There are 170 local policies, programs and other population health initiatives focused on healthy eating, active living and reducing harm from tobacco and e-cigarettes across the region.

- Health focus
  - 58% are focused on healthy eating
  - 29% are focused on active living
  - 12% are focused on reducing harm from tobacco and e-cigarettes
- Location
  - 51% are located in the Central Highlands region
  - 28% are located in the Wimmera Southern Mallee
  - 15% are located in the Grampians Pyrenees Goldfields
  - Remaining are located across multiple regions
- Ottawa Charter Action Area
  - 68% included a focus on creating supportive environments
  - 67% included a focus on developing personal skills
  - 47% included a focus on strengthening community action
  - 17% included a focus on building healthy public policy
  - 2% included a focus on reorienting health services

Local stakeholders and communities have built a solid foundation for a strong prevention system in the Grampians region. However, the data captured in the sub-regional epidemiological health and social indicator Data Snapshots (*Appendices 3.1-3.3*) highlight the case for targeted, community-driven programs aimed at improving the health and well-being of the Grampians population. In response to these data the initial focus of the GRPHP is in streams of work concerning healthy eating, active living and reducing harm from tobacco and e-cigarettes, as well as action for improved access to early detection and care for oral disease, cardiovascular disease and cancer. The data also present a strong case for needing to improve sexual and reproductive health outcomes in the region, particularly in terms of equitable access to abortion services.

Additionally, building on work already underway in seven of 11 LGAs in the region (as described in *Appendices 3.4 to 3.6*), population health work to optimise the health and well-being of children will expand to cover all LGAs in the first year of the GRPHP. While local data identifying the consequences so far from the effects of climate change are scarce, data relating to the local *risks* from our changing climate and the imperative to act are described briefly in *Appendix 6.7.*

These nine health priorities seek to advance outcomes in health promotion and disease prevention, and demonstrate where preventive activities integrate to enhance a value-based health care approach to the continuum of care in our region to effect improvement in health outcomes for our community. A more detailed outline of data and its use to inform actions for each priority stream is outlined in the *Appendices 6.1 - 6.9.*

## *3.2 "In our own words"*

This section contains reports of prevention actions and health promotion and health programs, data and plans written by staff of Ballarat and District Aboriginal Co-operative, Budja Budja Aboriginal Co-operative and Goolum Goolum Aboriginal Co-operative.

### 3.2.1 Ballarat and District Aboriginal Co-operative

### 3.2.2 Budja Budja Aboriginal Co-operative

### 3.2.3 Goolum Goolum Aboriginal Co-operative

# ‘In Our Own Words’- Grampians Population Health Plan

## Acknowledgement

We acknowledge the diverse community who live and connect to the Ballarat and District Aboriginal Co-operative (BADAC) services throughout the Ballarat and District area that refer to themselves by their clan, mob and/or country. For the purpose of this document, we respectfully refer to First Nations Peoples as Aboriginal and Community throughout.

BADAC acknowledges the Wadawurrung people and their ancestors who have been custodians of the Ballarat area for thousands of years performing age-old Cultural ceremonies, celebrations, and traditions. We also acknowledge the Ballarat Aboriginal Community, many of whom were forcibly removed from their families during the Stolen Generations decades and brought to Ballarat, and we pay our respects to all Elders past, present and emerging.

Established by members of the Ballarat Aboriginal Community in 1979, BADAC became a cooperative to deliver health, social, welfare and community development programs to local Aboriginal Community for over 40 years. Since 1979, the organisation has grown considerably and now delivers a wide range of services, underpinned by its adaption of Social Inclusion principles and self-determination.

## Strategic Plan and Vision

BADAC’s strategic plan has always been to aim for self-determination by growing our community, strengthening our culture, and honouring our heritage. This has included adopting the Social Inclusion principles to underpin our service delivery and program development
activities has led to meeting organisational goals. The vision is to support and encourage the Aboriginal Community to stay connected to culture and identity whilst empowering self- determination.

BADAC’s service setting vision for high-quality care is culturally informed, person-centred, community connected, evidence-based and accessible. BADAC is committed to ensuring the Community feels welcomed, respected, understood, and supported in managing their health and well-being issues. Culture is always at the forefront of service design, delivery, and review embracing all six values of Excellence, Leadership, Culture, Honesty, Accountability and Respect on all levels advocating strongly for Elders, Community and families.

## Our Community

BADAC is the Aboriginal Community-Controlled Organisation (ACCO) for the Ballarat and district area, covering five local government areas (LGAs): Ballarat, Moorabool, Hepburn, Golden Plains and Pyrenees from Bacchus Marsh in the east to Beaufort in the west, Talbot in the north to Meredith in the south. BADAC’s service area has a population of 4338 Aboriginal people, of which 54% are aged 24 and under, and 37% aged 0-14 Ballarat 3080, Moorabool 558, Hepburn 180, Golden Plains 376, and Pyrenees 144. Total: 4338 (ABS. 2021).

## Health Checks

BADAC Medical supports access to culturally safe health services that promote healthy ageing at any age, from the youngest Community members to the respected Elders. The Aboriginal and Torres Strait Islander, 715 Health Check is a free bulk billing service provided at BADAC specifically designed to encourage early detection, treatment of illnesses and chronic conditions, with prevention measures key in early intervention programs and management. The BADAC Medical Clinic completes an average of 300 Aboriginal Health Checks each year with a total of 323 completed last financial year (1st July 2022-23rd June 2023). Other services provided include dietitian, exercise physiology, audiologist, diabetes, smoking cessation, asthma education, podiatrist, and specialist nurses. The BADAC Medical Clinic value cultural safety by providing an environment that is respectful to culture, and country by supporting the health and wellbeing of all community.

> *"Cultural safety represents creating an environment that is safe to culture and country, respectful, free from assault, racism and discrimination, no challenge of identity and experience, removing barriers with accessing health services, and supporting self-determination."* – Paul Kochskamper Medical Clinic Practice Manager. BADAC

## Grampians Health Ballarat – Aboriginal Liaison Officers

Grampians Health Ballarat has committed to providing the local community with a culturally safe space for services and specialised care due to the unique contribution of the Aboriginal Hospital Liaisons Officers (AHLO), bringing connections to community, culture, and spiritual knowledge, providing culturally appropriate healthcare, and influencing the health services within which they work. AHLOs assist in improving communication between patients and clinicians, ensuring continuity of care and strong partnership between BADAC and Grampians Health Ballarat and attribute success to recognising and addressing local needs, including social determinants of health.

> *" AHLOs perform a variety of roles in patient care important in improving the cultural competence of healthcare workers to increase trust with First Nation patients and families. Providing cultural safety and appropriate advocacy, education and support for patients and families, reduces discharge against medical advice and can act as an intermediary between patients and other healthcare staff." - Emma Leehane, Aboriginal Team Leader, Aboriginal Health, Grampians Health Ballarat.*

## Smiles for Miles

BADAC's Perridak Burron Early Learning and Kindergarten program has had a huge success and achievement in the Smiles 4 Miles an initiative of Dental Health Services Victoria (DHSV) which aims to improve the oral health of children and their families in high-risk areas across Victoria. An achievement of fulfilling the requirements to be certified as a Smiles 4 Miles Centre, educating, and communicating three key messages for families: Drink Well, Eat Well, and Clean Well and as a result, Perridak Burron was chosen in a case study focus by the Healthy Eating Advisory Service and Dental Health Service's Victoria to take part in a case study. This
achievement is a great example of BADACs approach to supporting good health and wellbeing focus on health promotion and educational programs in a culturally appropriate setting.

> *"Feedback received from families that some of the key messages being taught to our children at Perridak Burron, are helping to form conversations at home. So, we know that we are doing something right."* Sophie Collins, Perridak Burron Manager, BADAC.

## Active Ageing and Healthy Lifestyle

BADAC Medical is partnering with the City of Ballarat and The Ballarat Aquatic Centre (YMCA) in a pilot program referring Elders and community members that use our Exercise Physiologist to gain a free 3-month YMCA membership with access to the centre's pool and gym. This is a fantastic initiative, empowering our community for healthy outcomes. Lena Vanderboom, the City of Ballarat Aboriginal Community Liaison Officer, is new to this role and is currently engaging with BADAC to support the Active Ageing and Healthy Lifestyle Pilot Program. The partnership between BADAC and the Ballarat City Council has grown stronger over the years, highlighted by past events such as the NAIDOC Football Netball Carnival' held in October 2017, Mars Stadium, Ballarat, a great example.

*"Current engagement with BADAC and the Ballarat Aquatic Centre to support the Active Ageing and Healthy Lifestyle Pilot Program will ensure health outcomes for First Nations Peoples are value heard and activated."* Lenka Vanderboom, Aboriginal Liaison Officer, City of Ballarat

## Climate and Health

BADAC partnered with Central Highlands Water's (CHW) for a two-year Community Water Bottle Partnership program a great initiative aimed at promoting the sales of CHW reusable sustainable stainless-steel water bottles, with 100% of all proceeds raised to be donated to support BADAC programs. The reusable water bottle message aligns with BADAC's healthy Country and healthy community vision. Through sales at the local Begonia Festival and the lead-up to this event a total of $14,795 was raised and presented to BADAC's Children & Youth Services to implement funding for family camps for the Community including partnering with other ACCOs in the Grampians to join later this year. BADAC's Cultural & Therapeutic Support programs manager, Shu Brown, recently joined the Central Highlands Water (CHW) Board as Independent Aboriginal Delegate.

*"Shu Brown's input will enhance the Reconciliation work of CHW across the region, by strengthening our understanding of First Nations peoples' strong spiritual connection to water in Aboriginal culture and identity, and the longstanding commitment to care for and protect water resources."* Central Highlands Water, Ballarat.

## Grampians Breast Screen Program

The partnerships through Grampians Health Ballarat and BreastScreen Victoria provided support to local community members to access safe and culturally appropriate services through the Grampians BreastScreen program. In 2022, Aboriginal women in the Grampians region had higher uptake of BreastScreen services (53.3%) compared to the participation of all eligible people in the region (50.5%) from July 2019 to June 2021. Achieved through strong relationships and collaboration between our Aboriginal Hospital Liaison Officers and BADAC and facilitated by Sandy Anderson. Group bookings for BADAC's BreastScreen Bus were arranged every month, providing easy access to a culturally sensitive, safe, and positive clinical environment. In 2020, Sandy Anderson received an Order of Australia in the Queen's Birthday Honors due to outstanding efforts at BADAC.

*"We've had feedback that clients feel 'cloaked in culture' and safe when having their BreastScreen done in one of the First Nation design gowns, and for us that makes all the difference."* Sandy Anderson OAM, Well Women's Nurse (retired), BADAC

## Social and Emotional Wellbeing

The Social and Emotional Wellbeing (SEWB) Service is a Primary mental health and drug and alcohol service that specialises in Aboriginal and Torres Strait Islander social and emotional wellbeing. 'The Balit Durn Durn Social & Emotional Wellbeing Wheel' represents a holistic approach to key cultural factors that support good mental health and how they work within the historical, political, and social determinants of health. SEWB services offer a range of specialist services designed to deliver programs in a holistic, and culturally appropriate manner. SEWB services have a diverse range of staff with specialist skills and work in a culturally competent way to ensure care is inclusive of individual, family, and community needs. A new initiative within the SEWB service is the Culture Care Connect Community- Controlled Suicide Prevention Network Program, which acknowledges the devastating and disproportionate impact of suicide and poor mental health on our wider communities. This program is an important step in working towards a significant and sustained reduction in suicide of Aboriginal and Torres Strait Islander people within the region.

*"Connecting community to culturally appropriate care and support is essential to building trust, strength and resilience creating a stronger community."* April Burgoyne, Network Coordinator, Cultural Care Connect, BADAC.

## Community Unity Immunity Campaign

BADAC's hands-on position in the COVID-19 pandemic helped position Ballarat's Aboriginal Community with one of the highest vaccination rates across the state due to the efforts of the BADAC Medical Clinic, Nurses, Doctors, and Aboriginal Health Workers, this is a testament to the efforts of BADAC's Medical staff and close working relationship with the Victorian
Government and the Victorian Aboriginal Community Controlled Health Organisation (VACCHO). Health promotional activities included the efforts of BADAC Staff and Community in creating a Rap to encourage local community members to get their COVID-19 vaccination.
BADAC's CEO Karen Heap was appointed a Member of the Order of Australia in the King's Birthday honours due to the amazing efforts leading BADAC in the COVID-19 response to the 'Community Unity Immunity' Campaign.

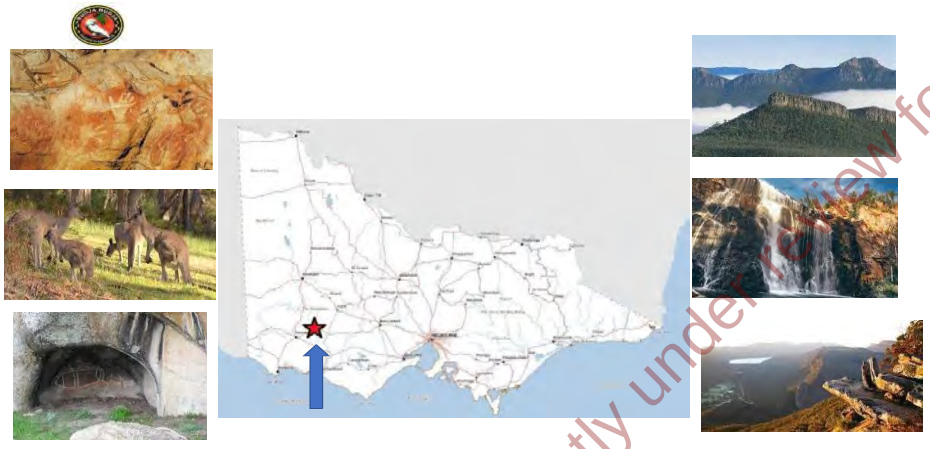
*"The principle of self-determination and community control is the way forward for the community to close the gap in areas such as health, social-emotional wellbeing, education, justice, and housing for Aboriginal and Torres Strait Islander people."* Karen Heap, CEO, BADAC.

## Future Planning and Vision

The Ballarat and District Aboriginal Co-operative are continuing to strengthen and develop strategies to ensure a culturally holistic community care approach is preserved. We are currently developing an Elders Supported Living Village to enable elders to live in a culturally appropriate environment as a small community together. BADAC Medical Clinic expansion will enable us to offer our community more doctors, nurses, mental health, and specialist services and reduce waitlist retaining our valued medical professionals. We are also in the middle of establishing a Long Day Care/Kinder in Ballan for the broader community to start educating all community on Aboriginal and Torres Strait Islander cultural values. Ensuring that the delivery of programs to the community is enshrined in a culturally appropriate delivery central to the self-determination of BADAC's planning, future, and vision.

## BUDJA BUDJA ABORIGINAL COOPERATIVE LTD (BBAC) JULY 2023

### 1 INTRODUCTION & HISTORY



Budja Budja Aboriginal Cooperative Ltd was established by the current CEO and Elder in July 1999 due to an identified gap in the provision of health and medical and other support services to the Aboriginal Community across both Ararat Rural City and Northern Grampians Shire.

It was initially established in an 80-year-old holiday house in Halls Gap which was just adequate to provide the funded government Aboriginal services at that time. Like most ACCHOs at that time, BBAC was initially established as a Community Meeting Place. It had only a one day a week GP service.

Due to increasing recognition by governments of the dire health of many in Aboriginal communities funding increased over time which enabled ACCHOs to transform into providing a broader range of health and medical and support services, including a five day a week GP service along with some other support services. However, much more still needs to be achieved, particularly in Closing the Aboriginal Health Gap.

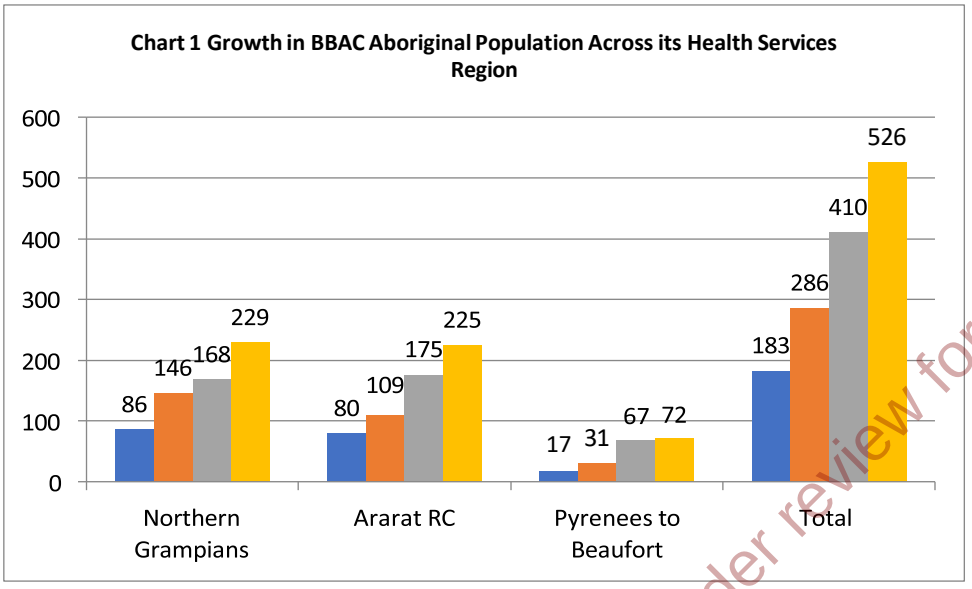
### 2 CURRENT SITUATION

Today, BBAC's Health Service Region mainly encompasses Ararat Rural City and Northern Grampians Shire. At times, Aboriginal residents from Pyrenees Shire west to Beaufort and south in Southern Grampians Shire may also attend our clinic due to their distance from alternate health services.

From a recent analysis of our Aboriginal patients' data, it has been found that 45% reside in Ararat and surrounds, 45% reside in Stawell and surrounds and the remainder in the Halls Gap area.

Also, from the ABS 2021 Census data BBAC now services 67% of the total Aboriginal population across this region, well above the Victorian ACCHO average.

The chart below indicates the recent growth in the Aboriginal Community population between the ABS 2006 and 2021 Censuses, with growth of 187%.

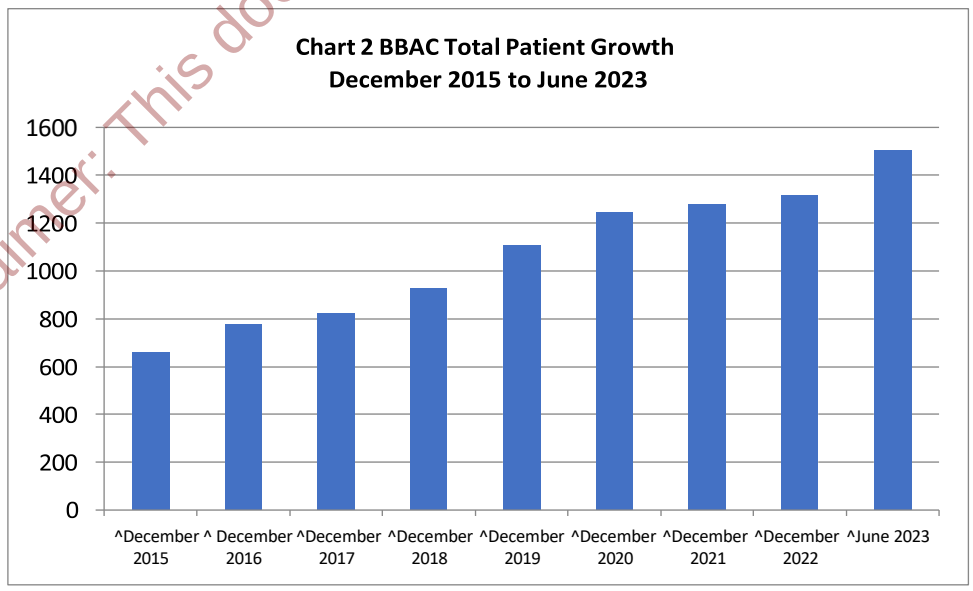



**Source ABS 2006 to 2021 Censuses**

Over the five-year period ended June 2023, BBAC's Aboriginal patients' growth was 129.3%, and 209.9% since July 2015.

Given BBAC's unique situation as being the only primary health service in Halls Gap and also serving some residents from Ararat and Stawell, there has been significant growth in overall patient numbers since 2015, as shown in Chart 1.

At the end of June 2023, the total number of patients serviced by BBAC is 1,505.



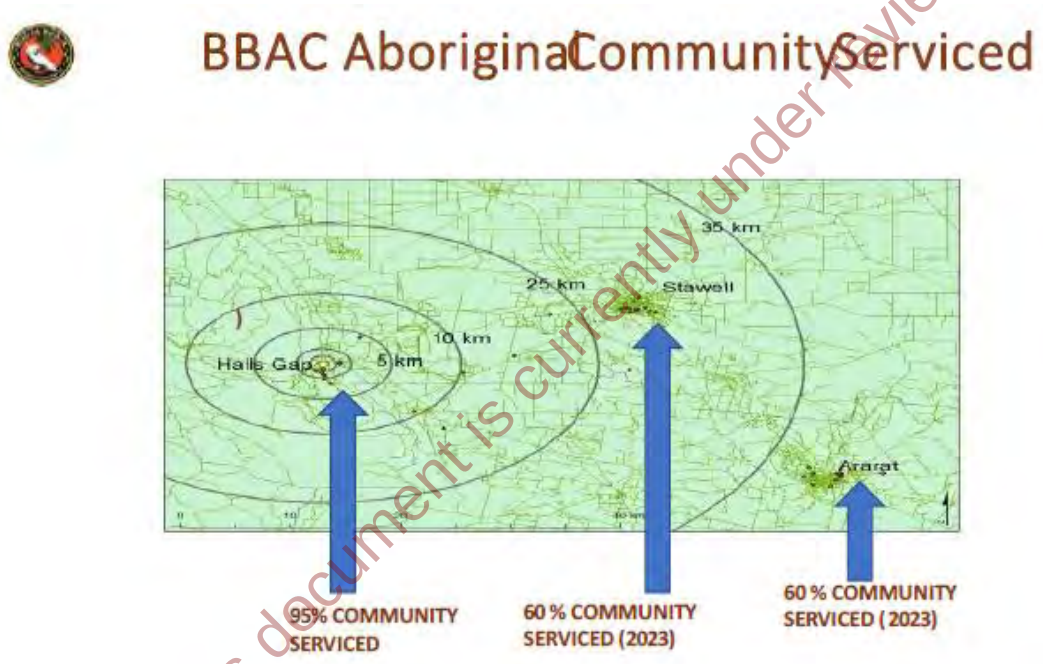
The growth in total patients was 128.7% over this period.

BBAC therefore has a wider role in not only servicing the Aboriginal Community, but also the wider population across the two LGAs, as well as the over 1.3 million annual visitors to Gariwerd National Park.

As previously indicated, BBAC is the only primary health service provider in Halls Gap and surrounds and due to its catchment area for patients, undoubtedly has a very important role in improving general population health outcomes. This includes alleviating some of the presentations to the two urgent care centres at Ararat and Stawell hospitals as well as other mainstream services.

That being said, BBAC always provides priority to servicing the needs of our Aboriginal Community, and as government funding programs require.

According to our medical records and the ABS 2021 Census for the Aboriginal population, the calculated penetration of this population by BBAC's services is indicated below.






## 3 HEALTH PROFILE OF OUR ABORIGINAL PATIENTS

### 3.1 COMPREHENSIVE HEALTH DATA SOURCES

BBAC has extensive information on all Aboriginal patients on our Medical Director electronic patient system, which encompasses results from every physical and mental health service provided by our employees.

The embedded data analysis software incorporated in this system, *Pencat* as well as *Patcat*, is frequently utilised to interrogate this data and identify overall Community needs, as well as individual patients with particular health for priority assessment and service provision.

BBAC is also able to analyse the prevalence of health and medical conditions in our Community relative to the national and Victorian situation and our comparative medical performance and outcomes from the monthly data downloads from Medical Director and report by VACCHO and the half yearly data download by the Department of Health and Aged Care.

### 3.2 THE HEALTH PRIORITIES FOR OUR COMMUNITY

BBAC maintains the strong view that not all Aboriginal people or Communities across Victoria and nationally face the same health issues and priorities and believes that more individual ACCHO self-determination in funding allocations and actual service delivery should apply.

Given this, the priorities that BBAC identifies in its Aboriginal patients are as follows:

#### 3.2.1 Co-morbidities

The definition and identification of co-morbidities in Medical Director relates to an Aboriginal patient that has one or more of the following – diabetes, respiratory, cardiovascular, renal impairment and/or mental health.

In June 2023 BBAC data indicates that 54.6% of our Aboriginal patients has one of these issues, 22.7% have two, 11.3% have three, 8.3% have four and 3.1% have more than four co-morbidities.

However, if a more detailed analysis is undertaken of any Aboriginal patients experiencing any chronic condition of 6 months or more, then this indicates that 85.8% have at least one identified chronic condition and 38.9% have two or more chronic conditions.

The take-out from this is that BBAC, and all ACCHOs in general, are dealing with Aboriginal patients with complex physical and mental issues.

The most prevalent diagnosed health conditions, which are also all above the Victorian average for the Aboriginal patients, according to the VACCHO data for June 2023 are:

Asthma, Type two diabetes, hypertension, osteoarthritis, renal failure and chronic kidney disease. Both ADHD and hyperlipidaemia are also significant, but in line with the Victorian average prevalence rate.

#### 3.2.2 Mental Health Issues

Of BBAC's Aboriginal patients with a Mental Health Care Plan, 54.4% have a mental health diagnosis. Most associated with anxiety and depression.

BBAC's psychologist reports that client presentations predominately involve trauma relating to family violence, childhood abuse and relationship issues, as well as anxiety and depression.

In general, identified mental health issues in Aboriginal people also relate to racism, intergenerational stress, including Stolen Generation and lateral violence.

BBAC's new SEWB Centre to open in July 2023 with an expanded professional team will focus on providing Social and Emotional Wellbeing, Alcohol and other Drugs (AOD) and mental health services, all of which are interrelated.

With SEWB, the emphasis will be on cultural and family reconnection and connection also to a broader range of traditional and other healing integrated with our GP clinic staff.

### 3.3 OVERALL FOCUS

There can be little doubt that many of BBAC's Aboriginal patients have long tern health conditions, which involve significant time, resources and cost in servicing. Due to this, the overall focus of BBAC is on continuing to provide a holistic, team and evidence-based service and culturally safe service, incorporating listening, consulting and obtaining feedback from our community in terms of their needs.

Related to the above, BBAC has a service dedication involving **innovation and partnerships** in assisting to improve health outcomes. Examples are provided below.

In terms of innovations over the past 5 years, BBAC has:

- Extended our clinic at Halls Gap to now provide a more contemporary clinic layout, which has significantly improved patient privacy and confidentiality and allowed for expansion of services and staff, in line with identified need. It provides a totally culturally safe facility and patient use of our services and satisfaction levels have increased significantly.

- Feedback from our patients identified that a barrier to accessing our services at Halls Gap was associated with both travel cost and time, especially from Ararat and Stawell. BBAC also identified a significant loss in staff productivity and increased cost associated with providing transport services. Following a study, BBAC, through a partnership arrangement with Deakin Rural Health, National Indigenous Australians Authority and the Victorian Department of Health, purchased a purpose designed and built mobile clinic van. This was only the second such facility operated by ACCHOs in Victoria at that time. This service is used to deliver GP, psychology, optometry, audiology, COVID-19 vaccinations and many other services. An evaluation of this service by Deakin Rural Health confirms that more (and many new) Aboriginal patients are accessing services and it has a high level of community support. Concomitant with that is an improvement in patient outcomes.

- BBAC has received capital funding from the Victorian government to construct a dedicated SEWB Centre at Halls Gap, which will open in July 2023. BBAC's focus on this relates to the findings and recommendations of the Victorian Government Royal Commission into Mental Health, and in particular its own internal findings relating to Aboriginal patient mental health. Feedback from our Aboriginal patients indicated that they prefer to access SEWB and mental health services in a separate centre to ensure privacy and confidentiality. The centre provides for individual, family and group consultations as well as mental health promotion and education sessions. The identified prevalence of patients with mental health issues and requiring SEWB services and support was also a significant driving factor. The centre is due to open in July 2023, with five to six professional and well experienced staff.

- BBAC is to commence operating a new satellite health and medical clinic in Ararat in September 2023. This initiative resulted from an analysis of our patient database (outlined earlier) which indicated that 45% of our existing Aboriginal patients resided in and around Ararat. It is also designed to increase staff productivity and patient outcomes by delivering services closer to where they reside and reducing BBAC's costs associated with transporting of patients to Halls Gap. The location of the clinic opposite the Ararat Hospital and Community Health Centre is also expected to provide opportunities for better integration with mainstream services, including by visiting medical specialists, dental, pathology, radiology etc. The opening of this clinic will also provide more capacity to service patients from Halls Gap and Stawell at the existing Halls Gap clinic which is currently operating at full capacity.

- In September 2023, at Halls Gap, BBAC is to provide an accommodation facility with three individual suites for students on clinical placement at BBAC. This will have many advantages with having students on placements for longer periods, where now we share them with mainstream services. It will also introduce students to the workings and many advantages associated with ACCHOs and potential career path. According to VACCHO data, there are currently about 3,500 staff employed across the 30 Victorian ACCHOs,

- BBAC has always valued and worked with mainstream partners in improving health outcomes of our Community. This is particularly relevant for our organisation which is rural/remote and classified as being in a MMM-5 location, meaning community being significantly disadvantaged in

term of access to health and medical services. BBAC is one of only 5 of the 26 Victorian ACCHOs which have been assigned this classification. This disadvantage also extends to areas such as attracting and retaining staff and in these members finding suitable rental or a house to purchase. It has been calculated that the cost disadvantage to a MMM-5 located clinic is four times the cost relative to a MMM-1 to MMM- 3 classified health facility with far better access to all mainstream services. Many of our patients requiring specialist medical services are currently transported to Ballarat or Melbourne.

- Our mainstream partnerships encompass a broad range of institutions which include universities, particularly Deakin Rural Health, which has provided support in a number of areas including financial contribution to the mobile clinic, access to qualified staff to provide services at Halls Gap and in developing frameworks for service evaluation for our mobile clinic and telehealth for our Aboriginal patients. The results of these have been reported in medical journals for wider distribution and use by other organisations.

- In term of recent public health initiatives, BBAC has recently signed a number of funding agreements with VACCHO, NACCHO and Victorian Department of Health covering breast screening, BBV/STI, HPV, bowel cancer screening and continuing COVID-19 vaccinations for our Aboriginal Community. These are in addition to the usual health screening undertaken by BBAC. However, many of these funds are only available for one to two years.

**3.4 CONTINUING CHALLENGES**

While the above innovations have resulted in more Aboriginal Community members accessing services at BBAC and assisting in improving physical and mental health outcomes, there are still many challenges, including:

- Ensuring that fundholders recognise the increased costs associated with smaller rural and regional located ACCHOs in serving their communities.
- Ensuring that fundholders also recognise that the smaller rural and regional ACCHOs combined service the needs of 45% of total Victorian Aboriginal people (around, 17,000 persons in total) living in rural areas and outside of the major regional cities.
- Ensuring that this cohort are provided with or able to access required health and medical services in line with Health Equity objective.
- Ensuring that BBAC itself is provided with funds to expand its vitally required services to its Aboriginal Community., BBAC is currently not provided with direct government program funding for family violence, homeless people, justice and corrections, family and child support, age care, disability services and others. Funding is required if BBAC is to truly meet the holistic needs of our Community.
- Ensuring that more existing mainstream Aboriginal health program funding be redirected to ACCHOs.


**Goolum Goolum Aboriginal Co-operative**

***Goolum Goolum… More than just a health service. We strive to provide a holistic model that supports the physical, social, emotional, cultural, and spiritual needs of our people.***

Goolum Goolum Aboriginal Co-operative celebrates 40 years' service to the community in 2023. Commonly referred to as an ACCO which means an **Aboriginal Community Controlled Organisation**. Goolum was incorporated in 1983, the organisation has grown significantly and as we look forward, we acknowledge the past. Our Traditional Owners include the Wotjobaluk, Jaadwa, Jadawadjali, Jupagulk and Wergaia people. We pay respect to our forebears who had the courage to advocate for services specifically for Aboriginal and Torres Strait Islander people. Our work today and into the future honours those who have gone before us and who started us on this journey.

Today we operate across 5 LGAs with sites in Horsham and Stawell. Our services include a complex range of integrated programs designed to care for our people from birthing to dreaming which is distinctively an Aboriginal model of care. From Primary and Allied Health, Maternal and Child Health Nurses (MCHN) to Adult and Youth Justice, Housing, Early years, Social and Emotional Well Being and a full range of Family Services incorporating Out of Home Care, Family Violence, Family Preservation and Reunification as well as emerging Therapeutic services models of practice.

Our future is exciting with major projects including:

- A new community Hub to be built in 2023-2024
- An Early Years centre scheduled for 2025-2026
- An Aboriginal Residential and Healing centre for those experiencing Family Violence scheduled for 2025-2026.

Our Strategic Plan for 2022-2026 is built on 4 key Pillars:

- Close The Gap
- Building our Future
- Focus on Families
- Strong Voices

Goolum Goolum partners with many organisations across the state and is a proud and active member of:

- The Aboriginal Health Forum
- The Aboriginal Children's Forum
- The Western Districts ACCO Collective (WDAC)
- Regional Aboriginal Justice Advisory Committee (RAJAC)
- VACCHO – Victorian Aboriginal Community Controlled Health Organisation
- NACCHO – National Aboriginal Community Controlled Health Organisation

All the above is evidence of a rich cultural underpinning of everything we do, it is about the strength of partnerships and always maintaining a strong Aboriginal Voice that advocates for better and more equitable outcomes for our people.

To achieve this, we must build partnerships with both Aboriginal and Mainstream services, across the Health Sector. Our challenge is to ensure we can be confident that whatever service any one of our people enters that they are welcomed and that they feel culturally acknowledged and safe in receiving that service. When we achieve this outcome, everyone benefits, and we will be one step closer to fulfilling our mutual obligations under the Commonwealth and State Closing the Gap commitments and initiatives.

Our challenges are many and we are under no illusion as to the road ahead. Some of our more prevalent challenges include:

- Funding equity for a population that is overrepresented in too many areas of disadvantage.
- Better communications between Health services and ACCOs particularly around intake and discharge of patients – again a resourcing issue that leaves ALO's and ACCOs to pick up many costs and responsibilities just because we are Aboriginal.
- The breadth of our services is hard to service with the costs of travel and supports for an ATSI population spread across 5 LGA's.
- We bear the expense of ensuring all our people get to appointments, many of which are in Melbourne or major regional cities that can be 200km-300km away requiring transport, accommodation, and meals, often for family groups, not just the individual receiving medical services.
- We are concerned that too many of our children are birthed off country.
- Aboriginal Workforce development is a key priority area for ACCOs in our region and we seek continued support for our young people to be given opportunities and supported pathways in to careers that give them the opportunity to care for their community.
- Maintaining equitable representation at decision making levels is important to achieving better outcomes and only with Strong Voices at the decision-making tables will we see improvement.
- We are still experiencing many gaps in access to health services with areas such as psychiatric and psychology services, dental and speech pathology for our children and families.

Despite some of these immediate challenges we continue to advocate at State and Commonwealth levels for appropriate resourcing and we continue to grow our services to meet the demands of our communities. Some of our recent successes have included funding for full-time MCHN services which is having an immediate and positive impact on our families, particularly supporting our young at-risk families. Receiving this small amount of funding has enabled a more complete integration of services. In 2022-2023 Goolum received, for the first-time funding for Aboriginal Social and Emotional Wellbeing (SEWB) services, enabling mental health supports to reflect Aboriginal ways of strengthening individuals and families. The National Strategic Framework for Aboriginal and Torres Strait Islander (ATSI) people's mental health and Social and Emotional Wellbeing 2017-2023 sets out nine guiding principles reflecting the holistic and whole of life definition of health held by ATSI peoples.

With a strong community, clear leadership from our Board and centuries of knowledge to draw on we know that ATSI models of health and wellbeing are in fact models of best practice and we encourage all of our partners to share in this knowledge and join us on the journey to a better future for all our people.

## 3.3 Community and expert decisions and priorities

Twenty-three interventions proposed by stakeholders and assessed to be feasible, measurable, and potentially scalable and sustainable were shared with stakeholders. Feedback was requested about stakeholders' readiness and capacity to implement each of the short-listed initiatives, as well as advice on enablers and barriers foresee in the implementation.

This process permitted stakeholder knowledge of the intervention environment, the assessment of organisational capabilities and understanding of the prevailing local prevention systems to inform the choices made. Responses from stakeholders are set out in *Appendix 5.2.*

Enablers to implementation included

- Alignment with existing programs,
- Existing expertise,
- Pre-existing partnerships.

Barriers to implementation included

- Resource capacity not available,
- Pre-determined funding guidelines that do not align with program design,
- Concerns about meeting funding reporting obligations,
- Non-alignment with existing programs.

Notwithstanding barriers and the varying levels of capacity, workforce and reporting obligations, stakeholders together identified at least one implementable intervention in each sub-region across each of the priority streams of *Healthy eating, Active living* and *Reducing harm from tobacco and e- cigarettes.* These interventions form the basis of the GRPHP strategy for 2023.

Information detailing these stakeholder-chosen interventions can be found in the following sections.

- *Figure 1* The Plan At A Glance in *Section 3.4*
- *Table 3* Plan of action in *Section 3.4*
- *Appendices 5.1* and *5.2* Priorities and voices of agencies, community and experts
- *Appendices 6.1* to *6.9* Rationale and detailed plan for each priority stream

## 3.4 GRPHP Interventions

### 3.4.1 The GRPHP at a glance

The lengthy inclusive iterative stakeholder engagement and deliberation process identified nine interventions which were determined feasible, measurable, potentially scalable and potentially sustainable in three health promotion and prevention streams (*Appendices 6.1-6.3*):

1. Healthy eating
2. Active living
3. Reducing harm from tobacco and e-cigarettes

In addition to the health promotion and prevention streams, four other priority areas were identified, through targeted stakeholder consultation (informed by data and known opportunities or service needs), as warranting action in the first year of the GRPHP (as set out in *Appendices 6.4 – 6.7*):

4. Promoting oral health and preventing oral disease1*
5. Sexual and reproductive health
6. Thriving children*
7. Tackling climate change and its impact on health

Two further priorities (further described in *Appendices 6.8 and 6.9*) were determined for which the prevention and population health approach provided by the GPHU and partners can *support* planned health service development by Western Victoria Primary Health Network (WPHN) and Grampians Health, together working with primary care and hospital teams across the Grampians regions. These priorities were (*Appendices 6.8-6.9*):

8. Systematising cardiac care
9. Regionalising early diagnosis and cancer care

Working with care delivery agencies in this way will illuminate the contribution that prevention can make to the value-based care paradigm, given that the most efficient strategy to meet care requirements is to prevent disease or the progression of disease and therefore reduce the need for health care or hospital care as much as possible. Because of their essential integration with care delivery, the priorities of oral health, sexual and reproductive health, cardiac care and cancer care are referred to as "end to end" (E2E) strategies in the GRPHP.

*Figure 1* shows priority streams and the interventions where identified by their location in any or all of the PPH Hubs. Timeframes for commencement of work on the GRPHP priorities identified are set out in *Figure 4* in *Section 5* of the GRPHP: *Our region - ready for opportunities and risks.*



[1] This was the result of targeted consultation in Edenhope where routine access to clinical dental services was made possible following the amalgamation of Edenhope and District Memorial Hospital into Grampians Health

*These commenced as priority streams of work 2022-2023 approved by the Department of Health

### 3.4.2 Stakeholder-identified interventions

*Table 3.2* sets out in more detail the nine stakeholder-identified interventions relating to healthy eating, active living and reducing harm from tobacco and e-cigarettes across Wimmera Southern Mallee, Grampians Pyrenees Goldfields and Central Highlands PPH team localities. Possible targets and outcomes may change as interventions commence implementation planning with stakeholder partners commencing in July 2023.

Specific interventions for the remaining priority streams of work will be further developed through targeted consultation in the first year of the GRPHP.

*Appendices 6.1-6.9* contain specific rationale, relevant literature and additional pertinent information including more detail of process, impact and outcome measures for each of the nine priority streams being led, coordinated or supported by the GPHU, and their initial interventions.



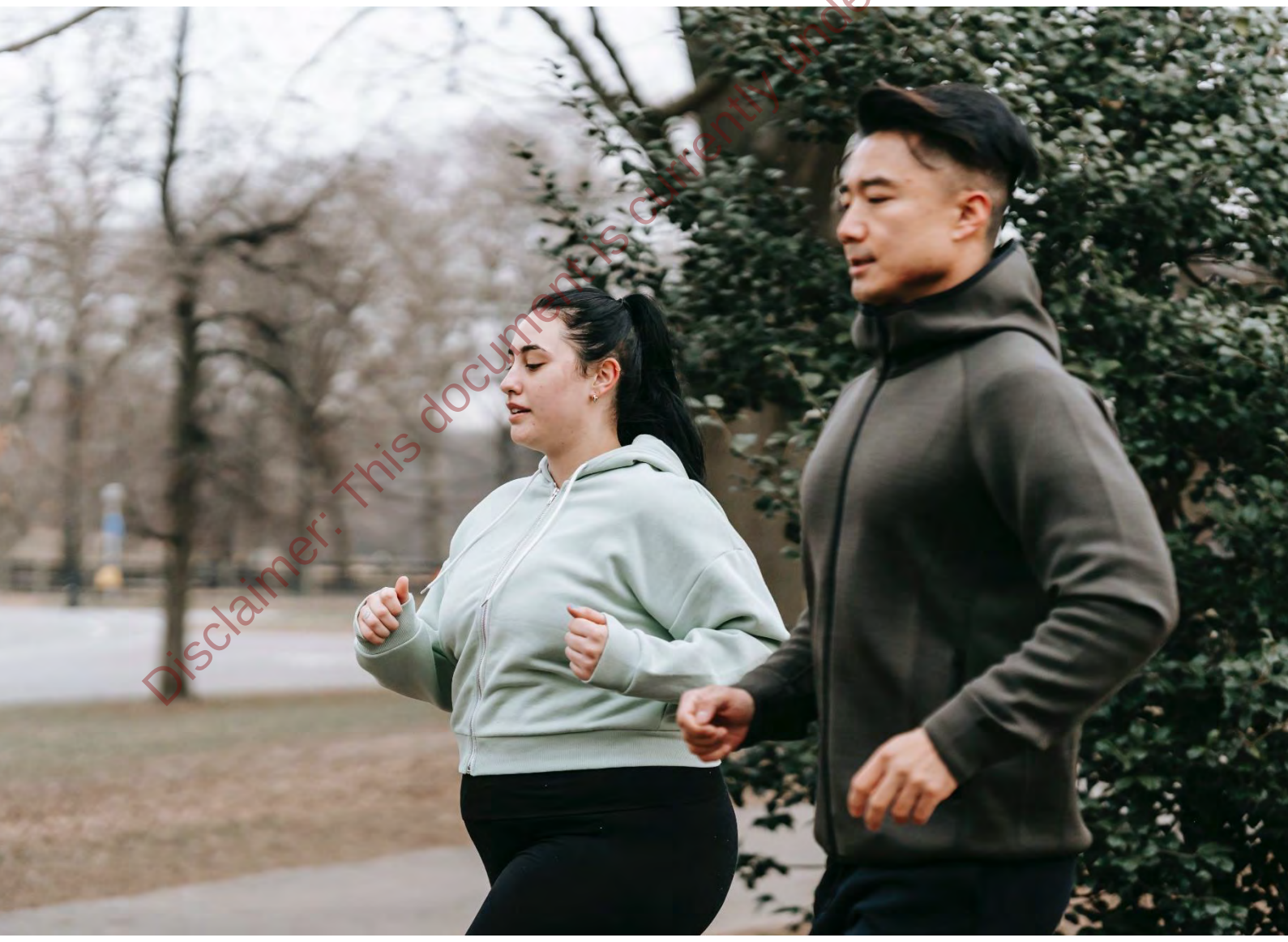
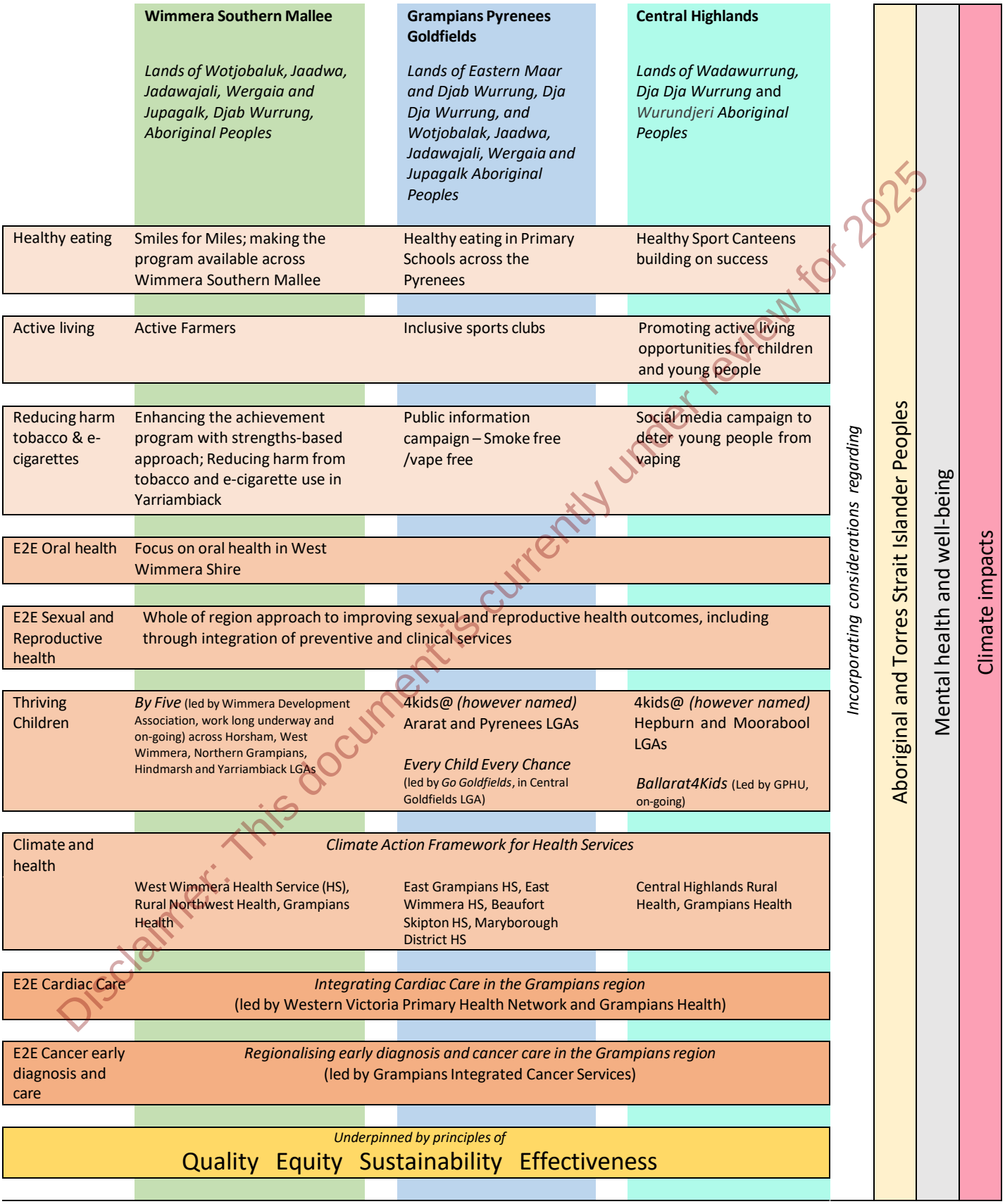


***Figure 1 The Plan at a Glance**: Grampians Region Population Health Plan priority streams, implementation location, underpinning principles and incorporated considerations*






E2E = end to end prevention and primary care teams integrating with secondary and tertiary teams using value-based healthcare approach

*Table 3.2 GRPHP Community stakeholder selected priority interventions: description, location, target population, goals, targets and stakeholders, 2023*

| Stream | Intervention | Description | Location | Target population | System goal (aim) | Target outcomes may include | Potential stakeholders and lead organisations | Resources required | Is it an adaptation of existing program? |
|---|---|---|---|---|---|---|---|---|---|
| *Healthy eating* | **Healthy Sport Canteens – building on success** | Scale-up of local successful sports & recreation venue canteens that are promoting and providing healthy food & drink options | **Central Highlands:** Ballarat, Hepburn Shire, Moorabool Shire | Community using local sport & recreation venues in the region, especially young people (5-18 years) and their families | More sports & recreation settings across the region provide access to and promote healthy food & drinks | **Outcome measures**<br>2 years<br>• At least one sport & recreation setting in the area* has achieved a "big bite" (Vic Kids Eat Well) or meets the Healthy Choices guidelines<br><br>5 years<br>• Five venues have increased access to and promote healthier food and drinks<br>• At least 20% increase in sales of healthier foods and/or drinks | – Sports Clubs & Associations<br>– Local Governments<br>– Community Health-Health Promotion (CH-HP) funded Health Promotion workforce<br>Other stakeholders<br>– Local youth - groups, clubs, schools<br>– Education networks<br>– Local media<br>– Peak bodies<br>– Local sporting celebrities<br>– Local sports networks<br>– Sport & Recreation Vic | • Existing health promotion staff/teams in Local Government and Community Health<br>• Communications resources<br>• Local network/working group backbone support<br>• University students to support campaign development | Yes.<br><br>Aligns with,<br>– Healthy Choices Guidelines for Sport & Recreation facilities<br>– Vic Kids Eat Well Program<br>– VicHealth programs<br>– Victorian Local Government Partnership<br>– All Central Highlands Local Governments & CH- HP funded agencies have work aligned to this |
| | **Healthy Eating in Primary Schools across the Pyrenees** | Develop a supported model to implement healthy eating, education and access to healthy options into Pyrenees Primary Schools | **Grampians Pyrenees Goldfields:** Pyrenees Shire | Primary Schools (up to 9 schools) | Collaborative effort offering support and simple ideas to boost healthy and delicious food and drink options in Primary Schools | **Impact measure**<br>Dependent on the concept model adopted but may include<br>• 90% increase in primary school children enjoying the increase serve of fruit and vegetable intake each week from targeted schools.<br>12 months<br>• 30% of Pyrenees Primary Schools registered and implementing a formal program: Vic Kids Eat Well/ Achievement Program<br>**Outcome measure**<br>2 Years<br>• 10% increase in children eating recommended fruit serves daily | – CH-HP funded Health Promotion workforce<br>– Primary Schools<br>– Health Services<br>– Council Youth Officer<br>– Stephanie Alexander Kitchen Garden Foundation Healthy Kids Advisor<br>– Community<br>– Volunteers | • Backbone support to develop a collaborative model<br>• Local existing health promotion staff/teams<br>• Council support through Youth Officer<br>• Community Health Organisations<br>• School staff<br>• Resources from Stephanie Alexander Kitchen Garden Foundation Healthy Kids Advisor | Yes.<br><br>Aligns with,<br>– Vic Kids Eat Well Program<br>– Achievement Program<br>– Grampians Pyrenees Prevention Network CH-HP Shared Action Plan |

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| | **Smiles 4 Miles Program** | Expansion of the existing Smiles for Miles program to be available to all Wimmera Southern Mallee Local Government Area communities | **Wimmera Southern Mallee:** Horsham, Yarriambiack, West Wimmera, Hindmarsh Shires | Early Childhood Services | Improve the oral health and healthy eating of children and their families in the early years setting | **Impact measures**<br>• Year- on-year increase in the first occasion of service for children - sustained over 10 years<br>• Year-on-year increase in the proportion of children attending for first occasion of service from lower Socio-Economic Status quintiles (using proxy markers to correlate lower Socio-Economic Status than community average)<br><u>3 years</u><br>– 80% uptake by WSM Kindergartens<br><u>2028</u><br>– All participating centres conduct annual dental screenings<br>**Outcome measure**<br><u>10 years</u><br>– Decrease in dental caries in early years population and at 12 years | – GPHU PPH<br>– LGA teams<br>– DHSV<br>– Early childhood centres and Kindergartens<br>– RFDS<br>– Private sector dental groups/dental associations<br>– Health services RNH, WWHS, GH, Goolum Goolum, Woomelang BNC, Harrow BNC<br>– University partner evaluators | • Work under current program delivery capacity, noting as delivery of program increases key stakeholder assistance/support will need to be reviewed to meet increased workload. | Yes.<br>– Current Smiles for Miles program |
| *Active living* | **Promoting active living opportunities for children & young people** | Broad cross-promotion of activities, events, settings, resources and opportunities for sport & active recreation for young people to increase awareness of and uptake of opportunities available | **Central Highlands:** Ballarat, Hepburn Shire, Moorabool Shire | Parents of children, and young people | Increase in awareness of and access to active living options and opportunities for children & young people | **Impact measure**<br><u>5 years</u><br>• 20% increase in awareness of active living options and opportunities for children & young people<br>• At least 5 sport or active recreation clubs, facilities or outdoor spaces have improved access for young people<br>**Outcome measures**<br><u>10 years</u><br>• 10% increase in proportion of children 5–12 yrs who are sufficiently physically active | – Local Government<br>– Sport & Recreation Vic<br>– Parks Victoria<br>– Regional Sports Assembly (Sports Central)<br>– Tertiary Institutions<br>– Local youth – groups, clubs, schools<br>– Sports Clubs & Associations<br>– Local Service Clubs<br>– Women's Health Grampians<br>– Child & Family Services<br>– Education settings & networks<br>– Peak Bodies | • Health Promotion staff<br>• Sports & Rec and other associated disciplines staff resourcing to develop content<br>• Comms & tech resources | Yes.<br>Aligns with,<br>– GetActive Victoria has an existing interactive map<br>– City of Ballarat has 'Active Ballarat' webpage<br>– Get Active Victoria<br>– Central Highlands Local Government Areas Municipal Public Health and Wellbeing plan priorities |

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| | **Working with sports clubs to become more inclusive** | Increasing participation of all genders in sports clubs through Women's Health Grampians Communities of Respect & Equality (CORE) program | **Grampians Pyrenees Goldfields:** Ararat Rural City, Northern Grampians Shire, Pyrenees Shire | Sports clubs<br><br>Women, girls and people who identify as non- binary | Increase in the number of sport clubs that are inclusive of women, girls and people who are non-binary | **Impact measure**<br><u>Program specific</u><br>• 10% increase year- on-year of sporting clubs in the target LGA participating in Act at Play program<br><br><u>Wider community effect</u><br><u>12 months</u><br>• One sports club in each LGA works with partners including Women's Health Grampians to promote inclusion<br><br><u>2 years</u><br>• 10% increase in female club membership in participating clubs | – Women's Health Grampians<br>– Sport clubs<br>– Local government<br>– Health promotion practitioners<br>– Sports Assemblies | • Time and resources of Women's Health Grampians<br>• Media & promotion resources<br>• Time and commitment from participating sports clubs<br>• Funding for any resources/ modifications the club requires | Yes.<br><br>Informed by<br>– Women's Health Grampians CoRE Alliance work with AFL Goldfields, Basketball Ballarat, Minyip Murtoa Football Netball Club and Horsham Basketball |
| | **Active Farmers Program Wimmera Southern Mallee (Yarriambiack)** | Expansion of Active Farmers Group Fitness Classes in Wimmera Southern Mallee. (Active Farmers is a Not-for-profit organisation to "build stronger and more resilient farming communities" | **Wimmera Southern Mallee:** Hindmarsh, Warracknabeal, Yarriambiack | Farmers & Farming communities | <u>To increase</u><br>Physical activity, social connection, knowledge and education on services locally available, education on Healthy eating<br><br><u>To improve</u><br>Health and wellbeing, mental health for local farm families | **Outcome**<br>A needs assessment is performed for each targeted (specific) community and the intervention is shaped to address the highest order need identified by the group<br><br><u>2 years</u><br>• Self-reported health status of participants improvement on pre and post surveys.<br><br>**Outcome measures**<br><u>3 years</u><br>• 10% increase in physical activity levels in program participants in each of the target communities | – Farm families<br>– Local support agencies<br>– Online community | • Can operate under current resources with current program reach but will require support from key stakeholders to expand the reach of the program across Wimmera Southern Mallee | Yes.<br><br>– Expand Pre-existing program based in Warracknabeal into Southern Mallee Farming communities in Yarriambiack and Hindmarsh shires |

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| *Reducing Harm from tobacco and e-cigarettes* | **Social media campaign to deter young people from vaping** | Localised health promotion campaign using social media to deter people from vaping, help them to say no and understand where to seek support | **Central Highlands:** Ballarat, Hepburn Shire, Moorabool Shire | Young people most vulnerable to peer pressure to take up vaping (age range to be determined on further consultation, ~ 12-18 yrs.) | Increased awareness of young people of how to reduce the harm of e-cigarettes to themselves and those around them | **Impact measures**<br>1-2 years<br>• Increase in % young people (12-17 years) who have acted to reduce harm from e- cigarettes to themselves or others<br>**Outcome measures**<br>2-5 years<br>• Slowing increase or plateau in proportion of adolescents who vape<br>10 years<br>10% decrease in proportion of adolescents 12–17 years who smoke or report ever used e-cigarettes | – CH-HP funded Health Promotion workforce<br><br>Other stakeholders<br>– Local Government<br>– QUIT Victoria, VicHealth, Cancer Council Victoria<br>– QUIT Tobacco- related harm Community of Practice<br>– Local schools<br>– Local media & film industry | • Local schools and youth councils<br>• Local Government led Youth programming<br>• CH-HP Health Promotion staff<br>• Comms & tech resources | Yes.<br><br>Aligns with,<br>– Current work from QUIT soon to be released includes a tool kit for parents and a state-wide campaign around vaping<br>– Victorian Local Government Partnership Program |
| | **Public Information Campaign - Smoke-free & Vape-free areas** | Media/social media campaign to inform the public about the restrictions on smoking & vaping around schools, playgrounds, hospitals, outdoor pools and government buildings in the Grampians Pyrenees region | **Grampians Pyrenees Goldfields:** Ararat Rural City, Northern Grampians Shire, Pyrenees Shire | Smokers & e-cigarette users and the general public | Increase public awareness and compliance with the Victorian Tobacco Act 1987<br><br>To protect members of the community from exposure to second-hand tobacco smoke and aerosol<br><br>To de-normalise smoking and e-cigarette use in the community | **Outcome measures**<br>Program specific<br>12 months<br>• 50% of LGAs have access to materials (campaign materials, brochures, posters, signage) and its guidance to actively advocate for compliance with the Act<br>2 years<br>• All LGAs participate in the campaign, including, local advocacy, information sessions, provision of advice to retailers, local businesses and government authorities working in the LGA of<br>i) the risks of vaping,<br>ii) the current inadequacy of legislation to control the health risk and<br>the laws necessary to protect all the community from exposure to second-hand e-cigarette smoke | – LGA Environmental Health Officer or Youth Officer<br>– Health promotion practitioners<br>– Health Services<br>– Schools<br>– Council owned recreational facilities<br>– Council asset management & maintenance<br>– Police and Magistrate Courts<br>– Hotels & Bars<br>– Public Transport<br>– Media<br>– QUIT Victoria<br>– Cancer Council | • Time commitment to meet regularly and develop ideas<br>• Funding for campaign material/promotion<br>• Funding for signage | Yes.<br><br>Aligns with,<br>City of Melbourne Breathe Easy Work which is being replicated in Gippsland |

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|---|---|---|---|---|---|---|---|---|---|
| | **Enhancing the Achievement Program to reduce harm from tobacco & E-cigarettes in Yarriambiack LGA** | Adapting the Achievement Program for smoking action across schools, early childhood services, and workplaces | **Wimmera Southern Mallee:** Yarriambiack | School students, early childhood service users, workplace employees & hospital employees | <u>Reducing</u> Harm from Tobacco & E-cigarette use<br><br><u>Reduced</u> smoking rates<br><br><u>Improved</u> health and wellbeing<br><br><u>Increased</u> knowledge and skills related to smoking prevention and cessation | **Outcome measures**<br><u>Program specific</u><br>• Year-on-year increase in the number of organisations (includes everything – schools, services, clubs and workplaces – for 4 years<br>• 20% increase in the proportion of participants 'strongly against' smoking and vaping<br>• 50% increase in participants identifying the severe health risks from vaping<br>• 100% in participants knowledge of inadequacy of legislation protecting people from the hazards of vaping<br><br><u>Community wide aspirational 5 years</u><br>• 10% Reduction smoking rates in Yarriambiack Shire<br><br><u>10 years</u><br>• Decreased rates of respiratory illness<br><br><u>20 years</u><br>• Decreased rates heart disease and cancer, across Yarriambiack Shire | – Rural Northwest Health management and health promotion staff<br>– Victorian Government<br>– Cancer Council Victoria<br>– Yarriambiack School administrators<br>– Department of Education<br>– Yarriambiack early learning centre directors<br>– Yarriambiack Shire staff | • Additional support from key stakeholder group for potential project officer support, educational materials and advertising, and program ongoing support as program expands across the target sector | Yes.<br><br>Aligns with,<br>– Achievement Program |

## 3.5 Supporting value-based care objectives

Regional and metropolitan health services host Victoria's nine LPHUs. This presents an ideal opportunity for the PPH teams to bring prevention skills to prevention of disease, early diagnosis and primary care, through to secondary prevention and the end of the disease spectrum.

International experience has demonstrated that value-based models of care have application in our region, especially where prevention, primary care and hospital care is integrated to reduce disease risk by managing risk factors, or reduce the progression of disease by earlier diagnosis and optimal management, so reducing the need for hospitalisation where care in hospital is no longer required. Including preventive actions in value-based health care initiatives has sustainability co-benefits including reducing the use of hospital resources, reducing health care and hospital emissions, and means hospitals are more able to direct their resources to care for those whose condition necessitates in-patient care.

The GPHU is eager to support work being led by the Western Victoria Primary Health Network (WVPHN) and Grampians Health to improve the end to end care for heart disease and cancer care across our region. These two pieces of work are particularly important in light of the aging population, inequitable health outcomes across the region and health services that are encountered significant strain during the COVID19 pandemic. The program planning for End to End (E2E) cardiac care and for cancer early diagnosis and care comprises *Appendices 6.8 and 6.9.*



## 3.6 Implementation of the GRPHP

The implementation of the interventions described in the GRPHP will be planned and enacted with attention to the elements of the LETTERS framework for implementation (*Appendix 7.1*). For each intervention, an implementation plan will be developed collaboratively with stakeholders. Implementation progress updates will be regularly provided to the SC to share how the activity is progressing and seek feedback from the committee.

### 3.6.1 Leadership and governance

The leadership and governance for the implementation of the GRPHP concerns the structures for governance and accountability over the plan, the responsibility for its development and implementation, the policy framework which guides the development of the GRPHP and risk management regarding its implementation.

It is part of Grampians Health's service agreement with the Department of Health that GH develop a population health plan with the GH Board's Primary Care and Population Health Advisory Committee (PCPHAC; members listed in *Appendix 10.1*) responsible for endorsement. It is a core requirement that the GPHU develop and implement a population health plan for its catchment, steered by a committee with membership from specified categories regarding the governing partnership structure as set out in its guiding document: the *LPHU population health catchment planning Framework (June 2023).* The members of the GRPHP Steering Committee are listed in *Appendix 10.2.* Risks relating to the implementation of the GRPHP will be reported to the GRPHP Steering Committee at each meeting using a standard template (*Appendix 7.6*).

The leaders of local Aboriginal Co-operatives were asked how they wished the communities they serve to be represented in the GRPHP. This resulted in each of Ballarat and District, Budja Budja and Goolum Goolum Aboriginal Co- operatives authoring *Section 3.2.*

### 3.6.2 Engaging with people, processes and evidence

The GRPHP has been developed in close consultation with stakeholders, community members, agencies, and clinical and service experts. It is informed by evidence derived from numerous sources, and in seeking to align, amplify or extend existing or proven programs has capitalised and will capitalise on available networks and processes for implementation. Stakeholder agencies and organisations participated in determining priorities and interventions for initial focus and interventions were assessed for feasibility, measurability, potential scalability and potential sustainability. Enablers and barriers for shortlisted ideas drove the final decisions around interventions for implementation in relation to healthy eating, active living and reducing harm from tobacco and e-cigarettes. Other priority programs were developed through discussion with key stakeholder agencies in the first instance and focus strategies for implementation agreed. Employing these methods gives the focus interventions every chance of successful implementation in the first instance. Similar methods will be used in developing further programs for implementation.

### 3.6.3 Training and education

Having prevention and population health (PPH) officers/ workforce nominated by their employer agency as available to assist with contributing to the GRPHP implementation in 2023-24 was a key determinant in selecting initial interventions for implementation across the priority areas of Healthy eating, Active living and Reducing harm from tobacco and e-cigarettes. The PPH workforce in the region is in high demand, and forming or extending collaborations to undertake the GRPHP interventions reflects the commitment of many diverse groups to the vision of the GRPHP.

Surveying stakeholders regarding their capacity to lead or participate has illuminated the limited reserve of the PPH workforce. Accordingly, actions to grow the PPH workforce are required to ensure programs can be scaled and sustained if warranted. This work will be supported by the GPHU which will seek to expand partnerships with academic, training and service organisations (including Federation, Deakin, and LaTrobe Universities, plus WVPHN) and VicHealth to scope opportunity for student placements, professional work experience and opportunities for student researchers to assist with evaluation.

PPH skills development and research training sessions will be provided to GPHU PPH staff and staff from partner organisations who wish to attend. Examples of training to be offered include in STICKE (Systems thinking in community knowledge exchange; Deakin University) and practical experience in planning and facilitating Group Model Building (GMB) workshops to tackle complex issues.

### 3.6.4 Tools and resources

*Appendix 7* comprises a series of tools and resources available to PPH workforce to assist with planning for and implementing the initial interventions. In the implementation of interventions, the PPH workforce will use additional tools where appropriate, informed by local stakeholder governance groups. Examples may include theory of change, program logic and systems mapping processes (in addition to STICKE).

### 3.6.5 Evaluation and audit

Implementation of the GRPHP will be audited and reviewed periodically and reported to the GRPHP SC.

Evaluation and audit of the implementation of the initial interventions will be determined at the time of planning the implementation with stakeholders. Outcome and impact measures (as described in *Section 3.4*), proposed by PPH, align to the Victorian Public Health and Wellbeing Framework. The RE- AIM framework requires that implementation is reviewed periodically. The timing of undertaking and reporting the outcomes of those reviews to the intervention's leadership team will be determined as part of the intervention's implementation plan.

### 3.6.6. Reporting and communication

In addition to implementation reporting to the SC, opportunity will exist for sharing the process of the development of the GRPHP. Over time, outcomes from interventions will be reported within GH, Department of Health (DH), to stakeholders, partner organisations, and publicly. It will be necessary for each intervention to plan its own reporting and communication schedule as determined by its leadership group or Steering Committee.

### 3.6.7 Sustainability

Identifying interventions that are successful, sustainable and where appropriate scalable, is fundamental to the aims of the GRPHP. As per the LETTERS framework, planning for sustainability from the start is critical to ensure that sustainability challenges are addressed early.

Interventions have been identified as feasible, measurable, scalable and sustainable, based on work completed or in progress, the impact and reach of which would be strengthened or deepened through amendments which innovate, upscale, apply to additional settings or communities, or benefit through partnership. The PPH workforce will, where appropriate, consider applying a regional approach through establishing mechanisms to build prevention capacity and encourage strategic collaboration for collective impact.

Identifying and creating opportunities for program sustainability will also ensure that there is value for the investment in the time and resources that are applied to the project.

In addition to program sustainability, the RE-AIM framework permits evaluation of a program's environmental footprint. The GRPHP aims to promote climate considerations in every program to limit the emissions contributions that programs make (along with equity considerations and incorporating advice from Aboriginal and Torres Strait Islander advisors). These considerations will be addressed in the implementation planning phase of the selected interventions.

# 4

# Evaluation Plan

## 4.1 Overview

The overarching goal for monitoring and evaluation of the GRPHP is to support the development of scientifically robust methods to track the progress of program interventions, identify and overcome challenges in their implementation and to discover broader public health effects from activities. To achieve this objective, two distinct strategies will be applied across the nine priority streams to monitor and evaluate the effect from targeted interventions and the processes used to deliver them.

The first strategy relates specifically to monitoring and measuring the effect of specific interventions and tracking changes in the target group observed over intervals between the baseline measurement and program endpoint, or cycle completion for longer term programs. A bespoke monitoring and evaluation plan will be created for each intervention in each stream as an integral part of the documentation and reporting activities within the program. Specific details of the contents of intervention evaluation plans are described in *sub-section 4.2* below.

The second strategy focuses on examining either cross-boundary or synergistic effects from different interventions applied within the same priority stream across the Grampians catchment. Incorporating this secondary approach recognises the potential for public health interventions to create positive or negative effects not ordinarily detectable or recognised by evaluations focused only on the target population or goal. Similarly, the approach recognises the potential for public health interventions applied in one specific geographic area to have wider effects on public health policy and practice beyond the local site of focus. Further explanation about monitoring and evaluating such effects are further described in *sub-section 4.3* below.

Like the choice of the interventions themselves, the process and methods selected to monitor and evaluate the effects of program interventions in the catchment plan will be developed in partnership between the GPHU and stakeholders involved in delivering the interventions.

## 4.2 Evaluating stream interventions

A bespoke monitoring and evaluation plan for each stream intervention will be designed by aligning the five domains of the RE-AIM framework with the best suited scientific method to capture and analyse information, based on organisational capability and capacity. The five RE-AIM domains include reach, effectiveness, adoption, implementation, and maintenance. The definition of each of these domains is described in the Evaluation Framework section of *Section 2 Methods* of this plan.

The monitoring and evaluation (M&E) plan designed for each priority stream intervention will include details of three core elements and integrated parts. These include defining the analytical strategy, data collection and management and interpreting the data for conclusions. Each of these elements will include a clear description of the process steps required to perform the task and the outputs created by the activity. These descriptions serve as an essential benchmark and checkpoint to compare progress of delivering the intervention over time and to identify potential barriers or challenges to be addressed for the intervention to succeed.

The first core component of stream intervention M&E plan provides a description of the analytical strategy selected to measure the effect of the intervention and the rationale used for the choice. This requirement for developing the plan seeks to encourage stakeholders to explore different analytical approaches and consider internal and external factors which might affect or alter the likelihood of capturing reliable information with high degrees of fidelity and validity. This process provides the stimulus to consider the key design features that address evaluation quality, including characteristics to improve reliability and validity (construct, internal and external) of the findings.

The second core part is the description of the methods and processes to capture, manage, query, and interpret the intervention data for each of the five domains (both qualitative and quantitative). This description includes data collection procedures, data handling protocols, processes for examining, categorising, tabulating, and testing the information and data collected, along with capture frequency and reporting periodicity. This element of the plan defines the progress indicators and aligns data selection to the RE-AIM domains. This important process is essential for maintaining quality assurance in data capture and data management. Incorporated into the data management description is the agreed process and mechanism for sharing data across different stakeholders, along with identifying business units within organisations responsible for the different activities involved in the data capture and management. This step is especially important where specialist stakeholders are engaged to perform data analyses to test relationships between variables and complete complex statistical analyses.

The third core component describes the method and collaborative process to test and interpret analytical findings or conclusions at different intervals along the intervention timeline. Monitoring the progress of observable effects against the expected change in the target cohort is essential to test the progress of the intervention and identify changes or modifications necessary for the intervention or its delivery. This description explains the roles and responsibilities of different stakeholders, along with decision-points for intervention review and modification if indicated. This element of the plan is especially important because the program interventions were selected as part of stakeholder collaboration process. Consequently, any modification to an agreed intervention needs to follow a collaborative decision-making process in a timely and efficient way.

*Table 4 GRPHP Core components of intervention monitoring and evaluation plan*

| Core components of M&E plan | Purpose/output |
|---|---|
| **Analytical strategy** | Defines the analytical strategy intended to measure the effect of the intervention. Includes rationale for approach including stakeholder capability and capacity. Defines process steps for analysis and assigns activity tasks to different stakeholders. Includes data management and data analysis processes required to achieve high quality assurance. |
| **Data methods** | Defines the type of information (data) to be captured, the sources of the data and the process required to capture, validate, store, and share the data with collaborating stakeholders. Definitions include the periodicity of data collection (frequency/ time-interval depending on the intervention and implementing agencies). Aligns data with RE- AIM domains. |

| | |
|---|---|
| **Intervention progress indicators** | Defines the specific data used to inform the progress of the intervention (as distinct from measuring effect) and key decision- points. |
| **Interpreting findings** | Describes the agreed process to review and interpret data collected and analysed as part of the monitoring process along the time- continuum. Specifies decision-points for the intervention along the monitoring path. |

## 4.3 Examining synergistic effects of stream interventions

Of the nine priority streams within the catchment plan, some are focused on enabling behaviour modification, some focus on a specific disease, while others centre on healthcare access and disease management. Consequently, the interventions selected for some streams will by default concentrate on a specific target population. To evaluate the effect of one intervention on another intervention within the same priority stream requires a specialised evaluation approach, one with established scientific rigor and with the flexibility to align methods with the RE-AIM framework.

Qualitative case-study methodology provides a robust and flexible means to examine such characteristics and other effects of different health interventions, including questions about events, processes, activities, performance, and outcomes. The advantage of this methodology is the high compatibility for examining public health interventions in the real-world context in which they occur, and linking existing program intervention logic, data collection and data analysis methods. A qualitative case study methodology will be devised for those priority streams whose interventions are focused exclusively on narrow population cohorts and groups. Depending on the type and nature of the intervention, the evaluation will incorporate analyses to assess the potential concomitant and trans- boundary effects from the delivery of an intervention in one geographic area to other areas not receiving the intervention.

## 4.4 Active monitoring of interventions

One of the key features of the evaluation framework is the process of active monitoring to assess if interventions are working as intended. This feature establishes pre-determined estimates of change dynamics at the inception of intervention and assigns data capture points along the time continuum to test the progress of intervention.

Monitoring the process and activities used to deliver the intervention against is highlighted as equally significant as the update or change observed in the intervention target group. Testing the process used to deliver the intervention is enabled by specifying the activities intended to deliver the intervention prior to commencement and comparing this description with the actual process observed.

*Table 5 GRPHP Features of active monitoring of interventions*

| Active monitoring feature | Purpose/output |
|---|---|
| **Intervention processes** | Defines the processes intended to implement the intervention. Allows a test of intended process versus actual (observed) process/activity. Allows assessment of implementation activities, identifies barriers, checks for unintended/unforeseen challenges that limit efficacy. Allows for modification of intervention function or target and to adapt intervention to best fit the local context and influencing factors. |
| **Changes in key indicator data** | Creates a timeline, and detail for all data capture and monitoring points. Creates query opportunities to compare expected change with actual change and explore reasons for any difference. Includes data points specific to RE-AIM domains of reach and efficacy and may include data to interpret cohort uptake, implementation, and maintenance characteristics. |
| **Magnitude of change** | Measures the actual magnitude of change in target group and compares with expected change. Provides a test-point to assess progress of the intervention and explore influence of local contextual factors. |
| **Rate of change** | Describes the relationship between the change in the indicator value and time. Creates a query opportunity to understand local contextual factors that affect the rate of change in the target population. |
| **Process of data review** | Describes the process used to review, analyse and interpret the indicator data nominated to be collected at specific time-points or at designated intervals between intervention inception and the program completion. |

# 5

# Our region: ready for opportunities and risks

The decade ahead promises opportunities and risks.

The GRPHP, for the first time, sets out programs of work with an expectation that PPH teams and stakeholders will be able to join the dots directly between *the efforts* of PPH workers and community members and *the improvements* to local health outcomes – in ways never before demonstrated. Many of the initial suite of interventions contained in the GRPHP have been developed by aligning, extending or pivoting from proven programs already underway. They have been created by adapting for our region programs with proven efficacy elsewhere, and through collaboration of stakeholders using system science to map a prevention system and identify leverage points for feasible change (to subsequently enact a stakeholder-designed program of work). For each program its reach, effectiveness, adoption, implementation and maintenance will be evaluated periodically and at a planned end-point to determine whether to scale and/ or sustain that program. The model for change, and process intended to achieve it described within the GRPHP, offers great hope for population health improvement in our region.

But that is not all that the GRPHP sets out to do. The GRPHP aims to promote *a way of working* that supports collaboration on major programs between many stakeholders inside and outside the health sector and inside and beyond government. This approach embraces sharing human and other resources to achieve outcomes, and permits horizon scanning to prepare together for the challenges ahead. As we learnt and practised in our region during the COVID19 pandemic response: *to get ahead we have to think ahead;* this section is about thinking ahead.

## 5.1 Opportunities

The integration of the former PCPs into the LPHUs (in effect into their host metropolitan and regional health services) has meant that, for the first time, opportunity exists to plan, implement and evaluate with a five- or 10-year horizon. Figure 4 illustrates schematically an opportunity and expectation that the initial interventions set out in the GRPHP can be added to in a staged and phased manner, with scoping new programs potentially getting underway when other interventions are in their implementation phase. This is made possible by stakeholder agencies and organisations working in collaboration and alliance, when an agency might variously lead a program, support another or help link components of a third together. Not all agencies need to be involved with all programs, nor do all programs need to be led by one agency. The GRPHP will continue to support these processes as they evolve, and does not seek to control or dictate them.

Also illustrated in *Figure 4* is an intention to scope and respond to other as yet unknown imperatives, to scale as evidence and need suggests, or to cease an intervention so that attention might be given to scoping something else. In this figure, scoping means undertaking consultation to develop an idea as has been done in the development of the GRPHP. That is, to join with stakeholders and community where a need is identified to determine the best approach to respond to it. While evaluation in this figure appears as something done at a mid-point, periodic evaluation using the RE-AIM framework will take place, with a major examination of progress at a time to be determined specific to the program intervention. Of note, not all programs will warrant scaling and sustaining, and will be ceased if shown to be ineffective or too resource-intensive to be maintained.

Other opportunities already apparent in our future include the following options.

- There will be increasing opportunity to learn from Aboriginal and Torres Strait Islander colleagues and organisations given their track record as exemplars in enacting a pragmatic population health approach in which local Aboriginal Co-operatives have developed effective supportive strategies to attenuate the impacts of socioeconomic determinants of health, to strengthen community action and re-orient health services. The GRPHP seeks to listen, hear and learn from local Aboriginal Co-operatives and communities and to ensure Aboriginal voices help shape programs
- The on-going implementation of Victoria's *Gender Equality Strategy* provides great opportunity for synergy with work to address social determinants using a population health approach, as well as to ensure gender considerations are included in the application of any equity lens through explicit gender impact assessment
- Collaborating with local stakeholders and communities to understand local health priorities and support the development of place-based responses
- Upgraded athletics infrastructure planned for our region in coming years presents a great opportunity for mobilising community interest in active living messages and activities for the region, for people of all ages and abilities
- Building peer leadership training strategies into programs can amplify effectiveness and action
- Partnering comprehensively with academic and training institutions in our region will both build workforce (through work experience and professional placements and teaching) and encourage student researchers to assist with evaluation of our programs
- Working with large employers can help improve the health outcomes of employees through worker health and fitness programs
- Growing prevention and population health capacity across our region will contribute to the control of a range of communicable conditions including blood borne viruses
- Becoming leaders in supporting local climate action is critical across both mitigation and adaptation, inside the health sector and beyond. While GRPHP includes the development of the *Climate Action Framework* for health services in the Grampians region, we note that health leaders are often, with other civic leaders, the leaders the community looks to for action and wisdom in testing times such as we are likely to experience in the next decade
- With emergency management lead agencies, the GPHU and our prevention and population health partners can work to mobilise all assets in our communities to prevent, prepare for, reduce risk, respond, recover and rebuild our communities in the event of extreme climate events - whether intense and short in duration (such as fires storms and floods), or relentless and prolonged (such as droughts)
- Prevention and population health efforts can maximise the effectiveness of collective action in health fields of cancer screening, immunisation and prevention of mental ill- health
- Seek opportunities to contribute to the development of models of care that ensure value to the use and to the health system

- The Grampians region is an ideal size with patterns of population diversity and distribution suited to
    - trialing new population health innovations to improve support for people facing daily impacts of determinants of health beyond their control such as living with the effects of violence, isolation, insecure housing and food insecurity
    - Participating in population-level trials of novel interventions targeting prevention and management of chronic disease risk, potentially as part of scoping and implementing (with primary care and specialist care teams) "end to end" programs to prevent disease or prevent the progression of diseases with high levels of morbidity in our region. These conditions might include a range of cancers, chronic respiratory disease, diabetes, cerebrovascular disease and osteoarthritis

## 5.2 Risks

Readiness to recognise and respond to new or emerging risks is core business for a public health unit with a mandate to protect our community's health. The residents of our region would expect all who work to protect the population's health (including Department of Health, LPHUs, community health services, and local government officers) to keep informed by being networked into local, state and national surveillance programs.

Climate change is the biggest threat to health of the 21st Century, and will impact every sector and every aspect of life. This is the decade to "aim high, go fast" (Steffen, et al 2021). For this reason, the GRPHP proposes an *action at all levels* approach to mitigation and adaptation, and will build on the work planned for 2023-24 in years to come. The risk of increasingly frequent, extreme, potentially simultaneous and compounding events increases the risk of the impact from those events. This includes flooding, drought, heatwave, fire, trauma, loss of services and livelihoods, contamination of food and water, and mosquito borne disease, as well as enduring impacts such as psychological distress and biodiversity loss. Prevention and preparedness are key foundations of emergency management (EM). Public health unit health protection and prevention and population health teams are likely to have an increasing role in EM response and recovery.

In addition to climate change and its direct and indirect sequelae locally, other risks to our population's health include

- the next pandemic
- evolving antimicrobial resistance
- an opioid epidemic as has occurred in other high-income countries, and
- prevention, population health and healthcare workforce shortages.

The GPHU will continue to work with all agencies in partnership to strengthen our capacities to maximise preventive and population health action as threats to health emerge; the GRPHP both reflects and creates a model for that collaborative work.

Whether testing a new health promotion intervention in a single location, enacting a broad preventive strategy for the region, or responding to the community's health needs after a population-level emergency, the GRPHP will enable prevention and population teams to form, collaborate and enact programs to meet community need so that people of the Grampians region can be stronger and healthier together.

*Figure 4 Schematic schedule of staged program of work to 2027 and beyond, based on five-year cycles*

Note: Programs of work may take less or more time to demonstrate effectiveness and become sustained, depending on breadth of program and timescale of outcomes

| Year | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| Priority | 22-23 | 23-24 | 24-25 | 25-26 | 26-27 | 27-28 | 28-29 | 29-30 | 30-31 | 32-33 |
| Healthy eating | Scope | Intervene | Evaluate | Scale | Sustain | | Scope | Intervene | Evaluate | Scale |
| | | Scope | Intervene | Evaluate | Scale | Sustain | | | | |
| | | | | Scope | Intervene | Evaluate | Scale | Sustain | | |
| Active living | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Tobacco/ e-cigarettes | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| E2E Oral disease | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| E2E Sexual/ repro health | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Thriving Children | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| E2E Heart disease | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| E2E Cancer | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Climate Change | S | I | E | S | S | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Other | | S | I | E | S | S | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Other | | | S | I | E | S | S | | | |
| | | | | | | | | | | |
| Other | | | | S | I | E | S | S | | |
| | | | | | | | | | | |

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Hepburn Shire
https://www.hepburn.vic.gov.au/files/assets/public/v/1/residents/documents/final-community-vision-and-council-plan-2021-2025.pdf

Hindmarsh Shire
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Horsham Rural City
https://www.hrcc.vic.gov.au/Our-Council/About-Us/Council-Plan

Moorabool Shire
https://www.moorabool.vic.gov.au/Services-and-support/Health-and-wellbeing/Municipal-Public-Health-Wellbeing-Plan-2021-2025

Northern Grampians Shire
https://www.ngshire.vic.gov.au/Residents/Public-health-services/Municipal-Public-Health-and-Wellbeing-Plan

Pyrenees Shire
https://www.pyrenees.vic.gov.au/About-Pyrenees-Shire-Council/Pyrenees-structure-and-policies/Council-Policies-and-Publications/Strategic-Plans

West Wimmera Shire
https://www.westwimmera.vic.gov.au/Council/Documents-and-publications/Council-Plan

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# Appendices

# Appendix 1

## Methods

# Appendix 1.1 Methods to assess health outcomes, strengths and needs

A mixed-methods methodology was adopted to obtain a comprehensive assessment of health, strengths and needs among people living in the Grampians region. For this assessment, there were four complimentary streams of data collected.

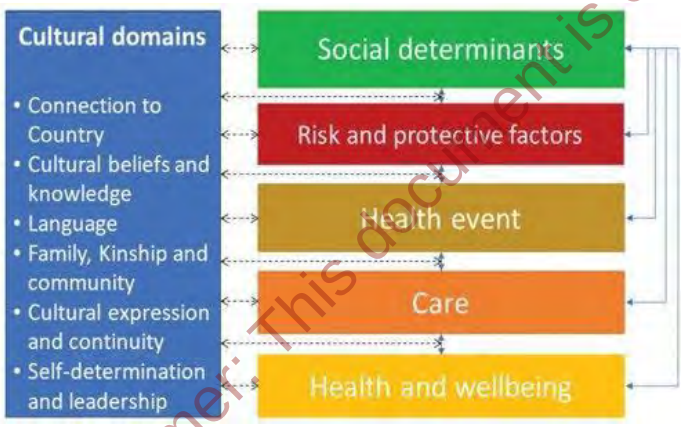
1. Epidemiological health and social information for the region
2. Mapping of prevention systems
3. Program participation data
4. Existing health priorities among health promoting agencies

## 1.1.1 Local epidemiological health and social profile

Quantitative epidemiological indicators of interest were identified through an exploration of the Victorian Department of Health's Public Health and Wellbeing Outcomes Framework (VPHWOF), publicly available data sets and locally commissioned reports. Data sources have been explicitly referenced throughout the report.

Indicators of interest were selected for each of the following categories; demographics, socioeconomic determinants of health, health risk and protective factors, health and wellbeing outcomes, and priority populations (women and children). These domains were informed by the Mayi Kuwayu Study conceptual model (*Figure A1.1_1*)

*Figure A1.1_1 Mayi Kuwayu Study conceptual model*




Results were reported according to the indicator of interest but were generally described as incidence or prevalence rates (per 100, 000 population), means or medians. Generally, indicators were reported by Local Government Area (LGA). Where available, data on gender, diversity and ability has also been included.

The results from each LGA were compared with other regional LGAs in the Grampians catchment and the Victorian state average to identify current strengths and challenges for people living in the region. The results are presented in a series of tables set out in *Appendix 2*. The sequence of the LGAs reported reflects their proximity to Melbourne, with those at greatest distance from Melbourne to the left of the tables

### 1.1.2 Mapping of prevention systems

Preventive and population health activities focused on active living, healthy eating and reducing harm from tobacco and e-cigarettes were identified to develop a detailed understanding of existing prevention systems and coverage across the Grampians region.

A desktop review, GPHU corporate knowledge and information from key contacts within the former Primary Care Partnership (PCP) networks were utilised to identify local policies, programs and initiatives, and obtain further details on the health focus, geographic setting and the target outcome the initiative.

Preventive health activities were also reviewed against the five key action areas of the Ottawa Charter for Health Promotion to identify where areas of action are occurring to inform the direction of possible future interventions (World Health Organisation, 1987). The Ottawa Charter five action areas are as follows.

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Re-orientating health services

This summary will continue to be revised and expanded as additional local stakeholder knowledge accrues.

Descriptive statistics were used to describe the results. Programs where multiple sites register to participate (i.e. the Achievement Program) are reflected in the results as one program. Program participation results (*Appendix 4.3*) contains further details about the number of sites that are participating in these initiatives.

GPHU would like to specifically acknowledge and thank Gippsland Region Public Health Unit (GRPHU) for sharing their approach and the resources they developed to map their prevention systems. This information formed the foundation of GPHU's assessment of local prevention systems.

### 1.1.3 Program participation data

An assessment of participation rates across Victorian prevention programs was performed to better understand the locations and settings where program participation and gaps are occurring. Prevention programs outlined in the Community Health – Health Promotion Guidelines and locally implemented programs were selected for inclusion. Participation data was accessed using program websites and specific data dashboards. The results are reported using descriptive statistics.

### 1.1.4 Existing health priorities

The health focus areas of local agencies were assessed to understand local health priorities. Municipal health and wellbeing plans were reviewed. A Department of Health table illustrating its assessment the priorities of health promoting agencies and organisations mapped against the *Victorian Public Health and Well-being Plan 2019-2023* comprises *Table A5.1_1* in *Appendix 5.1*. Stakeholder input will further refine community health priorities and strategies for action.

# Appendix 1.2 Methods to engage with stakeholders

Voices of experience in the communities served by the GPHU were central to the development and implementation of the GRPHP. Local leaders are well placed to identify public health priorities and placed-based solutions as they are key knowledge holders for their communities. To achieve our vision of a stakeholder driven approach to the GRPHP, a plan was iteratively developed to meaningfully engage with stakeholders.

The stakeholder engagement plan was informed by the International Association of Public Participation (IAP2) engagement design methodology (International association for public participation, 2020). The IAP2 provides a framework to guide an engagement process using a three-step approach: Design, Plan and Manage.

## 1.2.1 Design stage

In the first phase, GPHU team members met regularly to consider key factors that would form the foundation and set the direction of the stakeholder engagement process. Considerations included

- context in which the GRPHP was being developed,
- purpose and scope of the stakeholder engagement,
- identifying stakeholders,
- stakeholder analysis.

## 1.2.2 Planning stage

In the second phase, a series of planning activities were performed to translate the engagement design into a clear plan for action.

*Sequence of activities during the engagement process*

Engagement activities commenced by building awareness about the GRPHP among partner organisations in the Grampians region. Following this, a series of online and in-person workshops sought stakeholder participation to discuss interventions to improve outcomes across the GPHU health streams. After the participation phase, findings will be disseminated to stakeholders.

*Methods for stakeholder engagement*

A systems science approach was adopted by GPHU to guide the development of the GRPHP. The methodology is described in greater detail in *Appendix 7.4*. Briefly, systems science is a research practice whereby systems are perceived as dynamic networks comprised of a series of interconnected elements that work together to achieve an outcome (Pescud et al., 2021). Participants were introduced to the system science methodology to identify opportunities for interventions that could be enacted to improve outcomes.

*Resources required*

To support the online stakeholder forums for the active living, healthy eating and reducing harm from tobacco and e-cigarette streams, a *Data Snapshot Report* was prepared for each LGA in the Grampians catchment, collated by sub-region in which that LGA is located (*Appendices 3.1-3.3*). The report contains population health outcome and risk factor data. Stakeholders provided feedback on each *Data Snapshot Report* and a revised version was subsequently distributed via email back to stakeholders.

### 1.2.3 Managed stage

#### *1.2.3.A Deliver*

Initially, the GPHU Prevention and Population Health newsletter was used to raise awareness of the project. This newsletter has a distribution base of 1300 contacts ranging from the Not-for-profit (NFP) sector, community groups, Aboriginal Community Controlled Health Organisations, Social Support Organisations, For-Profit businesses, Councils and Government agencies. Contacts were asked to express their interest to contribute to the 2023 GRPHP via this newsletter. Contacts who had expressed interest, and contacts who were labelled as a previously engaged stakeholder by the GPHU PPH team were then included in a separate specialised GRPHP-specific distribution list. This final list included 743 contacts. The GRPHP was also raised in the weekly *Grampians Region Public Health Briefing*[#] (conducted using MS Teams), which garners regular attendance from local councils, health agencies, multi-sector government agencies and community organisations.

Following a period of awareness raising, the stakeholder participation phase commenced. Stakeholders were invited to participate in online and in-person workshops. Email communications were the preferred method of communicating to this audience based on the strong engagement through email replies. The Electronic Direct Mail platform SendGrid was utilised to stratify stakeholders according to their respective PPH hub catchment to ensure they were invited to the workshop events in their region. A Microsoft Form was included in each email inviting stakeholders to register for the events. Five emails in total were sent to the distribution list including 'One Week to Go' emails and 'Don't Forget to Register'. Stakeholders who were labelled as 'high priority' and who had not yet registered for the sessions received a follow-up phone call from PPH staff members.

The engagement events commenced with online forums, titled 'Data Spotlights', where local population health outcome results were presented. The forums were held for each of the three PPH hubs using the Zoom software platform. During the sessions, local data were discussed and feedback was encouraged. Following the sessions, a 'Did you miss the Data Spotlight?' email was sent to unregistered contacts. Additional stakeholders then viewed the recording and provided feedback to the GPHU.

An online stakeholder meeting was held for those involved in the *Ballarat4Kids* program (part of the *Thriving Children* stream). This forum provided an opportunity to discuss a report setting out data that will be collated annually relating to outcomes for children.

[#]*The Grampians Region Public Health Briefing has been held at least weekly since commencing on 5 January 2022*

Following the online forums, in person workshops were then held in Bungaree, Avoca and Horsham. The workshops focused on the *Active living, Healthy eating* and *Reducing harm from tobacco and e-cigarettes* streams. Stakeholders were invited to participate in a series of activities. Initially, stakeholders were presented with the systems map that the GPHU team prepared for the Healthy eating stream. Participants were invited to identify stakeholders who were missing from the map and then describe the operational linkages between stakeholders. This process was replicated for the Active living and Reducing harm from tobacco and e-cigarettes streams. In the second activity, stakeholders were encouraged to work in small groups with participants on their table to identify two interventions that could improve healthy eating. The interventions may have been small modifications to existing programs that could enhance the population effect. This task was repeated for the other two health streams.

Targeted stakeholder consultation for Strengthening oral health, Sexual and reproductive health and viral hepatitis, Thriving children, Tackling climate change and enhancing cardiac and cancer care priorities occurred in parallel. Further details about stakeholder engagement for each of the priority streams are included in *Appendices 6.1 - 6.9.*

### *1.2.3.B Evaluation and review*

At the conclusion of each of the workshops in Bungaree, Avoca and Horsham, a staff debrief was performed. Reflections and opportunities to strengthen the workshop were discussed and embedded in the subsequent session. A more detailed debrief and staff review was performed in July 2023 which distilled lessons learnt to inform future engagement processes.

Stakeholders who attended the in-person workshops were invited to provide feedback about the sessions. Results will support workshop planning in the future.

# Appendix 1.3 Methods to determine preventive interventions

## 1.3.1 Review of stakeholder proposed interventions

Following the engagement workshops for the *Healthy Eating, Active Living* and *Reducing harm from tobacco and e-cigarettes* streams, data obtained during the workshop on the stakeholder-identified interventions were collated and synthesised into themes. The GPHU PPH team assessed each of the stakeholder proposed interventions to identify a list of interventions that would progress to the next phase of stakeholder engagement.

To perform this assessment, the GPHU team reviewed the feasibility, measurability, potential for scalability and potential for sustainability by considering and asking questions as set out in *Table A1.3_1*.

*Table A1.3_1 Considerations and questions to determine feasibility, measurability, scalability and sustainability (FMSS) of stakeholder proposed interventions*

| Considers | Asks |
|---|---|
| **Feasibility** | |
| • The engagement of critical stakeholders<br>• The capacity of stakeholders<br>• The alignment to existing work<br>• The efficacy of the intervention aim to address an identified need | • Is the intervention likely to succeed?<br>• Will the intervention aim address the need of a specific cohort or community?<br>• Is the intervention supported by stakeholders?<br>• Does the intervention goal align to stakeholder priorities? (*Appendix* 6.1) |
| **Measurability** | |
| • The capacity to understand the impact of the intervention and clearly describe this | • How will we know if our work is benefiting community?<br>• Will this model of service deliver clear outcomes which can be measured by progress, impact and outcome measures in the short, medium and long term? |
| **Scalability** | |
| • The strength of the intervention model | • Is the model applicable to other communities?<br>• Regarding the factors for success of the current program, are these sites specific or is there /could there be tools and resources developed to support delivery of the intervention?<br>• The capacity for the stakeholder group to understand and articulate the model to community and new stakeholders<br>• Is the program part of a trusted /respected brand? |
| **Sustainability** | |
| • Leadership capacity and appetite to support on-going implementation | • Does the program require additional funds to implement the proposed amendment?<br>• Is there likely to be funding available to expand or continue the intervention? Has legislation or announcement been made which may impact future funding opportunities? (e.g. 2023 vaping legislation and anticipated Vic Health toolkit) |

| | |
|---|---|
| | • Do the current stakeholders and those who proposed /indicated support for intervention receive ongoing funding to support target group and address this focus area? |

Assessments were recorded for each idea as per feasibility, measurability, scalability and sustainability (*Table A1.3_2*), and a decision made as to whether the intervention idea should progress to the next iteration of decision-making (*Table A1.3_3*)

*Table A1.3_2 Example considerations regarding feasibility measurability, scalability and sustainability*

| | Feasibility | Measurability | Scalability | Sustainability |
|---|---|---|---|---|
| Example considerations | • Existing program<br>• Potential lead stakeholder identified<br>• Capacity of stakeholders<br>• Addressing an identified need - data | • Existing evaluation framework<br>• Dataset reflecting need | • Multi location project<br>• Existing community of practice<br>• Existing toolkit | • Funding environment<br>• Alignment to current planning cycle for stakeholders e.g.<br>• Municipal Public Health and Wellbeing Plans<br>• Shared and organisation specific Community Health - Health Promotion plans (*Appendix* 6.1) |

*Table A1.3_3 Feasibility, measurability, scalability and sustainability assessment template applied to all stakeholder program ideas*

| Intervention idea | PPH Hub | Feasibility | Measurability | Scalability | Sustainability | → Progression for review by stakeholders? |
|---|---|---|---|---|---|---|
| *Healthy eating* | | | | | | |
| | Central Highlands | | | | | |
| | Grampians Pyrenees Goldfields | | | | | |
| | Wimmera Southern Mallee | | | | | |
| *Active living* | | | | | | |
| | Central Highlands | | | | | |
| | Grampians Pyrenees Goldfields | | | | | |
| | Wimmera Southern Mallee | | | | | |
| *Reducing harm from tobacco and e-cigarettes* | | | | | | |
| | Central Highlands | | | | | |
| | Grampians Pyrenees Goldfields | | | | | |
| | Wimmera Southern Mallee | | | | | |



### 1.3.2 Stakeholder selection of interventions

Intervention ideas which were assessed as meeting all the criteria were sent to the stakeholder attendees, including organisations whom had expressed interest but could not attend on the day. Stakeholders were invited to review short-listed interventions for each area in the streams of *Healthy eating, Active living* and *Reducing harm from tobacco and e-cigarettes*. Stakeholders were asked to indicate which intervention their organisation could support without additional resourcing via a Microsoft Form, and also invited to nominate potential enablers and barriers to successful implementation of each intervention. The stakeholder feedback is summarised in *Appendix 5.2*. Follow-up phone calls were made by the PPH team leads where required to discuss the interventions with interested organisations.

Interventions included in the GRPHP for implementation in its first year include those which the most stakeholders' organisations could support. Where interventions were supported equally, the team further weighted readiness for implementation and the strength of local stakeholder support. These programs comprise the preventive interventions of the GRPHP, as set out in *Section 3.4.*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# Appendix 2

## Local epidemiological health and social profile

# Appendix 2.1 Demographics

## Population size

*Table A2.1_1* demonstrates a breakdown of the population in terms of total persons and the proportion of males and females per LGA as recorded in the 2021 Australian Census. The largest LGA in our region is the City of Ballarat, with approximately 113,800 people, while the smallest LGA is West Wimmera, which has approximately 4,000 people. The median population size of LGAs in the Grampians catchment is 11,953.

*Table A2.1_1 Population size across the Grampians region (2021 census data) (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (Total) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Population Size** | 3,999 | 5,705 | 20,430 | 6,577 | 11,953 | 11,865 | 7,669 | 13,449 | 113,757 | 16,606 | 37,611 | 6,503,491 |
| **- Male (%)** | 50.29% | 50.01% | 48.98% | 50.83% | 50.08% | 52.84% | 52.22% | 49.36% | 48.11% | 49.11% | 49.55% | 49.22% |
| **- Female (%)** | 49.71% | 49.99% | 51.02% | 49.17% | 49.92% | 47.16% | 47.78% | 50.64% | 51.89% | 50.89% | 50.45% | 50.78% |
| **Population Change 2011-2021** | -7.20% | -3.40% | 5.60% | -9.40% | -1.40% | 4.40% | 12.60% | 6.40% | 19.20% | 12.60% | 32.20% | 18.20% |

Between 2011-2021 the population of the region grew in eight of 11 LGAs, most notably in Moorabool which increased by 32%. Hindmarsh, West Wimmera and Yarriambiack decreased in population size over the ten-year period.

## Age

In general, the region demonstrates an ageing population profile relative to the total state population (*Table A2.1_2*). Throughout the region, there tends to be fewer younger people compared with the state total across most LGAs and in most age categories from 0-4 years through to 50-55 years of age. This is not uniformly the case however, with Ballarat, Horsham, Moorabool, West Wimmera, and Yarriambiack demonstrating higher numbers of children in some age categories. Similarly, the region demonstrates a consistent pattern across all 11 LGAs of higher numbers of people in the >55 years age categories compared with the state figure.

*Table A2.1_2 Age Structure for Total Population, by Local Government Area (2021 census data) (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-4 years | 6.0% | 5.0% | 5.7% | 4.3% | 4.9% | 4.9% | 4.1% | 3.9% | 5.8% | 4.1% | 6.3% | 5.8% |
| 5-9 years | 5.1% | 4.9% | 6.2% | 5.0% | 5.0% | 5.1% | 5.0% | 5.1% | 6.4% | 4.8% | 6.8% | 6.2% |
| 10-14 years | 5.7% | 5.0% | 6.4% | 6.3% | 5.1% | 5.2% | 5.6% | 5.7% | 6.5% | 5.3% | 7.0% | 6.0% |
| 15-19 years | 4.1% | 5.4% | 5.8% | 5.3% | 4.7% | 4.7% | 5.1% | 5.1% | 6.1% | 4.4% | 5.7% | 5.6% |
| 20-24 years | 3.4% | 3.9% | 5.6% | 3.7% | 4.7% | 4.7% | 3.9% | 4.1% | 6.3% | 2.8% | 5.1% | 6.3% |
| 25-29 years | 4.6% | 5.6% | 6.3% | 4.2% | 5.4% | 5.7% | 3.9% | 4.3% | 7.1% | 3.5% | 6.0% | 7.3% |
| 30-34 years | 4.5% | 5.2% | 6.3% | 4.7% | 5.8% | 6.4% | 4.6% | 4.4% | 6.6% | 4.3% | 6.7% | 7.7% |
| 35-39 years | 5.0% | 4.7% | 5.8% | 4.5% | 4.9% | 5.5% | 4.9% | 4.0% | 6.4% | 5.0% | 6.9% | 7.5% |
| 40-44 years | 4.8% | 4.6% | 5.3% | 4.4% | 4.5% | 5.5% | 5.1% | 4.2% | 6.0% | 5.5% | 6.7% | 6.6% |
| 45-49 years | 5.1% | 5.0% | 5.9% | 4.8% | 5.5% | 6.0% | 6.6% | 5.5% | 6.2% | 6.7% | 6.6% | 6.4% |
| 50-54 years | 7.8% | 6.6% | 6.0% | 6.5% | 6.8% | 6.8% | 8.1% | 7.0% | 6.0% | 7.9% | 6.9% | 6.3% |
| 55-59 years | 8.4% | 7.4% | 6.6% | 8.0% | 7.6% | 7.1% | 7.5% | 7.6% | 5.9% | 8.5% | 6.4% | 5.9% |
| 60-64 years | 8.7% | 8.6% | 6.8% | 9.2% | 8.2% | 7.6% | 8.5% | 8.1% | 5.8% | 9.1% | 5.9% | 5.6% |
| 65-69 years | 8.1% | 7.3% | 5.8% | 8.2% | 7.9% | 7.3% | 9.0% | 8.5% | 5.5% | 9.5% | 5.4% | 4.9% |
| 70-74 years | 7.3% | 6.5% | 5.3% | 7.2% | 7.2% | 6.6% | 8.0% | 8.2% | 5.0% | 7.9% | 5.0% | 4.4% |
| 75-79 years | 4.4% | 5.4% | 3.9% | 5.7% | 5.4% | 4.5% | 5.1% | 6.2% | 3.6% | 4.9% | 3.2% | 3.1% |
| 80-84 years | 3.6% | 3.9% | 3.0% | 3.7% | 3.2% | 3.2% | 2.7% | 4.4% | 2.4% | 2.9% | 1.7% | 2.2% |
| 85+ years | 3.6% | 5.0% | 3.2% | 4.5% | 3.2% | 3.1% | 2.5% | 3.7% | 2.5% | 2.8% | 1.7% | 2.2% |

Key:

Lower than the state aggregated figure

Higher than the state aggregated figure

**Ethnicity**

There is a broad range of ethnic backgrounds represented throughout the Grampians Catchment area (see *Table A2.1_3*). All LGAs, with the exception of West Wimmera, demonstrated a higher proportion of Aboriginal or Torres Strait Islander people compared with the state (range 0.8% - 2.1%, state proportion: 1.0%). Between 6.7% - 14.3% of the population were born overseas, with a broad range of different countries of origin represented. Between 2.2 – 7.8% of the population speak a language other than English at home, with the most common languages spoken differing between LGAs.

*Table A2.1_3 Aboriginal and/or Torres Strait Islander peoples, persons born overseas and languages spoken in the Grampians catchment area (2021 Census Data) (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 0.8% | 1.6% | 1.6% | 1.6% | 1.6% | 1.8% | 2.0% | 2.1% | 1.8% | 1.0% | 1.4% | 1.0% |
| Persons born overseas | 6.7% | 10.5% | 7.1% | 6.7% | 9.2% | 11.3% | 9.6% | 9.2% | 11.3% | 14.0% | 14.3% | 35.0% |
| 5 most common countries | England<br>NZ<br>Philippines<br>India<br>Germany | England<br>Myanmar<br>Thailand<br>Philippines<br>India | England<br>India<br>Philippines<br>NZ<br>Thailand | England<br>NZ<br>India<br>Philippines<br>Netherlands | England<br>Philippines<br>India<br>Taiwan<br>NZ | England<br>NZ<br>India<br>Philippines<br>Taiwan | England<br>NZ<br>Netherlands<br>Philippines<br>Scotland | England<br>NZ<br>Philippines<br>Netherlands<br>Scotland | England<br>India<br>NZ<br>Philippines<br>China | England<br>NZ<br>Netherlands<br>Germany<br>USA | England<br>India<br>NZ<br>Scotland<br>Malta | India<br>England<br>China<br>NZ<br>Vietnam |
| Uses a language other than English at home | 2.4% | 7.1% | 4.7% | 2.9% | 5.4% | 5.0% | 2.2% | 3.0% | 7.0% | 4.8% | 7.8% | 30.20% |
| 5 most common languages | Tagalog<br>Italian<br>German<br>Gujarati<br>Malayalam<br>Filipino | Tagalog<br>Malayalam<br>Vietnamese<br>Filipino<br>Greek<br>Nepali<br>Samoan | Malayalam<br>Italian<br>Mandarin<br>Nepali<br>Tagalog | Malayalam<br>Spanish<br>Greek<br>Nepali<br>Punjabi | Mandarin<br>Tagalog<br>Filipino<br>Punjabi<br>Spanish | Mandarin<br>Punjabi<br>Urdu<br>Samoan<br>Filipino | French<br>Italian<br>Japanese<br>Tagalog<br>German | Filipino<br>Nepali<br>Greek<br>Mandarin<br>Tagalog | Mandarin<br>Punjabi<br>Malayalam<br>Hindi<br>Urdu | Italian<br>German<br>Mandarin<br>French<br>Serbian | Punjabi<br>Italian<br>Hindi<br>Spanish<br>Greek | Mandarin<br>Punjabi<br>Vietnamese<br>Greek<br>Arabic |

Abbreviations: NZ = New Zealand, USA = United States of America

*Table A2.1_4* provides data on the number of permanent migrants who entered Australia during 2021 with last known address within the Grampians region.

*Table A2.1_4 Permanent migrants entering Australia during 2021, by Local Government Area (Source: Department of Home Affairs, 2022)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (Total) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Offshore Humanitarian Program | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 | 0 | 0 | 1 764 |
| Family stream visa | 5 | 5 | 19 | <5 | 14 | 21 | <5 | 18 | 189 | 34 | 36 | 27 808 |
| Skill stream visa | <5 | 11 | 34 | 19 | 30 | 13 | <5 | 26 | 278 | 15 | 34 | 33 085 |

## Disability

A high proportion of the population living in the Grampians region reported living with a disability (range: 19.2% - 29.4%) (see *Table A2.1_5*). The highest proportion was observed in the Central Goldfields LGA, where 29.4% of the population reported living with a disability. Central Goldfields also recorded the highest proportion of people who needed assistance with core activities for daily living (10.4%) and National Disability Insurance Scheme (NDIS) participants (34.6 per 100,000). Hindmarsh LGA reported the highest proportion of people who are carers at 15% of the population.

*Table A2.1_5 Persons living with a disability and carers in the Grampians region*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Persons living with a disability (2018)* | 19.2% | 23.2% | 19.9% | 27.5% | 22.8% | 23.9% | 28.6% | 29.4% | 20.8% | 24.5% | 22.4% | 17.0% |
| Persons who have need for assistance with core activities for daily living (2021)^ | 6.7% | 8.2% | 6.3% | 9.3% | 7.3% | 7.8% | 7.7% | 10.4% | 7.4% | 6.3% | 6.3% | 5.90% |
| Number of NDIS participants (per 100,000 population) (2022)# | 17.3 | 19.8 | 29.7 | 29.0 | 26.5 | 31.9 | 21.0 | 34.6 | 31.4 | 19.0 | 25.7 | 23.6 |
| Persons who are carers (2021)+ | 14.00% | 15.00% | 13.70% | 15.50% | 13.90% | 12.90% | 14.00% | 14.90% | 14.20% | 14.90% | 14.20% | 12.90% |

*Source: Australian Bureau of Statistics, 2020; ^ Source: Australian Bureau of Statistics, 2023, # Source: NDIS, 2023, +Source: PHIDU, 2023

### People who identify as Lesbian, Gay, Bisexual, Transgender, Queer (or questioning) and Intersex (LGBTIQ+)

There was variability across LGAs in terms of the proportions of the population who identified as LGBTIQ+, according to the 2017 Victorian Population Health Survey. The highest proportion of people identifying as LGBTIQ+ was in Ballarat at 9.6% of the population, while the lowest was in Yarriambiack at 1.8%. (*Table A2.1_6*) Given the data are over five years old, it is possible that these figures underestimate the true proportion of people identifying as LGBTIQ+ in the Grampians region.

*Table A2.1_6 Proportion of people who identify as Lesbian, Gay, Bisexual, Transgender, Queer (or questioning) and Intersex (LGBTIQ+) in the Grampians region (Source: Victorian Agency for Health Information, 2020)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adults who identify as LGBTIQ+ (2017) | 2.5% | 3.2% | 3.3% | 1.8% | 5.1% | 2.2% | 3.8% | 5.2% | 9.6% | 7.5% | 4.0% | 5.70% |

### Socioeconomic index for areas (SEIFA)

The Index of Relative Socioeconomic Disadvantage (IRSD) is based on a range of information about the economic and social conditions of people and households within a particular area. It is specifically designed to capture disadvantage within an area and does not provide an indication of relative advantage. This is useful information for targeting programs and resources to disadvantaged areas. IRSD data has been used to rank all 79 LGAs in Victoria, with 1 being the most disadvantaged LGA and 79 the least disadvantaged in the state. In general, the Grampians region demonstrates high levels of disadvantage, with Central Goldfields ranking first in the state in terms of socioeconomic disadvantage, with five of the 10 most disadvantaged LGAs in Victoria, and with two LGAs only (Hepburn and Moorabool) ranking among the more advantaged half of all LGAs in the state (*Table A2.1_7*).

*Table A2.1_7 Index of relative socioeconomic disadvantage (IRSD) ranking of Local Government Areas (Source: Australian Bureau of Statistics, 2018)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool |
|---|---|---|---|---|---|---|---|---|---|---|---|
| IRSD Victorian ranking 1-79 (2016) | 33 | 10 | 30 | 7 | 6 | 8 | 17 | 1 | 29 | 44 | 53 |

Note: Index position of 1 = most disadvantaged

# Appendix 2.2 Social Determinants of Health

### Early Years Education

Between 7% (Hindmarsh) and 54.7% (West Wimmera) of children aged 4 and 5 in the Grampians Region were enrolled in a preschool program in 2021 (Victoria: 23.7%) (see *Table A2.2_1*). The proportion of children at school entry who were determined to be developmentally on track in all five domains of the Australian Early Development Census ranged from 33.3% in Hindmarsh to 62.7% in Yarriambiack (Victoria: 57.2%).

*Table A2.2_1 Education indicators in the Grampians region (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of children at school entry who are developmentally on track on all five domains of the Australian Early Development Census (2021) * | 45.2% | 33.3% | 54.3% | 62.7% | 46.9% | 50.8% | 55.9% | 42.7% | 57.4% | 56.1% | 56.8% | 57.2% |
| Proportion of children aged 4 and 5 enrolled in a preschool program (2021) * | 54.7% | 7.0% | 24.2% | 38.4% | 15.3% | 36.7% | 23.2% | 24.1% | 28.4% | 33.0% | 26.5% | 23.4% |
| Level of highest educational attainment – year 10 or below (Persons aged 15 years or over) (2021) | 34.4% | 38.7% | 30.7% | 36.4% | 33.6% | 36.4% | 39.1% | 41.6% | 27.2% | 25.7% | 29.7% | 17.1% |
| Level of highest educational attainment – year 12 or equivalent (Persons aged 15 years or over) (2021) | 36.7% | 34.6% | 42.5% | 33.8% | 39.0% | 37.5% | 34.8% | 33.1% | 52.7% | 51.4% | 49.6% | 48.5% |
| Level of highest educational attainment - post year 12 training (Persons aged 15 years or over) (2021) | 41.9% | 42.0% | 50.0% | 41.3% | 43.6% | 43.2% | 44.1% | 41.0% | 55.9% | 57.0% | 55.0% | 43.3% |

* Source: PHIDU, 2023

### Highest Educational Attainment

For all 11 LGAs within the Grampians region, a greater proportion of people aged over 15 years reported their highest level of educational attainment as year 10 or below (range 25.7% (Hepburn) - 41.6% (Central Goldfields) compared with the state average (17.1%). Central Goldfields LGA reported the lowest proportion of people with year 12 or post-year 12 training (41%) (Victorian average 43.3%).

## Employment

Compared with the Victorian average, fewer people participate in the labour force across the Grampians Catchment area (see *Table A2.2_2*). This may be indicative of higher levels of retirees in the region as well as the high proportions of people living with disability for whom many barriers to employment may exist.

*Table A2.2_2 Employment indicators, by Local Government Area (2021 Census data) (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Employed, worked full-time | 37.8% | 32.7% | 36.4% | 29.7% | 31.7% | 30.2% | 28.1% | 22.8% | 34.0% | 27.6% | 39.2% | 37.1% |
| Employed, worked part-time | 18.2% | 16.1% | 20.8% | 17.1% | 18.1% | 17.1% | 16.4% | 16.3% | 21.3% | 20.7% | 19.4% | 20.2% |
| Employed, away from work | 2.5% | 2.1% | 3.0% | 2.6% | 3.1% | 2.9% | 2.8% | 2.5% | 3.2% | 3.2% | 3.4% | 4.0% |
| Unemployed | 1.8% | 1.9% | 1.9% | 1.4% | 2.0% | 1.8% | 1.8% | 2.6% | 2.9% | 2.1% | 2.4% | 3.1% |
| Not in the labour force | 32.9% | 41.4% | 33.4% | 41.7% | 37.7% | 42.6% | 43.4% | 49.2% | 34.3% | 39.5% | 31.1% | 32.2% |
| Proportion of young people 15–24 years who are engaged in full time education and/or work* | 84.4% | 83.8% | 83.0% | 76.1% | 82.9% | 79.0% | 77.2% | 76.1% | 85.2% | 82.2% | 87.1% | 88.3% |

* Source: PHIDU, 2023

## Financial security

The median weekly income of households across the Grampians region was below the state average ($1,759) for all LGAs, except for Moorabool ($1,785). The lowest weekly income was in Central Goldfields LGA ($904) (Table A2.2_3).

Central Goldfields LGA recorded the highest proportion of low-income households with both mortgage stress (9.7%) and rental stress (35.7%), both higher than the state average (8.8% and 25.1%, respectively). Ballarat LGA recorded the highest proportion of low-income households under financial stress from mortgage /rent (25.9%).

*Table A2.2_3 Financial security indicators, by Local Government Area (Source: PHIDU, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Median Household weekly income (AUD)^ | 1,207 | 1,159 | 1,381 | 1,102 | 1,124 | 1,252 | 1,101 | 904 | 1,429 | 1,281 | 1,785 | 1,759 |
| Proportion of low-income households with mortgage stress | 4.60% | 3.20% | 5.70% | 5.70% | 6.80% | 7.40% | 8.20% | 9.70% | 5.70% | 9.60% | 7.10% | 8.80% |
| Proportion of low-income households with rental stress | 12.00% | 20.10% | 28.90% | 21.00% | 26.10% | 26.00% | 29.80% | 35.70% | 29.40% | 32.60% | 28.80% | 25.10% |
| Proportion of low-income households under financial stress from mortgage/rent | 5.50% | 8.00% | 20.60% | 8.80% | 13.70% | 16.20% | 11.40% | 16.50% | 25.90% | 16.90% | 22.40% | 27.80% |

^ Source: Australian Bureau of Statistics, 2023

## Housing security

*Table A2.2_4* presents the numbers of people experiencing homelessness across each of the LGAs in the region. As a proportion of the total population, Ballarat (0.006) and Hindmarsh (0.006) LGAs demonstrated higher prevalence than the state average (0.005). It is acknowledged that obtaining accurate data on homelessness can be difficult due to under-reporting.

Between 3% (West Wimmera LGA) and 5.3% (Central Goldfields LGA) of people lived in crowded dwellings across the region.

*Table A2.2_4 Housing security indicators, by Local Government Area (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of people experiencing homelessness (2021) | 0 | 32 | 95 | 18 | 31 | 41 | 5 | 24 | 638 | 39 | 94 | 30605 |
| Proportion of people living in crowded dwellings^ | 3.0% | 5.0% | 3.2% | 4.9% | 4.2% | 4.6% | 5.1% | 5.3% | 3.7% | 4.0% | 3.7% | 6.1% |

^ Source: PHIDU, 2023

### Food security

Across the state of Victoria, 5.9% of adults reported running out of food and being unable to buy more (*Table A2.2_5*). In the Grampians region, most LGAs reported a lower proportion of people experiencing such food insecurity, however for Hepburn (6.1%) and Central Goldfields (13.2%) LGAs there was a higher proportion reporting running out of food and being unable to purchase more.

*Table A2.2_5 Food security in the Grampians region, by Local Government Area (Source: Victorian Agency for Health Information, 2022a)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who ran out of food and could not afford to buy more (2020) | No data | 4.8% | 4.2% | 5.7% | 5.0% | 2.1% | 1.4% | 13.2% | 4.5% | 6.1% | 5.7% | 5.9% |

### Healthcare access

Based on modelled data, the estimated age-standardised rate of adults who experience a barrier to accessing healthcare when needed varied across the region. The main barrier, reported as cost of service, was experienced by between 1.3% of adults (Ararat, Hindmarsh, West Wimmera and Yarriambiack LGAs) and 2.4% of adults (Ballarat LGA) (*Table A2.2_6*).

*Table A2.2_6 Healthcare access in the Grampians region, by Local Government Area (Source: PHIDU, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Estimated number of people aged over 18 who experienced a barrier to accessing healthcare when needed it in the last 12 months, with the main reason being cost of service (Age standardised rate per 100) (2014) | 1.3 | 1.3 | 2.2 | 1.3 | 1.4 | 1.3 | 1.5 | 1.5 | 2.4 | 1.5 | 1.5 | 1.6 |

### Transport

*Table A2.2_7* demonstrates the estimated number of people aged over 18 who often had difficulty or could not get places needed with transport. This ranged from 3.6% (Hindmarsh, West Wimmera, Yarriambiack) to 4.2% (Central Goldfields). The number of private dwellings with no motor vehicle ranged from 2.9% (Pyrenees) to 6% (Ballarat). These figures were below the state total figure.

*Table A2.2_7 Transport indicators, by Local Government Area (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Estimated number of people aged over 18 who often had difficulty or cannot get places needed with transport, including housebound (Age standardised rate per 100) (2014)^ | 3.6 | 3.6 | 3.8 | 3.6 | 4 | 3.8 | 3.9 | 4.2 | 3.9 | 4.1 | 3.9 | 4.2 |
| Private dwellings with no motor vehicle (2021) | 3.7% | 5.6% | 5.9% | 4.7% | 5.6% | 5.8% | 2.9% | 5.6% | 6.0% | 3.2% | 3.1% | 7.5% |

^ Source: PHIDU, 2023

### Community engagement and inclusion

Generally, across the region there were higher proportions of people who live alone (range 22.9% (Moorabool) to 37.1% (Central Goldfields) (State average: 25.9%) (*Table A2.2_8*). However, for all LGAs, the proportion of adults who belonged to an organised group was considerably higher than the state average (range: 88.3% (Northern Grampians) – 93.1% (Pyrenees), state average: 58.3%). Similarly, most (10/11) LGAs in the Grampians region reported a higher than state average proportion of adults who have someone outside their household they can rely on to care for them or their children, in an emergency.

These findings suggest that there is a higher-than-average level of social connectedness within the region which is a key community strength to potentially build health promotion activities upon. Of note however, these indicators are based on data from before the COVID-19 pandemic and it is unclear whether cancellations to organised activities, lockdowns and social distancing may have disrupted some of these social connections within the community.

Across all 11 LGAs, internet access at private dwellings was below the state average, ranging from 70.5% of private dwellings in Hindmarsh to 82.6% of private dwellings in Moorabool (state average 83.7%). Of note, these data pertained to the 2016 census, with more recent data not available. It is probable, with expansion of the National Broadband Network, the COVID-19 pandemic, increased uptake of smartphones and the progression of time, that a higher proportion of dwellings now have access the internet in the region.

*Table A2.2_8 Community engagement and inclusion indicators, by Local Government Area (Source: Department of Health (Victoria), 2023a)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of people who live alone (2021)^ | 35.2% | 33.5% | 31.6% | 36.4% | 35.2% | 32.5% | 31.6% | 37.1% | 30.3% | 32.6% | 22.9% | 25.9% |
| Proportion of adults who belonged to an organised group (2019) | 74.8% | 70.7% | 64.4% | 72.7% | 59.1% | 59.6% | 58.0% | 42.6% | 58.6% | 54.6% | 43.5% | 56.1% |
| Proportion of adults who have someone outside their household they can rely on to care for them or their children, in an emergency (2017) | 92.6% | 85.1% | 89.6% | 89.2% | 88.3% | 88.6% | 93.1% | 89.5% | 91.6% | 92.6% | 90.9% | 86.0% |
| Proportion of adults who feel most adults can be trusted (2020) | 46.9% | 32.7% | 38.0% | 40.0% | 41.0% | 36.2% | 31.6% | 34.6% | 33.2% | 32.9% | 28.0% | 36.1% |
| Proportion of adults who feel valued by society (2020) | 68.3% | 53.6% | 54.4% | 58.8% | 54.6% | 51.1% | 51.5% | 48.1% | 46.8% | 53.7% | 51.0% | 51.7% |
| Proportion of adults who thought multiculturalism made life in their area better (2020) | 56.9% | 57.4% | 57.5% | 52.0% | 54.3% | 61.4% | 50.9% | 44.3% | 61.0% | 66.1% | 46.4% | 63.5% |
| Internet access (2016)* | 71.2% | 70.5% | 75.2% | 71.0% | 71.9% | 72.3% | 71.0% | 68.2% | 80.6% | 77.8% | 82.6% | 83.7% |

^ Source: Australian Bureau of Statistics, 2023; * Source: PHIDU, 2023

# Appendix 2.3 Health risk and protective factors

**Physical activity**

In general, the Grampians region demonstrated a lower proportion of adults who were classified as sedentary (0 minutes of moderate or vigorous intensity physical activity and 0 muscle strengthening sessions per week) compared with the state average (2.5%); with the exception of adults in Ararat LGA (2.8%) (*Table A2.3_1*). However, there was generally a higher proportion of adults who were classified as having insufficient physical activity compared with the state average (44.1%) (with the exception of Ararat, Hepburn and West Wimmera LGAs). Ballarat reported the highest proportion of adults who were classified as having insufficient physical activity (49.4%). Insufficient physical activity was based on the national guidelines and refers to less than 150 minutes of moderate intensity or 75 minutes of vigorous intensity physical activity per day or equivalent for those aged 18-64, and less than 30 minutes of moderate intensity physical activity per day for adults aged over 65 years. (Department of Health, 2014)

Ten of 11 LGAs demonstrated considerably higher proportions of people participating in organised sport in 2021 than the Victorian population total (VicHealth, 2023).

*Table A2.3_1 Physical activity indicators, by Local Government Area (Source: Department of Health (Victoria), 2022)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who were classified as sedentary (2017) | 1.5% | 1.4% | 2.1% | No data | No data | 2.8% | 2.2% | 1.2% | 2.2% | 1.4% | 2.4% | 2.5% |
| Proportion of adults who were classified as having insufficient physical activity (2017) | 32.5% | 46.8% | 47.1% | 48.7% | 44.7% | 36.4% | 48.8% | 49.1% | 49.4% | 31.6% | 45.0% | 44.1% |
| Proportion of adults who were sufficiently physically active (2017) | 63.7% | 49.9% | 47.6% | 46.3% | 51.9% | 55.8% | 40.2% | 43.1% | 46.1% | 64.5% | 50.6% | 50.9% |
| Proportion of people participating in organised sport in 2021^ | 17.8% | 19.3% | 18.0% | 22.1% | 16.0% | 13.8% | 16.3% | 15.6% | 14.7% | 11.2% | 15.1% | 12.9% |

^ VicHealth, 2023

## Nutrition

In keeping with state level findings, very few adults consume a sufficient amount of fruit and vegetables in the Grampians region (range: 2.2% - 5.4%, state average: 3.6%) (*Table A2.3_2*). Furthermore, a high proportion of adults consumed snack foods or takeaways more than once per week (range 4.6% - 17.9%, state average: 15.3%) and many consumed sugar-sweetened beverages on a daily basis (range 9.1% - 25.4%, state average 10.1%).

*Table A2.3_2 Nutrition indicators, by Local Government Area (2017 Victorian Population Health Survey Data) (Source: Department of Health (Victoria), 2022)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who consume sufficient fruit and vegetables | 2.2% | 2.2% | 3.3% | 4.2% | 5.3% | 2.3% | 3.4% | 3.5% | 5.4% | 4.6% | 4.9% | 3.6% |
| Mean serves of fruit consumed daily | 1.50 | 1.40 | 1.60 | 1.50 | 1.40 | 1.50 | 1.40 | 1.40 | 1.70 | 1.60 | 1.60 | 1.60 |
| Mean serves of vegetables consumed daily | 2.10 | 2.20 | 2.10 | 2.10 | 2.10 | 2.20 | 2.10 | 2.00 | 2.30 | 2.40 | 2.10 | 2.20 |
| Proportion of adults who consumed snackfoods or takeaways more than once per week | No data | 9.6% | 14.5% | 10.4% | 12.6% | 13.7% | 17.9% | 10.0% | 16.7% | 4.6% | 23.7% | 15.3% |
| Proportion of adults who consume sugar-sweetened beverages daily | 18.7% | 15.2% | 16.5% | 13.3% | 19.3% | 14.4% | 25.4% | 17.5% | 11.2% | 9.1% | 17.7% | 10.1% |

## Body Mass Index

Across all 11 LGAs, a higher proportion of adults reported a Body Mass Index (BMI) > 25 (considered overweight) compared with the state average (range: 52.2% - 66.8%, state average 51%) (*Table A2.3_3*). Furthermore, a higher proportion of adults reported a BMI >30 (considered obese) (range: 23.3% - 38.2%, state average 20.9%). Given this data was self-reported, it is possibly an underestimate of the true prevalence of overweight and obesity in the region.

*Table A2.2_3 Body Mass Index, by Local Government Area (2020 Victorian Population Health Survey Data) (Source: Victorian Agency for Health Information, 2022a)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who have BMI>25 (self-report) | 58.4% | 56.7% | 56.2% | 64.2% | 62.1% | 65.6% | 66.8% | 65.7% | 60.9% | 52.2% | 59.5% | 51.0% |
| Proportion of adults who BMI>25 to 29.99 (self-report) | 25.3% | 27.6% | 27.5% | 26.0% | 31.0% | 36.9% | 30.4% | 34.2% | 32.3% | 29.0% | 28.1% | 30.1% |
| Proportion of adults who BMI>30 (self-report) | 33.2% | 29.1% | 28.7% | 38.2% | 31.1% | 28.7% | 36.5% | 31.5% | 28.7% | 23.2% | 31.4% | 20.9% |

### Smoking and e-cigarettes

As demonstrated in *Table A2.3_4*, most LGAs in the region (with the exception of Pyrenees and West Wimmera) demonstrated a higher proportion of adults who smoked daily compared with the state average. The highest proportion was in Central Goldfields at 22.1% (state average: 12%) of adults. All LGAs demonstrated a higher proportion of mothers who smoked tobacco in the first 20 weeks of pregnancy than the state figure (range: 10.3% in Hepburn to 24.9% Yarriambiack, state figure: 8.0%).

Data on e-cigarette use was not available.

*Table A2.3_4 Smoking prevalence, by Local Government Area (2020 Victorian Population Health Survey Data) (Source: Victorian Agency for Health Information, 2022a)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who smoke daily | 11.4% | 18.8% | 13.2% | 20.8% | 15.7% | 12.9% | 11.2% | 22.1% | 12.7% | 17.2% | 13.8% | 12.0% |
| Proportion of mothers who smoked tobacco in the first 20 weeks of pregnancy^ | 13.2% | 14.0% | 16.3% | 24.9% | 14.5% | 18.3% | 10.4% | 19.5% | 14.4% | 10.3% | 12.1% | 8.0% |

^ Source: PHIDU, 2023

**Immunisation**

High rates of childhood immunisation were noted throughout the region (*Table A2.3_5*). Most LGAs had higher than state average levels of immunisation for children at 1 and 5 years of age. West Wimmera was noted to have lower levels of immunisation for children at 1 year (91.2%), but 100% of children fully immunised at 5 years of age, while Hepburn was noted to have only 90.7% of children fully immunised at 5 years of age (state average 95.5%).

Ballarat, Hepburn, West Wimmera and Yarriambiack demonstrated some lower than state-average levels of HPV vaccination coverage for girls and/or boys aged 15 years.

*Table A2.3_5 Immunisation indicators, by Local Government Area (Source: PHIDU, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Children fully immunised at 1 year of age (2018) | 91.2% | 96.1% | 96.9% | 96.7% | 94.1% | 99.0% | 93.9% | 96.0% | 96.1% | 94.3% | 96.5% | 94.3% |
| Children fully immunised at 5 years of age (2018) | 100.0% | 100.0% | 97.5% | 94.9% | 95.0% | 95.4% | 97.6% | 97.2% | 97.7% | 90.7% | 96.9% | 95.5% |
| HPV three-dose vaccination coverage for females turning 15 years of age (2017) | 76.3% | 97.5% | 80.6% | 85.9% | 102.8% | 87.4% | 94.8% | 85.8% | 78.8% | 70.9% | 82.0% | 80.0% |
| HPV three-dose vaccination coverage for males turning 15 years of age (2017) | 79.5% | 97.5% | 76.8% | 65.0% | 92.6% | 90.0% | 93.0% | 81.6% | 72.3% | 69.6% | 76.3% | 76.5% |

**Preventative health checks**

There was variability in the coverage of preventative health checks in the region (*Table A2.3_6*). In the preceding two years:

- Between 77.4% and 91.7% of adults in the region reported having their blood pressure measured (4/11 LGAs below the state average of 79.6%)
- Between 44.1% - 56.3% of adults had their blood lipid profile assessed (all LGAs below the state average of 56.8%), and
- Between 43.5% and 56.8% of adults had their blood glucose checked (6/11 LGAs below the state average of 50.7%).

*Table A2.3_6 Preventative health checks, by Local Government Area (2017 Victorian Population Health Survey Data) (Source: Department of Health (Victoria), 2022)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who had their blood pressure measured in the preceding two years | 82.3% | 85.5% | 81.7% | 91.7% | 87.2% | 77.4% | 77.4% | 79.2% | 78.9% | 77.7% | 78.0% | 79.6% |
| Proportion of adults who had their blood lipid profile assessed in the preceding two years | 56.3% | 53.8% | 54.4% | 49.7% | 52.3% | 46.7% | 53.0% | 50.6% | 46.8% | 44.1% | 52.2% | 56.8% |
| Proportion of adults who had their blood glucose checked in the preceding two years | 50.8% | 51.1% | 45.5% | 56.3% | 47.2% | 45.8% | 51.3% | 45.6% | 43.5% | 48.4% | 56.8% | 50.7% |

### Cancer screening

All areas within the Grampians catchment demonstrated lower than state average levels of cervical cancer screening participation among females aged 25- 75 (range: 37.3% (Northern Grampians) - 45.9% (Moorabool, state average: 47.4%) (*Table A2.3_7*). In contrast, most areas had higher than state average levels of breast (range 42.8% - 58.6%) and bowel (range 43.7% - 48.7%) cancer screening participation.

*Table A2.3_7 Participation in cancer screening programs, by Local Government Area (Source: PHIDU, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Participation in cervical screening program in target group (females aged 25-74) | 40.10% | 38.10% | 43.20% | 42.40% | 37.30% | 37.70% | 38.90% | 37.90% | 40.70% | 44.70% | 45.90% | 47.4% |
| Participation in breast screening program in target group (females aged 50-74) | 58.60% | 49.80% | 56.60% | 52.30% | 51.80% | 44.20% | 47.60% | 48.40% | 50.60% | 42.80% | 46.00% | 46.5% |
| Participation in bowel screening program in target age group (people aged 50-74) | 45.90% | 45.90% | 50.90% | 48.90% | 47.90% | 45.70% | 46.60% | 46.70% | 50.30% | 47.60% | 46.80% | 46.0% |

# Appendix 2.4 Health and wellbeing outcomes

## General wellbeing

Less than half of all adults in the region reported that their health was very good or excellent (range: 31.3% - 49.1%, state average: 40.5%) (*Table A2.4_1*). While small numbers reported very high overall life satisfaction (range 27.5% - 42.6%) this was higher for all LGAs compared with the state figure (26.9%). Between 27.8% (Northern Grampians) and 58% (Pyrenees) of adults reported that their life is worthwhile (state figure: 32.3%).

*Table A2.4_1 General Wellbeing indicators, by Local Government Area (Source: Victorian Agency for Health Information, 2022a)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who self-rate their health as very good or excellent (2020) | 46.6% | 38.2% | 48.8% | 31.3% | 39.7% | 43.5% | 49.1% | 37.5% | 42.0% | 42.8% | 48.3% | 40.5% |
| Proportion of adults who reported very high overall life satisfaction (2020) | 42.6% | 33.1% | 32.8% | 34.3% | 34.0% | 29.3% | 32.9% | 30.7% | 27.5% | 30.4% | 32.8% | 26.9% |
| Proportion of adults report that their life is worthwhile (2017)^ | 40.4% | 32.0% | 43.3% | 50.5% | 27.8% | 40.3% | 58.0% | 40.3% | 36.4% | 43.4% | 37.5% | 32.3% |

^ Source: Department of Health (Victoria), 2022

## Mortality

Life expectancy provides an indication of how long the average person is expected to live based on current age and sex-specific mortality rates (Australian Institute of Health and Welfare, 2022).

Based on mortality data over the period 2013-2017, ten of the 11 LGAs in the region had lower than state average life expectancy at birth for both males and females. The lowest life expectancy was recorded in Central Goldfields at 76.1 years for males (almost 6 years below the state average for males (81.9 years)) and 81.88 years for females (almost 4 years below the state average for females (85.6 years)). The highest life expectancy was 82.48 for males in Yarriambiack and 86.8 years for females in Horsham (*Table A2.4_2*).

*Table A2.4_2 Life expectancy 2013-2017, by Local Government Area and sex (Source: Victorian Agency for Health Information, 2022b)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | 78.10 | 79.88 | 80.25 | 82.48 | 78.74 | 79.49 | 81.76 | 76.11 | 79.76 | 80.82 | 80.63 | 81.9 |
| Female | 83.49 | 82.62 | 86.83 | 83.69 | 83.04 | 84.39 | 84.25 | 81.88 | 83.79 | 83.52 | 85.30 | 85.6 |

Life expectancy trends at the statistical area level 4 (SA4) for males and females calculated using data periods from 2008-2010 to 2019-21 are depicted in Figure A2.4_1. While life expectancy in the Melbourne region has generally increased for males and females over the past 15 years, the life expectancy in Ballarat and North West SA4s has declined over the past decade and a broadening of the life expectancy gap is demonstrated between the Melbourne and Grampians regions, particularly for males. Figure A2.4_2 demonstrates life expectancy trends by LGA.

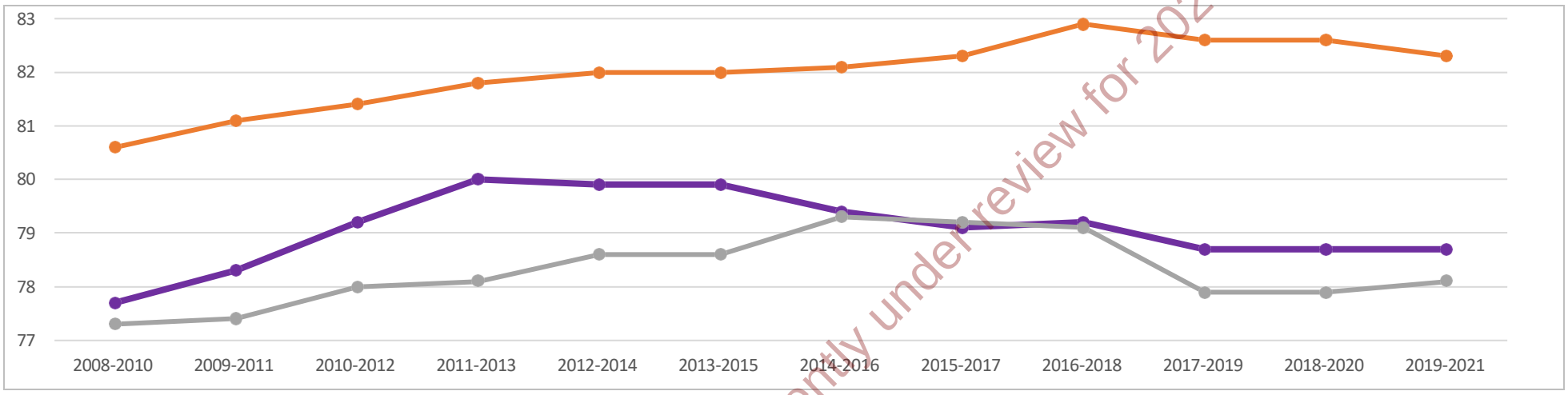
The premature death rate was considerably higher than state average across all 11 LGAs (range: 291.1 per 100, 000 (Hepburn) – 463.4 per 100, 000 (Central Goldfields), state average: 220 per 100,000). The leading cause of death across the catchment was Coronary Heart Disease for 9/11 LGAs and Dementia for 2/11 LGAs (Ararat and Yarriambiack) (*Table A2.4_3*).

*Table A2.4_3 Mortality statistics 2020, by Local Government Area (Source: PHIDU, 2023)*

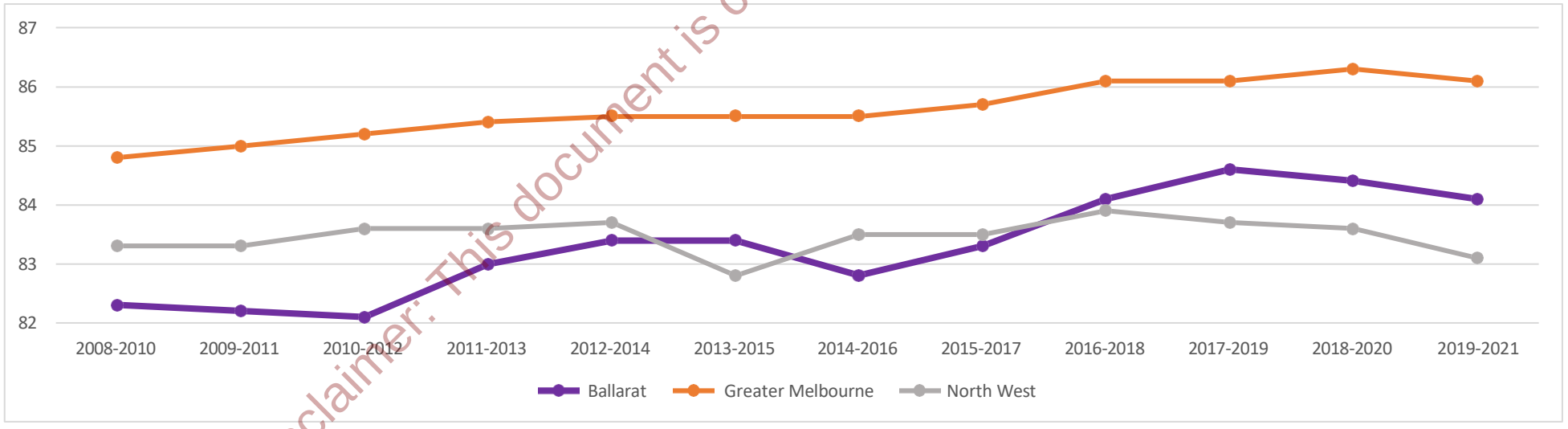
| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Median age of death | 81.5 | 84.0 | 83.0 | 84.0 | 81.0 | 81.0 | 78.0 | 81.0 | 81.0 | 82.0 | 79.0 | 82.0 |
| Premature death rate (ASR per 100,000) | 341.0 | 387.8 | 330.8 | 361.5 | 378.5 | 344.2 | 341.4 | 463.4 | 345.3 | 291.9 | 292.6 | 220.0 |
| Leading cause of mortality (Victorian data) | CHD | CHD | CHD | Dementia | CHD | Dementia | CHD | CHD | CHD | CHD | CHD | CHD |

CHD: Coronary Heart Disease, Dementia (including Alzheimer's disease)

*Figure A2.4_1 Trends in expectation of life, Grampians region, 2008-2010 – 2019-2021, by SA4 region. A: Males, B: Females (Source: Australian Bureau of Statistics, 2022)*

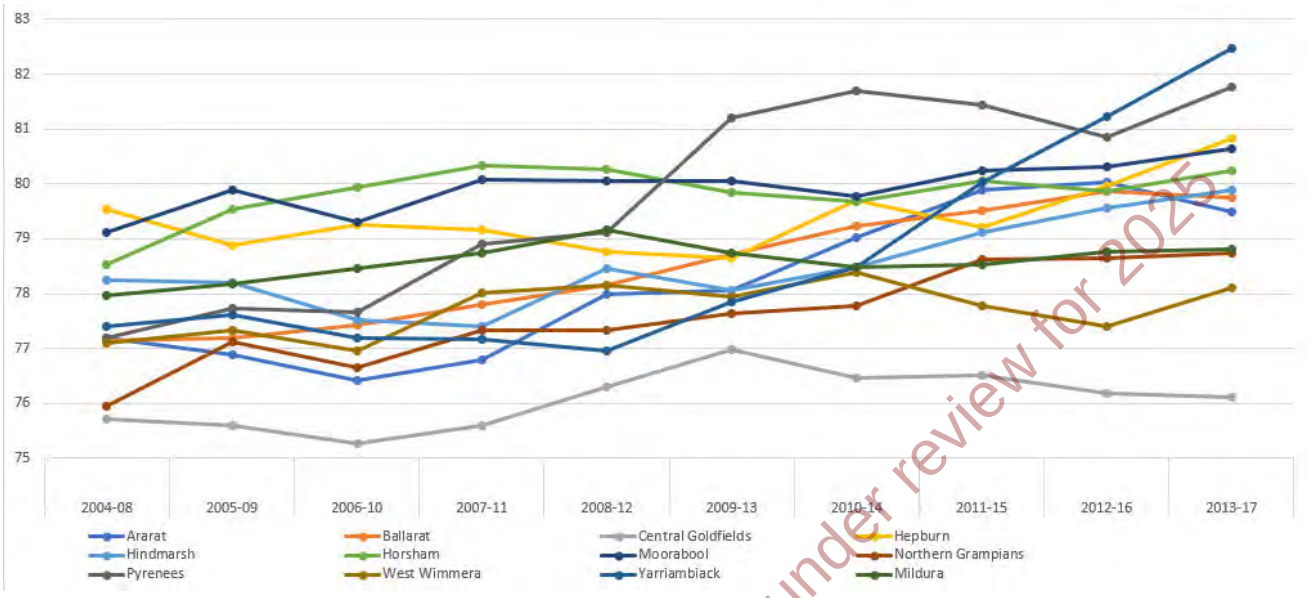



A

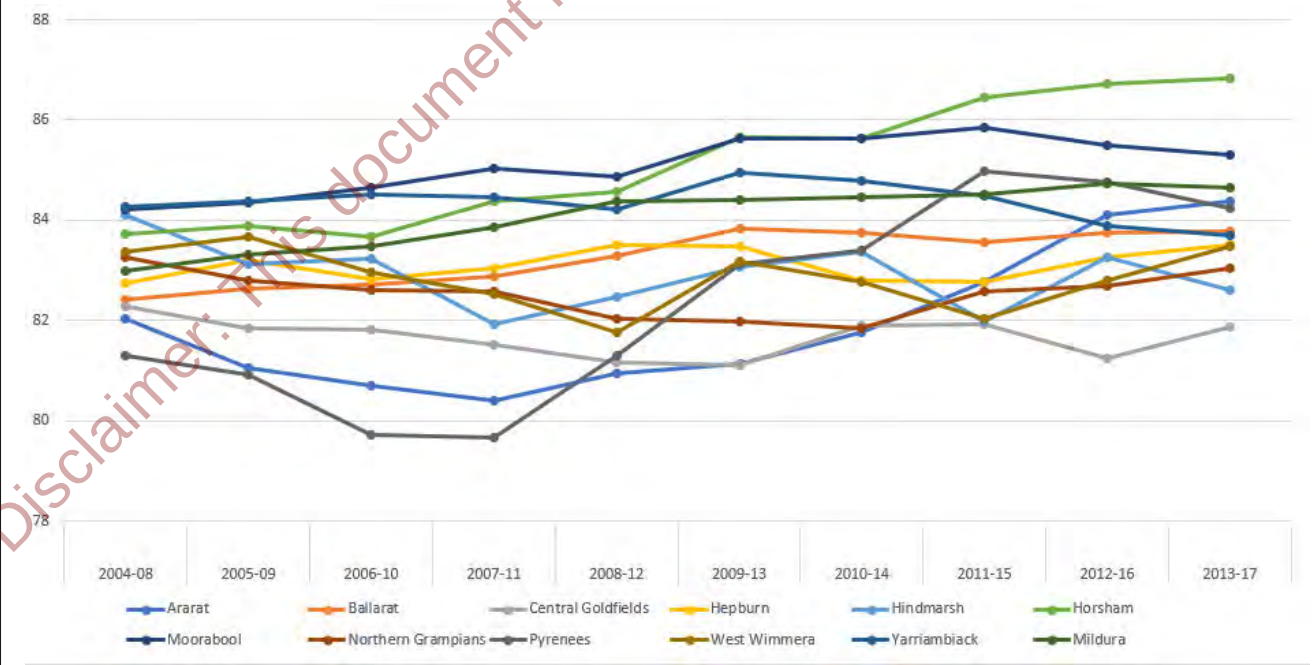



B

*Figure A2.4_2 Life expectancy trends, by Local Government Area, A: Males, B: Females (Source: Victorian Agency for Health Information, 2022b. Please note that the LGA-level data used in the below figures are from 2017 or earlier)*




A




B

**Oral Health**

*Table A2.4_4* demonstrates that rates of potentially preventable dental hospitalisation of children 0- 9 years were higher than the state average in 10/11 LGAs within the Grampians region (state average 6.1 per 1,000, range: 4.7 – 13.8 per 1,000). There were high proportions of children presenting to public dental services with at least one decayed, missing or filled primary or permanent tooth across our region, and in most LGAs these proportions were higher than the state figure. Public dental care waiting times ranged from 4.6 months (Ararat) to 24.6 months (Central Goldfields) (state figure = 16.5 months).

**Mental Health**

Between 9.1% (West Wimmera) and 14% (Central Goldfields) of people within the Grampians catchment reported they had a mental health condition which was higher than the state average of 8.8% across all 11 LGAs (*Table A2.4_5*). This is likely an underestimate of the true prevalence of mental health conditions in the region, as mental health conditions are often under-reported and under- diagnosed, particularly in rural regions.

The premature death rate due to suicide and self-inflicted injuries was higher than the state average across all 11 LGAs, with Hindmarsh LGA in particular demonstrating a premature death rate of 30.6 per 100,000 due to suicide and self-inflicted injuries (state average 10.6 per 100, 000).

**Alcohol and other drugs**

The proportion of adults who regularly consumed alcohol at a level which placed them at increased lifetime risk of harm was high across the region (*Table A2.4_6*). The Pyrenees LGA in particular, demonstrated almost half (45.8%) of the adult population consumed alcohol weekly at an increased lifetime risk of harm (state average 24.7%). 8/11 LGAs in the Grampians region demonstrated a higher than state average proportion of adults who consumed alcohol in amounts that placed them at risk of alcohol-related injury at least monthly (range: 6.9% (Central Goldfields) - 19.3% (Moorabool), state average: 12.8%).

*Table A2.4_4 Oral health indicators in the Grampians region (2019), by Local Government Area (Source: Dental Health Services Victoria, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of potentially preventable dental hospitalisation of children 0–9 years (per 1,000) | 6.50 | 8.40 | 10.90 | 10.80 | 13.10 | 13.80 | 4.70 | 7.70 | 10.10 | 8.50 | 8.50 | 6.10 |
| Proportion of children presenting with at least one decayed, missing or filled primary or permanent tooth, attending public dental services (age 0-5) | 36.0% | 29.0% | 28.0% | 33.0% | 38.0% | 32.0% | 36.0% | 35.0% | 33.0% | 26.0% | 34.0% | 26.0% |
| Proportion of children presenting with at least one decayed, missing or filled primary or permanent tooth, attending public dental services (age 6) | No data | 57.0% | 60.0% | 59.0% | 72.0% | 60.0% | 64.0% | 44.0% | 65.0% | 50.0% | 36.0% | 51.0% |
| Proportion of children presenting with at least one decayed, missing or filled primary or permanent tooth, attending public dental services (age 12) | No data | 68.0% | 54.0% | No data | 75.0% | 70.0% | 70.0% | 56.0% | 77.0% | 61.0% | 70.0% | 59.0% |
| Average number of decayed, missing or filled primary (baby) and permanent teeth for children attending public dental services (age 0-5) | 0.6 | 1.6 | 1.2 | 2.6 | 1.8 | 1.3 | 1.5 | 1.3 | 1.5 | 1.0 | 1.5 | 1.1 |
| Average number of decayed, missing or filled primary (baby) and permanent teeth for children attending public dental services (age 6) | No data | 2.3 | 2.8 | 2.1 | 3.4 | 3.3 | 2.6 | 2.0 | 3.5 | 2.1 | 1.2 | 2.4 |
| Average number of decayed, missing or filled primary (baby) and permanent teeth for children attending public dental services (age 12) | No data | 1.6 | 1.4 | No data | 6.0 | 2.9 | 3.4 | 2.0 | 3.3 | 1.5 | 2.2 | 1.9 |
| Self-reported rating of excellent dental health among adults (2017) | 35.0% | 24.0% | 36.0% | 27.0% | 36.0% | 34.0% | 41.0% | 27.0% | 36.0% | 39.0% | 40.0% | 37.0% |
| Proportion of adults who delayed or avoided visiting a dental professional because of cost | 69.0% | 28.0% | 27.0% | 28.0% | 40.0% | 38.0% | 37.0% | 45.0% | 43.0% | 35.0% | 46.0% | 34.0% |
| Self-reported gum disease among adults (2017)^ | 9.1% | 9.1% | 8.4% | 8.5% | 10.6% | 6.2% | 6.2% | 7.2% | 10.4% | 11.4% | 12.4% | 10.8% |
| Public dental (general) care waiting times (months)* | 21.70 | 21.70 | 27.60 | 13.00 | 13.00 | 25.00 | 28.10 | 44.10 | 28.10 | 27.10 | 39.90 | 16.50 |

^Source: Department of Health (Victoria), 2022; *Source: Australian Dental Association, Victoria, 2023

*Table A2.4_5 Mental Health Indicators, by Local Government Area*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People who reported they had a mental health condition (including depression or anxiety)^ | 9.1% | 10.4% | 10.1% | 11.9% | 10.7% | 10.9% | 11.7% | 14.0% | 13.1% | 11.2% | 10.2% | 8.80% |
| Proportion of adult population who report high or very high levels of psychological distress# | 15.1% | 23.5% | 17.8% | 27.2% | 26.0% | 15.9% | 22.0% | 20.7% | 25.5% | 15.9% | 23.1% | 23.5% |
| Proportion of adult population who sought help for a mental health related problem in the previous year~ | 14.2% | 18.5% | 20.4% | 16.8% | 18.5% | 19.9% | 8.2% | 15.3% | 22.0% | 20.6% | 21.7% | 17.6% |
| Premature death rate due to suicide and self-inflicted injuries (ASR per 100,000)* | No data | 30.60 | 14.20 | 30.30 | 21.90 | 20.90 | No data | 13.20 | 20.20 | 15.50 | 15.90 | 10.60 |

^Source: ABS, 2023; #Victorian Agency for Health Information, 2022a; ~Department of Health (Victoria), 2022; *Source: PHIDU, 2023

*Table A2.4_6 Alcohol and other drug use indicators, by Local Government Area*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of adults who consume alcohol at lifetime risk of harm^ | 67.0% | 58.9% | 56.6% | 61.0% | 66.1% | 62.1% | 76.2% | 59.1% | 62.8% | 65.7% | 67.2% | 59.5% |
| Proportion of adults who consume alcohol at risk of alcohol-related injury on a single occasion at least monthly* | 12.8% | 15.1% | 13.5% | 15.7% | 18.1% | 9.9% | 9.9% | 6.9% | 13.4% | 8.5% | 19.3% | 12.8% |
| Alcohol-related ambulance attendances (1 July 2021 - 30 June 2022)# | 13 | 12 | 254 | 41 | 84 | 45 | 35 | 89 | 559 | 89 | 111 | 25391 |
| Illicit drug-related ambulance attendances (1 July 2021 - 30 June 2022)# | <5 | 6 | 49 | 8 | 25 | 16 | <5 | 41 | 282 | 15 | 61 | 12968 |

^ Source: Department of Health (Victoria), 2023a; *Source: Department of Health (Victoria), 2022; #Turning Point, Eastern Health, 2023

**Sexual and Reproductive Health**

*Family and sexual violence*

*Table A2.4_7* demonstrates indicators of interest with regard to family and sexual violence in the Grampians region. Overall, the data demonstrated high rates of sexual and intimate partner violence across the region. Of note, rates of sexual offences for females were higher than the Victorian LGA average across 8/11 LGAs in the region (range: 4.2 per 10,000 (Hepburn) - 25.1 per 10, 000 (Northern Grampians), LGA average: 14.9 per 10, 000). Rates of sexual offences against males was decidedly lower than that for females, yet 4 LGAs across the region did demonstrate higher than average rates of sexual offences against males.

*Table A2.4_7 Family and sexual violence indicators, by Local Government Area (Source: Women's Health Atlas Victoria, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victorian LGA average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of sexual offences (per 10,000) – Female | 25.0 | 22.8 | 24.5 | 16.8 | 25.1 | 23.6 | 19.6 | 20.8 | 13.5 | 4.2 | 10.9 | 14.9 |
| Rate of sexual offences (per 10,000) – Male | 0.0 | 2.6 | 2.0 | 2.3 | 3.4 | 1.3 | 2.0 | 3.7 | 1.9 | 0.9 | 1.3 | 2.1 |
| Aggregate 2 year % known to victim – Female | 100.0% | 83.3% | 78.5% | 94.3% | 80.0% | 83.1% | 84.5% | 86.2% | 79.8% | 90.5% | 83.8% | 76.4% |
| Aggregate 2 year % known to victim – Male | 37.5% | 100.0% | 77.8% | 100.0% | 100.0% | 80.0% | 100.0% | 81.8% | 59.6% | 100.0% | 77.8% | 71.5% |
| Rate of intimate partner violence (per 10, 000) – Female | 64.9 | 68.5 | 150.3 | 59.5 | 144.8 | 113.6 | 60.0 | 103.1 | 100.8 | 54.2 | 61.4 | 75.8 |
| Rate of intimate partner violence (per 10, 000) – Male | 12.5 | 21.1 | 37.7 | 18.3 | 26.8 | 26.1 | 17.0 | 37.1 | 27.2 | 13.3 | 19.7 | 18.9 |

Across all 11 LGAs, the aggregate 2-year proportion of sexual offences where the perpetrator was known to the victim was higher than the whole of Victoria LGA average (range: 78.5% (Horsham) – 100% (West Wimmera), LGA average: 76.4%). Rates of intimate partner violence against females were higher than the state LGA average across 5/11 LGAs and tended to be 3-5 times the rate of intimate partner violence against males.

*Sexually transmitted infections and blood borne viruses*

Rates of notifiable sexually transmitted infections (STIs), Blood borne viruses (BBVs) and diseases associated with sexual transmission (Mpox and Shigella) are presented in *Table A2.4_8.* Overall, based on data from 2022, notification rates were generally lower across the region compared with the state-wide rate.

*Table A2.4_8 Notification rates for Sexually Transmitted Infections and Blood Borne Viruses in 2022 (per 100,000 population) (Source: Department of Health (Victoria), 2023b)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victorian LGA average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Chlamydia^ | 255.6 | 243.9 | 181.7 | 148.4 | 146.8 | 170.8 | 369.8 | 253.6 | 349.1 | 269.9 | 315.4 | 367.4 |
| Gonorrhoea | 25.6 | 17.4 | 15.1 | 14.8 | 0.0 | 25.6 | 0.0 | 23.1 | 73.5 | 77.1 | 101.0 | 151.3 |
| Syphilis - infectious | 0.0 | 0.0 | 15.0 | 14.8 | 17.3 | 8.5 | 27.4 | 0.0 | 11.6 | 45.0 | 9.2 | 27.4 |
| Hepatitis B – newly acquired | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.9 | 0.0 | 0.0 | 0.2 |
| Hepatitis C – newly acquired | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 3.1 | 0.5 |
| HIV – newly acquired | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.9 |
| Mpox | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Shigella | 0.0 | 0.0 | 0.0 | 14.8 | 0.0 | 0.0 | 0.0 | 0.0 | 1.9 | 0.0 | 0.0 | 0.0 |

^ Data based on 2021 notifications

However, there were several notable exceptions to this including:

- The Pyrenees LGA demonstrated higher than state average rates of chlamydia notifications (369.8 per 100, 000 population, statewide rate: 367.4 per 100, 000)
- Hepburn LGA demonstrated a considerably higher rate of notification for infectious syphilis at 45 per 100, 000 population compared with 27.4 per 100, 000 for Victoria
- Ballarat LGA demonstrated a higher rate of newly acquired hepatitis B notifications at 1.9 per 100, 000 population compared with the state figure (0.2 per 100, 000)
- The rate of notification for newly acquired Hepatitis C was higher than the state average in Moorabool (3.1 per 100,000 population, rate for Victoria: 0.5 per 100,000)
- Ballarat and Yarriambiack LGAs demonstrated higher than state average notification rates for Shigella (1.9 per 100, 000 and 14.8 per 100, 000, respectively, rate for Victoria: 0 per 100, 000). Of note, Shigella is commonly transmitted from person-to-person via the faecal-oral route, however sexual transmission is also known to occur, particularly among men who have sex with men (MSM). It is uncertain from the publicly available data whether the cases reported in 2022 were associated with transmission in the MSM population. The Yarriambiack rate appears high due to the small population at risk.

*Table A2.4_9* presents data from the Viral Hepatitis Mapping project which provided estimates of Chronic Hepatitis B and C infection prevalence based on notification data and population profiles (World Health Organization Collaborating Centre for Viral Hepatitis, The Doherty Institute, 2021). Prevalence refers to the total number of people currently living with a disease and is useful for health services planning. Based on this data, the prevalence of Chronic Hepatitis C infection in the region was estimated to be above state average across most of the Grampians catchment area (range: 0.65% (Grampians SA3) – 0.82% (Maryborough/Pyrenees SA3), state average: 0.65%). The proportion of people living with chronic hepatitis C who accessed treatment was estimated to be between 48.3% (Ballarat SA3) and 75.9% (Creswick, Daylesford, Ballan SA3) (state average: 55.2%). Hepatitis C is now a curable disease with appropriate direct acting antiviral medication, and as such, the National Strategy Target of 65% treatment uptake by 2022 was established in an effort to eliminate Hepatitis C (Department of Health (Australia), 2019). There is some evidence to suggest that this target has been, or is close to being, met in most regions, with the exception of Ballarat SA3.

*Table A2.4_9 Hepatitis C and Hepatitis B - estimated prevalence and care uptake, by Level 3 Statistical Areas (SA3) (Source: World Health Organization Collaborating Centre for Viral Hepatitis, The Doherty Institute (2021))*

| LGA | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SA3** | **Grampians** | | | | | | **Maryborough/ Pyrenees** | | **Ballarat** | **Creswick/Daylesford / Ballan** | | |
| Prevalence of chronic Hepatitis C^ (%) | 0.65 | | | | | | 0.82 | | 0.69 | 0.7 | | 0.65 |
| Hepatitis C treatment uptake* (%) | 63 | | | | | | 67.7 | | 48.3 | 75.9 | | 55.2 |
| Prevalence of chronic Hepatitis B# | 0.44 | | | | | | 0.42 | | 0.47 | 0.43 | | 0.96 |
| Hepatitis B – care uptake+ | 11.5 | | | | | | < 6 receiving care | | 8.2 | 13.4 | | 24.46 |
| Hepatitis B – treatment uptake~ | 5.4 | | | | | | < 6 receiving care | | 3.8 | 6.7 | | 11.02 |

^ based on published estimated of national prevalence and notifications from the NNDSS; * measured cumulatively as the total proportion of people treated of those living with Hepatitis C at the start of 2016, based on MBS and PBS records; # modelled prevalence based on census data and published seroprevalence; + based on receiving either MBS items 68482 and 69483 – viral load testing); ~based on PBS data

The estimated prevalence of Chronic Hepatitis B infection was lower than the state average across the Grampians catchment region (range: 0.42% (Maryborough/Pyrenees SA3) – 0.47% (Ballarat SA3), state average: 0.96%). However, access to hepatitis B management (measured through evidence of viral load monitoring and/or treatment with relevant antiviral medication) was considerably lower than state average across the region.

*Access to abortion*

There are few providers in the region providing abortion services. Two public clinics were identified in Ballarat LGA (Ballarat Community Health and Grampians Health), and only three private providers were identified in the region (Ochre Health Medical Centre, Creswick, Hamilton Street Medical Centre, Horsham and Nightingale Clinic, Maryborough) (Western Victoria Primary Health Network, 2023 and 1800myoptions, 2023). This is in keeping with the finding that rates of PBS 10211K prescriptions (for medical abortion drugs) per 1,000 population by prescriber location tended to be lower than the state LGA average for all locations except for Horsham and Central Goldfields. The rate of PBS 10211K prescriptions per 1,000 population by patient location however, demonstrated a significant demand for services throughout the region (see *Table A2.4_10*). Ararat in particular demonstrated a rate of PBS 10211K prescriptions by patient location of 10.6 per 1,000 population, yet the rate of prescriptions by provider and pharmacy location is 0, indicating no local service provision.

This demand and supply mismatch is reproduced throughout most LGAs in the region, particularly so for Moorabool and Pyrenees LGAs, where the rate of prescription by provider and pharmacy location is 0, despite these LGAs demonstrating higher than average numbers of people residing in the area obtaining medical abortion. These findings indicate that people living within the Grampians region are seeking termination of pregnancy from outside the region, possibly Melbourne or Geelong. Of note, the number of abortion services available in the Geelong region is close to triple that which is available in the Grampians region (Western Victoria Primary Health Network, 2023).

*Table A2.4_10 Rate of PBS 10211K prescriptions for medical abortion, per 1000 population (Source: Women's Health Atlas Victoria, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victorian LGA average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of PBS 10211K prescriptions by patient location | 3.6 | 2.5 | 6.6 | 2.2 | 5.1 | 10.2 | 6.0 | 4.2 | 6.6 | 6.5 | 4.9 | 4.5 |
| Rate of PBS 10211K prescriptions by prescriber location | 0.0 | 0.0 | 5.3 | 0.0 | 1.1 | 0.0 | 0.0 | 5.6 | 1.4 | 0.8 | 0.0 | 4 |
| Rate of PBS 10211K prescriptions by Pharmacy location | 0.0 | 0.0 | 5.9 | 0.0 | 1.1 | 0.0 | 0.0 | 0.0 | 8.9 | 1.9 | 0.9 | 2.5 |

*Access to long-term contraception*

Access to effective long-term contraception methods is an important aspect of sexual and reproductive health and primary prevention method for unplanned pregnancy.

Effective long-term contraceptive methods include contraceptive implants and intrauterine devices (IUDs) which require additional skills and training to insert by medical practitioners.

*Table A2.4_11* demonstrates the rate of contraceptive insertion for both implants and IUDs per 1000 by patient location and provider location. For most LGAs in the region, the rate of contraceptive insertion for both implants and IUDs was higher for the patient location compared with the provider location. This suggests that there is unmet demand for long-term contraception across the region. The exceptions to this finding were Horsham and Ballarat LGAs, where there were higher rates of insertion based on the provider location compared with the patient location, suggesting these regional hubs may be providing services to women from the broader region.

*Table A2.4_11 Rate of long-term contraceptive insertion, per 1000, by Local Government Area (Source: Women's Health Atlas Victoria, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victorian LGA average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Rate of contraceptive implant insertion by patient location | 9.0 | 6.7 | 7.5 | 10.2 | 8.1 | 9.5 | 10.6 | 10.0 | 9.3 | 6.7 | 8.0 | 8.2 |
| Rate of contraceptive implant insertion by provider location | 3.5 | 3.9 | 8.4 | 4.3 | 4.4 | 9.6 | 6.0 | 10.2 | 11.1 | 5.8 | 6.3 | 7.5 |
| Rate of contraceptive IUD insertion by patient location | 6.0 | 6.3 | 9.7 | 4.3 | 3.9 | 4.8 | 7.4 | 6.1 | 10.5 | 6.0 | 6.4 | 7.1 |
| Rate of contraceptive IUD insertion by provider location | 0.0 | 0.0 | 10.4 | 0.0 | 0.5 | 1.8 | 0.8 | 3.4 | 14.9 | 1.9 | 2.5 | 5.9 |

*Birth rates*

Birth rates were higher than the state LGA average in West Wimmera, Ballarat and Moorabool. The 2-year aggregate adolescent birth rate was higher than state LGA average across 9/11 LGAs in the region as reported in *Table A2.4_12*. Yarriambiack and Northern Grampians LGAs have the highest adolescent birth rates in the state (Victorian Women's Health Atlas, 2023).

*Table A2.4_12 Birth rates in the Grampians region, by Local Government Area (Source: Women's Health Atlas Victoria, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victorian LGA average |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Birth rate, per 10, 000 (2020) | 28.4 | 21.6 | 21.3 | 20.9 | 19.0 | 19.3 | 19.9 | 16.0 | 23.1 | 14.6 | 24.9 | 21.8 |
| Adolescent birth – aggregate 2-year rate (per 1000) (2019/20) | 15.9 | 11.0 | 19.2 | 26.0 | 25.5 | 19.3 | 9.7 | 19.0 | 14.3 | 5.2 | 4.3 | 8.2 |

**Chronic disease**

The premature death rate (age-standardised) due to cancer, cardiovascular disease, diabetes and chronic respiratory disease was higher than state average across all 11 LGAs in the region, ranging from 132.3 deaths per 100, 000 in Hepburn to 225.7 deaths per 100, 000 in Hindmarsh (state rate: 134.4 deaths per 100, 000) (*Table A2.4_13*).

*Table A2.4_13 Premature death rate due to chronic disease, by Local Government Area (Department of Health (Victoria), 2023a)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Premature death rate due to cancer, cardiovascular, diabetes and chronic respiratory disease (per 100,000 population) | 192.3 | 225.7 | 162.9 | 164.3 | 198.2 | 170.1 | 156.5 | 204.9 | 157.5 | 132.3 | 150.3 | 134.4 |

*Cardiovascular and cerebrovascular disease*

All 11 LGAs in the region demonstrated higher than state average rates of people who reported they had heart disease (including a heart attack or angina), people who reported they had a stroke and people dying prematurely from circulatory disease (*Table A2.4_14*). Central Goldfields LGA in particular, demonstrated rates for heart disease, stroke and premature death which were approximately double the state figures.

*Respiratory disease*

There is a high burden of chronic respiratory disease in the Grampians region as depicted in *Table A2.4_15*. The percentage of the population who self- reported asthma on the 2021 census was higher than the state figure for all 11 LGAs (Range: 8.63% in West Wimmera – 11.84% in Yarriambiack, state figure: 8.35%). The percentage of people who reported they had a lung condition (including COPD or emphysema) was generally 2-3 times higher across the region (range: 2.36% in Moorabool – 4.71% in Central Goldfields, State figure 1.50%). The premature death rate due to respiratory system diseases was approximately double the state level in 6/11 LGAs in the region.

*Table A2.4_14 Prevalence and premature death rates associated with cardiovascular and circulatory disease, per Local Government Area (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (state) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of people who reported they had heart disease (including a heart attack or angina) | 5.63% | 5.85% | 5.15% | 6.39% | 5.55% | 5.34% | 6.13% | 6.96% | 4.66% | 5.89% | 4.11% | 3.74% |
| Proportion of people who reported they had a stroke | 1.13% | 1.63% | 1.41% | 1.57% | 1.29% | 1.27% | 1.60% | 1.91% | 1.18% | 1.37% | 1.12% | 0.92% |
| Premature death rate due to circulatory disease (ASR per 100,000 population)(2016-2020)^ | 52.1 | 82.6 | 61.2 | 77 | 66 | 63.5 | 76 | 77.2 | 58.9 | 62.3 | 51.9 | 40.7 |
| Premature death rate due to coronary heart disease (ASR per 100,000 population)(2016-2020)^ | 0 | 0 | 0 | 0 | 0 | 42.1 | 0 | 28.1 | 14.3 | 0 | 19.7 | 17.1 |
| Premature death rate due to stroke (ASR per 100,000 population)(2016-2020)^ | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7.5 | 0 | 0 | 6.2 |

^ Source: PHIDU, 2023.

*Table A2.4_15 Prevalence and premature death rates associated with chronic respiratory diseases, by Local Government Area (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People who reported they had asthma | 8.63% | 10.10% | 9.63% | 11.84% | 9.57% | 9.82% | 9.95% | 10.75% | 11.38% | 9.70% | 9.82% | 8.35% |
| People who reported they had a lung condition including COPD or emphysema | 2.75% | 2.91% | 2.35% | 3.30% | 3.13% | 2.69% | 3.59% | 4.71% | 2.43% | 3.21% | 2.36% | 1.50% |
| Premature death rate (ASR per 100,000) due to respiratory system diseases (2016-2020)^ | 0 | 33 | 24.2 | 19.1 | 26 | 30.9 | 30.7 | 37.6 | 30.6 | 17.5 | 15.1 | 13.9 |

^ Source: PHIDU, 2023

*Diabetes*

Data from the 2021 census indicated that there is a high burden of diabetes in the region (*Table A2.4_16*). All 11 LGAs had a higher prevalence of diabetes than the Victorian state figure (4.66%). The highest prevalence in the region was noted in Central Goldfields LGA (7.57%). Central Goldfields also demonstrated a considerably higher premature death rate due to diabetes at 16.3 per 100, 000, (state figure: 5.1 deaths per 100, 000). Horsham and Ballarat LGAs also reported higher than state premature death rates due to diabetes.

*Table A2.4_16 Prevalence and premature death rates associated with diabetes, by Local Government Area (Source: Australian Bureau of Statistics, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People who reported they had diabetes (excluding gestational diabetes) | 5.90% | 7.12% | 5.31% | 7.09% | 6.40% | 5.59% | 6.10% | 7.57% | 5.16% | 5.13% | 4.96% | 4.66% |
| Premature death rate due to diabetes (ASR per 100, 000) (2016-2020)^ | 0.0 | 0.0 | 12.2 | 0.0 | 0.0 | 0.0 | 0.0 | 16.3 | 9.3 | 0.0 | 5.0 | 5.1 |

^ Source: PHIDU, 2023

*Cancer*

Based on self-reported data from the 2021 census, the proportion of people in the Grampians region who reported they had cancer was higher than the state figure across all 11 LGAs (range: 3.11% Moorabool – 4.54% Central Goldfields, state: 2.76%). The incidence rate (rate of new diagnoses) of all cancers was also higher across all 11 LGAs than the state incidence (*Table A2.4_17*). The incidence rates of breast, bowel and lung cancer and melanoma were consistently reported as higher than the Victorian incidence rates across all 11 LGAs in the Grampians catchment region.

*Table A2.4_17 Incidence, prevalence and premature death rates associated with cancer, by Local Government Area*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| People who reported they had cancer (including remission) * | 3.33% | 4.14% | 3.75% | 4.12% | 4.33% | 3.74% | 4.28% | 4.54% | 3.44% | 4.31% | 3.11% | 2.76% |
| Incidence all cancers^ | 443.8 | 405.3 | 398.3 | 384.2 | 393.1 | 370.9 | 392.5 | 397.6 | 351.1 | 351.4 | 345.8 | 314.5 |
| Incidence prostate cancer^ | 93.3 | 112.4 | 93.1 | 83.1 | 131.9 | 87.5 | 88.8 | 94.4 | 111.9 | 81.4 | 97.8 | 100.1 |
| Incidence breast cancer^ | 90.6 | 79.3 | 100.6 | 77.6 | 87.4 | 82.3 | 97.5 | 85.7 | 97.1 | 81.3 | 95.6 | 55.2 |
| Incidence melanoma^ | 49.0 | 62.4 | 62.4 | 45.1 | 72.5 | 72.4 | 56.3 | 56.2 | 39.7 | 55.4 | 39.6 | 26.0 |
| Incidence bowel cancer^ | 64.6 | 63.3 | 68.6 | 63.6 | 80.7 | 55.4 | 57.4 | 66.4 | 39.9 | 38.8 | 50.0 | 31.8 |
| Incidence lung cancer^ | 75.5 | 64.3 | 41.4 | 54.1 | 45.7 | 38.2 | 51.6 | 49.4 | 30.2 | 38.3 | 38.2 | 24.8 |
| Premature death rate due to cancer* | 180.6 | 145.9 | 133.6 | 143.6 | 158.3 | 132.4 | 124.7 | 172.8 | 133.4 | 118.2 | 129.6 | 92.8 |

*Source: Australian Bureau of Statistics, 2023; ^ Age-standardised rate per 100, 000, Data year: 2017-2021, Source: Victorian Cancer Registry (unpublished); *Age-standardised rate per 100, 000, Data year: 2016-2020, Source: PHIDU, 2023.

# Appendix 2.5 Health across the life course

## Children and young people

The proportion of children who were born of low birthweight (<2500g) was lower than the state figure across 6/11 LGAs (*Table A2.5_1*). Rates of exclusive breastfeeding at 3 months of age were lower than the state rate in 8/11 LGAs (range: 51.3% in Pyrenees to 64.8% in Horsham, state rate: 63.4%).

*Table A2.5_1 Children's health indicators, by Local Government Area (Source: PHIDU, 2023)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of infants born of low birthweight | 6.0% | 6.7% | 6.5% | 2.9% | 6.4% | 6.5% | 7.3% | 7.1% | 7.4% | 5.5% | 8.3% | 6.7% |
| Proportion of infants exclusively breastfed to three months of age | 59.3% | 59.2% | 64.8% | 59.3% | 58.0% | 59.4% | 51.3% | 53.5% | 64.3% | 61.9% | 64.3% | 63.4% |

## Older people

Hospitalisation rates due to falls in older people are demonstrated in *Table A2.5_2*. There was variability across the region, with Hepburn, Ballarat, Pyrenees, Ararat, Northern Grampians, and Horsham LGAs demonstrating lower rates than the aggregated state rate.

*Table A2.5_2 Hospitalisation rate due to falls (per 100, 000 population) (Source: Department of Health (Victoria), 2023a)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Older Adults (65 years and older) | 4507.2 | 4529.4 | 3179.6 | 4902.8 | 2933 | 3245.7 | 2423.4 | 3840.1 | 3455.6 | 2609.7 | 3762.5 | 3659.4 |

# Appendix 2.6 Impacts of climate change

Surveillance data from 2022 indicated variable rates of salmonellosis, an infection resulting in gastroenteritis symptoms which is typically associated with the consumption of contaminated food (*Table A2.6_1*). High rates in some LGAs may be due to localised outbreaks with small population sizes. Salmonella infection is noted to have seasonal variation and a correlation between increasing temperature with the incidence of Salmonella infection has been shown (Akil, Ahmad & Reddy, 2014).

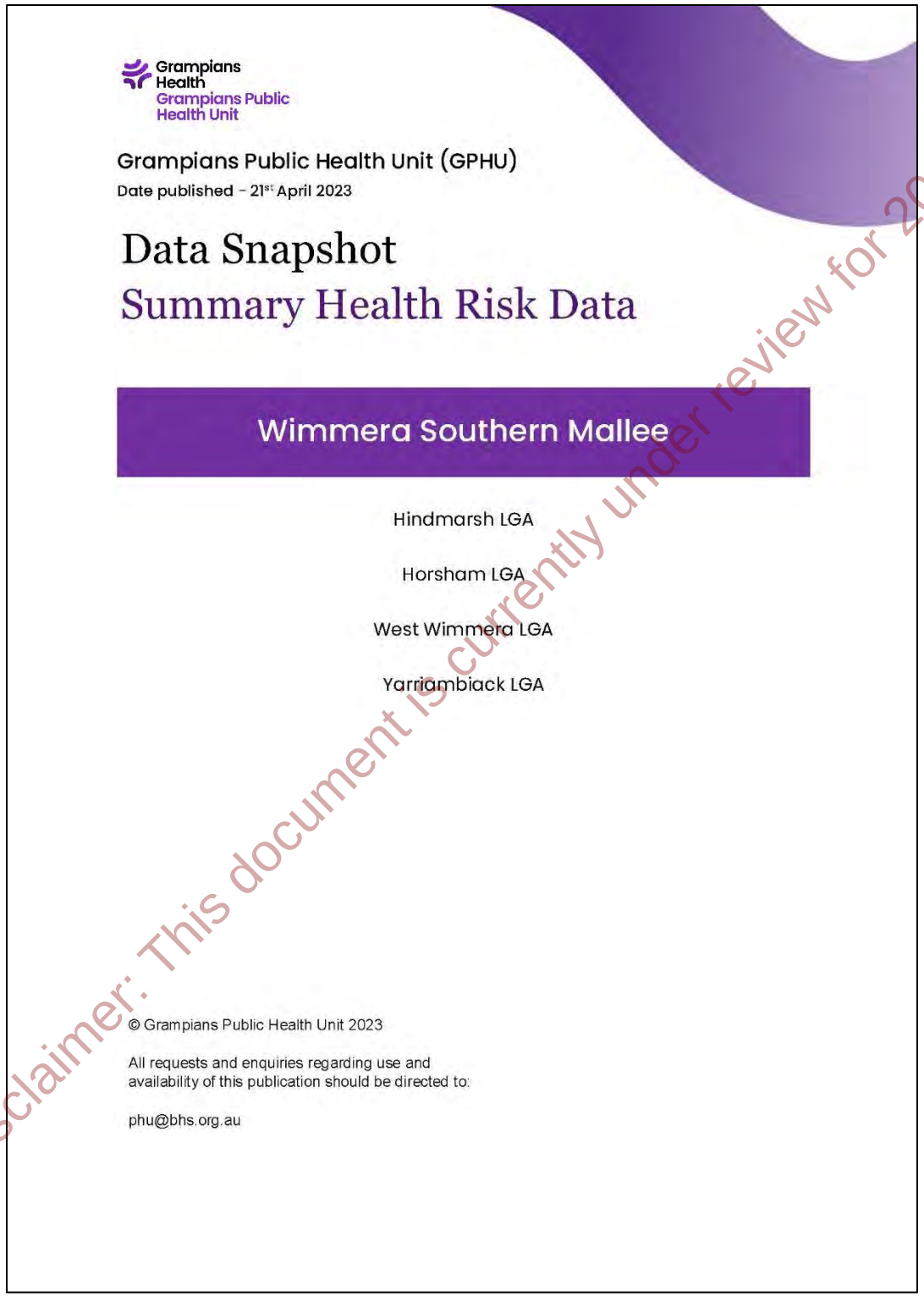
*Table A2.6_1 Notification rate of Salmonellosis in 2022 (Source: Department of Health (Victoria), 2023b)*

| | West Wimmera | Hindmarsh | Horsham | Yarriambiack | Northern Grampians | Ararat | Pyrenees | Central Goldfields | Ballarat | Hepburn | Moorabool | Victoria (State) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Notification rate of salmonellosis (per 100,000 population) | 102.2 | 87.1 | 30.3 | 89 | 77.7 | 25.6 | 27.4 | 15.4 | 31.9 | 25.7 | 24.5 | 29.8 |

# Appendix 3

## Data Snapshots: indicative outcome indicators by sub-region/target populations

# Appendix 3.1 Wimmera Southern Mallee Data Snapshot



Grampians Health
Grampians Public Health Unit

Grampians Public Health Unit (GPHU)

Date published – 21st April 2023

## Data Snapshot

## Summary Health Risk Data

**Wimmera Southern Mallee**

Hindmarsh LGA

Horsham LGA

West Wimmera LGA

Yarriambiack LGA

Grampians Health
Grampians Public Health Unit

## Grampians Public Health Unit (GPHU)

Hindmarsh LGA Data Snapshot – 21st April 2023

# Hindmarsh LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 5,787 | 5,722 | 5,650 | 5,587 | 5,580 |
| Deaths | 69 | 85 | 65 | 91 | 87 |
| Premature deaths (<75 years) | 18 | 22 | 17 | 30 | 20 |
| Potentially avoidable deaths (PAD) | 8 | 13 | 10 | 14 | 11 |
| PAD % premature deaths | 45.5 | 53.3 | 52.2 | 54.8 | 54.2 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 13.1 | 1. Dementia | 16.0 |
| 2. Prostate cancer | 7.9 | 2. Lung cancer | 7.6 |
| 3. Colorectal cancer | 6.0 | 3. Coronary heart disease | 5.8 |
| 4. Lung cancer | 6.0 | 4. Heart failure | 5.3 |
| 5. Accidental falls | 4.4 | 5. Cerebrovascular disease | 5.3 |
| 6. Cerebrovascular disease | 4.0 | 6. Chronic obstructive pulmonary disease | 4.9 |
| 7. Dementia | 3.6 | 7. Hypertensive kidney disease | 4.4 |
| 8. Chronic obstructive pulmonary disease | 3.6 | 8. Accidental falls | 4.0 |
| 9. Kidney failure | 2.8 | 9. Colorectal cancer | 3.6 |
| 10. Liver cancer | 2.0 | 10. Lymphomas | 2.7 |
| Total all cause deaths (n) | 210 | Total all cause deaths (n) | 187 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

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Hindmarsh LGA Data Snapshot – 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 55.3 | 56.7 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 26.7 | 27.6 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 28.6 | 29.1 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 2.2 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.40 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.20 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 9.6 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 15.2 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 1.4 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 46.8 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 49.9 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 6.9 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 17.7 | 18.8 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

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Hindmarsh LGA Data Snapshot – 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 85.5 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 53.8 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 51.1 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 39.2 | 45.4 | 45.9 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 45.5 | 55.3 | 56.0 | 49.8 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 38.1 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

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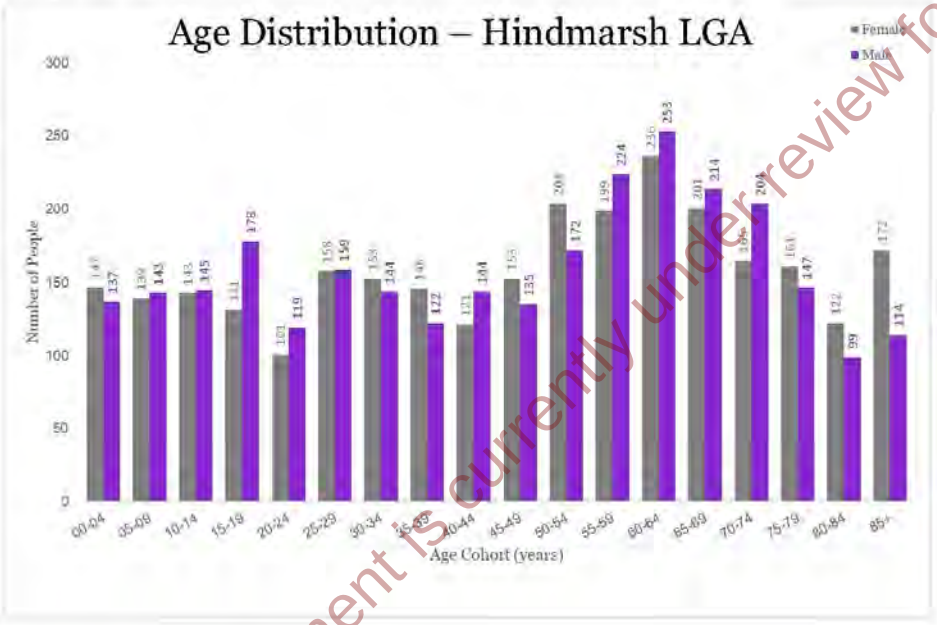
Hindmarsh LGA Data Snapshot – 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution




### 3.2 Other demographic characteristics

| Population characteristic | Hindmarsh LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.6% | 1.00% |
| Persons born overseas | 10.5% | 35.00% |
| Uses a language other than English at home | 7.1% | 30.20% |
| Persons living with a disability | 23.2% | N/A |
| Persons who have need for assistance with core activities for daily living | 8.2% | 5.90% |
| People of adults who identify as LGBTIQ+ | 3.2% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 10 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

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## Grampians Public Health Unit (GPHU)

Horsham LGA Data Snapshot – 21st April 2023

# Horsham LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 19,884 | 19,915 | 19,909 | 19,962 | 20,059 |
| Deaths | 174 | 172 | 167 | 194 | 186 |
| Premature deaths (<75 years) | 60 | 48 | 47 | 61 | 50 |
| Potentially avoidable deaths (PAD) | 35 | 24 | 26 | 36 | 22 |
| PAD % premature deaths | 58.4 | 49.0 | 54.2 | 61.0 | 44.0 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 12.9 | 1. Coronary heart disease | 10.7 |
| 2. Lung cancer | 7.2 | 2. Dementia | 8.1 |
| 3. Chronic obstructive pulmonary disease | 5.9 | 3. Cerebrovascular disease | 5.5 |
| 4. Cerebrovascular disease | 5.3 | 4. Influenza and Pneumonia | 5.3 |
| 5. Dementia | 4.8 | 5. Accidental falls | 4.8 |
| 6. Colorectal cancer | 3.6 | 6. Lung cancer | 4.3 |
| 7. Prostate cancer | 3.6 | 7. Chronic obstructive pulmonary disease | 4.1 |
| 8. Accidental falls | 3.0 | 8. Colorectal cancer | 3.8 |
| 9. Heart failure | 2.3 | 9. Breast cancer | 3.8 |
| 10. Diabetes | 2.3 | 10. Heart failure | 3.8 |
| Total all cause deaths (n) | 473 | Total all cause deaths (n) | 419 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books



Horsham LGA – Preparatory Data for GPHU 'Data Spotlight' Workshop

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Horsham LGA Data Snapshot – 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 51.1 | 56.2 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 27.4 | 27.5 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 23.7 | 28.7 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 3.3 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.60 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.10 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 14.5 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 16.5 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 2.1 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 47.1 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 47.6 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 11.0 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 16.1 | 13.2 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

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## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 81.7 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 54.4 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 45.5 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 46.9 | 48.7 | 50.9 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 58.5 | 60.7 | 59.6 | 56.6 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 50.5 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

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Horsham LGA Data Snapshot – 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution


### 3.2 Other demographic characteristics

| Population characteristic | Horsham LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.6% | 1.00% |
| Persons born overseas | 7.1% | 35.00% |
| Uses a language other than English at home | 4.7 | 30.20% |
| Persons living with a disability | 19.9% | N/A |
| Persons who have need for assistance with core activities for daily living | 6.3% | 5.90% |
| People of adults who identify as LGBTIQ+ | 3.3% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 30 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

Horsham LGA – Data Snapshot – Second Iteration

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## Grampians Public Health Unit (GPHU)

West Wimmera LGA Data Snapshot - 21st April 2023

# West Wimmera LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 3,938 | 3,893 | 3,845 | 3,828 | 3,807 |
| Deaths | 50 | 42 | 50 | 45 | 38 |
| Premature deaths (<75 years) | 12 | 13 | 16 | 12 | 9 |
| Potentially avoidable deaths (PAD) | 5 | 10 | 5 | 8 | 5 |
| PAD % premature deaths | 40.0 | 64.5 | 29.7 | 77.1 | 55.5 |
| Australia (PAD % premature deaths) | **50.8** | **50.8** | **50.2** | **49.6** | **49.1** |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 13.3 | 1. Cerebrovascular disease | 10.8 |
| 2. Prostate cancer | 8.3 | 2. Coronary heart disease | 7.1 |
| 3. Lung cancer | 6.9 | 3. Dementia | 6.9 |
| 4. Cerebrovascular disease | 5.4 | 4. Lung cancer | 6.7 |
| 5. Accidental falls | 3.9 | 5. Breast cancer | 5.8 |
| 6. Chronic obstructive pulmonary disease | 3.6 | 6. Hypertensive kidney disease | 5.6 |
| 7. Colorectal cancer | 3.1 | 7. Colorectal cancer | 5.3 |
| 8. Diabetes | 3.0 | 8. Chronic obstructive pulmonary disease | 4.8 |
| 9. Hypertensive kidney disease | 2.8 | 9. Cardiac arrhythmias | 4.6 |
| 10. Dementia | 2.2 | 10. Pancreatic cancer | 3.3 |
| Total all cause deaths (n) | 124 | Total all cause deaths (n) | 101 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

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# Grampians Public Health Unit (GPHU)

West Wimmera LGA Data Snapshot – 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 62.6 | 58.4 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 39.8 | 25.3 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 22.7 | 33.2 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 2.2 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.50 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.10 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | No data | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 18.7 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 1.5 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 32.5 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 63.7 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 5.8 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 13.5 | 11.4 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

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West Wimmera LGA Data Snapshot – 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 82.3 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 56.3 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 50.8 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 39.2 | 45.9 | 45.9 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 47.1 | 56.8 | 63.0 | 58.6 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 40.1 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

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West Wimmera LGA Data Snapshot – 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution


### 3.2 Other demographic characteristics

| Population characteristic | West Wimmera LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 0.8% | 1.00% |
| Persons born overseas | 6.7% | 35.00% |
| Uses a language other than English at home | 2.4% | 30.20% |
| Persons living with a disability | 19.2% | N/A |
| Persons who have need for assistance with core activities for daily living | 6.7% | 5.90% |
| People of adults who identify as LGBTIQ+ | 2.5% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 33 | N/A |

Source 1: ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

Source 2: VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

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## Grampians Public Health Unit (GPHU)

Yarriambiack LGA Data Snapshot – 21st April 2023

# Yarriambiack LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 6,740 | 6,678 | 6,656 | 6,623 | 6,581 |
| Deaths | 93 | 90 | 116 | 109 | 87 |
| Premature deaths (<75 years) | 21 | 22 | 31 | 26 | 21 |
| Potentially avoidable deaths (PAD) | 11 | 9 | 17 | 10 | 12 |
| PAD % premature deaths | 52.3 | 41.0 | 51.5 | 41.7 | 57.1 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 12.1 | 1. Dementia | 13.6 |
| 2. Prostate cancer | 7.3 | 2. Cerebrovascular disease | 8.6 |
| 3. Dementia | 6.9 | 3. Coronary heart disease | 7.4 |
| 4. Cerebrovascular disease | 6.0 | 4. Breast cancer | 4.9 |
| 5. Colorectal cancer | 5.2 | 5. Lung cancer | 4.5 |
| 6. Lung cancer | 4.8 | 6. Colorectal cancer | 4.1 |
| 7. Chronic obstructive pulmonary disease | 4.0 | 7. Heart failure | 3.7 |
| 8. Cancer of unknown primary | 3.2 | 8. Accidental falls | 3.7 |
| 9. Suicide | 3.2 | 9. Cancer of unknown primary | 3.7 |
| 10. Liver cancer | 2.4 | 10. Chronic obstructive pulmonary disease | 2.5 |
| Total all cause deaths (n) | 249 | Total all cause deaths (n) | 244 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

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Yarriambiack LGA Data Snapshot – 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 55.2 | 64.2 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 28.2 | 26.0 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 27.0 | 38.2 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 4.2 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.50 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.10 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 10.4 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 13.3 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | N/A | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 48.7 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 46.3 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 11.4 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 17.7 | 20.8 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Yarriambiack LGA Data Snapshot – 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 91.7 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 49.7 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 56.3 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 39.2 | 46.1 | 48.9 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 44.0 | 60.6 | 54.3 | 52.3 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 42.4 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Yarriambiack LGA – Data Snapshot – Second Iteration

Grampians Health
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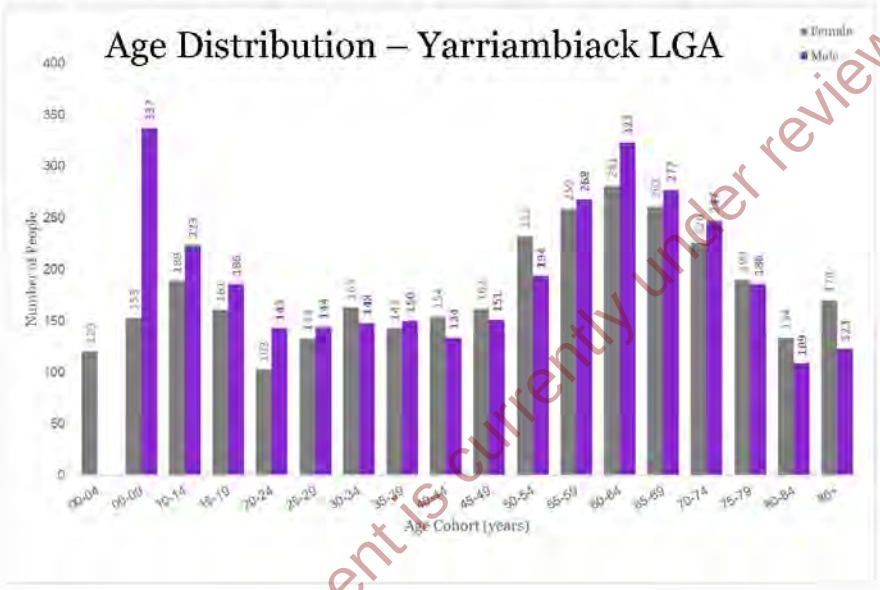
# Grampians Public Health Unit (GPHU)

Yarriambiack LGA Data Snapshot – 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution




### 3.2 Other demographic characteristics

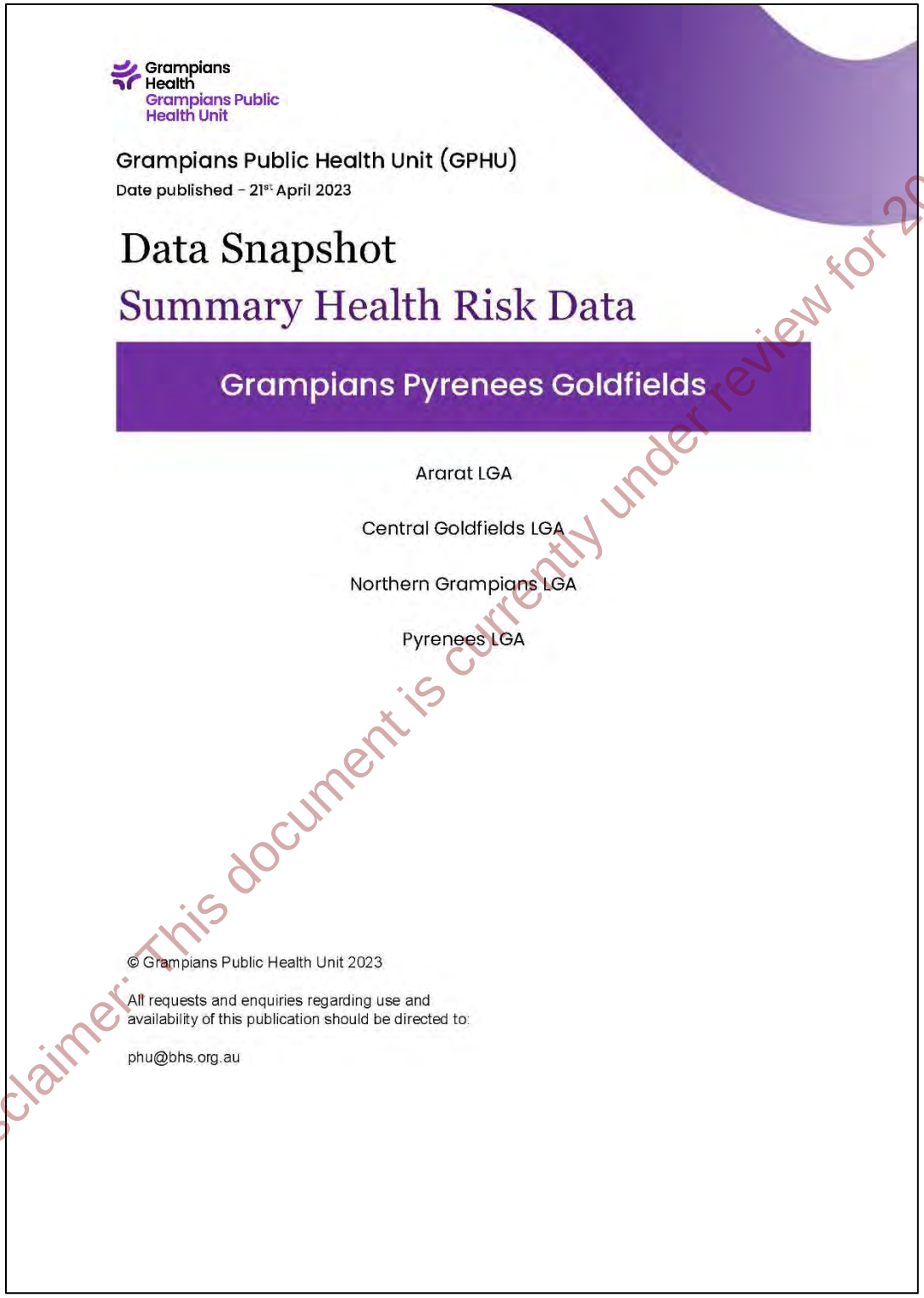
| Population characteristic | Yarriambiack LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.6% | 1.00% |
| Persons born overseas | 6.7% | 35.00% |
| Uses a language other than English at home | 2.9% | 30.20% |
| Persons living with a disability | 27.5% | N/A |
| Persons who have need for assistance with core activities for daily living | 9.3% | 5.90% |
| People of adults who identify as LGBTIQ+ | 1.8% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 7 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

Yarriambiack LGA – Data Snapshot – Second Iteration

## Appendix 3.2 Grampians Pyrenees Goldfields Data Snapshot



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Date published – 21st April 2023

# Data Snapshot

## Summary Health Risk Data

### Grampians Pyrenees Goldfields

Ararat LGA

Central Goldfields LGA

Northern Grampians LGA

Pyrenees LGA



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## Grampians Public Health Unit (GPHU)

Ararat LGA Data Snapshot - 21st April 2023

# Ararat LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 11,746 | 11,775 | 11,799 | 11,856 | 11,988 |
| Deaths | 121 | 134 | 108 | 125 | 105 |
| Premature deaths (<75 years) | 29 | 42 | 36 | 45 | 36 |
| Potentially avoidable deaths (PAD) | 15 | 21 | 21 | 18 | 22 |
| PAD % premature deaths | 53.2 | 50.4 | 55.5 | 43.8 | 63.0 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 10.9 | 1. Dementia | 13.0 |
| 2. Dementia | 8.0 | 2. Chronic obstructive pulmonary disease | 7.6 |
| 3. Chronic obstructive pulmonary disease | 6.2 | 3. Coronary heart disease | 7.4 |
| 4. Prostate Cancer | 4.6 | 4. Lung cancer | 6.4 |
| 5. Lung cancer | 4.6 | 5. Cerebrovascular disease | 6.1 |
| 6. Cerebrovascular disease | 4.0 | 6. Diabetes | 4.6 |
| 7. Accidental falls | 3.4 | 7. Heart failure | 3.5 |
| 8. Diabetes | 3.1 | 8. Accidental falls | 3.0 |
| 9. Pancreatic cancer | 2.8 | 9. Cancer of unknown primary | 3.0 |
| 10. Suicide | 2.2 | 10. Colorectal cancer | 2.7 |
| Total all cause deaths (n) | 327 | Total all cause deaths (n) | 265 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

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Ararat LGA Data Snapshot – 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 54.6 | 65.6 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 33.8 | 36.9 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 20.8 | 28.7 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 2.3 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.5 | N/A | 1.90 Port Philip | 1.6 |
| Mean serve of veg daily | 2.2 | N/A | 2.70 Queenscliff | 2.2 |
| % adults consume snack food or takeaway >1 per week | 13.7 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 14.4 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 2.8 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 36.4 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 55.8 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 7.9 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 17.2 | 12.9 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

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# Grampians Public Health Unit (GPHU)

Ararat LGA Data Snapshot – 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 77.4 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 46.7 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 45.8 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 40.2 | 44.5 | 45.7 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 47.6 | 53.0 | 51.7 | 44.2 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 37.7 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Ararat LGA – Data Snapshot – Second Iteration

Grampians Health
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# Grampians Public Health Unit (GPHU)

Ararat LGA Data Snapshot – 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution


### 3.2 Other demographic characteristics

| Population characteristic | Ararat LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.8% | 1.00% |
| Persons born overseas | 11.3% | 35.00% |
| Uses a language other than English at home | 5.0% | 30.20% |
| Persons living with a disability | 23.9% | N/A |
| Persons who have need for assistance with core activities for daily living | 7.8% | 5.90% |
| People of adults who identify as LGBTIQ+ | 2.2% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 8 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

Ararat LGA – Data Snapshot – Second Iteration

Grampians Health
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Grampians Public Health Unit (GPHU)

Central Goldfields LGA Data Snapshot - 21st April 2023

# Central Goldfields LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 13,084 | 13,156 | 13,239 | 13,218 | 13,133 |
| Deaths | 219 | 157 | 196 | 185 | 204 |
| Premature deaths (<75 years) | 76 | 47 | 69 | 61 | 65 |
| Potentially avoidable deaths (PAD) | 40 | 27 | 39 | 26 | 34 |
| PAD % premature deaths | 53.3 | 57.1 | 56.3 | 44.6 | 51.6 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 13.3 | 1. Dementia | 10.1 |
| 2. Chronic obstructive pulmonary disease | 7.0 | 2. Coronary heart disease | 8.3 |
| 3. Dementia | 6.0 | 3. Cerebrovascular disease | 7.1 |
| 4. Prostate cancer | 5.6 | 4. Chronic obstructive pulmonary disease | 4.5 |
| 5. Lung cancer | 5.4 | 5. Lung cancer | 3.2 |
| 6. Cerebrovascular disease | 4.4 | 6. Colorectal cancer | 3.0 |
| 7. Diabetes | 4.2 | 7. Influenza and pneumonia | 3.0 |
| 8. Colorectal cancer | 3.9 | 8. Breast cancer | 2.8 |
| 9. Kidney failure | 2.4 | 9. Heart failure | 2.8 |
| 10. Heart failure | 2.2 | 10. Accidental falls | 2.8 |
| Total all cause deaths (n) | 497 | Total all cause deaths (n) | 463 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

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# Grampians Public Health Unit (GPHU)

Central Goldfields LGA Data Snapshot - 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 64.1 | 65.7 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 33.5 | 34.2 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 30.6 | 31.5 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 3.5 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.40 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.00 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 10.0 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 17.5 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 1.2 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 49.1 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 43.1 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 9.3 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 16.3 | 22.1 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Central Goldfields LGA Data Snapshot - 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 79.2 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 50.6 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 45.6 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 40.5 | 43.7 | 47.9 |
| Best performing LGA | 46.9 | 55.7 | 57.7 |
| Victorian average | 38.1 | 43.2 | 46.0 |
| Australian average | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 49.1 | 51.4 | 41.8 | 48.4 |
| Best performing LGA | 59.4 | 66.9 | 64.2 | 61.3 |
| Victorian average | 54.6 | 54.1 | 53.9 | 46.5 |
| Australian average | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 37.9 |
| Best performing LGA | 61.8 |
| Victorian average | 47.4 |
| Australian average | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Central Goldfields LGA – Data Snapshot – Second Iteration

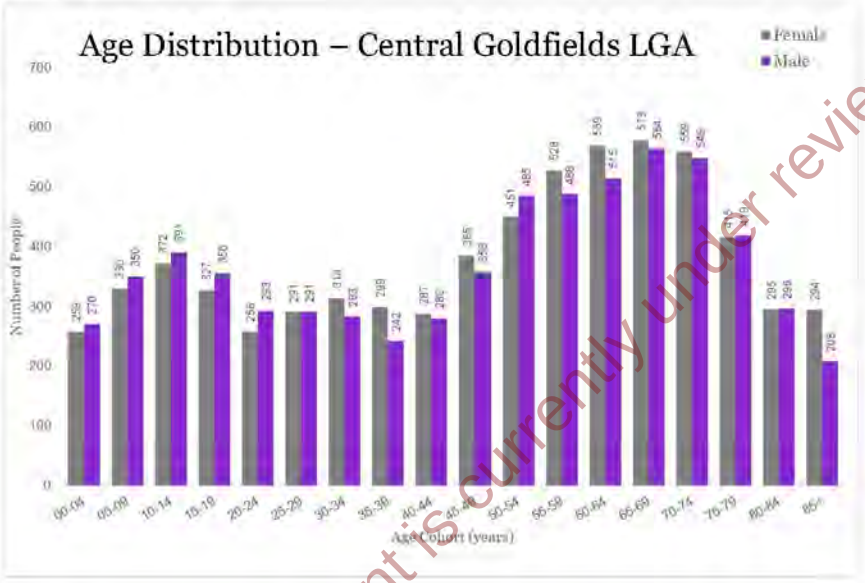
Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Central Goldfields LGA Data Snapshot - 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution




### 3.2 Other demographic characteristics

| Population characteristic | Central Goldfields LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 2.1% | 1.00% |
| Persons born overseas | 9.2% | 35.00% |
| Uses a language other than English at home | 3.0% | 30.20% |
| Persons living with a disability | 29.4% | N/A |
| Persons who have need for assistance with core activities for daily living | 10.4% | 5.90% |
| People of adults who identify as LGBTIQ+ | 5.2% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 1 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

Central Goldfields LGA – Data Snapshot – Second Iteration

Grampians Health
Grampians Public Health Unit

## Grampians Public Health Unit (GPHU)

Northern Grampians LGA Data Snapshot - 21st April 2023

# Northern Grampians LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 11,570 | 11,490 | 11,408 | 11, 382 | 11,384 |
| Deaths | 147 | 147 | 128 | 101 | 113 |
| Premature deaths (<75 years) | 40 | 47 | 53 | 31 | 44 |
| Potentially avoidable deaths (PAD) | 21 | 20 | 29 | 12 | 24 |
| PAD % premature deaths | 52.5 | 42.6 | 54.7 | 38.7 | 54.5 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 15.6 | 1.Coronary heart disease | 11.7 |
| 2. Dementia | 6.7 | 2. Dementia | 10.0 |
| 3. Chronic obstructive pulmonary disease | 6.1 | 3. Cerebrovascular disease | 5.8 |
| 4. Prostate Cancer | 4.6 | 4. Lung cancer | 5.5 |
| 5. Lung Cancer | 4.3 | 5. Chronic obstructive pulmonary disease | 4.9 |
| 6. Cerebrovascular disease | 3.4 | 6. Accidental falls | 4.5 |
| 7. Accidental falls | 2.8 | 7. Breast cancer | 3.6 |
| 8. Diabetes | 2.8 | 8. Pancreatic cancer | 3.2 |
| 9. Pancreatic Cancer | 2.7 | 9. Cardiac arrhythmias | 2.9 |
| 10. Suicide | 2.5 | 10. Colorectal cancer | 2.9 |
| Total all cause deaths (n) | 327 | Total all cause deaths (n) | 309 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Northern Grampians LGA Data Snapshot - 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 59.5 | 62.1 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 31.5 | 31.0 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 27.9 | 31.1 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 5.3 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.40 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.10 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 12.6 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 19.3 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | N/A | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 44.7 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 51.9 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 8.1 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 16.6 | 15.7 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Northern Grampians LGA Data Snapshot - 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 87.2 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 52.3 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 47.2 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 40.5 | 43.7 | 47.9 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 42.8 | 58.5 | 58.1 | 51.8 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 37.3 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Northern Grampians LGA – Data Snapshot – Second Iteration

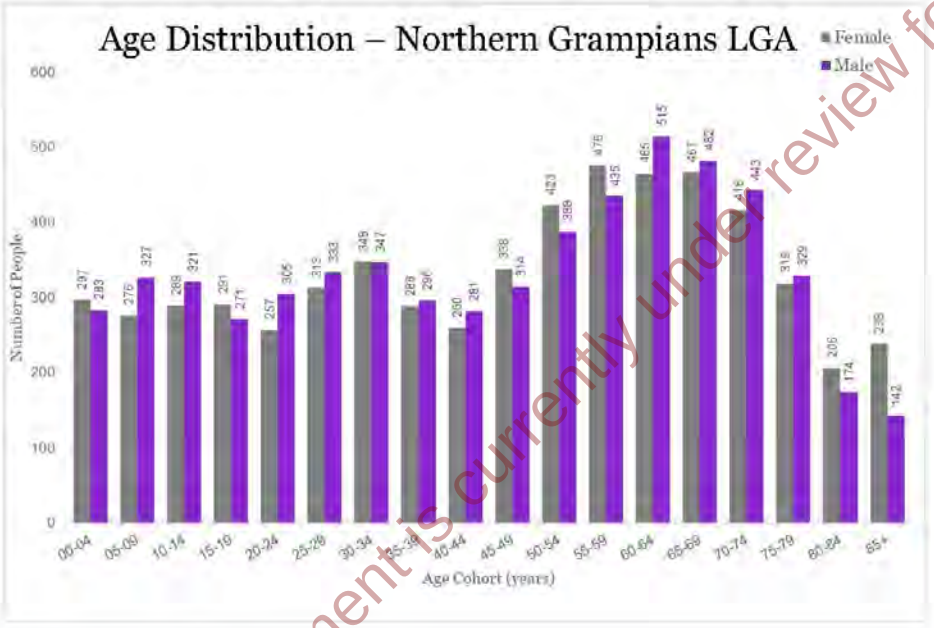
Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Northern Grampians LGA Data Snapshot - 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution




### 3.2 Other demographic characteristics

| Population characteristic | Northern Grampians LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.6% | 1.00% |
| Persons born overseas | 9.2% | 35.00% |
| Uses a language other than English at home | 5.4% | 30.20% |
| Persons living with a disability | 22.8% | N/A |
| Persons who have need for assistance with core activities for daily living | 7.3% | 5.90% |
| People of adults who identify as LGBTIQ+ | 5.1% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 6 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

Northern Grampians LGA – Data Snapshot – Second Iteration

Grampians Health
Grampians Public Health Unit

## Grampians Public Health Unit (GPHU)

Pyrenees LGA Data Snapshot – 21st April 2023

# Pyrenees LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 7,323 | 7,359 | 7,347 | 7,450 | 7,520 |
| Deaths | 78 | 56 | 66 | 72 | 74 |
| Premature deaths (<75 years) | 31 | 27 | 24 | 26 | 34 |
| Potentially avoidable deaths (PAD) | 14 | 21 | 18 | 7 | 21 |
| PAD % premature deaths | 45.5 | 70.8 | 63.2 | 31.8 | 61.1 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 12.0 | 1. Dementia | 12.5 |
| 2. Chronic obstructive pulmonary disease | 8.0 | 2. Coronary heart disease | 7.7 |
| 3. Colorectal cancer | 5.0 | 3. Cerebrovascular disease | 6.0 |
| 4. Prostate Cancer | 4.5 | 4. Lung Cancer | 5.4 |
| 5. Land transport accidents | 4.5 | 5. Chronic obstructive pulmonary disease | 4.8 |
| 6. Dementia | 4.0 | 6. Heart failure | 4.7 |
| 7. Cerebrovascular disease | 3.5 | 7. Diabetes | 3.0 |
| 8. Lung cancer | 2.5 | 8. Accidental falls | 2.4 |
| 9. Leukaemia | 2.5 | 9. Breast cancer | 1.8 |
| 10. Liver disease | 2.5 | 10. Land transport accidents | 1.8 |
| Total all cause deaths (n) | 188 | Total all cause deaths (n) | 158 |

**Source:** AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Pyrenees LGA Data Snapshot –21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 61.5 | 66.8 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 31.6 | 30.4 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 29.9 | 36.5 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 3.4 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.40 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.10 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 17.9 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 25.4 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 2.2 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 48.8 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 40.2 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 9.1 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 20.6 | 11.2 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/ /media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Pyrenees LGA Data Snapshot -21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 77.4 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 53.0 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 51.3 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 41.3 | 46.5 | 46.6 |
| Best performing LGA | 46.9 | 55.7 | 57.7 |
| Victorian average | 38.1 | 43.2 | 46.0 |
| Australian average | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 44.9 | 53.9 | 52.4 | 47.6 |
| Best performing LGA | 59.4 | 66.9 | 64.2 | 61.3 |
| Victorian average | 54.6 | 54.1 | 53.9 | 46.5 |
| Australian average | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 38.9 |
| Best performing LGA | 61.8 |
| Victorian average | 47.4 |
| Australian average | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Pyrenees LGA – Data Snapshot – Second Iteration

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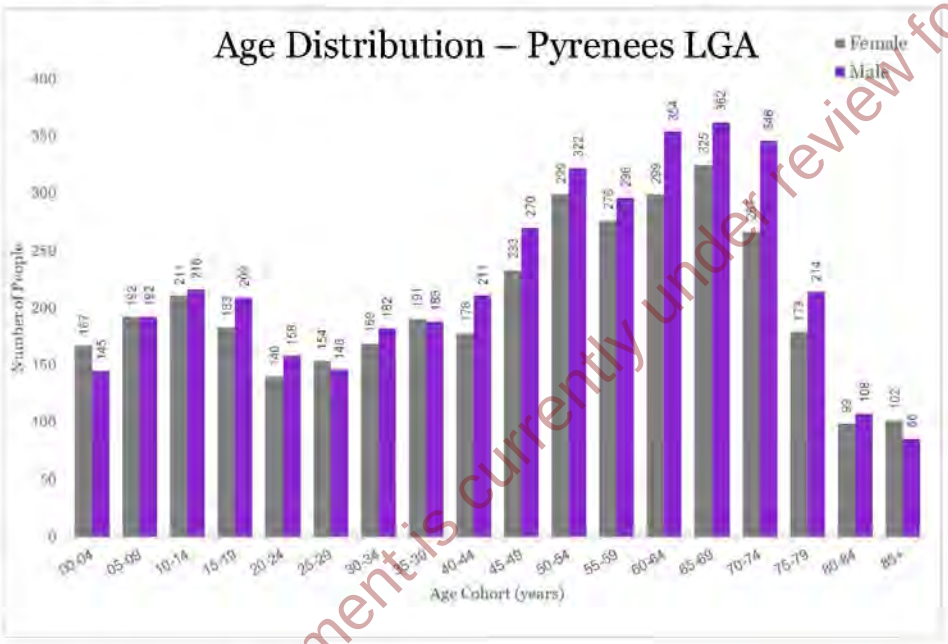
# Grampians Public Health Unit (GPHU)

Pyrenees LGA Data Snapshot –21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution




### 3.2 Other demographic characteristics

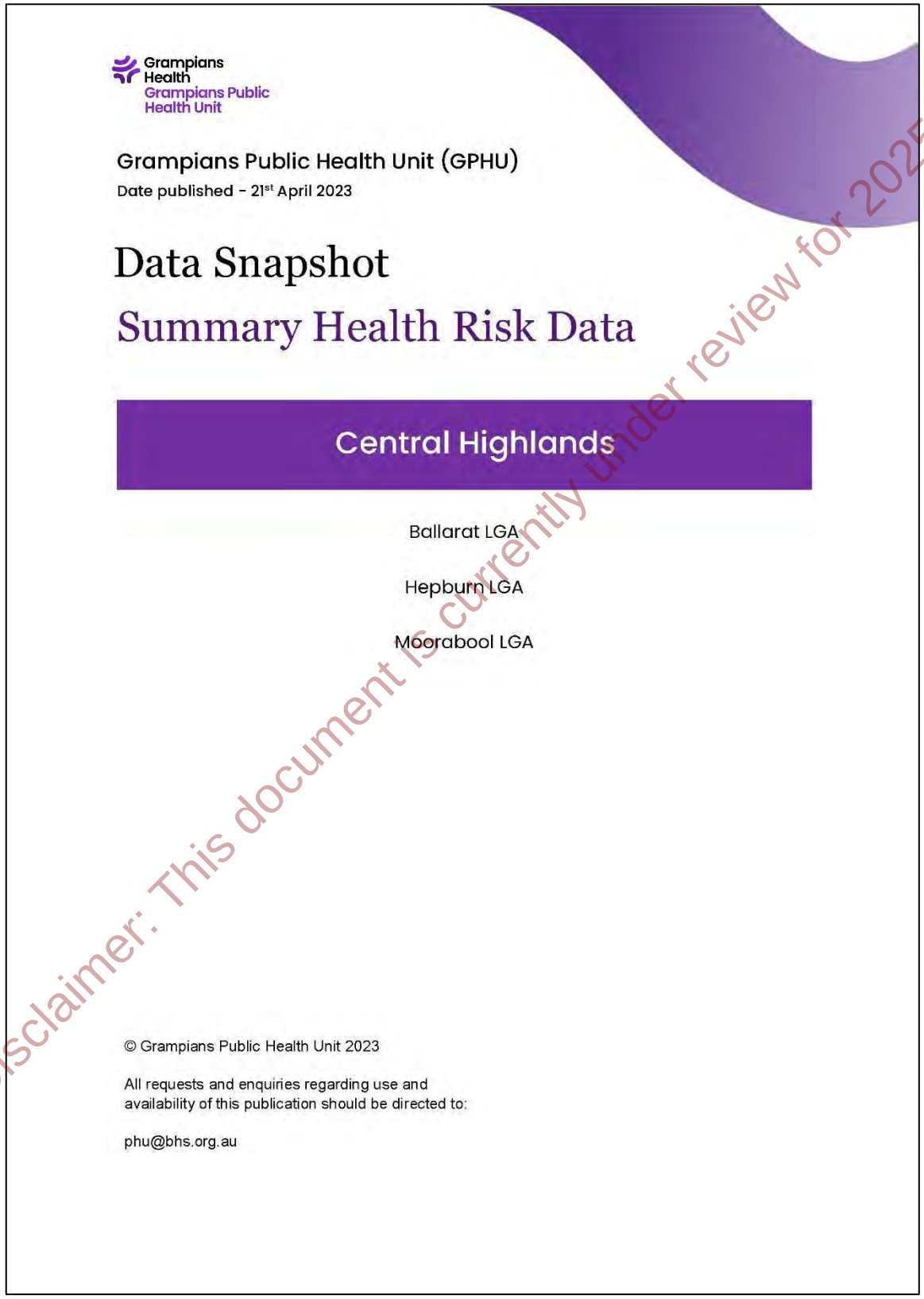
| Population characteristic | Pyrenees LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 2.0% | 1.00% |
| Persons born overseas | 9.6% | 35.00% |
| Uses a language other than English at home | 2.2% | 30.20% |
| Persons living with a disability | 28.6% | N/A |
| Persons who have need for assistance with core activities for daily living | 7.7% | 5.90% |
| People of adults who identify as LGBTIQ+ | 3.8% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 17 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-201

Pyrenees LGA – Data Snapshot – Second Iteration

# Appendix 3.3 Central Highlands Data Snapshot



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Grampians Public Health Unit (GPHU)

Date published - 21st April 2023

## Data Snapshot

## Summary Health Risk Data

### Central Highlands

Ballarat LGA

Hepburn LGA

Moorabool LGA

Grampians Health
Grampians Public Health Unit

## Grampians Public Health Unit (GPHU)

Ballarat LGA Data Snapshot – 21st April 2023

# Ballarat LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 103,515 | 105,414 | 107,334 | 109,539 | 111,436 |
| Deaths | 810 | 834 | 815 | 937 | 841 |
| Premature deaths (<75 years) | 253 | 277 | 270 | 308 | 296 |
| Potentially avoidable deaths (PAD) | 121 | 154 | 133 | 152 | 148 |
| PAD % premature deaths | 47.9 | 53.2 | 47.5 | 53.5 | 50.1 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 12.5 | 1. Dementia | 10.1 |
| 2. Chronic obstructive pulmonary disease | 5.8 | 2. Coronary heart disease | 9.7 |
| 3. Cerebrovascular disease | 5.3 | 3. Cerebrovascular disease | 8.1 |
| 4. Prostate cancer | 5.3 | 4. Lung cancer | 5.0 |
| 5. Dementia | 5.2 | 5. Chronic obstructive pulmonary disease | 4.9 |
| 6. Lung cancer | 4.4 | 6. Breast cancer | 4.1 |
| 7. Colorectal cancer | 4.1 | 7. Colorectal cancer | 3.3 |
| 8. Suicide | 3.1 | 8. Heart failure | 3.1 |
| 9. Accidental falls | 2.8 | 9. Accidental falls | 2.6 |
| 10. Diabetes | 2.6 | 10. Influenza and pneumonia | 2.4 |
| Total all cause deaths (n) | 2,113 | Total all cause deaths (n) | 2,124 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

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# Grampians Public Health Unit (GPHU)

Ballarat LGA Data Snapshot - 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 51.8 | 60.9 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 28.3 | 32.3 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 23.6 | 28.7 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 5.4 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.70 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.30 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 16.7 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 11.2 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 2.2 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 49.4 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 46.1 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 10.0 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 13.5 | 12.7 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Ballarat LGA Data Snapshot – 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 78.9 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 46.8 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 43.5 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 43.5 | 48.2 | 50.3 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 52.4 | 57.5 | 58.0 | 50.6 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 40.7 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Ballarat LGA – Data Snapshot – Second Iteration

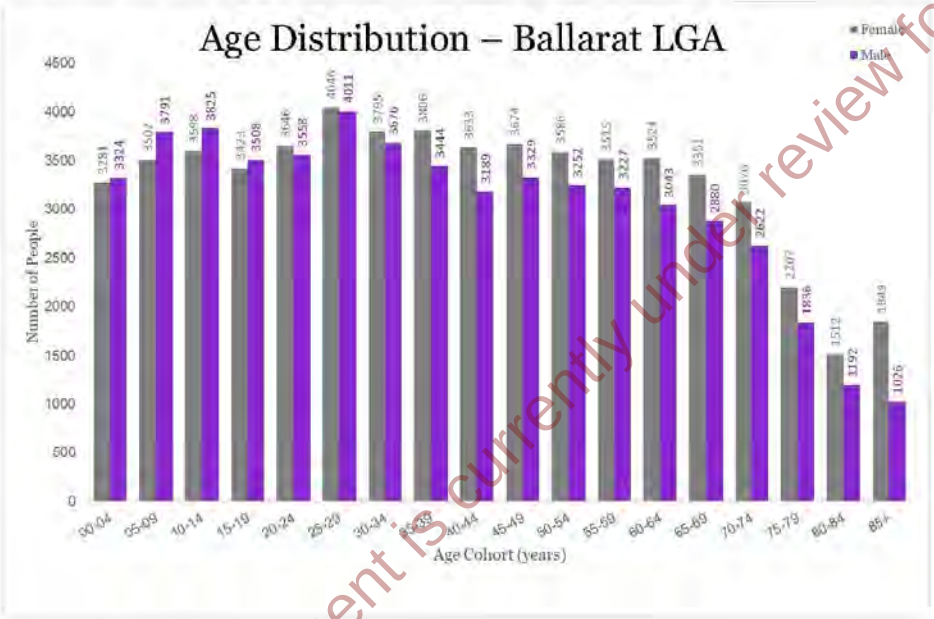
Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Ballarat LGA Data Snapshot - 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution




### 3.2 Other demographic characteristics

| Population characteristic | Ballarat LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.8% | 1.00% |
| Persons born overseas | 11.3% | 35.00% |
| Uses a language other than English at home | 7.0% | 30.20% |
| Persons living with a disability | 20.8% | N/A |
| Persons who have need for assistance with core activities for daily living | 7.4% | 5.90% |
| People of adults who identify as LGBTIQ+ | 9.6% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 29 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

Ballarat LGA – Data Snapshot – Second Iteration

Grampians Health
Grampians Public Health Unit

## Grampians Public Health Unit (GPHU)

Hepburn LGA Data Snapshot - 21st April 2023

# Hepburn LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 15,507 | 15,603 | 15,754 | 15,892 | 16,039 |
| Deaths | 145 | 125 | 125 | 169 | 161 |
| Premature deaths (<75 years) | 49 | 45 | 36 | 56 | 55 |
| Potentially avoidable deaths (PAD) | 26 | 24 | 23 | 30 | 32 |
| PAD % premature deaths | 54.0 | 50.9 | 61.6 | 57.8 | 57.8 |
| **Australia (PAD % premature deaths)** | **50.8** | **50.8** | **50.2** | **49.6** | **49.1** |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 13.2 | 1. Dementia | 10.8 |
| 2. Lung cancer | 7.3 | 2. Cerebrovascular disease | 10.3 |
| 3. Cerebrovascular disease | 6.9 | 3. Coronary heart disease | 8.5 |
| 4. Dementia | 5.0 | 4. Chronic obstructive pulmonary disease | 5.8 |
| 5. Prostate cancer | 4.4 | 5. Accidental falls | 5.4 |
| 6. Colorectal cancer | 4.4 | 6. Breast cancer | 4.4 |
| 7. Land transport accident | 3.5 | 7. Diabetes | 3.6 |
| 8. Chronic obstructive pulmonary disease | 3.5 | 8. Lung cancer | 3.5 |
| 9. Diabetes | 2.8 | 9. Heart failure | 3.3 |
| 10. Suicide | 2.3 | 10. Colorectal cancer | 3.0 |
| Total all cause deaths (n) | 361 | Total all cause deaths (n) | 363 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

Moorabool LGA – Preparatory Data for GPHU 'Data Spotlight' Workshop

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Hepburn LGA Data Snapshot – 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 46.0 | 52.2 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 27.3 | 29.0 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 18.6 | 23.2 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 4.6 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.60 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.40 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 4.6 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 9.1 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 1.4 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 31.6 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 64.5 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 7.1 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 15.3 | 17.2 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Hepburn LGA Data Snapshot – 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 77.7 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 44.1 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 48.4 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
|---|---|---|---|
| **Bowel Cancer Screening Participation** Crude Rate (%) | 39.5 | 44.0 | 47.6 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 44.0 | 48.3 | 48.9 | 42.8 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | N/A | N/A | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 44.7 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Hepburn LGA – Data Snapshot – Second Iteration

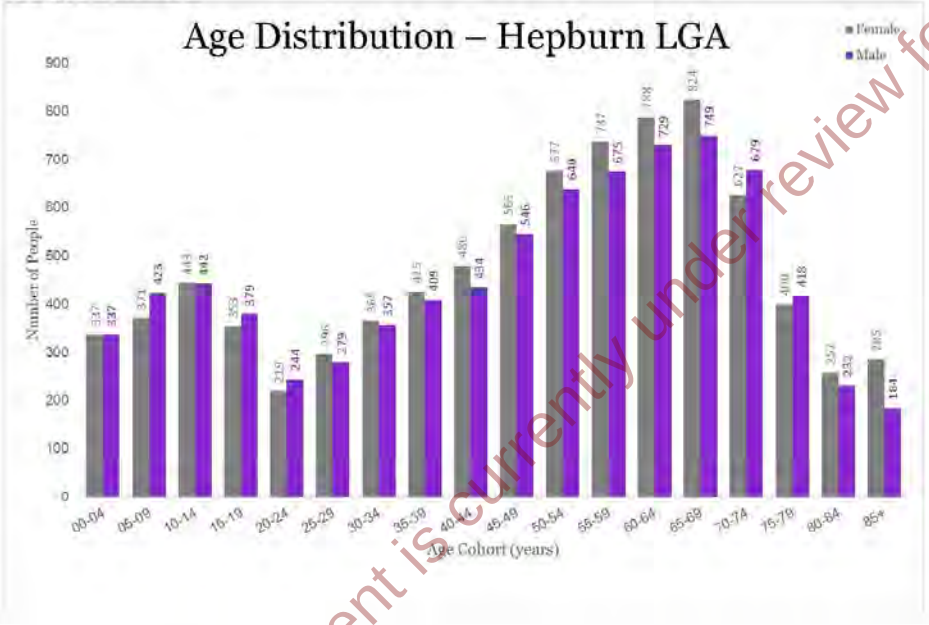
Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Hepburn LGA Data Snapshot – 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution




### 3.2 Other demographic characteristics

| Population characteristic | Hepburn LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.0% | 1.00% |
| Persons born overseas | 14.0% | 35.00% |
| Uses a language other than English at home | 4.8% | 30.20% |
| Persons living with a disability | 24.5% | N/A |
| Persons who have need for assistance with core activities for daily living | 6.3% | 5.90% |
| People of adults who identify as LGBTIQ+ | 7.5% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 44 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-2017

Hepburn LGA – Data Snapshot – Second Iteration

Grampians Health
Grampians Public Health Unit

Grampians Public Health Unit (GPHU)

Date published - 21st April 2023

# Moorabool LGA

## 1. Mortality Data

### 1.1 Summary Mortality Data 2016-2020

| Year | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| Population | 32,667 | 33,457 | 34,206 | 35,105 | 36,068 |
| Deaths | 196 | 196 | 187 | 208 | 262 |
| Premature deaths (<75 years) | 75 | 77 | 83 | 79 | 88 |
| Potentially avoidable deaths (PAD) | 35 | 40 | 39 | 39 | 41 |
| PAD % premature deaths | 46.4 | 49.9 | 45.2 | 54.1 | 46.0 |
| Australia (PAD % premature deaths) | 50.8 | 50.8 | 50.2 | 49.6 | 49.1 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

### 1.2 Leading Causes of Death 2016 – 2020

| Male | % | Female | % |
|---|---|---|---|
| 1. Coronary heart disease | 12.0 | 1. Dementia | 12.4 |
| 2. Lung cancer | 7.5 | 2. Coronary heart disease | 7.9 |
| 3. Prostate Cancer | 5.9 | 3. Chronic obstructive pulmonary disease | 5.9 |
| 4. Dementia | 5.5 | 4. Cerebrovascular disease | 5.0 |
| 5. Cerebrovascular disease | 4.6 | 5. Breast cancer | 4.7 |
| 6. Chronic obstructive pulmonary disease | 4.5 | 6. Lung cancer | 4.3 |
| 7. Colorectal cancer | 4.0 | 7. Heart failure | 3.8 |
| 8. Liver cancer | 3.2 | 8. Colorectal cancer | 3.7 |
| 9. Pancreatic Cancer | 3.1 | 9. Diabetes | 2.8 |
| 10. Diabetes | 2.9 | 10. Influenza and pneumonia | 2.7 |
| Total all cause deaths (n) | 535 | Total all cause deaths (n) | 514 |

Source: AIHW, 2022, MORT books. https://www.aihw.gov.au/reports/life-expectancy-death/mort-books/contents/mort-books

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Moorabool LGA Data Snapshot – 21st April 2023

## 2. Health Risk and Wellbeing Data

### 2.1 Body Weight, Nutrition, Exercise, Smoking

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian Average |
|---|---|---|---|---|
| **Body Weight** | | | | |
| % adults Body Mass Index >25 | 59.6 | 59.5 | 35.5 Melbourne | 51.0 |
| % adults Body Mass Index between 25-29 | 28.9 | 28.1 | 23.7 Buloke | 30.1 |
| % adults Body Mass Index >30 | 30.7 | 31.4 | 9.9 Melbourne | 20.9 |
| **Nutrition** | | | | |
| % adults consume recommended daily intake fruit & veg | 4.9 | N/A | 9.5 Queenscliff | 3.6 |
| Mean serve of fruit daily | 1.60 | N/A | 1.90 Port Philip | 1.60 |
| Mean serve of veg daily | 2.10 | N/A | 2.70 Queenscliff | 2.20 |
| % adults consume snack food or takeaway >1 per week | 23.7 | N/A | 2.3 Yarriambiack | 15.3 |
| % adults consume sugar-sweetened drinks daily | 17.7 | N/A | 2.7 Manningham | 10.1 |
| **Physical Activity** | | | | |
| % adults sedentary | 2.4 | N/A | 0.5 Queenscliff | 2.5 |
| % adults insufficient exercise | 45.0 | N/A | 30.9 Towong | 44.1 |
| % adults sufficiently active | 50.6 | N/A | 66.80 Towong | 50.9 |
| % people participating in organised sport | N/A | 10.3 | 31.2 Buloke | 12.9 |
| **Smoking** | | | | |
| % of adults smoke daily | 17.2 | 13.8 | 3.6 Surf Coast | 12.0 |

**Source 1:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

**Source 2:** Public Health Information Development Unit (PHIDU) 2017, 2018, 2020, https://phidu.torrens.edu.au/

**Source 3:** VicHealth. Sport participation in Victoria 2015-2020 and the impact of COVID-19 on participation. https://vichealth-prd-cd.vichealth.vic.gov.au/-/media/VH_Sport-participation-2015-20_Research-Summary.pdf?la=en&hash=2CA4C80925121AA21E800C9D188E57720BF5BA45

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Moorabool LGA Data Snapshot – 21st April 2023

## 2.2 Preventative Health Checks

| Health Indicator | 2017 Health Survey | 2020 Health Survey | Best performing LGA | Victorian average |
|---|---|---|---|---|
| **Preventative Health Checks** | | | | |
| % adults with blood pressure measured in last 2 years | 78.0 | N/A | 91.7 Yarriambiack | 79.6 |
| % adults with blood lipids tested in last 2 years | 52.2 | N/A | 68.0 Whittlesea | 56.8 |
| % adults with blood glucose tested in last 2 years | 56.8 | N/A | 64.2 Whittlesea | 50.7 |

**Source:** Victorian Population Health Survey, 2017 and 2020, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey

## 2.3 Cancer Screening Data

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 |
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| **Bowel Cancer Screening Participation** Crude Rate (%) | 37.7 | 44.4 | 46.8 |
| **Best performing LGA** | 46.9 | 55.7 | 57.7 |
| **Victorian average** | 38.1 | 43.2 | 46.0 |
| **Australian average** | **37.6** | **41.3** | **43.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2018, 2022 and 2023, https://phidu.torrens.edu.au/

| Year | 2014 – 2015 | 2016 – 2017 | 2018-2019 | 2019-2020 |
|---|---|---|---|---|
| **Breast Cancer Screening Participation** Crude Rate (%) | 47.2 | 54.0 | 54.2 | 46.0 |
| **Best performing LGA** | 59.4 | 66.9 | 64.2 | 61.3 |
| **Victorian average** | 54.6 | 54.1 | 53.9 | 46.5 |
| **Australian average** | **N/A** | **N/A** | **54.8** | **49.9** |

**Source:** Public Health Information Development Unit (PHIDU) 2019, 2021 and 2023, https://phidu.torrens.edu.au/

| Year | 2018 – 2020 |
|---|---|
| **Cervical Cancer Screening Participation** Crude Rate (%) | 45.9 |
| **Best performing LGA** | 61.8 |
| **Victorian average** | 47.4 |
| **Australian average** | **47.5** |

**Source:** Public Health Information Development Unit (PHIDU) 2023, https://phidu.torrens.edu.au/

Moorabool LGA – Data Snapshot – Second Iteration

Grampians Health
Grampians Public Health Unit

# Grampians Public Health Unit (GPHU)

Moorabool LGA Data Snapshot – 21st April 2023

## 3. Demographic Profile

### 3.1 Age Distribution


### 3.2 Other demographic characteristics

| Population characteristic | Moorabool LGA | Victorian Average |
|---|---|---|
| Aboriginal and/or Torres Strait Islander peoples | 1.4% | 1.00% |
| Persons born overseas | 14.3% | 35.00% |
| Uses a language other than English at home | 7.8% | 30.20% |
| Persons living with a disability | 22.4% | N/A |
| Persons who have need for assistance with core activities for daily living | 6.3% | 5.90% |
| People of adults who identify as LGBTIQ+ | 4.0% | 5.70% |
| Socio-economic index for areas (SEIFA). Index of relative socioeconomic disadvantage (IRSD) ranking 1-79 in Vic | 53 | N/A |

**Source 1:** ABS, 2021, https://www.abs.gov.au/census/find-census-data/quickstats/2021/AUS

**Source 2:** VPHS, 2017, https://www.health.vic.gov.au/population-health-systems/victorian-population-health-survey-201

Moorabool LGA – Data Snapshot – Second Iteration

Appendix 3.4 By Five – Reporting On Our Progress in 2022

BY FIVE
WSM Early Years Initiative

# Contents



murdoch children's research institute

The Royal Children's Hospital Melbourne

*This report was developed by the Centre for Community Health (CCCH), the learning partner to the By Five Innovation & Equity Hub. CCCH is a research group of the Murdoch Children's Research Institute and a department of the Royal Children's Hospital.*

BYFIVE
WSM Early Years Initiative

# Part 1: Our story so far

The gap in outcomes between rural and urban children in Victoria is large and growing, and this is an issue that is particularly stark for the Wimmera Southern Mallee (WSM).

**By Five Early Years Project 2016-2020**
Between 2016 and 2020 an early childhood-focused place-based initiative, known as the By Five Early Years Project, was founded and delivered as a response to this gap in outcomes for children in the WSM. The initiative was funded by the Victorian Departments of Education and Training (DET) and Health and Human Services (DHHS), governed by the Wimmera Southern Mallee Regional Partnership and co-led by DET and CCCH at the Murdoch Children's Research Institute.

**By Five Innovation & Equity Hub 2021-2024**
In 2021, the Wimmera Development Agency (WDA) was funded for a four-year period by DET to transition the By Five Early Years Project to a community-led early years innovation and equity hub. Building on the foundational and enabling changes achieved during 2016-2020, the By Five Hub's goal is to narrow the gap in school entry outcomes for children in WSM, by focusing efforts on the following priority areas:

- Equitable access to services for all children and families in the WSM
- High-quality services for all children and families
- High engagement and participation in services by children and families
- Confident and connected families across the WSM
- Community environments that support all children and families to thrive

The By Five Innovation & Equity Hub is responsible for facilitating engagement with the WSM community and service system to identify, design, test, and implement innovative solutions. As a result, it will produce learnings that can be applied in other parts of rural Victoria and Australia.


The Wimmera Southern Mallee region includes the traditional lands of the Wotjobaluk, Jaadwa, Jadawadjali, Wergaia and Jupagalk peoples and sections of the land of the Dja Dja Warrung people, Taungurung people and the Yorta Yorta people.

BY FIVE
WSM Early Years Initiative

# Part 2: Our progress in 2022

## 1 Setting the foundations for the next phase

- WDA took ownership of the By Five Hub, establishing a new local team to ensure the initiative is locally driven.
- The SC4C steering committee broadened its scope to become the By Five Innovation and Equity Hub Steering Committee.
- The By Five Hub team developed the By Five Strategic Plan 2022-2025 which outlines the plan to improve the outcomes of children in the WSM.
- Together with CCCH, the By Five Hub team and steering committee designed a Monitoring, Evaluation and Learning Framework that will guide and track implementation, learning and impact.

## 2 Evolving the By Five Hub's flagship Paediatric Project

- 135 co-consultations with 99 children ranging in age from 4 months to 18 years were conducted, enabling improved paediatrician access for the children in the region.
- The project modified its delivery by 1) running small sessions tailored to families experiencing vulnerability, 2) introducing multidisciplinary case-based sessions, and 3) ceasing referrals from non-clinicians.
- Wave 2 of the Paediatric Project Evaluation was undertaken, comprising process and impact findings to inform next steps.
- Of particular note, families described feeling reassured, reduction in stress (for both parent and child), and increased skills and confidence to manage their child's health condition since attending the co-consultations.

## 3 Learning about drivers and barriers to service access

- Project managers dedicated to the new Allied Health and Antenatal Care projects were recruited.
- Deep learning was undertaken about the status of, and drivers and barriers to access to 1) antenatal services, 2) early childhood education and care, and 3) paediatric allied health services across the region. This involved gathering local data and key stakeholder insights, resulting in the creation of reports for each service area.
- Key service stakeholders were identified and engaged to support the commencement of addressing the enablers and barriers to antenatal services and early childhood education and care.

BY FIVE
WSM Early Years Initiative

# Part 3: Our reflections about how we do the work

In 2022, the By Five Innovation and Equity Hub established a learning partnership with the Centre for Community Child Health (CCCH) at the Murdoch Children's Research Centre. The objective of the learning partnership is to support and build the capacity of the By Five Hub to learn within projects and across the initiative, whilst simultaneously building a learning culture.

Learning activities comprised individual coaching, group reflection sessions and workshops about approaches to planning, implementation and evaluation of place-based initiatives. Key reflections from the By Five Hub team resulting from learning activities in 2022 are shown to the right.


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BY FIVE
WSM Early Years Initiative

# Part 4 : Our next steps

**Action 1**

Start implementing our Monitoring, Evaluation and Learning framework to support understanding of our progress and impact.

**Action 2**

Commence work on the recommendations cited in the ECEC, Allied Health and Antenatal Care reports, to build the enablers and tackle the barriers to service access.

**Action 3**

Continue to expand the By Five Paediatric Project in conjunction with RCH and local health professionals based on findings from the evaluation.

**Action 4**

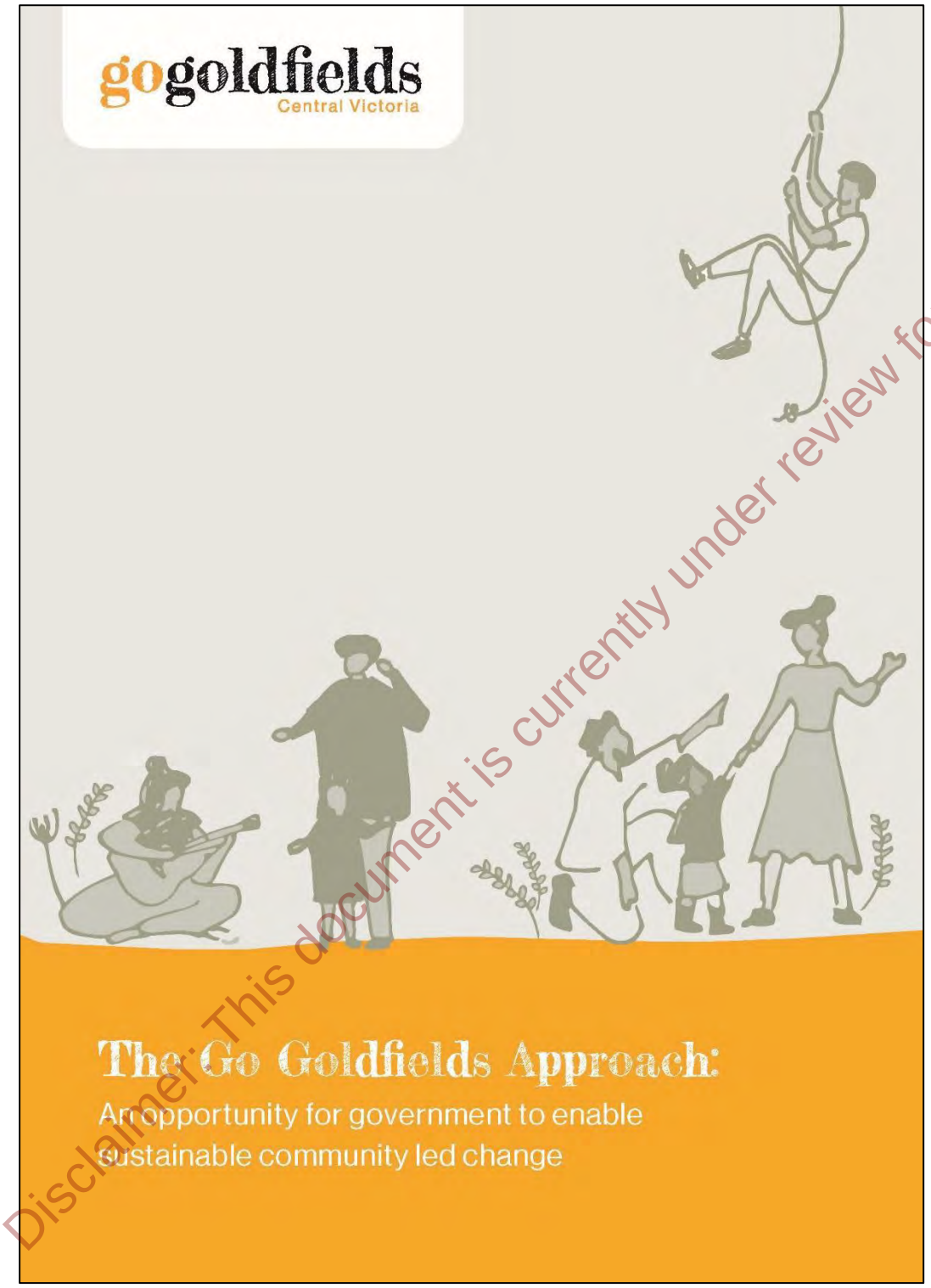
Identify opportunities to strengthen the capacity for family and community engagement across the initiative's priority areas.

If you would like more information about the By Five Innovation and Equity Hub Initiative please visit our website: **www.wda.org.au/services/byfive**

**Jo Martin, Executive Director:** jo.martin@wda.org.au

07

# Appendix 3.5 Go Goldfields – Every Child, Every Chance






**Note:** This document comprises collated excerpts from two Go Goldfields publications (reproduced with permission):

*The Go Goldfields Approach: an opportunity for government to enable sustainable community led change* (2022)

*Go Goldfields Data Dashboards* (2020)

# 01 Summary

'Go Goldfields' is a place-based initiative in the Central Goldfields region demonstrating that investment in place-based initiatives to improve systems and services can significantly improve outcomes for children and their families in highly disadvantaged areas. This paper identifies how the Victorian Government can enhance the effectiveness of social reform and investment for those who most need it, through further embedding place-based practice for social reforms and long term investment in local backbones such as Go Goldfields.

Go Goldfields operates in an area where significant entrenched and intergenerational socio-economic disadvantage is compounded by;

- geographical isolation,
- a lack of public transport connection
- service decline (leaving people with a high number of visiting or distant services)
- limited economic opportunities
- the impacts of catastrophic events (such as floods and institutional abuse)
- a history of decisions made for the community from outside the community.

The Victorian Government has demonstrated a whole-of-government commitment to improving social outcomes through its significant investment in family services, family safety, mental health, and early education reforms.

To support the significant investment in social spending, *The Victorian Framework for place-based approaches: The start of a conversation about working differently for better outcomes* was developed. The Framework recognises the need for the public sector to move past listening to the community (place-focused), towards relinquishing some control and collaborating with local partners to achieve locally led outcomes.

In the 2020/21 Victorian State Budget short-term financial support was provided to several established place-based initiatives in low socio-economic communities across Victoria, including Go Goldfields' *Every Child, Every Chance* initiative. Every Child, Every Chance focuses on the important elements needed to support children in Central Goldfields region to grow up healthy, safe and confident.

The cycle of intergenerational disadvantage has significant costs to children, families, communities, and governments. Changing this is resource intensive, particularly in communities where there are compounding challenges of skill shortages and transport. It requires effective communication, coordination, and a local anchor to provide ongoing stability for the community.

This paper illustrates what funding our Backbone has generated for our area, capitalising on the social reforms and funding opportunities to benefit the community. However, it also highlights the need for the Victorian Government to commit to long term funding for our backbone and others like it. Moreover, that it continues to embed the recommendations of the Victorian Framework for place-based initiatives in its practice, policy, and program design. Only through this meaningful support will communities with significant disadvantage like Central Goldfields be able to regenerate rather than falling further behind.

# 02 The Challenge

## High levels of disadavantage

| LEVELS OF DISADVANTAGE | CENTRAL GOLDFIELDS | VICTORIA |
|---|---|---|
| **Household Income** | | |
| Households in the most disadvantaged quartile of the Index of Household Advantage and Disadvantage (IHAD) (ABS, 2022) | **39%** | 25% |
| **Labour Force Participation** | **44%** | 65% |
| **Vulnerable Children** | | |
| Intellectual disability, developmental delay or learning disability | **13%** | 8.2% |
| Children are vulnerable on two or more domains (AEDC 2021) | **20.8%** | 10.2% |
| **Families experiencing stress** | | |
| Alcohol or drug related problem in family (SEHQ 2021) | **9.3%** | 3.6% |
| History of abuse to parent | **19.6%** | 5.4% |
| History of abuse to child | **6.5%** | 1.9% |
| Child witness to violence | **14%** | 3.5% |
| History of mental illness of parent | **17%** | 9% |
| **Housing** | | |
| More likely live in a caravan, cabin, or improvised home (such as a tent or shed) | **1.7%** | 0.4% |

# 03 The Go Goldfields Approach

Go Goldfields is a place-based partnership between State and local government, service providers and the Central Goldfields community committed to achieving better societal outcomes. Go Goldfields has adopted a social ecological model and facilitates work at four levels simultaneously. The work places significant emphasis on forming relationships at all levels of the socio-ecological model (image below). It is the relationships that make way for the constructive conversations, collaboration, shared trust and impact.

**We operate through:**

**A Backbone**
to facilitate all work and build relationships

**A Leadership Table**
to enable high level collaboration

"Brokering relationships takes time, but trust has been earned. This trust has built because our stakeholders have seen we have done what we said we would do, through hard work, integrity, and with the best interests of the community at heart."

Backbone Manager


# 03 Every Child, Every Chance

In 2020, Go Goldfields was armed with research conducted by Murdoch Children's Research Institute (MCRI) *Restacking The Odds* (RSTO) that stated 'stacking' evidence based interventions known to improve children's outcomes will provide a cumulative impact to better enable change for children and their families experiencing disadvantage.

Equally compelling was the overwhelming evidence underpinning the importance of the first 1000 days of life where experience and supports in early years shapes health, development and wellbeing across a lifetime. This includes exposure to chronic stress and cumulative adverse experiences impacting on children's neurological and biological development. Worse still is the discrepancies in health and social outcomes between children from advantaged and disadvantaged backgrounds which emerge early and widen steadily without positive intervention.

This evidence, combined with the opportunity to complement State Government reforms led to a more directive approach by the Backbone. A narrowed focus on early childhood and altered governance structure to a more decision focussed Leadership Table would lay the foundation for our work to ensure Every Child in Central Goldfields has Every Chance to grow up healthy, safe, and confident.

Like other places across the State, the early years in Central Goldfields are serviced by a complex range of departments and services well suited to the Go Goldfields collective impact approach.

Priority areas have been identified to address the research and data.


**Developed five priority areas that aligned with Go Goldfields Theory of Change.**

Each priority area is based in evidence of improving life outcomes for children and their families, current available data, existing investment where value could be added, and our community's energy.

**The Five Every Child, Every Chance Priority Areas and our future visions for these are:**

### Healthy & Supported Pregnancies

The future of our community starts with every pregnancy being supported to maximise choice, opportunity, and the health and well-being of parent and child.

### Confident & Connected Parents

All parents and carers are empowered, resourced, and supported to confidently parent. They are well connected and influence the delivery of programs and services that impact their lives and family.

### Safe & Thriving Children

All children are raised in psychologically, physically, emotionally, and culturally safe environments that listen and respond to them appropriately, enabling them to thrive and meet their potential.

### Valued Early Years Education & Care

Community, services, business and governments invest in early childhood education and care to empower and support families and the workforce to create opportunity and growth for the community.

### A Great Start to School for all Kids

Services, schools and kindergartens work collaboratively to support children and their families to ensure everyone is ready to get the most out of their foundation education.

# 06 Achievements to date

Since the launch of Every Child, Every Chance in November 2020, the Go Goldfields Backbone has taken a direct approach to leading and demonstrating collaborative and innovative responses to address some of the most apparent needs in the community. These include:

**Creating The Nest.**
A parent-informed space located in central Maryborough. The Nest supports families early in their parenting journey to increase confidence, connection, and capacity. A full-time facilitator is employed to welcome parents and carers, increase awareness of services, encourage peer support, and provide warm referrals to services and social support networks. The Nest offers drop-in sessions and programs facilitated by Go Goldfields and partner organisations. Over the first 3 months of operation, the Nest has demonstrated the importance of a warm and relational entry point for families in the Shire to engage with other parents, services, and support.


**A systematised Centralised Kindergarten Registration.**
Improving the registration process to increase transparency, access and communication with families and providers for 3 and 4 year old kinder. Go Goldfields introduced a customer relationship management system (CRM) along with new processes and locally agreed priority of access criteria to ensure all children across Central Goldfields were able to access a program to suit their needs.

**Implementation of the Empowering Parents, Empowering Communities program.**
An evidence-based peer-to-peer parenting program that builds confidence and capacity through a sustainable approach. On completion of the eight-week 'Being a Parent' program, participants are given the opportunity to train as facilitators of the program to increase the reach of the program to build social capital and parenting skills.

**A local approach to Early Years Transition.**
Go Goldfields Backbone leveraged relationships with kindergarten providers, local primary schools, and the Department of Education to drive a joint-funded project. The project brings together early years educators, foundation teachers, Maternal and Child Health, allied health practitioners and family services providers to a consistent Shire-wide approach and network for early years transitions. It supports improved quality and consistency of practice. The project will culminate in a Shire-wide Transition Plan to support children and their families through their early years.

"(ECEC has) built on things that [are] already happening. It has catalysed energy in the gaps and built on available resources... That's where you've got to be showing that you are making those incremental changes and that they are making a difference."

Government department stakeholder

**A local service model to increase provision of early intervention services.**
Early childhood intervention services in Central Goldfields are subject to extensive waiting lists, often over 12 months long. Go Goldfields initiated a survey to local parents to identify needs and appetite for different models of service to cut waiting times. The results catalysed an agreement with an NDIS provider to conduct weekly group sessions from The Nest focusing on emotional regulation and sensory processing, increasing access and equity to services locally.

**Delivery of local festival for families.**
Partnering with the Committee for Maryborough and Maryborough Rotary Club, Go Goldfields is delivering an inaugural Goldfields Community Festival in October 2022. The festival is a completely free and accessible day of activities targeted at local children and their families. It is designed to improve community engagement and enhance general mental health and well-being – particularly after COVID-19 lockdowns.


**Implementation of local program and practitioner to address attendance.**
The program is designed to reduce barriers and support a culture of strong attendance in early years education. Go Goldfields has partnered with local primary school principals and Schools Plus to appoint a full-time Education Engagement Practitioner (EEP) within the Go Goldfields Backbone. The EEP will work with students and families across six primary schools and seven local kindergartens, to embed a culture of attendance through the locally driven 'Supportive (and) Helpful Attendance Program (for) Everyone' and contribute to the Central Goldfields Great Start to School Transition Plan.

**Delivery of the Early Years Forum.**
Quarterly community of practice forum for early years services and practitioners working within Central Goldfields Shire. The forum provides participants an opportunity to share knowledge and service information, increasing the local workforce capacity and connection.

# 07 Building on collaborative momentum to address local early years infrastructure and service needs

To complement the change process, the Central Goldfields Shire Council in partnership with Go Goldfields commenced an Early Years Masterplan Project. The Central Goldfields Shire Early Years Infrastructure Masterplan Project, Phase 1 Report compiled by Semann and Slattery draws on qualitative and quantitative data to underscore findings of significant unmet need for early years infrastructure and services in the Central Goldfields region. Phase 1 Early Years Masterplan recommendations call for additional investment in:

- Kinder and day care infrastructure.
- Maternal & Child Health infrastructure.
- Enhanced Maternal Child Health and Supported Playgroup programs.
- Allied health and early detection and intervention of children with additional needs.
- Provision of long day care and flexible occasional care.
- Access and awareness of services for children and families.

**Stakeholders for the project identified the following as key considerations for future early years infrastructure and services:**

- Collaboration and information sharing across services
- Inter professional learning and cultural awareness
- Improved capacity of local services to better support families
- the creation of a hub in central Maryborough to include services such as Maternal Child Health, early intervention allied health, support for families, peer to peer learning and support opportunities and mental health services.

The Phase 1 report stated that the majority of stakeholders felt that Go Goldfields would be a natural fit to play an important role in the early years' infrastructure space going forward. Moreover, several stakeholders discussed the importance of the work on the five Every Child, Every Chance priority areas and the footings of a strong partnership framework already in place.

# Go Goldfields stakeholders identified the following impact and strengths of Go Goldfields

## Impact

**Improved communication between community, service providers and funders.**

Stakeholders reported their contribution to, or involvement with, Go Goldfields has improved collaboration with other services, and many reported that they had improved connection with community and other providers.

**Creation of a common agenda for the early years.**

Every Child, Every Chance and the 5 priority areas has provided a common language and agenda in the Central Goldfields Shire for practitioners, service providers, and decision makers to participate in.

**Improved capacity and capability in the community.**

Go Goldfields has invested in programs and projects to empower the local community and service system.

"We have a much greater understanding of what the system is in Central Goldfields around supporting and responding to the needs of families with young children within that local government area."

Leadership Table member

## Strengths

**Brings a community development lens.**

The Backbone offers valuable skills and perspectives to collaborative discussions and decision-making as most partner organisations are primarily clinicians, social workers or educators.

**Ability to test and trial.**

Go Goldfields is well positioned to take small scale risks and then share learnings and identify opportunities for growth, which has been beneficial to Council and other services.

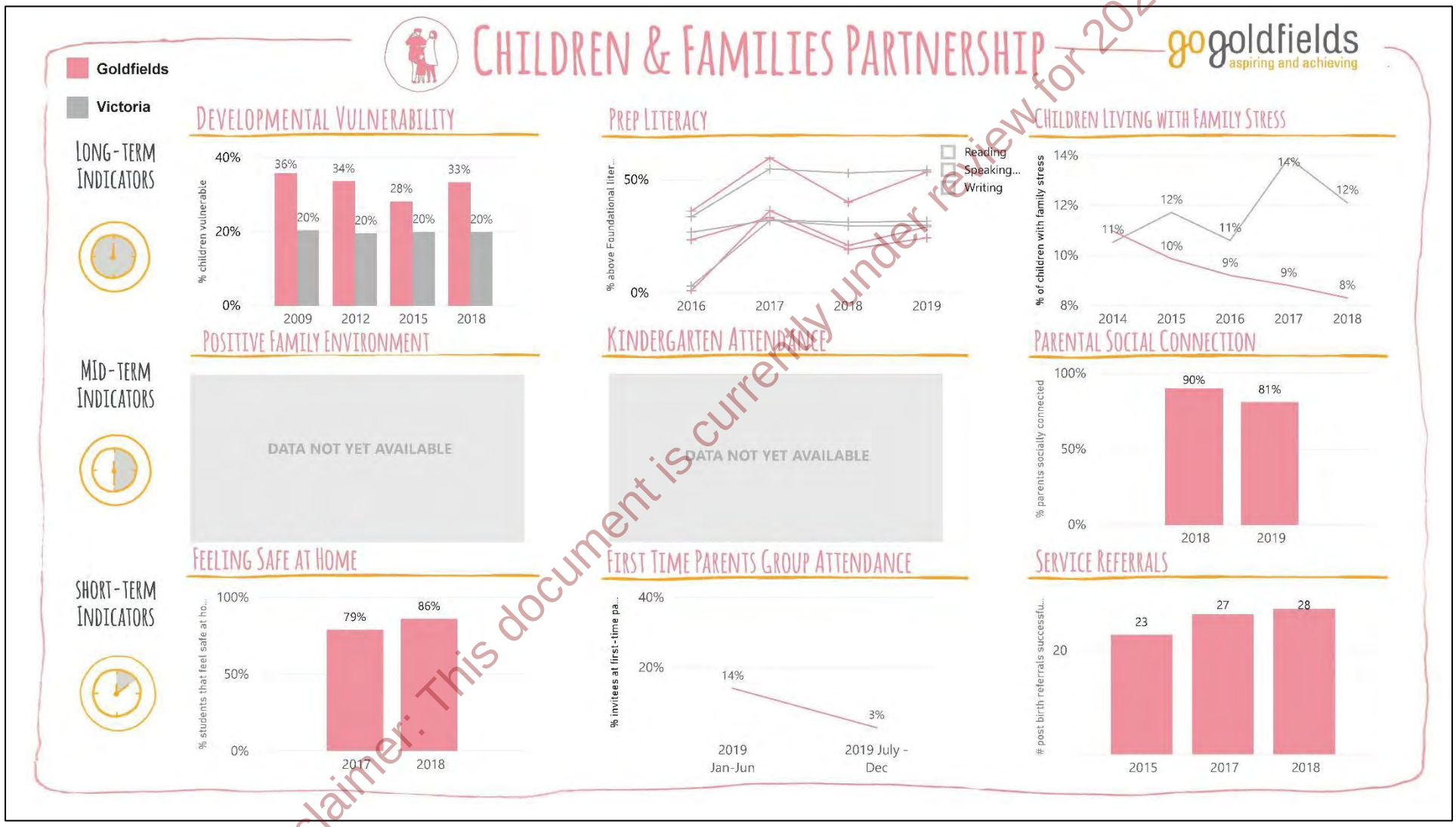
**Ability to translate policy to inform local program design and implementation.**

A skilled and experienced Backbone team with links to state government is an asset for place-based work. It means the Backbone functions as a conduit and "translator" between what occurs at a policy level and at a service delivery level.

**Flexibility to pursue opportunities and respond to needs as they arise.**

This is enabled through a funding model for the backbone staff which does not prescribe how FTE should be used.

**Data dashboard 2020** – *Baseline trends* https://gogoldfields.org/data-dashboards/



# DATA DASHBOARD INFORMATION

gogoldfields
aspiring and achieving

## GO GOLDFIELDS IS A PARTNERSHIP INITIATIVE CREATING PLACE-BASED SOLUTIONS TO COMPLEX SOCIAL ISSUES IN THE CENTRAL GOLDFIELDS SHIRE, VICTORIA, AUSTRALIA.

Our collaborative approach brings community, business, service organisations, and decision-makers together to improve outcomes for children, youth and families. ***'Our community aspiring, achieving and living a full life'***; is the vision that drives us towards a positive future.

The Go Goldfields Children and Families Partnership provide guidance to the Early Years' Service Sector and community to deliver innovative local solutions. Our initiatives focus on the importance of positive family relationships and community connectivity. Our strategies ensure that all children are provided with the resources and support they require for them to reach their full potential for a positive future. Together, we collaborate to achieve our aspiration; ***'All children are confident, creative, safe and healthy.'***

## DEVELOPMENTAL VULNERABILITY

**Outcome:** *All children experience a positive, supportive family environment.*

**Indicator:** % of children developmentally vulnerable in one or more AEDC domains.

**Headline Stat:** 33% of children reported as being vulnerable (2018) in comparison to the Victorian average of 22%.

**Source:** Australian Early Development Census (AEDC) from the Australian Department of Education.

**Note:** The AEDC is a nationwide data set collected to measure early childhood development at the time children commence their first year of primary school. The AEDC collects data relating to five key domains being; Physical Health and Wellbeing, Social Competence, Emotional Maturity, Language and Cognitive Skills and Communication Skills and General Knowledge. The data for this indicator is collected via teacher observation.

## PREP LITERACY

**Outcome:** *Children and families actively engage and participate in MCH, Playgroup, Kindergarten and Primary School.*

**Indicator:** % of students above the Foundational literacy level.

**Headline Stat:** Reading domain showed 24.3% of students above the 'Foundational' level (2019) compared to the Victorian average of 31.7%.

**Source:** English Online Interview from the Victorian Department of Education and Training.

**Note:** The English Online Interview (EOI) assesses the English skills of students and all Prep students must be assessed during Term 1 each year in Victorian government schools. EOI is comprised of three dimensions, Speaking and Listening, Reading and Writing with assessment levels ranging from Foundational (at the lowest end) to Above Level 4 (at the highest performing end).

## CHILDREN LIVING WITH FAMILY STRESS

**Outcome:** *All children experience a positive, supportive family environment.*

**Indicator:** % of children with high levels of family stress.

**Headline Stat:** 12.1% of children were living with family stress (2018) compared to the Victorian average of 8.3%.

**Source:** School Entrant Health Questionnaire (SEHQ) from the Victorian Department of Education and Training.

**Note:** This indicator is measuring the proportion of children at school entry whose parents report high levels of family stress in the past month. The SEHQ is an integral part of the Primary School Nursing Program and also provides valuable information about outcomes for children at State and local levels. It is completed by the child's parent or carer and therefore the data reflects parental responses and concerns. It does not report medical diagnoses or the opinions of health professionals.

## POSITIVE FAMILY ENVIRONMENT

**Outcome:** *All children experience a positive, supportive family environment.*

**Indicator:** % of families who spend time focusing on playing, teaching, and supporting their 0-2-year-old.

**Source:** Central Goldfields Best Start Survey.

**Note:** This data is planning to be collected by the Central Goldfields Best Start project in partnership with Go Goldfields. Note: This data is collected via a parent-reported survey of parents with children who are 0-2 years of age. This indicator focuses on parental perception of whether their family ensures they make time to play, teach and support their child.

*Data and source information is correct at the time of publication. info@gogoldfields.org*

# DATA DASHBOARD INFORMATION

go goldfields
aspiring and achieving

## KINDERGARTEN ATTENDANCE

**Outcome:** *Children and families actively engage and participate in MCH, Playgroup, Kindergarten and Primary School.*

**Indicator:** This indicator is yet to be confirmed.

**Source:** Central Goldfields Shire kindergartens.

**Note:** After extensive research was conducted, it was found that local-level data was not currently available to measure this issue. A partnership has been established between Go Goldfields and local kindergartens to begin collecting this data in 2020. It is important to gather this data to effectively advocate for increased allocation of resources, and the development of place-solutions, to raise attendance rates if required.

Total population of the Shire 12,995 (2016 Census)

## PARENTAL SOCIAL CONNECTION

**Outcome:** *All children experience a positive, supportive family environment.*

**Indicator:** % of parents that reported satisfaction with their current level of social connection.

**Headline Stat:** 81% of parents surveyed in 2019 reported feeling satisfied with their current level of social connection in comparison to 90% in 2018.

**Source:** Central Goldfields Best Start Survey.

**Note:** This data was collected by the Central Goldfields Best Start project in partnership with Go Goldfields. The data is looking at reported levels of social connection for parents of children who are 0-2 years of age. This data is collected biannually, and an average is then calculated for the annual, total average.

In the Financial Year of 2017 – 2018, the Shire recorded 115 birth notifications, and 33 first time mothers (Maternal and Child Health services annual report)

## FEELING SAFE AT HOME

**Outcome:** *All children experience a positive, supportive family environment.*

**Indicator:** % of year 3 - 6 students that feel safe at home.

**Headline Stat:** Feelings of safety in the home increased for year 3-6 students from 79% in 2017 to 86% in 2018.

**Source:** Central Goldfields Combined Primary Resilience Survey Year Level Report 2018 and 2017.

**Note:** The Central Goldfields Combined Primary Resilience Survey was conducted in primary schools in the shire, averaging data from students in grades 3, 4, 5, and 6. The Resilience Survey was run in 2017 and 2018 in Central Goldfields but there are currently no plans to continue the collection of this data. Go Goldfields is currently investigating partnerships to resolve this data gap.

Nearly 20% of families in the Shire are 1 parent families, higher than the Victorian proportion of 15.53% (2016 Census)

## FIRST TIME PARENTS GROUP ATTENDANCE

**Outcome:** *Children and families actively engage and participate in MCH, Playgroup, Kindergarten and Primary School.*

**Indicator:** % of invitees that attended first-time parents group.

**Headline Stat:** Current average attendance rates at MCH First Time Parents groups is 3%.

**Source:** Central Goldfields Maternal and Child Health (MCH) Services.

**Note:** First Time Parent Groups are generally run by a qualified MCH nurse and cover a lot of topics, from breastfeeding and sleep-and-settling to family relationships and wellbeing. The groups run for 6-8 weeks and involve other parents from local communities who have also recently given birth to their first child and are free to attend. This data is currently collected directly from the Central Goldfields MCH service. Go Goldfields is investigating partnerships to supplement this indicator with additional local data.

## SERVICE REFERRALS

**Outcome:** *All children experience a positive, supportive family environment.*

**Indicator:** Number of post-birth referrals successfully referred to support services.

**Headline Stat:** MCH referrals has increased from 23 referrals in 2015 to 28 referrals in 2018.

**Source:** Central Goldfields Maternal and Child Health (MCH) services annual reports.

**Note:** This data is currently collected from the Central Goldfields Maternal and Child Health service and is used in their annual reporting. The referral domains being; Emotional, Physical, Social Interaction Impaired, Domestic Violence, and Planning, and pertain to post-birth referrals for the mother and/or family of the child. All data sets are recorded in financial years.

The population of Aboriginal people has increased by 31.9% from 2011-2016 (2016 Census)

*Data and source information is correct at the time of publication. info@gogoldfields.org*

Contact us
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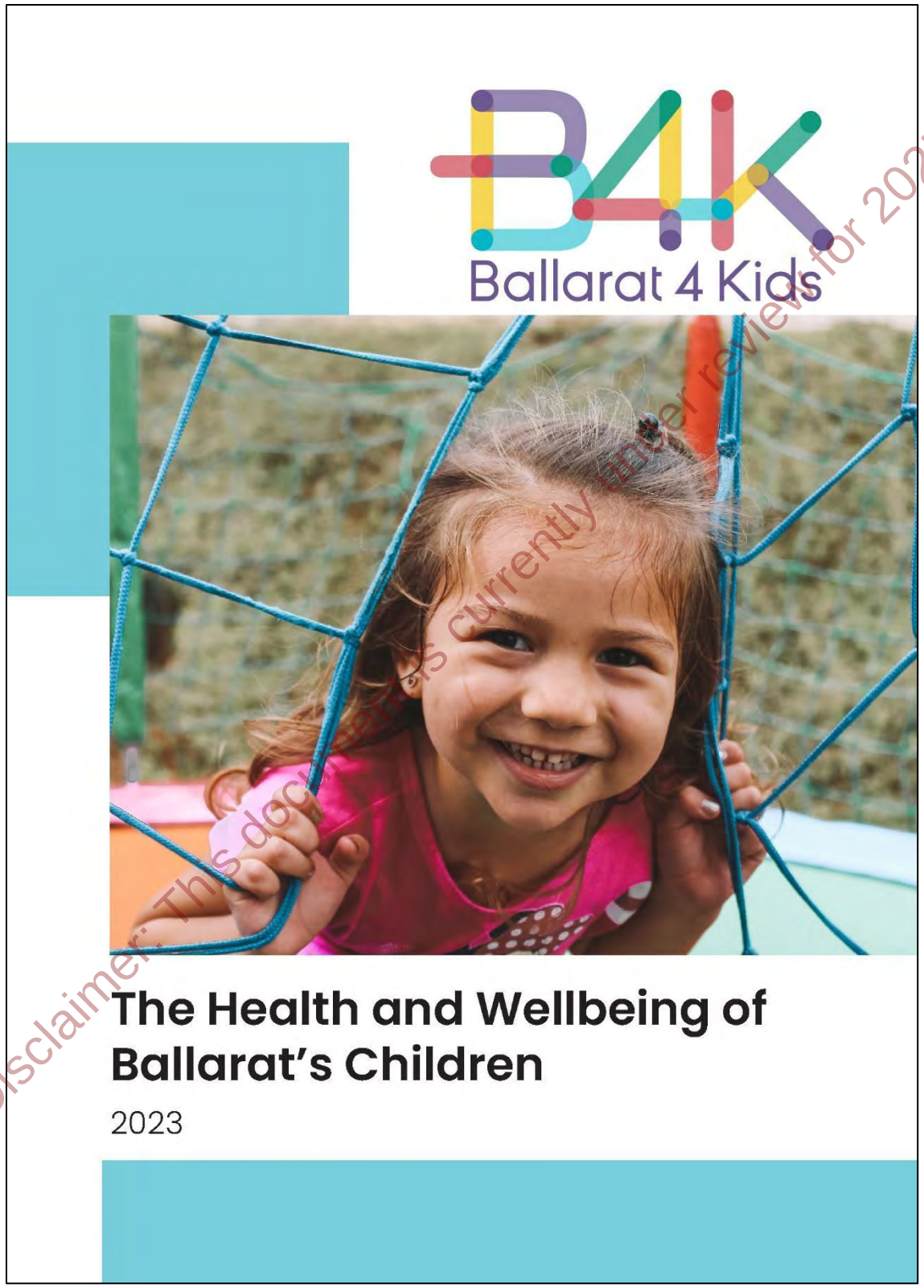
Appendix 3.6 The Health and Wellbeing of Ballarat's Children



## ACKNOWLEDGMENTS

Ballarat 4 Kids acknowledges the Traditional Custodians of the land we live and work on, the Wadawurrung and Dja Dja Wurrung People, and recognise their continuing connection to the land and waterways.

We pay our respect to their Elders past, present and emerging and extend this to all Aboriginal and Torres Strait Islander People.

Ballarat 4 Kids would like to thank those who helped in the data collection for and production of this report, including the City of Ballarat, Federation University, Uniting, Grampians Public Health Unit, and all participating partners of Ballarat 4 Kids.

## OVERVIEW OF BALLARAT

Ballarat is a key regional city with health services, education, retail and new housing estates attracting new residents of all ages from both rural towns and city areas. In 2023 the City of Ballarat was estimated to have a population of around 117,000 and nearly 1 in 5 residents (22,000) are aged under 15 years. The level of cultural diversity is increasing with 11% of the population born overseas and 3% of the population identify as Aboriginal and/or Torres Strait Islander. There is a greater proportion of low- and medium-income households when compared to state levels, and 31% of all households are renting. There is a higher level of need for assistance within the community including 7.6% of all children under the age of 10.

## ABOUT BALLARAT 4 KIDS

Ballarat 4 Kids (B4Kids) was formed in 2019 as a coalition of local organisations pursuing a whole-of-city approach to ensure all children get all they need to thrive in life. With now over 35 participating members representing early learning, health, community services, education, sport, First Nations, disability, LGBTQIA+, justice, local and state government, we work collaboratively towards fulfilling the vision of creating a city where all children can thrive.

## THE NEST

The Nest [1] is an Australian evidence-based framework for child and youth wellbeing, developed by the Australian Research Alliance for Children and Youth (ARACY). It defines 6 interlocking areas of wellbeing that must be supported for children and young people to thrive.

These areas are:

- **Loved and safe:** being loved and safe and experiencing positive relationships with family, friends and community;
- **Material basics:** stable housing and secure environments that are protected from poverty;
- **Healthy:** having timely access to services to support healthy growth and development;
- **Learning:** high quality education and opportunities to learn through sport and outdoor play
- **Participating:** participating in community life and having a say about what matters to them; and
- **Positive sense of Identity and Culture:** strong family and cultural connections and a sense of belonging, cultural identity and spiritual wellbeing

For more information on The Nest visit: www.aracy.org.au/the-nest-in-action

## ABOUT THIS REPORT

This report aims to provide an overview of the current health and wellbeing of children in Ballarat in alignment with the six domains of the Nest. It uses the latest available data from a number of sources, which are referenced and described at the conclusion of the report. Data is averaged at a local government area (LGA) level, and it is worth noting that many outcomes are unequally distributed along socioeconomic gradients.

The intention of this report is to provide baseline data against which to measure long-term change and also to assist in identifying priority areas for action.

1. *ARACY 2021*

# LONG TERM LEAD INDICATOR

Ballarat 4 Kids

The Australian Early Development Census collects data relating to five key areas of early childhood development referred to as 'domains'. These include physical health and wellbeing, social competence, emotional maturity, language and cognitive skills (school-based), and communication skills and general knowledge. Data is collected at the time children commence their first year of school.

As a coalition, Ballarat 4 Kids has identified that the percentage of children arriving at school developmentally on track in each domain is a long term lead indicator that reflects the health and wellbeing of Ballarat's children. Developmentally on track means that children are considered to be developing well, whereas developmentally vulnerable means that children are facing some significant challenges in their development.

In 2021, the percentage of children in Ballarat that **started school developmentally on track in each domain** is as follows:

**79%** Physical health and wellbeing[2]

**78%** Social competence[2]

**77%** Emotional maturity[2]

**81%** Language and cognitive skills[2]

**81%** Communication skills and general knowledge[2]

**Compared to 2018, in 2021 there was:**

A **significant decrease** in children on track for social competence, language and cognition skills, and communication skills and general knowledge.[2]

A **significant increase** in the number and percentage of children who were developmentally vulnerable in one or more domains.[2]

While the above percentages are an average at an LGA level, indicators are unevenly distributed across the Ballarat community. For instance, 22% of Ballarat children overall are vulnerable in at least one developmental domain. This rises to 39% in some areas. For those with developmental vulnerability in two or more domains, the rates in some areas are more than double the Ballarat average of 12%. This demonstrates the variation and inequity across our city.

2. *AEDC 2021*

# LOVED AND SAFE

Ballarat 4 Kids

## FAMILY VIOLENCE

**2,129**

**REPORTS OF FAMILY VIOLENCE IN BALLARAT** [3]
(YEAR ENDING SEPTEMBER 2022)

The rate of incident is

**32%**

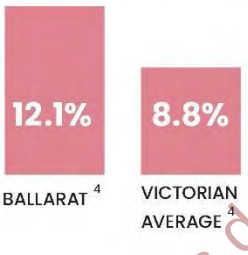
**higher** than state average[3]

**AFFECTED FAMILY MEMBERS** [3]

FEMALE **1613** MALE **512**

AGE 0 - 17
**153**

## FAMILIES EXPERIENCING HIGH OR VERY HIGH STRESS




BALLARAT [4]

VICTORIAN AVERAGE [4]

## MANAGEMENT OF BULLYING

Between

**63% to 81%**

of Ballarat students in Years 4 - 6 perceive that their school handles bullying and harrassment appropriately[5]

3. *Crime Statistics Agency 2022*
4. *School Entrant Health Questionnaire 2021*
5. *Attitudes to School Survey 2021*

3

# MATERIAL BASICS

Ballarat 4 Kids

## HOUSING AND PARENTAL EMPLOYMENT

**31.6%**

OF BALLARAT RENTERS **SPEND MORE THAN 30% OF THEIR HOUSEHOLD INCOME ON RENT**

11.8% increase since 2016[6]

**10%**

OF BALLARAT HOMEOWNERS ARE **FACING MORTGAGE STRESS**

5.5% below the 2021 Victorian Average[6]

**240**

BALLARAT RESIDENTS RECEIVED THE **'PARTNERED PARENTING PAYMENT'**

45% decrease since 2016[7]

**1560**

BALLARAT RESIDENTS RECEIVED THE **'SINGLE PARENTING PAYMENT'**

This statistic has remained fairly consistent over the past 10 years[7]

## FAMILIES REQUESTING HOMELESSNESS SUPPORT

**324**

Families with children under the age of 18 requested **homelessness support services**

of those,

**705**

children under the age of 18 were involved in the request
(JULY 2021 TO JUNE 2022) [8]

### BALLARAT HOMELESSNESS SERVICE CLIENTS

(JUNE 2021 TO JUNE 2022) [8]

| HOMELESS | AT RISK* | NOT STATED |
|---|---|---|
| **142** (Aged 0-9) | **94** (Aged 0-9) | **58** (Aged 0-9) |
| **197** (Aged 10-19) | **97** (Aged 10-19) | **26** (Aged 10-19) |

** A person is at risk of homelessness if they are at risk of losing their accommodation or they are experiencing one or more of a range of factors that can contribute to homelessness.*

6. *ABS Census 2021*
7. *DSS Parenting Payments by LGA December 2022*
8. *Uniting Ballarat Homelessness Service Data*

# HEALTHY

Ballarat 4 Kids

## DENTAL HEALTH

PROPORTION OF CHILDREN **PRESENTING WITH AT LEAST ONE DECAYED, MISSING OR FILLED** BABY OR PERMANENT ADULT TOOTH, ATTENDING PUBLIC DENTAL SERVICES[9]


AVERAGE NUMBER OF **DECAYED, MISSING OR FILLED** BABY OR ADULT TEETH FOR CHILDREN ATTENDING PUBLIC DENTAL SERVICES[9]


## SPEECH AND LANGUAGE DIFFICULTIES

**18.9%**

OF CHILDREN REPORTED TO HAVE **DIFFICULTIES WITH SPEECH AND/OR LANGUAGE**[4]

Victorian average = 16.4%

**27.6%**

OF THESE ARE **REPORTED TO BE SEEING A SPEECH PATHOLOGIST**[4]

Victorian average = 28.4%

## ASTHMA

**9.4%**

OF BALLARAT CHILDREN AGED 0-14 HAVE BEEN TOLD BY A DOCTOR OR NURSE THEY HAVE A **LONG TERM ASTHMA CONDITION**[6]

Victorian average = 6.4%

## MENTAL HEALTH

**3.5%**

OF BALLARAT CHILDREN AGED 0-14 HAVE A **LONG-TERM MENTAL HEALTH CONDITION**[6]

Victorian average = 2.0%

## CHILDREN AT HIGH RISK OF BEHAVIOURAL AND EMOTIONAL PROBLEMS

**11.1%**

OF BALLARAT CHILDREN ARE AT **HIGH RISK OF BEHAVIOURAL AND EMOTIONAL PROBLEMS**[5]

Victorian average = 7.1%

**4.** *School Entrant Health Questionnaire 2021*
**5.** *Attitudes to School Survey 2021*
**6.** *ABS Census 2021*
**9.** *Dental Health Services Victoria 2020*

5

# LEARNING

Ballarat 4 Kids

## KINDERGARTEN ENROLMENT RATES

**1523**

CHILDREN **ENROLLED IN 4 YEAR OLD KINDER** IN 2021

Compared to 1492 in 2020 [10]

**161**

CHILDREN ACCEPTED **EARLY START KINDERGARTEN PLACES** THROUGH THE CITY OF BALLARAT CENTRAL KINDERGARTEN REGISTRATION SCHEME IN 2022

Compared to 133 acceptances in 2021 [10]

Early Start Kindergarten gives eligible children 15 hours of free or low-cost kindergarten a week for 2 years before starting school.

## SENSE OF CONNECTEDNESS

Between

**64% to 82%**

of Ballarat students in Years 4 - 6 report that they feel a sense of belonging at their school[5]

## ENGLISH AND MATHS PERFORMANCE

Between

**76% to 89%**

of Ballarat students are working at or above expected standards in **English** [11]

Victorian average = 85%

Between

**71% to 73%**

of Ballarat students are working at or above expected standards in **Maths** [11]

Victorian average = 86%

5. *Attitudes to School Survey 2021*
10. *City of Ballarat 2021*
11. *Teacher Judgement of Student Achievement 2021*

# PARTICIPATION

Ballarat 4 Kids

## PARTICIPATION IN SUPPORTED PLAYGROUP

**208** FAMILIES PARTICIPATED IN **SUPPORTED PLAYGROUPS** IN 2022[10]

Supported Playgroups are a free program for families with children from birth to school age that may require extra support.

## PARTICIPATION IN MATERNAL CHILD HEALTH SERVICES

**73.4%**

OF FAMILIES WITH **CHILDREN AGED 0 - 3.5 YEARS OLD PARTICIPATED IN MATERNAL CHILD HEALTH SERVICES** [10]

**97.8%**

OF FAMILIES **PARTICIPATED IN THE 4-WEEK MATERNAL CHILD HEALTH** VISIT [10]

**76.6%**

OF FAMILIES **PARTICIPATED IN THE 12-MONTH MATERNAL CHILD HEALTH** VISIT [10]

**58.6%**

OF FAMILIES **PARTICIPATED IN PARENT GROUP** FOR THE FIRST TIME IN 2022 [10]

## PARTICIPATION IN SPORTS AND RECREATION

51% OF CHILDREN AGED 4-14 **PARTICIPATED IN ORGANISED SPORT** IN 2018 [12]


10. *City of Ballarat 2021*
12. *Sport Participation Report 2021*

# IDENTITY AND CULTURE

Ballarat 4 Kids

## CULTURAL CONNECTEDNESS

Having a positive sense of identity and culture is central to the wellbeing of all children and young people. This is important for all, regardless of background, but in Australia, especially for Aboriginal and Torres Strait Islander young people.

It encompasses having spiritual needs met, a sense of cultural connectedness, belonging and acceptance at home and in the community – and confidence that their identity, culture and community is respected and valued. It involves feeling safe and supported in expressing one's identity, regardless of gender, sexuality, culture or language.[1]

In Ballarat there were

**280**

pre-school aged children (0-4) and

**351**

primary aged children (5-11) who identified as **Aboriginal and/or Torres Strait Islander** for the 2021 Census[6]

In 2021, there were

**726**

children aged 0-14 living in Ballarat who were born in another country and[6]

**4046**

children aged 0-14 who had at least one parent born overseas, with potentially strong connections to other cultures[6]

The number of people in Ballarat who identified as Aboriginal and/or Torres Strait Islander has **increased by over 40% since the last census.** This trend was similarly observed across Australia and in previous census reports.

The Australian Bureau of Statistics (ABS) suggest this is partly due to people changing identification over time, or in the case of children their parents being more willing to identify themselves and their children as Aboriginal and/or Torres Strait Islander.[6]

1. *ARACY 2021*
6. *ABS Census 2021*

8

# DATA REFERENCE LIST

Ballarat 4 Kids

### 1. Australian Research Alliance for Children and Youth – 2021

The Australian Research Alliance for Children and Youth (ARACY) was established in 2002 by Prof. Fiona Stanley AC, and continues her vision of using the best available evidence to help all children and young people in Australia to thrive. The Nest is central to the work of ARACY. Released in 2013 after consultations with more than 4000 children, families and experts, the Nest defines six interlocking areas of wellbeing which must be supported for a child to thrive.

Information within this report has been taken from the following resource:
Goodhue, R., Dakin, P., Noble, K. (2021) What's in the Nest? Exploring Australia's Wellbeing Framework for Children and Young People. ARACY, Canberra.

### 2. Australian Early Development Census – 2021

The Australian Early Development Census (AEDC) is a nationwide data collection of early childhood development at the time children commence their first year of full-time school. The AEDC is held every three years, with the 2021 AEDC data collection being the fifth collection. The census involves teachers of children in their first year of full-time school completing a research tool, the Australian version of the Early Development Instrument.

The Instrument collects data relating to five key areas of early childhood development referred to as 'domains', these include:

- Physical health and well being
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge

The AEDC domains have been shown to predict later health, wellbeing and academic success.

### 3. Crime Statistics Agency – Year ending September 2022

The Crime Statistics Agency (CSA) is responsible for processing, analysing and publishing Victorian crime statistics, independent of Victoria Police. The CSA aims to provide an efficient and transparent information service to assist and inform policy makers, researchers and the Victorian public. Data for the previous 12 months is reported quarterly.

### 4. School Entrant Health Questionnaire – 2021

The School Entrant Health Questionnaire (SEHQ) is part of the Primary School Nursing Program. It is completed by the child's parent or carer and therefore reflects parental responses and concerns and does not report medical diagnoses or opinions of health professionals. The data is this report is from the most recently published results from 2021. In the LGA of Ballarat, 1168 children were involved in the 2021 SEQH data collection.

### 5. Attitudes to School Survey – 2021

The Attitudes to School Survey is administered to all students in Years 4 to 12 at Victorian Government schools. It has versions for students in Years 4 to 6, Years 7 to 9, Years 10 to 12 and an upgraded accessible version with a reduced number of items. Demographic questions are the only survey questions that must be answered. All other survey items can be skipped. The data within this report is from six Ballarat government primary schools that have been selected to represent the geographical and socio-economic demographical spread of schools in Ballarat.

Results have been published within the '2021 Annual Report to the School Community' for each selected school, freely available on respective school websites.

### 6. Australian Bureau of Statistics Census – 2021

The Australian Bureau of Statistics (ABS) are Australia's national statistics agency. Every five years, the ABS counts every person and household in Australia and collects information from them. This is called the Census of Population and Housing. Census data tells us about the economic, social and cultural make-up of Australia. Data included within this report was gathered in the 2021 Census.

### 7. Department of Social Services Parenting Payments by LGA – 2022

The Department of Social Services report quarterly on the various support payments made to residents within a local government area. The information is available to all through the Australian Government open data platform. Parenting Payment provides income support for parents or guardians to help with the cost of raising children. Parenting Payment Partnered is an income support payment for partnered parents with a youngest child under six years of age. Parenting Payment Single is an income support payment for single parents with a child under eight years of age. Data includes recipients who are determined to be current (i.e. entitled to be paid) on the Centrelink payment system.

### 8. Uniting Ballarat Homelessness Service Data – 2022

Data represents families presenting to Uniting Care entry point to request homelessness support. It may not accurately reflect all requests for support and does not represent support provided.

### 9. Dental Health Services Victoria – 2020

Dental Health Services Victoria, in partnership with the Victorian Department of Health and Human Services, has developed oral health profiles to provide local government with population oral health data and risk factor indicators to undertake comprehensive public health and wellbeing planning.
The statistical profile of each local government area includes indicators relating to
- Tooth decay experience for children attending public dental services
- Potentially Preventable Hospitalisations (PPH) due to dental conditions for children ages 0-9 years
- Self-rated dental health

The data comes from children who accessed public dental services in 2017-19. Oral health status data is collected for most people presenting for public dental care at the initial examination before any treatment is undertaken by Dental Health Services Victoria. Care should be taken when interpreting the data due to differences in sample sizes. Furthermore, the data is only collected for people accessing public dental health services (predominantly concession card holders) and does not represent the overall general population.

### 10. City of Ballarat Council Data – 2021 and 2022

The City of Ballarat Council is a participating member of Ballarat 4 Kids and have been instrumental in providing local data from 2021 and 2022 for this report. We thank them for their contributions and support.

### 11. Teacher Judgement of Student Achievement - 2021

Based on the evidence, teachers make an on-balance, holistic and defensible judgement against the achievement standards. This report includes teacher judgement of the percentage of students working at or above expected standards in English and mathematics, using data from six Ballarat government primary schools that have been selected to represent the geographical and socio-economic demographical spread of schools in Ballarat – as per the Attitudes to School Survey data. Results of teacher judgement of student achievement for these selected schools have been published within the '2021 Annual Report to the School Community' for each school, freely available on respective school websites.

### 12. Sport Participation Report - 2021

Report is provided by Victoria University and Federation University to the City of Ballarat, Ararat Rural City Council, Golden Plains Shire Council, Hepburn Shire Council, Moorabool Shire Council, Northern Grampians Shire Council and Pyrenees Shire Council, produced by Federation University, Australia - School of Science, Psychology and Sport, and Victoria University – Institute for Health and Sport. Statistics within the report were compiled from sources including Victorian governing bodies of the following sports: Australian football, basketball, cricket, football (soccer), gymnastics, hockey, netball, sailing, swimming and tennis. Report author and contact Professor Rochelle Eime, as well as the City of Ballarat, have provided consent for Ballarat sport participation data to be shared in this report.

Ballarat 4 Kids

**The Health and Wellbeing of Ballarat's Children 2022**

Published March 2023

# Appendix 4

## Mapping of prevention systems

# Appendix 4.1 Overview, location, our key outcomes of prevention systems

## 4.1.1 Overview of preventive health activities

Across the Grampians region there is a strong network of preventive and population health activities (*Table A4.1_1*). This report uses the term "preventive health activity" to refer to existing local policies, programs and initiatives. *Table A4.1_1* demonstrates that the majority (58.2%) of preventive health activities in the Grampians region are focused on healthy eating. Active living programs and programs aiming to reduce harm from tobacco and e-cigarettes represented 29.4% and 12.4% of preventive health activities, respectively. *Table A4.2_1* details preventive health activities across the Grampians region.

*Table A4.1_1 Overview of preventive health activities across the Grampians region*

| Preventive health activity | Number of activities | (%) |
|---|---|---|
| Active living | 50 | 29.4% |
| Healthy eating | 99 | 58.2% |
| Reducing harm from tobacco and e-cigarettes | 21 | 12.4% |
| **Total** | 170 | 100.0% |

## 4.1.2 Location of preventive health activities

The Central Highlands region has the highest proportion (51.2%) of preventive health activities in the Grampians region. There are fewer activities delivered in Wimmera Southern Mallee (27.6%) and Grampians Pyrenees Goldfields (14.7%) regions (*Table A4.1_2*). There are a small proportion (4.7%) of preventive health programs that are delivered in multiple regions within the Grampians catchment.

*Table A4.1_2 Location of preventive health activities across the Grampians region*

| Region | Number of activities | (%) |
|---|---|---|
| Central Highlands | 87 | 51.2% |
| Grampians Pyrenees Goldfields | 25 | 14.7% |
| Wimmera Southern Mallee | 47 | 27.6% |
| Multiple regions | 8 | 4.7% |
| **Total** | 170 | 100.0% |

## 4.1.3 Key outcome for preventive health activities

The majority of active living (38.0%) and reducing harm from tobacco and e-cigarettes (61.9%) activities appeared to have a key target outcome of strengthening the capacity of individuals to increase their physical activity and decrease smoking or vaping (*Table A4.1_3* and *Table A4.1_5*). For the healthy eating activities, increasing access to nutritious foods was the most common (40.4%) target outcome (*Table A4.1_4*). This reflects the high number of food relief initiatives in the region.

*Table A4.1_3 Assessment of key target outcomes for active living activities across the Grampians region*

| Key outcome | Number of activities | (%) |
|---|---|---|
| Building capacity | 19 | 38.0% |
| Increase participation | 14 | 14.0% |
| Accessible spaces | 11 | 22.0% |
| Active transport | 4 | 8.0% |
| Decrease sedentariness | 2 | 4.0% |
| **Total** | 50 | 100.0% |

*Table A4.1_4 Assessment of key target outcomes for healthy eating activities across the Grampians region*

| Key outcome | Number of activities | (%) |
|---|---|---|
| Increase access | 40 | 40.4% |
| Building capacity | 29 | 29.3% |
| Food security | 28 | 28.3% |
| Adjust purchasing behaviours | 1 | 1.0% |
| Adjust socio-cultural norms | 1 | 1.0% |
| **Total** | 99 | 100.0% |

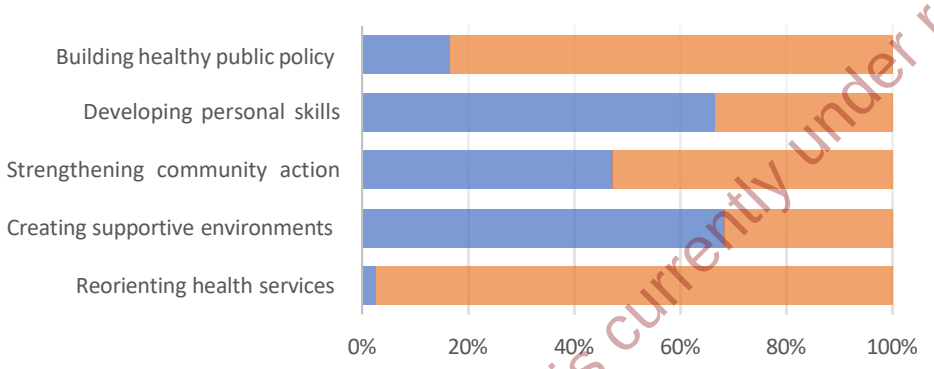
*Table A4.1_5 Assessment of key target outcomes for reducing harm from tobacco activities across the Grampians region*

| Key outcome | Number of activities | (%) |
|---|---|---|
| Building capacity | 13 | 61.9% |
| Create healthy environments | 7 | 33.3% |
| Uptake of stop-smoking aids | 1 | 4.8% |
| **Total** | 21 | 100.0% |

# Appendix 4.2 Alignment with Ottawa Charter Action Areas

The majority of preventive health activities in the Grampians region aligned with two of the Ottawa Charter Action Areas: creating supportive environments and developing personal skills (*Figure A4.2_1*). In the Grampians region, 68.2% of population health activities included a focus on creating supportive environments, 66.5% incorporated an element of developing personal skills, 47.1% involved strengthening community action, 16.5% encompassed building healthy public policy and only 2.4% embraced reorienting health services. Please note, that each preventive health activity may incorporate more than one Ottawa Charter Action Area. Community based activities, such as community gardens, cooking classes and food swaps tended to align with multiple action areas. A detailed description of preventive health activities and their alignment with Ottawa Charter action areas is provided in *Table A4.2_1.*

*Figure A4.2_1 Preventive health activities alignment with Ottawa Charter Action Areas*




| | Reorienting health services | Creating supportive environments | Strengthening community action | Developing personal skills | Building healthy public policy |
|---|---|---|---|---|---|
| Yes | 2.40% | 68.20% | 47.10% | 66.50% | 16.50% |
| No | 97.60% | 31.80% | 52.90% | 33.50% | 83.50% |

*Table A4.2_1 Detailed description of preventive health activities across the Grampians region*



| Stream | Name | Description of activity | Grampians region | Key outcome | Ottawa Charter Action Areas | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | Building Healthy Public Policy | Creating Supportive Environments | Strengthening Community Action | Developing Personal skills | Reorienting health services |
| Active living | Accessible options - City of Ballarat | Providing and promoting flexible, diverse and accessible recreation and leisure opportunities | Central Highlands | Accessible spaces | N | Y | N | N | N |
| Active living | Achievement program | Achievement program helps create a healthier environment for working and learning | All | Participation | N | Y | Y | Y | N |
| Active living | Active for Life - Central Highlands Rural Health | Provision of active living health promotion messages to residents who are a recipient of community programs such as Meals on Wheels | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Active for Life - Grampians Community Health | Provides recreational activities for older adults and people with disabilities | Grampians Pyrenees Goldfields | Participation | N | Y | N | N | N |
| Active living | Active to School Passport | Promoting physical activity to get from one place to another | Central Highlands | Active transport | N | Y | Y | N | N |
| Active living | Active Women and Girls | Encouraging women and girl's participation in physical activity by creating equitable opportunities | Central Highlands | Participation | N | Y | Y | N | N |
| Active living | BeUpstanding | Workplace policy to promote sitting less at work | Central Highlands | Decrease sedentariness | N | N | N | Y | N |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Active living | Bike education and safety | Partnership with the local primary schools to deliver bike education to help children develop skills to ride safely and independently on roads and paths | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Active living | Black Cockatoos playgroup | Provide education on healthy eating and physical activity to adults and children | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Active living | Cardiac Rehabilitation and Healthy Hearts Program | Program providing education workshops and supervised exercise sessions | Grampians Pyrenees Goldfields | Capacity | N | Y | N | Y | N |
| Active living | Community Garden - Kaniva Link | Regular visits to gardens and arrange guest speakers on gardening practices | Wimmera Southern Mallee | Participation | N | Y | Y | Y | N |
| Active living | Community Health - Health Promotion | Health promotion program largely delivered by local community funded agencies through a place based, partnership approach and aims to achieve better and more equitable health and wellbeing outcomes for Victorians | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Daughters of the West | Program that aims to increase participation in physical activity and provide education | Central Highlands | Participation | N | Y | Y | Y | N |
| Active living | Day Program | Provision of activities for people living with a disability | Grampians Pyrenees Goldfields | Participation | N | Y | N | N | N |
| Active living | Gender equality - Moorabool Shire Council | Promote gender equality programs, bystander training and cultural training for sporting clubs and community groups - Act@Play, CoRE, Quick Wins, E4A (Equality for All) | Central Highlands | Accessible spaces | N | Y | N | N | N |
| Active living | Gender equity programs through partnerships - Hepburn Shire | Partner with local sporting clubs to implement a targeted gender equity programme such as Act@Play | Central Highlands | Accessible spaces | N | Y | N | N | N |
| Active living | Health promotion - Moorabool Shire Council | Promotion of walking and cycling initiatives | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Health promotion - Moorabool Shire Council | Provide support for health and other providers to engage older people in low impact physical activity sessions | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Health promotion messages - Hepburn Shire Council | Promote resources with walking paths and trails, park and recreation spaces detailing amenities and accessibility | Central Highlands | Capacity | N | N | N | Y | N |

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|---|---|---|---|---|---|---|---|---|---|
| Active living | Health promotion messages and campaigns - Central Highlands Rural Health | Support promotion of active living campaigns | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Health promotion resources - Rural Northwest Health | Offers community resource containing physical activity options | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Active living | Healthy lifestyle for diabetes group | Support participants to increase healthy eating, physical activity and manage stress to prevent diabetes, heart disease and stroke | Grampians Pyrenees Goldfields | Capacity | N | N | N | Y | N |
| Active living | Life! Program | Free program to support participants to increase healthy eating, physical activity and manage stress to prevent diabetes, heart disease and stroke | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Active living | Move it! Mondays | Encourages students and teachers to use active transport to travel to school and was developed as part of Active Travel 4 Climate Action program | Wimmera Southern Mallee | Active transport | N | Y | Y | N | N |
| Active living | Municipal Public Health and Wellbeing Plan - Ararat Rural City Council | Work with partners to develop initiatives that improve streetscapes, encourage consumption of food grown in community gardens and development of nature based physical recreational opportunities. | Grampians Pyrenees Goldfields | Accessible spaces | Y | Y | Y | N | N |
| Active living | Municipal Public Health and Wellbeing Plan - Central Goldfields | Support active living using a holistic approach addressing upstream determinants | Grampians Pyrenees Goldfields | Accessible spaces | Y | Y | Y | Y | N |
| Active living | Municipal Public Health and Wellbeing Plan - City of Ballarat | Support the community to increasingly choose active and public transport options. Increased access to and participation in active recreation and increased access to public open spaces | Central Highlands | Accessible spaces | Y | Y | Y | Y | N |
| Active living | Municipal Public Health and Wellbeing Plan - Hepburn Shire | Optimise the use of public spaces to increase participation and community connection | Central Highlands | Access | Y | Y | N | N | N |
| Active living | Municipal Public Health and Wellbeing Plan - Hindmarsh Shire | Provide opportunities for active living through supporting our community to engage in physical activities | Wimmera Southern Mallee | Capacity | Y | Y | N | Y | N |
| Active living | Municipal Public Health and Wellbeing Plan - Horsham Rural City Council | Increasing healthy eating and active living | Wimmera Southern Mallee | Capacity | Y | Y | N | Y | N |

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|---|---|---|---|---|---|---|---|---|---|
| Active living | Municipal Public Health and Wellbeing Plan - Moorabool Shire | Support residents to be more active by addressing Ottawa Charter action areas | Central Highlands | Accessible spaces | Y | Y | Y | Y | N |
| Active living | Municipal Public Health and Wellbeing Plan - Northern Grampians | Work in partnership to engage children and young people in developing projects to improve healthy eating and physical activity. Build age-friendly communities | Grampians Pyrenees Goldfields | Participation | Y | Y | Y | N | N |
| Active living | Municipal Public Health and Wellbeing Plan - Pyrenees Shire | Increase levels of activity undertaken by residents and provide public spaces that support active living | Grampians Pyrenees Goldfields | Participation | Y | Y | Y | N | N |
| Active living | Municipal Public Health and Wellbeing Plan - West Wimmera Shire | Create a healthy, active and vibrant community | Wimmera Southern Mallee | Accessible spaces | Y | Y | Y | Y | N |
| Active living | Municipal Public Health and Wellbeing Plan - Yarriambiack Council Shire | Create a healthy and inclusive community | Wimmera Southern Mallee | Accessible spaces | Y | Y | N | N | N |
| Active living | Reducing sedentary activity policy - Grampians Health Ballarat | Promote decrease of sedentary behaviour at work | Central Highlands | Decrease sedentariness | N | Y | N | N | N |
| Active living | Ride 2 School Day | Promoting physical activity to get from one place to another | Wimmera Southern Mallee | Active transport | N | Y | Y | N | N |
| Active living | School holiday program | School holiday programs with a focus on health eating and physical activity | Wimmera Southern Mallee | Participation | N | Y | Y | Y | N |
| Active living | Smiles 4 Miles | Provides health promotion messages of 'eat well', 'drink well' and 'clean well'. Also provides healthy lunchbox education | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Sons of the West | Program that aims to increase participation in physical activity and provide education | Central Highlands | Participation | N | Y | Y | Y | N |
| Active living | Staff fitness program - Grampians Health Ballarat | To promote physical activity within the work environment | Central Highlands | Participation | N | Y | N | N | N |
| Active living | Stride Into Sport | Health promotion campaign promoting sporting opportunities and highlight how the barriers to sport can be overcome. | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Support development of active living policies - Grampians Health | Support schools across Horsham Rural City Council and Dimboola to develop and implement active living polices | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Active living | This Girl Can | Health promotion campaign that supports women to participate in physical activity in a way that suits the individual. | Central Highlands | Capacity | N | N | N | Y | N |

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| Active living | VicHealth Gender Equality Quick Wins - Moorabool Shire Council | Facilitate female exercise groups in Council leisure facilities | Central Highlands | Accessible spaces | N | Y | N | N | N |
| Active living | VicHealth Youth program | Regional Sport Assemblies will work with young people to understand what they need based on their own experiences and the barriers they face. The assemblies will partner with local stakeholders to deliver physical activity and social connection opportunities | Wimmera Southern Mallee | Participation | N | Y | N | N | N |
| Active living | Virtual Reality: physical activity in schools' pilot | Pilot trialing innovative access to the implementation of physical activity in primary schools via virtual reality technology | Central Highlands | Participation | N | Y | N | N | N |
| Active living | Walk to school program - Grampians Health | Encourages active transport to travel to school | Wimmera Southern Mallee | Active transport | N | Y | Y | N | N |
| Active living | Wellbeing Scripts | Social prescribing program to support stronger links and pathways between community and health practitioners | Central Highlands | Capacity | N | N | N | Y | N |
| Active living | Wow group | Offers gentle exercise activities, accompanied by a healthy lunch and education session | Wimmera Southern Mallee | Access | N | N | Y | Y | N |
| Healthy eating | Achievement program | Achievement program helps create a healthier environment for working, learning and living | All | Socio-cultural Norms | N | Y | Y | Y | N |
| Healthy eating | Achievement program - Rethink Sugary Drinks | Promotion of fresh foods and water choices at all events, through grant applications for water bottles, healthy messaging and ensuring access to water at all events. | Central Highlands, Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Healthy eating | Achievement program - Vic Kids Eat Well | Vic Kids Eat Well provides schools, outside of school care, community organisations, workplaces and sports clubs with clear, simple and achievable steps to making healthy food and drink options available. | All | Access | N | Y | Y | Y | N |
| Healthy eating | Ballarat Food Access Network | Partnership of food relief agencies who share information, resources and advocate for greater food access and food security in the Ballarat region | Central Highlands | Food security | N | Y | N | N | N |

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|---|---|---|---|---|---|---|---|---|---|
| Healthy eating | Black Cockatoos playgroup | Provide education on healthy eating and physical activity to adults and children | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Healthy eating | Breakfast club - Murtoa College | Offers students a free and health breakfast prior to school | Wimmera Southern Mallee | Access | N | Y | Y | N | N |
| Healthy eating | Breastfeeding support - Moorabool Shire Council | Free breastfeeding support to residents | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | BreezeWay Meals Program | Offers cooked meals, meal packs and other essential items | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Café 102 - Salvation Army | Offers cooked meals twice per week | Central Highlands | Food security | N | Y | Y | Y | N |
| Healthy eating | City of Ballarat Good Food For All Food Strategy 2019-2022 | Increase access to and promotion of safe and nutritious food | Central Highlands | Access | Y | N | N | N | N |
| Healthy eating | Community breakfast - Anglicare Ballarat | Offers cooked meals, meal packs and other essential items | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Community garden - Woomelang and District Bush Nursing Centre | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Yarriambiack | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - City of Ballarat | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Central Highlands | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Creswick Neighbourhood Centre | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Central Highlands | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Edenhope | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community Garden - Horsham Salvation Army | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Maryborough Community House | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Grampians Pyrenees Goldfields | Access | N | Y | Y | Y | N |

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|---|---|---|---|---|---|---|---|---|---|
| Healthy eating | Community garden - Mill House Neighbourhood House | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Grampians Pyrenees Goldfields | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Murtoa | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Nhill | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Rainbow | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community Garden - Rupanyup | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Central Highlands | Access | N | Y | Y | Y | N |
| Healthy eating | Community Garden - Warracknabeal | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Community garden - Wendouree Neighbourhood Centre | Opportunity for people to come together to learn, grow fresh food, learn and connect community | Central Highlands | Access | N | Y | Y | Y | N |
| Healthy eating | Community Health - Health Promotion. Ballarat Community Health | Statewide health promotion program largely delivered by local community funded agencies through a place based, partnership approach and aims to achieve better and more equitable health and wellbeing outcomes for Victorians | Central Highlands | Capacity | N | Y | Y | Y | N |
| Healthy eating | Community Health - Health Promotion. Central Highlands Rural Health | Statewide health promotion program largely delivered by local community funded agencies through a place based, partnership approach and aims to achieve better and more equitable health and wellbeing outcomes for Victorians | Central Highlands | Capacity | N | Y | Y | Y | N |
| Healthy eating | Community lunch - Ballarat Neighbourhood Centre | Weekly community lunch on Friday and provision on bread | Central Highlands | Food security | N | Y | Y | Y | N |

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|---|---|---|---|---|---|---|---|---|---|
| Healthy eating | Community lunch - Murtoa Neighbourhood house | Community lunches & carers lunches monthly | Wimmera Southern Mallee | Food security | N | Y | Y | N | N |
| Healthy eating | Community Pantry - Darley Neighbourhood House | Offers a range of food products for community members experiencing food insecurity | Central Highlands | Food security | N | Y | Y | Y | N |
| Healthy eating | Community Pantry - Yarriambiack Shire | Food grown from community gardens across that catchment are available in a community pantry for residents | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Cooking and gardening classes - Woomelang and District Bush Nursing Centre | Offers cooking classes using fresh produce from the community garden | Wimmera Southern Mallee | Capacity | N | Y | Y | Y | N |
| Healthy eating | Cooking classes - Grampians Health Horsham | Delivering cooking programs to the youth, young mothers and people experiencing homelessness | Wimmera Southern Mallee | Capacity | N | Y | Y | Y | N |
| Healthy eating | Cooking classes - Kaniva LINK Neighbourhood House | Classes to learn how to plan and prepare meals | Wimmera Southern Mallee | Capacity | N | Y | Y | Y | N |
| Healthy eating | Cooking classes - Wendouree Neighbourhood Centre | Classes to learn how to plan and prepare meals | Central Highlands | Capacity | N | Y | Y | Y | N |
| Healthy eating | Cooking classes - West Wimmera Health Service | Classes to learn how to plan and prepare meals | Wimmera Southern Mallee | Capacity | N | Y | Y | Y | N |
| Healthy eating | Council to offer free fruit for staff | Provision of fresh fruit to staff members | Central Highlands | Access | N | Y | N | N | N |
| Healthy eating | Council policy to offer free fruit at community events | Policy to support healthy eating | Wimmera Southern Mallee | Access | Y | Y | N | N | N |
| Healthy eating | Eat Well Feel Good Ballarat | Program to support people shopping at a supermarket to identify healthy food options using the health star rating | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | Food is Free Laneway | A community space for people to access free fresh food that has been donated by community members and connect with the neighbourhood | Central Highlands | Food security | N | Y | Y | Y | N |
| Healthy eating | Food relief - Anglicare | Provides food distribution for people experiencing food insecurity | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Food relief - Anglicare & Clunes Neighbourhood House | Provide food hampers to local residents | Central Highlands | Access | N | Y | N | N | N |
| Healthy eating | Food relief - Anglicare Victoria | Provision of food and vouchers | Central Highlands | Food security | N | Y | N | N | N |

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|---|---|---|---|---|---|---|---|---|---|
| Healthy eating | Food relief - Hepburn Shire Council | Promotes and distributes local food relief resources. In partnership with Department of Health, provides education to local food relief agencies to deliver culturally appropriate foods | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Food relief - Salvation Army | Provision of emergency food relief | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Food relief - St Vinnies | Provision of food, vouchers and essential items | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Food relief - The Seventh Day Adventist Good Samaritan Centre | Access to groceries for a nominal cost | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Food relief - Uniting Ballarat | Offers a free grocery shop for people with a health care card. | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Food relief - Uniting Care | Provision of emergency food relief | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Food relief program delivered by Central Highlands Rural Health | Provides emergency food relief and fuel for residents | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Foodbank - Ararat Neighbourhood House | Provision of emergency food relief | Grampians Pyrenees Goldfields | Food security | N | Y | N | N | N |
| Healthy eating | Foodbank - Avoca Food Pantry | Provision of emergency food relief | Grampians Pyrenees Goldfields | Food security | N | Y | N | N | N |
| Healthy eating | Foodbank - Beaufort Food Pantry | Provision of emergency food relief | Grampians Pyrenees Goldfields | Food security | N | Y | N | N | N |
| Healthy eating | Foodbank - Hilltop Church | Provision of emergency food relief | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Foodbank - St Arnaud Community Resource Centre | Provision of emergency food relief | Grampians Pyrenees Goldfields | Food security | N | Y | N | N | N |
| Healthy eating | Foodbank - Stawell Neighbourhood House | Provision of emergency food relief | Grampians Pyrenees Goldfields | Food security | N | Y | N | N | N |
| Healthy eating | Gardening workshops for children - Food is Free | Interactive workshop for children | Central Highlands | Capacity | N | Y | Y | Y | N |
| Healthy eating | Gents Kitchen cooking classes | Gents Kitchen allows men to meet in a safe space to learn how to cook healthy meals | Wimmera Southern Mallee | Capacity | N | Y | Y | Y | N |
| Healthy eating | Go 4 Green | Climate and Health Program: A Vic Kids Eat Well Initiative supporting schools to action innovative and sustainable project ideas that are healthy for the planet and young people | Central Highlands | Access | N | Y | Y | Y | N |

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| Healthy eating | Gordon Mt Egerton Food is Free initiative | Community led and run social media webpage that enables members to swap produce and offer excess produce to other | Central Highlands | Access | N | Y | Y | Y | N |
| Healthy eating | Guys & Gals | School program aimed at promoting positive self-esteem, physical activity, nutrition, building resilience and increasing confidence and cooperation | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Healthy eating | Health promotion- Central Highlands Rural Health | Shares health promotion campaigns. Provides health promotion messages about programs and events | Central Highlands | Capacity | | | | Y | |
| Healthy eating | Health promotion - City of Ballarat | Provides health promotion messages about healthy eating | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | Health promotion- Hepburn Shire Council | Provides health promotion messages about programs and events | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | Health promotion - Moorabool Shire Council | Promote initiatives such as food swaps, community meals, school breakfasts, food banks, community gardens and other community lead food projects | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | Health promotion messages - Grampians Health | Provides health promotion messages at schools and sporting clubs | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Healthy eating | Healthy choices | Councils collaborate with local partners to create supportive environments for healthy eating | All | Purchase | N | Y | Y | Y | N |
| Healthy eating | Healthy food and drink policy - Grampians Health | Work towards development, implementation and promotion of a new Grampians Health Healthy Food and Drink Policy | All | Access | N | Y | Y | N | N |
| Healthy eating | Healthy food and drink policy - Grampians Health Ballarat | Healthy food and drink policy across the workplace | Central Highlands | Access | N | Y | Y | N | N |
| Healthy eating | Healthy food and drink policy - Hepburn Shire Council | Healthy food and drink policy across the workplace | Central Highlands | Access | N | Y | Y | N | N |
| Healthy eating | Healthy food basket | Map the cost of healthy food in areas of disadvantage | Central Highlands | Access | N | Y | N | N | N |
| Healthy eating | Healthy lifestyle for diabetes group | Integrated health promotion activity for West Wimmera Health Service | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |

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|---|---|---|---|---|---|---|---|---|---|
| Healthy eating | Meals for Change - Uniting Care | Offers access to healthy and affordable meals in local cafes | Central Highlands | Food security | N | Y | Y | Y | N |
| Healthy eating | Meals on wheels | Hospital staff and volunteers deliver meals to community members | Central Highlands | Access | N | Y | Y | Y | N |
| Healthy eating | Meals program - Murtoa Neighbourhood house | Provides meals on wheels and a centre-based meal program | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | Men's Shed healthy eating sessions | Education to increase healthy eating | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - Ararat Rural City Council | Work with partners to develop initiatives that improve streetscapes, encourage consumption of food grown in community gardens and development of nature based physical recreational opportunities | Grampians Pyrenees Goldfields | Access | Y | Y | Y | N | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - Central Goldfields | Support access to healthy foods and drinks using a holistic approach addressing upstream determinants | Grampians Pyrenees Goldfields | Access | Y | Y | Y | Y | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - City of Ballarat | Increased access to and consumption of healthy, safe, affordable foods through a sustainable local food system | Central Highlands | Access | Y | Y | Y | N | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - Hepburn Shire | Assist the community to increase access to healthy food to improve nutrition, reduce chronic disease, improve mental wellbeing and strengthen the local food production system. | Central Highlands | Access | Y | Y | Y | Y | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - Hindmarsh Shire | Provide opportunities to build a healthier food culture | Wimmera Southern Mallee | Capacity | Y | N | N | Y | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - Horsham Rural City Council | A healthy and inclusive community | Wimmera Southern Mallee | Capacity | Y | N | N | Y | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - Moorabool Shire | Support access to healthy foods and drinks by addressing Ottawa Charter action areas | Central Highlands | Access | Y | Y | Y | Y | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - Northern Grampians | Work in partnership to engage children and young people in developing projects to improve healthy eating and physical activity. Build age-friendly communities | Grampians Pyrenees Goldfields | Access | Y | Y | Y | N | N |

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|---|---|---|---|---|---|---|---|---|---|
| Healthy eating | Municipal Public Health and Wellbeing Plan - Pyrenees Shire | Increase equitable access to fresh fruit and vegetables, water and reduce access to sugar sweetened beverages | Wimmera Southern Mallee | Access | Y | Y | Y | Y | N |
| Healthy eating | Municipal Public Health and Wellbeing Plan - West Wimmera Shire | Create a healthy, active and vibrant community | Wimmera Southern Mallee | Accessible spaces | Y | N | N | Y | N |
| Healthy eating | My school lunchbox | Education and cooking sessions promoting the benefits of a healthy lunch box and regular physical activity | Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Healthy eating | Neighbourhood share 'food is free' initiative - Creswick Neighbourhood Centre | People can access free food that has been donated by community members | Central Highlands | Food security | N | Y | Y | Y | N |
| Healthy eating | School garden | Kitchen garden programs at schools and early learning centres (independent of Stephanie Alexander program) | Central Highlands and Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | School holiday program | School holiday programs with a focus on health eating and physical activity | Wimmera Southern Mallee | Access | N | Y | Y | Y | N |
| Healthy eating | SecondBite - Ballarat Community Health | SecondBite rescues fresh and nutritious food that would otherwise go to waste and distributes it free of charge to over 1000 charities nationwide – thus reducing carbon emissions and reducing the food costs of charities. | Central Highlands | Food security | N | Y | Y | N | N |
| Healthy eating | SecondBite - Moorabool Shire Council | SecondBite rescues fresh and nutritious food that would otherwise go to waste and distributes it free of charge to over 1000 charities nationwide – thus reducing carbon emissions and reducing the food costs of charities. | Central Highlands | Food security | N | Y | Y | N | N |
| Healthy eating | Smiles 4 Miles | Provides health promotion messages of 'eat well', 'drink well' and 'clean well'. Also provides healthy lunchbox education | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | Stephanie Alexander's Kitchen Garden Programs | Provides food education to children and young people | Central Highlands and Grampians Pyrenees Goldfields | Capacity | N | N | Y | Y | N |

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| Healthy eating | Sustainable Healthy Integrated Food Towns (SHIFT) - Hepburn | An emerging circular economy that provides a health lunch kitchen, a young growers program and a cooking for wellbeing program | Central Highlands | Access | N | Y | Y | Y | N |
| Healthy eating | The Cook, the Chef and & Us | Engages students at risk of early school leaving in alternative education programs. The program engaged students in the hospitality industry to support education, wellbeing and enhanced employment pathways | Central Highlands | Capacity | N | N | Y | Y | N |
| Healthy eating | The Neighbours Place | Provides groceries for people experiencing food insecurity | Central Highlands | Food security | N | Y | N | N | N |
| Healthy eating | Wellbeing Scripts | Social prescribing program to support stronger links and pathways between community and health practitioners | Central Highlands | Capacity | N | N | N | Y | N |
| Healthy eating | Wow group | Offers gentle exercise activities, accompanied by a healthy lunch and education session | Wimmera Southern Mallee | Access | N | N | Y | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Achievement program | Achievement Program helps create a healthier environment for working, learning and living | All | Environment | N | Y | Y | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Cardiac Rehabilitation and Healthy Hearts Program | Program providing education workshops and supervised exercise sessions | Grampians Pyrenees Goldfields | Capacity | N | N | N | Y | Y |
| Reducing Harm from Tobacco & E-cigarettes | Education in schools | Community health services partnering with secondary schools to deliver prevention and early intervention programs | Central Highlands and Wimmera Southern Mallee | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Education with retailers | Facilitate education to retailers of e-cigarettes and vaping equipment to increase their awareness of their legal responsibilities | Central Highlands | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Health promotion messages - Moorabool Shire Council | Provide antenatal and pre-pregnancy education on tobacco related harm | Central Highlands | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Municipal Public Health and Wellbeing Plan - Central Goldfields | Reducing the harms of gambling, tobacco and alcohol using a holistic approach addressing upstream determinants | Grampians Pyrenees Goldfields | Environment | Y | Y | Y | Y | Y |
| Reducing Harm from | Municipal Public Health and Wellbeing Plan - City of Ballarat | Strengthening tobacco control at the local level | Central Highlands | Environment | Y | Y | N | N | N |

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|---|---|---|---|---|---|---|---|---|---|
| Tobacco & E-cigarettes | | | | | | | | | |
| Reducing Harm from Tobacco & E-cigarettes | Municipal Public Health and Wellbeing Plan - Horsham Rural City Council | Reducing harmful alcohol and drug use | Wimmera Southern Mallee | Capacity | Y | N | Y | N | N |
| Reducing Harm from Tobacco & E-cigarettes | Municipal Public Health and Wellbeing Plan - Moorabool Shire | Support residents to reduce harmful additions by addressing Ottawa Charter action areas | Central Highlands | Environment | Y | Y | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Municipal Public Health and Wellbeing Plan - West Wimmera Shire | Create a healthy, active and vibrant community | Wimmera Southern Mallee | Capacity | Y | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Quit Smoking Program - East Grampians Health Service | Control tobacco activity to reduce the prevalence of smoking | Grampians Pyrenees Goldfields | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Quit Smoking Program - Maryborough District Health Service | Control tobacco activity to reduce the prevalence of smoking | Grampians Pyrenees Goldfields | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Smoke and vape free policy - Grampians Health | Work towards development, implementation and promotion of a new Grampians Health smoke and vape free environment policy for all Grampians Health campuses) | All | Environment | N | Y | N | N | N |
| Reducing Harm from Tobacco & E-cigarettes | Smoking cessation - Grampians Health Ballarat | Smoking cessation aids are supplied to hospital inpatients | Central Highlands | Uptake of stop-smoking aids | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Smoking cessation program - Grampians Health | Program to support residents to quit smoking | Central Highlands | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Smoking cessation support in primary care | Smoking cessation support to assist patients to quit smoking | Central Highlands | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Smoking cessation support in primary care | Dedicated smoking cessation nurse supports patients to quit smoking. | Central Highlands | Capacity | N | N | N | Y | N |

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|---|---|---|---|---|---|---|---|---|---|
| Reducing Harm from Tobacco & E-cigarettes | Smoking cessation support in primary care | Support and education for people who would like to reduce or cease smoking | Grampians Pyrenees Goldfields | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Smoking status client audit process development - Grampians Health Ballarat | Working towards the development of a process for smoking status documentation: recording client's smoking status and the support that were offered by the clinician, as well as developing an audit process | Central Highlands | Capacity | N | N | N | Y | N |
| Reducing Harm from Tobacco & E-cigarettes | Tackling Indigenous Smoking - East Grampians Health Service | Program to reduce the prevalence of tobacco use through population health promotion activities | Grampians Pyrenees Goldfields | Environment | N | Y | Y | Y | Y |
| Reducing Harm from Tobacco & E-cigarettes | Tackling Indigenous Smoking - Goolum Goolum Aboriginal Co-operative | Program to reduce the prevalence of tobacco use through population health promotion activities | Grampians Pyrenees Goldfields | Environment | N | Y | Y | Y | Y |

# Appendix 4.3 Program participation

There are many prevention programs available in Victoria in which local communities, education settings, sporting organisations and workplaces can participate. *Table A4.3_1* demonstrates that although there are many programs available, participation varies across the Grampians region. Ballarat has the highest number of prevention programs (111 sites) whereas Pyrenees has the least (14 sites). In Ballarat, there was a particularly high uptake of the Smiles for Miles program and the Achievement program in schools and early childhood services. Across all LGAs, there appeared to be a low uptake of the Vic Kids Eat Well program in school settings, sporting clubs and community and council owned facilities. School breakfast programs had the highest participation among all programs across the region.

The generally low participation figures for many of the programs may reflect some of the challenges facing our region, including competing health and social priorities, limited workforce capacity, volunteering fatigue and an aging population. The high number of breakfast programs may reflect a high burden of food insecurity across the region.

It is important to acknowledge that this analysis has a number of limitations. The data were collected in February and March 2023 (with the exception of the Smiles for Miles data which was accessed in May 2023) and participation figures will have fluctuated since they were collected. The data presented here reflects program registration only, and information about the program implementation and outcomes is not included. It is also possible that some existing programs have not been captured in the data.



*Table A4.3_1 Overview of participation in prevention programs across the Grampians region*

| Program | Local government area | | | | | | | | | | | Data units | Data year | Data source |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Ararat | Ballarat | Central Goldfields | Hepburn | Hindmarsh | Horsham | Moorabool | Northern Grampians | Pyrenees | West Wimmera | Yarriambiack | | | |
| Vic Kids Eat Well - Schools | 0 | 5 | 5 | 2 | 0 | 1 | 3 | 4 | 1 | 3 | 1 | Schools involved | 2023 | Vic Kids Eat Well Dashboard |
| Vic Kids Eat Well – Outside School Hours Care | 0 | 1 | 1 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | 1 | Schools involved | 2023 | Vic Kids Eat Well Dashboard |
| Vic Kids Eat Well – Sports Clubs | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 4 | 0 | Sports clubs involved | 2023 | Vic Kids Eat Well Dashboard |
| Vic Kids Eat Well – Community & Council Owned Facilities | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | Facilities involved | 2023 | Vic Kids Eat Well Dashboard |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Vic Kids Eat Well – Sports & Recreation Facilities | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | Clubs / groups involved | 2023 | Vic Kids Eat Well Dashboard |
| Achievement Program - Schools | 0 | 13 | 0 | 6 | 0 | 0 | 2 | 3 | 1 | 0 | 0 | Organisations active | 2023 | Achievement Program Dashboard |
| Achievement Program – Early Childhood Services | 0 | 21 | 0 | 4 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | Organisations active | 2023 | Achievement Program Dashboard |
| Achievement Program – Workplaces | 0 | 3 | 0 | 1 | 1 | 2 | 0 | 3 | 0 | 0 | 1 | Organisations active | 2023 | Achievement Program Dashboard |
| INFANT Program | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | Active programs | 2023 | INFANT |
| Life! Program | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | Current providers | 2023 | Life! Program - Diabetes Aust Vic |
| Active Farmers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | Current providers | 2023 | Active Farmers website - activefarmers.com.au |
| Park Run | 1 | 3 | 1 | 0 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | Current providers | 2023 | Park Run website - parkrun.com.au |
| Stephanie Alexandra Kitchen Gardens School Program | 1 | 6 | 0 | 1 | 1 | 0 | 3 | 0 | 0 | 3 | 0 | Schools / centres with kitchen garden programs | 2023 | Kitchen Garden Website - kitchengardenfoundation.org.au/content/kitchen-garden-community |
| Smiles for Miles | 9 | 31 | 6 | 7 | 1 | 7 | 1 | 4 | 3 | 1 | 1 | Early child education services involved | 2023 | Department of Health |
| FReeZA | 0 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 | 1 | Funded projects | 2022-24 | FReeZA website - FReeZA \| Youth Central |
| School Breakfast Program | 7 | 23 | 6 | 8 | 4 | 7 | 11 | 11 | 8 | 3 | 8 | Schools involved | 2023 | Regional Coordinator (Western) - Foodbank Victoria |
| Total | 18 | 111 | 20 | 30 | 10 | 22 | 24 | 29 | 14 | 16 | 16 | | | |


Disclaimer: This document is currently under review for 2025

# Appendix 5

## Agency, community and expert priorities

# Appendix 5.1 Priorities of health promoting agencies and organisations mapped against Victorian Public Health and Wellbeing plan 2019-2023

*Table A5.1_1 Priorities of health promoting agencies and organisations mapped against the Victorian Public Health and Wellbeing Plan 2019-2023*

| Grampians PHU | Increasing healthy eating | Increasing active living | Reducing tobacco related harm | Tackling climate change | Improving mental health | Preventing all forms of violence | Improving sexual and reproductive health | Reducing harmful alcohol and drug use | Reducing injury |
|---|---|---|---|---|---|---|---|---|---|
| **Council/LGA** | | | | | | | | | |
| Ararat Rural City | | ■ | | ■ | ■ | ■ | | | |
| Central Goldfields Shire. | ■ | ■ | ■ | ■ | ■ | ■ | | | |
| City of Ballarat | ■ | ■ | ■ | ■ | ■ | ■ | | ■ | |
| Hepburn Shire | ■ | | | ■ | ■ | ■ | | | |
| Hindmarsh Shire | ■ | ■ | | | ■ | ■ | | | ■ |
| Horsham Rural City | ■ | ■ | | ■ | ■ | ■ | ■ | ■ | |
| Moorabool Shire | ■ | ■ | ■ | ■ | ■ | ■ | ■ | ■ | |
| Northern Grampians Shire | ■ | ■ | | ■ | ■ | ■ | | | |
| Pyrenees Shire | ■ | ■ | | | | ■ | | | |
| West Wimmera Shire | ■ | ■ | | | ■ | ■ | | ■ | |
| Yarriambiack Shire | ■ | ■ | ■ | ■ | ■ | ■ | | ■ | |
| **Community Health** | | | | | | | | | |
| Ballarat Community Health | ■ | ■ | ■ | | ■ | | ■ | | |
| Grampians Community Health | ■ | ■ | | | ■ | | | | |
| Ballarat Health Services | ■ | ■ | ■ | | ■ | | | | |
| East Grampians Health Service | ■ | ■ | | | ■ | | | | |
| Maryborough District HS | ■ | ■ | | | ■ | ■ | | | |
| Stawell Regional Health | ■ | ■ | | | | | | | |
| Wimmera Health Care Group | ■ | ■ | ■ | | ■ | | | | |
| Beaufort & Skipton HS | ■ | ■ | | | ■ | | | | |
| Central Highlands Rural Health | ■ | ■ | | | ■ | | | | |
| West Wimmera Health Service | ■ | ■ | ■ | | ■ | | | | |
| Rural Northwest Health | ■ | ■ | | | ■ | | | | |
| Edenhope & District Memorial | ■ | ■ | ■ | | ■ | | | | |
| East Wimmera Health Service | ■ | | | | | | | | |
| **Women's Health** | | | | | | | | | |
| Women's Health Grampians | | | | | | ■ | ■ | | |
| **Sexual and Reproductive Health** | | | | | | | | | |
| Ballarat Community Health (central and Ararat) | | | | | | | ■ | | |

Source: [i]Department of Health 2022.

Note: *Table A5.1_1* does not capture preventive work being undertaken outside of the DH funding stream pertaining to the VPHWP 2019-2023. Examples (not exhaustive) include work by Moorabool Shire, Horsham Rural City, Ballarat Health Services, Grampians Community Health, Wimmera Health Care Group, and West Wimmera Health Care Services' work in sexual and reproductive health and West Wimmera Health Services' work in climate change adaptation. Additionally, other organisations including Aboriginal co-operatives actively undertake prevention work (however are not funded through this funding stream).

# Appendix 5.2 Community and experts' decisions and priorities

*Table A5.2_1 Community and experts' decisions and priorities (Yellow highlighting indicates agreed program for implementation)*

| Region | Intervention name | Stakeholders who have capacity to contribute to the activity | Enablers as described by stakeholders | Barriers as described by stakeholders |
|---|---|---|---|---|
| **Central Highlands** | **Healthy eating in canteens: expand to other settings** | **6** | Extension of funding current programs which includes staff resourcing<br><br>Staff currently working with established networks through projects<br><br>Connection with vulnerable families & parents, ability to influence behaviours & habits around eating<br><br>Connection with various clubs and organisations, and could provide support to implement healthy eating interventions<br><br>MoUs with local stakeholders has enabled development of an organisational healthy food and drink policy and improved Healthy Choices in S&R initiative<br><br>Pre-existing networks, community groups wanting to change, supportive internal teams of professionals | Some projects are labour & time intensive with capacity to add only one more venue<br><br>Workforce availability or capacity, competing priorities<br><br>CH-HP guidelines outline our responsibilities as lead or support which could be a barrier<br><br>Funding challenges such as recent health promotion funding cuts<br><br>Consistent contact with families<br><br>Some sports clubs have difficulty cooperating or providing healthy choices due to lack of volunteers OR other reasons out of their control (such as lack of facilities to prepare healthy food)<br><br>Community groups NOT ready or wishing to change, perception of getting more profit from selling junk food), budget constraints for external and internal teams to get changes off the ground |
| **Central Highlands** | **INFANT Program - scale-up** | **4** | Sufficient funding for one year of the INFANT program<br><br>Connection with vulnerable families and parents Staff working on this project. Networks established<br><br>Deep networks with LGBTIQA+ community and programs, including community activities<br><br>Commitment to funding interventions identified by community and happy to partner with organisations in order to progress this plan | Funding to cover staff wages<br><br>Consistent contact with families<br><br>Workforce availability or capacity, recent health promotion funding cuts; INFANT is a support responsibility only under CH-HP Guidelines<br><br>The INFANT program was investigated, staff trained, and elements of the program included within the New Parents Group program, but there is limited capacity for the program to be implemented in its entirety<br><br>No additional capacity to increase action in this area<br><br>Challenges of ensuring there is consistent engagement with LGBTIQA+ communities to build trust and share information |

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| **Central Highlands** | **Healthy eating in schools – information sharing and collaboration** | **5** | Staff working on this project. Networks established<br><br>Connection with vulnerable families and parents<br><br>Excellent relationship with local businesses, schools and organisations<br><br>Learning Diversity Leader Network<br><br>Ability to share resources<br><br>Trained health promotion officer and nutritionists on staff | Limited workforce availability or capacity, recent health promotion funding cuts<br><br>CH-HP guidelines outline agency responsibilities as lead or support which could be a barrier<br><br>Consistent contact with families<br><br>Resourcing, funding, workforce availability and competing priorities<br><br>Time and competing core business Priorities<br><br>No barriers identified |
| **Central Highlands** | **None of the above** | **1** | Funding to both continue and scale up the INFANT program | No funding for INFANT |
| **Grampians Pyrenees Goldfields** | **Extend the implementation of INFANT program to a second LGA** | **3** | Existing networks in the LGA | The infant program is a model that does not integrate within current work priorities of local MCH agencies or agencies supporting young parents<br><br>INFANT would be additional work on a small team |
| **Grampians Pyrenees Goldfields** | **Work with primary schools in unsupported LGA's to increase the healthy food options available** | **4** | Existing interest, networks and informal programs in the community<br><br>Potential to support via youth staff and early years project officer<br><br>Ability to work collaboratively | Capacity, limited staffing & changeover of staff<br><br>CH-HP guidelines outline agency our responsibilities as lead or support which could be a barrier |
| **Grampians Pyrenees Goldfields** | **To increase access to food relief** | **4** | Support from relief agencies. Established relationships with key stakeholders, existing fortnightly market | Lack of funding, funding for portable infrastructure, community support and ability to get sufficient local produce to the market site regularly<br><br>Appropriate time and day to run market |
| **Grampians Pyrenees Goldfields** | **None of the above** | **4** | | Interventions not identified as priorities in community needs assessment<br><br>Interventions similar to those already working on as part 2022-23 Action Plan but without additional funding or hands on support difficult to expand |

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| | | | | Identified gaps within communities include lack of funding, capacity and resources to support healthy eating initiatives |
| **Wimmera Southern Mallee** | **Smiles for Miles Program** | | Pre-existing networks and staffing working on similar project with capacity to assist with sharing resources and planning<br><br>Pre-existing similar programs<br><br>Taking advantage of grant opportunities that allow for the onboarding of temporary project officers to set up and launch programs forward is a possibility | Competing priorities, capacity of volunteers<br><br>Workforce capacity is the main challenge<br><br>Competing priorities, time constraints, part time staff, other commitments, small budget for health promotion<br><br>Resource Allocation |
| **Wimmera Southern Mallee** | **None of the above** | **2** | | |
| **Central Highlands** | **Promoting active living opportunities for children and young people** | **9** | Walking friendly communities<br><br>Currently have a newsletter and online community directory<br><br>Promote active living through the Achievement program<br><br>Connection to vulnerable families, could embed messages in their work<br><br>Learning Diversity Leader Network<br><br>Some existing organisations are very familiar with projects of this type and have a broad network of organisations, schools and clubs to collaborate with<br><br>Currently have an Active to School passport initiative which we could build upon. Also involved in the Active 2 School program giving us an excellent foundation to expand; pre-existing networks, schools and community groups heading the change<br><br>There may be some capacity to upscale our promotion of opportunities | Car centric world<br><br>Restructure in teams, positions yet to be filled<br><br>Resourcing, workforce availability and competing priorities<br><br>Competing priorities and capacity of community groups<br><br>Current number of actions we are already committed to within our Plan and core business |
| **Central Highlands** | **INFANT program support & uptake across the region** | **4** | Sufficient funding for one year of the INFANT program<br><br>Support role in INFANT and currently deliver in partnership with another stakeholder. Teams could embed messages in their work | Key barrier for delivering the INFANT program is funding to cover the staff wages<br><br>Workforce availability or capacity |

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| **Central Highlands** | **Upscale Act@Play to other priority populations** | **2** | Some organisations already familiar with projects of this type and have a broad network of organisations, schools and clubs to collaborate with<br><br>Some organisations have supported and developed similar projects before in inclusive space locally, including women and girls' participation plans<br><br>Could link to existing activities that contribute to these goals, access our volunteers and networks | Project team is small and there are continuously many other projects ongoing throughout region<br><br>No barriers |
| **Central Highlands** | **None of the above** | **1** | | No funding |
| **Grampians Pyrenees Goldfields** | **Working with sports club to become more inclusive** | **4** | An already inviting community, accepting of people with disabilities; key priority area that our Health Promotion Officer is looking to implement more strategies<br><br>A current project has potential to build greater network for clubs<br><br>Encourage local grant applications that encourage access to incidental exercise programs, improved active participation projects and inclusivity training into committees. Stakeholders can support reach into local sporting clubs and committees, promotion and advocacy | Time, long term funding to maintain networks, lack of funding for sports clubs to invest in such activities; competing demands, willingness of sporting clubs, gaps in local business networks to communicate directly on this initiative (i.e. no chamber of commerce, only one business association limited to one section of the Shire etc.) |
| **Grampians Pyrenees Goldfields** | **Introduce 15-minute walking meetings into office settings across the region** | **1** | Key contacts already established in larger organisations in the region<br><br>No funding constraints<br><br>No negative impacts | Practicality of leveraging change into local business community would be a challenge with small resource levels in local business, i.e. a lot of businesses are direct customer facing, not able to manage significant breaks (and not a great volume of well-resourced staff business – EFT numbers of office bound business employees is low)<br><br>Monitoring and implementation are at the discretion of the external organisations |
| **Grampians Pyrenees Goldfields** | **None of the above** | **6** | Preferred interventions would include: Work with stakeholders to consider free outdoor gym/play space, active transport options as a priority for our community. Continuing to work with stakeholders through feedback into public surveys and planning. | This intervention does not necessary fit our needs as a community<br><br>Without additional resources and/or funding, we are unable to support these interventions |

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| **Wimmera Southern Mallee** | **Active Farmers program - Wimmera Southern Mallee (Yarriambiack)** | **6** | Some local organisations and staff have a strong knowledge of agronomy and farming. There have been initial discussions of building a school farming project and expansion of a kitchen garden program to the wider community to increase consumption of fruit and vegetables<br><br>Pre-existing networks<br><br>Staff to work with GPHU and the wider network to share resources and assist with planning<br><br>Can incorporate into existing networks and groups | Workforce capacity is the main challenge<br><br>Competing priorities, age criteria group, workforce capacity is a huge challenge for us<br><br>Time restraints, part time staff and other commitments, small budget for health promotion<br><br>Male farmers are hard to get involved in active living programs<br><br>Farming commitments<br><br>Social isolation<br><br>Breaking down the barriers of addictive behaviours |
| **Wimmera Southern Mallee** | **Health and Wellbeing program** | **5** | Delivery part of the program within scope and knowledge<br><br>Access pre-existing networks or staff members working on similar projects<br><br>Pre-exiting networks<br><br>Strong program existing with possibly synergies in messaging and/or information<br><br>Access to networks across Wimmera Southern Mallee. We are already managing wonderful programs in the active living space, so tweaking what we already do will be the key. Open up to a broader cohort in the community and breaking down barriers. | Additional training required for staff to deliver program<br><br>Specific cultural lens required for programs that may not fit into mainstream program delivery<br><br>Limited staff and priorities with core business<br><br>Time constraints, part time staff and other priorities, small budget |
| **Wimmera Southern Mallee** | **None of the above** | **2** | | |
| **Central Highlands** | **Social media campaign to deter young people from vaping** | **7** | Current program underway<br><br>Upcoming QUIT social media campaign on vaping harm<br><br>Ability to embed messages in existing team<br><br>Pre-existing networks, schools super keen to have something done about this<br><br>Keen to link public health unit to all the LGBTIQA+ orgs and groups that might be able to impact this goal | No specific funding or officer dedicated to this work<br><br>Workforce availability and capacity. Prioritisation of messages above other core work<br><br>Resourcing, workforce availability and competing priorities<br><br>Ability to provide professional education to staff educating our community, tailored for both young people, parents and the broader community<br><br>No barriers |

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| **Central Highlands** | **Education for health professionals to promote smoking cessation** | **2** | Pre-existing networks<br><br>Currently working on a project to educate health professionals to promote smoking cessation | Funding (internal, external), workforce availability and resources, stigma, personal prejudice<br><br>Workforce availability and capacity |
| **Central Highlands** | **Central Highlands Network of Smoke Free Services** | **2** | Member of the Victorian Network of Smokefree Health Services<br><br>Pre-existing networks, internal staff wanting to assist in the change | Workforce availability and capacity<br><br>Funding (internal, external), workforce availability and resources, stigma, personal prejudice |
| **Central Highlands** | **Increase contact with fathers-to-be about the harms of smoking and how to commence cessation and reduce smoking harm** | **2** | Large maternal and child health presence in the community, internal staff wanting to assist in the change<br><br>Current teams could embed these messages in their work | Funding (internal, external), workforce availability and resources, stigma, personal prejudice<br><br>Prioritisation of messages above other core work<br><br>No capacity to introduce something new as already promote smoking cessation<br><br>Smoking not identified as a priority within our plan |
| **Central Highlands** | **None of the above** | **3** | | No capacity to introduce something new |
| **Grampians Pyrenees Goldfields** | **Public Intervention Campaign - Smoke-free & Vape-free areas** | **8** | Connections with local communities<br><br>Relationships with other Stakeholders<br><br>Well research evidence base to support the intervention<br><br>Staff member working on an existing project<br><br>Community Nurse working on similar project<br><br>Action in the current HP plan | Funding+++<br><br>Competing demands<br><br>Enforcement & signage - different stakeholders would have different responsibilities - leadership should be at state level<br><br>More intervention than prevention - is it the best use of resources;<br><br>Limited on the ground support<br><br>Current activities around reducing harm from tobacco/e-cigarettes focuses on the organisation internally |
| **Grampians Pyrenees Goldfields** | **Youth led Information Campaign to discourage the use of e-** | **6** | Connections with local communities<br><br>Relationships with other Stakeholders | Inconsistent structures for youth councils/input across local government areas |

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| | **cigarettes among peers using micro-influencers** | | | |
| **Grampians Pyrenees Goldfields** | **Recycling of e-cigarettes** | **3** | Relationships with other stakeholders | Not seen as prevention/health promotion<br><br>Beyond remit of LGAs given that Sustainability Victoria has responsibility for state-wide waste management & planning |
| **Grampians Pyrenees Goldfields** | **None of the above** | **2** | No reason given | No reason given |
| **Wimmera Southern Mallee** | **Enhancing the Achievement Program with a strength-based approach; reducing harm from tobacco & E- cigarette use in Yarriambiack region** | **8** | Already running program<br><br>Access pre-existing networks or staff members working on similar projects. Staff can work with GPHU and the wider network to share resources and assist with planning<br><br>KIP (Knowledge is Power) Drug Education program for Year 6s has already been developed. This includes a session on smoking/vaping<br><br>Potential for current facilitators to train facilitators in other regions to deliver the program<br><br>Currently new appointed Environment Health Technician increasing resources around tobacco controls and education<br><br>Feel we can work around things to incorporate<br><br>Taking advantage of grant opportunities that allow for the onboarding of temporary project officers to set up and launch programs is one way forward | Competing priorities, workforce capacity is the main challenge<br><br>Resource allocation<br><br>Time Constraints, small budget for health promotion, workforce availability, priorities with core business |
| **Wimmera Southern Mallee** | **None of the above** | **2** | | None of the programs align with currently funded projects with specific deliverables. It is difficult to augment funding for programs when we have not had the opportunity to co- design<br><br>If we were to make a financial contribution we would need to see data on the program including status of outcomes and deliverables before being able to decide<br><br>We would welcome further discussion on opportunities for shared priorities |

# Appendix 6

## Rationale and detailed plan for each priority stream

# Appendix 6.1 Grampians Region Population Health Plan Strategic Priority Brief – Healthy eating

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| **Priority** | **Increasing healthy eating in the Grampians region** |
| **Program leads** | Melissa Deutscher and Alicia Gregor |

**Rationale/Problem:** Increasing healthy eating in the Grampians region

Eating a variety of nutritious foods and beverages supports health and wellbeing. Diets that contain excessive or insufficient amounts of energy and nutrients are linked to many conditions, including cardiovascular disease, diabetes, some cancers and dental decay (AIHW, 2021), and premature mortality (AIHW, 2018). In 2018, dietary-related risk factors contributed to 5.4% of the total burden of disease in Australia, which was the third highest risk factor, following tobacco use, being overweight and obesity (AIHW, 2018).

In Australia, the quality of an individual's diet and their associated health outcomes, occurs along a social gradient (VicHealth, 2015). Inequities among the social determinants of health, effects a person's ability to eat a healthy and balanced diet, which impacts health outcomes. Food security is one measure that reflects access to a healthy diet. In 2020, two of 11 Grampians region local government areas (LGAs) had a higher proportion of adults who experienced food insecurity, compared to the Victoria average (5.9%).

The Victorian public health and wellbeing outcomes framework (VPHWOF) provides a comprehensive picture of dietary intake among adults living in the Grampians region. In six of 11 Grampians region LGAs, the proportion of adults who consumed sufficient fruits and vegetables was lower than the state average of 3.6%. In seven of 11 LGAs, adults consumed fewer serves of both fruit and vegetables than the rest of Victorians. The mean serves of fruit consumed by adults across all 11 LGAs was lower (1.4 - 1.7 serves) than the recommended two serves per day for adults (as recommended by the Australian Dietary Guidelines). Vegetable consumption is more concerning, with the mean serves of vegetable consumed across all 11 LGAs less than half the recommended five to six serves per day for adults. Consumption of sugar-sweetened beverages (SSBs) across the Grampians region was also very high. In 10 of 11 LGAs, the proportion of adults who consumed SSBs daily was higher than the rest of Victoria, with seven of those LGAs exceeding the state average (10%) by more than 50%. Take-away consumption is a proxy for population discretionary food intake. None of the LGAs across the Grampians catchment had higher rates of take-away consumption than the state average.

In addition to adults, the dietary intake among young people also poses a significant challenge. In 2018, only 10.8% of young people met the minimum daily recommended serves of fruit and vegetables per day (VCAMS, 2018). Vegetable consumption is of particular concern, with only 2.3% of young people meeting the recommended vegetable intake.

The Australian Dietary Guidelines recommends that breastfeeding is encouraged, supported and promoted. In eight of 11 LGAs, rates of breasting (exclusive to three months of age) were lower than the rest of Victoria (PHIDU 2019).

In the Grampians region, there is a high burden of diet-related ill health. In 9 of 11 LGAs, coronary heart disease was the leading cause of mortality (AIHW, 2020). All 11 LGAs had higher rates of self-reported heart disease and diabetes than the rest of Victoria (VPHWOF, 2021). All 11 LGAs had a higher proportion of adults with a self-reported body mass index (BMI) greater than 30, compared with the rest of Victoria (VPHWOF, 2017). In 9 of 11 LGAs, the proportion of potentially avoidable admissions for oral disease was higher and 10 of 11 LGAs had a higher proportion of persons with at least one decayed, missing or filled tooth than elsewhere in Victoria (DHSV, 2020).

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| ***Key objective*** | To support the capacity and opportunities to design, implement, evaluate, sustain, and where possible scale stakeholder driven interventions across the Central Highlands, Grampians Pyrenees Goldfields and Wimmera Southern Mallee regions to elsewhere in the Grampians region. |
| ***What we want to achieve*** | • Increase in the proportion of adults, adolescents and children who consume sufficient fruit and vegetables<br>• Increase in mean serves of fruit and vegetables for adults, adolescents and children<br>• Reduction in discretionary food consumption of adults, adolescents and children<br>• Reduction in proportion of adults, adolescents and children who consume sugar-sweetened beverages daily |
| ***How might this be achieved?*** | Multiple action areas in health promotion practice (Ottawa Charter) can be utilised to achieve the goals above. Multiple strategies aimed at the individual, communities, the food system and the food environment will be needed to achieve the targets in this focus area, with health promotion actions across the spectrum of prevention.<br><br>This strategy seeks to increase the consumption of healthy food and drinks, as well as decrease the consumption of discretionary foods and drinks, that are contributing to population disease burden, via place-based primary prevention interventions. The interventions might aim to increase access, capacity to consume, socio-cultural norms and/or exposure to healthier foods and drinks, and/or decrease access and exposure to discretionary foods and drinks, of the communities living, working, learning and playing in our region.<br><br>As informed through our consultations with (and the selections made by) community stakeholders across the catchment, GPHU will support a series of initiatives across the Grampians region that seek to enable conditions that support an increase in healthy eating amongst adults, adolescents and/or children.<br><br>Initially, these may include:<br><br>• **Smiles 4 Miles Program** (Expansion of the existing Smiles 4 Miles program to ensure that the program is available to all Wimmera Southern Mallee Local Government area communities)<br>• **Healthy Eating in Primary Schools across the Pyrenees** (Develop a supported model to implement healthy eating, education and access to healthy options into Primary Schools in the Pyrenees Shire)<br>• **Healthy Sport Canteens – building on success** (Scale-up of local successful sports & recreation venue canteens that are promoting and providing healthy food & drink options in the Central Highlands area)<br><br>For more information on these interventions, see *Section 3.4* |
| ***Alignment with existing local, regional and/or state programs, initiatives and plans?*** | • Municipal Health and Wellbeing Plans (see Section 6 References)<br>• Victorian public health and wellbeing plan 2019-2023<br>• Victorian Public Health and Wellbeing Outcomes Framework 2016 |

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| | • Healthy Kids Healthy Futures (October 2021)<br>• National Preventive Health Strategy 2021-2030<br>• Smiles 4 Miles;<br>• Vic Kids Eat Well<br>• Achievement Program<br>• Healthy Choices Guidelines |
| ***How we will know if our plan is working?*** | We will utilise the RE-AIM framework to assess the reach, effectiveness, adoption, implementation and maintenance of the healthy eating interventions. In partnership with stakeholders, a set of process, impact and outcome measures, comprised of both qualitative and quantitative indicators will be identified.<br><br>**NB** – Further refinement and development of measures to be finalised upon development of the evaluation plan, following further consultation with stakeholders, which will include:<br>• Short term localised indicators of intervention progress<br>• Feasible evaluation methods for monitoring impacts |

# Appendix 6.2 Grampians Region Population Health Plan Strategic Priority Brief – Active living

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| **Priority** | **Improving active living in the Grampians region** |
| **Program leads** | Suzannah Burton |

**Rationale/Problem:** Improving active living in the Grampians region

Physical activity is one of the cornerstones to achieving good physical health and mental health and wellbeing (NPHS, 2021). Physical activity is the expenditure of energy resulting from any bodily movement produced by muscles (WHO, 2022). Insufficient levels of physical activity is a risk factor for chronic diseases, including cardiovascular disease, diabetes, osteoporosis, dementia and some cancers (AIHW, 2022), and premature mortality (AIHW, 2018).

Active living is influenced by many factors including individual, social, economic and structural determinants (NPHS, 2021). The environments in which we live, work and grow are particularly important factors that can enable or limit physical activity. The design of neighbourhoods including the accessibility to local amenities, structured activities, schools, greenspaces, transport, climate, safety influence the level of activity in communities. Active communities, as noted in the Victorian Health and Wellbeing Plan 2019-2023, contribute to many positive effects including improving mental health, social connectedness, disease prevention and alleviation, workplace productivity and environmental benefits.

In Victoria, active living has been identified as a public health priority. The Victorian public health and wellbeing outcomes framework (VPHWOF) provides a comprehensive picture of activity levels among adults living in the Grampians region. In eight of 11 Grampians region local government areas (LGAs), the proportion of people who reported insufficient physical activity was higher than the Victorian average (44.1%). There were no LGAs in the region that had higher rates of sedentary behaviour (note that there was no data available for two LGAs). However, all LGAs had a higher proportion of people who had a body mass index (BMI) greater than 30. This may reflect a potential mismatch between reported levels of activity and current health outcomes.

In rural areas, there has been great emphasis and success in enhancing sports participation. Organised sports support increased volunteerism, employment and social connections, which contribute to positive health and wellbeing outcomes. Despite this, levels of participation in organised sport remain modest (5.8% to 11.4%) across the Grampians community (VicHealth, 2020).

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| ***Key objective*** | Support the capacity and opportunities to design, implement, evaluate, sustain and, where possible scale, stakeholder-driven interventions to improve active living across the Central Highlands, Grampians Pyrenees Goldfields and Wimmera Southern Mallee areas. |
| ***What we want to achieve*** | Across the region, the outcomes that will be needed to achieve a greater level active living will comprise:<br>• Increasing the prevalence of those who are sufficiently active<br>• Decreasing the average time that people sit or be sedentary<br>• Increasing participation in organised sport and recreation<br>• Increasing active transport use |

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| ***How might this be achieved?*** | Multiple action areas in health promotion practice must be utilised to achieve the above active living goals. Multiple strategies aimed at the individual, communities, and the environment will be needed to achieve the targets in this focus area. The influence of the Grampians Region Population Health Plan (the plan) over its duration will target these determining factors, among others, as the plan evolves:<br>• Improve neighbourhood and precinct planning to better support active living<br>• Increase accessible and adaptable spaces for active living, ensuring compliance with appropriate state and national regulations and standards Increase socio-cultural norms reinforcing active living<br>• Increase capacity to be more physically active and less sedentary Improve integration and accessibility of public transport<br><br>Through our consultations and the selections made by community stakeholders across the catchment, the GPHU will support a series of initiatives that seek to improve physical activity and reduce sedentary behaviours.<br><br>Initially, these may include:<br>• Increase the delivery of the Active Farmers Program across the Yarriambiack local government area in the Wimmera Southern Mallee area<br>• Work with sports clubs in the Grampians Pyrenees Goldfields area to become more inclusive<br>• Promoting active living opportunities specifically to children & young people in the Central Highlands area.<br><br>For more information on these interventions, see *Section 3.4* |
| ***Alignment with existing local, regional and/or state programs, initiatives and plans?*** | • Community Health – Health Promotion Plans (*Community Health-Health Promotion* Funded Agencies)<br>• Community Health Women's Health Plans (Women's Health Grampians)<br>• Municipal Public Health and Wellbeing Plans (see *Section 6* References)<br>• Victorian Public Health and Wellbeing Outcomes Framework 2016<br>• Victorian public health and wellbeing plan 2019–2023<br>• National Preventive Health Strategy 2021-2030 |
| ***How we will know if our plan is working?*** | We will utilise the RE-AIM framework to assess the reach, effectiveness, adoption, implementation and maintenance of the active living interventions. In partnership with stakeholders, a set of process, impact and outcome measures, comprised of both qualitative and quantitative indicators will be identified.<br><br>**NB** – Further refinement and development of measures to be finalised upon development of the evaluation plan, following further consultation with stakeholders, which will include:<br>• Short term localised indicators of intervention progress<br>• Feasible evaluation methods for monitoring impacts |

# Appendix 6.3 Grampians Region Population Health Plan Strategic Priority Brief – Reducing harm from tobacco and e-cigarettes

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| **Priority** | **Reducing harm from tobacco and e-cigarettes in the Grampians region** |
| **Program leads** | Joanne Richie |

**Rationale/Problem:** Reducing harm from tobacco and e-cigarettes in the Grampians region

In Australia, strong tobacco control over the past 50 years (Department of Health & Aged Care, 2018) has contributed to decreasing rates of smoking at a national level (Australian Institute of Health and Welfare, 2020). Despite this, tobacco smoking continues to be the leading cause of preventable disease and death in Australia (Australian Institute of Health and Welfare, 2023).

The Victorian public health and wellbeing outcomes framework (VPHWOF) reports rates of smoking by Victorian local government areas (LGAs). In 9 of 11 Grampians region LGAs, the proportion of adults who smoke daily is higher than the Victorian average (12.0%). Rates of smoking were greatest in the Central Goldfields (22.1%), Yarriambiack (20.8%) and Hindmarsh (18.8%) LGAs. From an equity lens, rates of smoking are disproportionally higher among some populations. People living in regional and remote areas (Australian Institute of Health and Welfare, 2023), First Nations peoples and people high levels pf psychological distress experience higher rates of smoking (Victorian Government, n.d.).

Reducing rates of tobacco smoking during pregnancy is another public health priority due to the increased risk of pregnancy related complications. All 11 LGAs had higher rates of smoking among pregnant (first 20 weeks) mothers, compared with the Victorian average (8.0%) (Torrens University, 2023). Rates were highest in Yarriambiack (24.9%), Central Goldfields (19.5%) and Ararat (18.3%).

In Australia, vaping has become an emerging public health issue due to the rising rate of e-cigarette use. Between 2016 and 2019, lifetime use of e-cigarettes has increased from 8.8% to 11.3% (Australian Institute of Health and Welfare, 2020). E-cigarette use has increased across most age groups. Of particular concern, there has been marked rise in use among young people. Although the majority (69%) of people who use e-cigarettes were current smokers, 23% considered themselves to be a 'never smoker' at the time of survey (Australian Institute of Health and Welfare, 2020). In 2019, people who use e-cigarettes reported varied reasons for using the devices, including:

- Tried out of curiosity (54%)
- To help quit smoking (32%)
- Think they are less harmful than regular cigarettes (23%)
- To try to cut down the on the number of cigarettes smoked (22%)
- To try and stop going back to regular cigarettes (17.8%)
- They are cheaper than regular cigarettes (17.7%)
- Think they taste better than regular cigarettes (16.1%)

The Australian Secondary Students' Alcohol and Drug Survey provides additional information about e-cigarette use among young people. In 2017, 14% of 12- to 17-year-old students reported ever using e-cigarettes (Cancer Council Victoria, 2018). Like tobacco use, e-cigarette use appears to increase with age. Among students who had ever used e-cigarettes, 48% had not smoked tobacco before their first e-cigarette (Cancer Council Victoria, 2018). Furthermore, approximately 25% of these students who had tried an e-cigarette reported later trying tobacco (Cancer Council Victoria, 2018).

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| ***Key objective*** | To support the capacity and opportunities to design, implement, evaluate, sustain, and where possible scale, stakeholder driven interventions across the Central Highlands, Grampians Pyrenees Goldfields and Wimmera Southern Mallee areas to elsewhere in the Grampians region. |
| ***What we want to achieve*** | • A reduction in the proportion of adults and adolescents that smoke daily |
| ***How might this be achieved?*** | Multiple action areas in health promotion practices (Ottawa charter) can be utilised to achieve the goals above. Multiple strategies aimed at the individual, communities, and the built environment will be needed to achieve the targets in this focus area.<br><br>Through our consultations and the selections made by community stakeholders across the catchment, GPHU will support a series of initiatives across the Grampians region. These interventions have been developed to decrease the number of environments in which to smoke, decrease exposure to second- and third-hand smoke, decrease the social acceptability of smoking and vaping, increase capacity to stop smoking and use of nicotine, and increase to uptake of stop-smoking supports.<br><br>Initially, the interventions may include:<br>• Enhancing the Achievement Program with a strengths-based approach to reducing harm from tobacco & E-cigarette use in the Yarriambiack local government area (Wimmera Southern Mallee)<br>• The development of a public information campaign to increase awareness of smoke-free & vape-free areas in communities across Grampians Pyrenees Goldfields<br>• The development of a social media campaign to deter young people from vaping in the Central Highlands area<br><br>For more information about these interventions see *Section 3.4* |
| ***Alignment with existing local, regional and/or state programs, initiatives and plans?*** | • Municipal Health and Wellbeing Plans (see Section 6 References)<br>• Victorian Public Health and Wellbeing Outcomes Framework 2016<br>• Victorian public health and wellbeing plan 2019-2023<br>• National Preventive Health Strategy 2021-2030<br>• Victoria's tobacco reforms<br>• National Tobacco Strategy 2023–2030 |
| ***How we will know if our plan is working?*** | We will utilise the RE-AIM framework to assess the reach, effectiveness, adoption, implementation and maintenance of the reducing harm from tobacco and e-cigarettes interventions. In partnership with stakeholders, a set of process, impact and outcome measures, comprised of both qualitative and quantitative indicators will be identified.<br><br>**NB** – Further refinement and development of measures to be finalised upon development of the evaluation plan, following further consultation with stakeholders, which will include:<br>• Short term localised indicators of intervention progress<br>• Feasible evaluation methods for monitoring impacts |

# Appendix 6.4 Grampians Region Population Health Plan Strategic Priority Brief – Strengthening oral health

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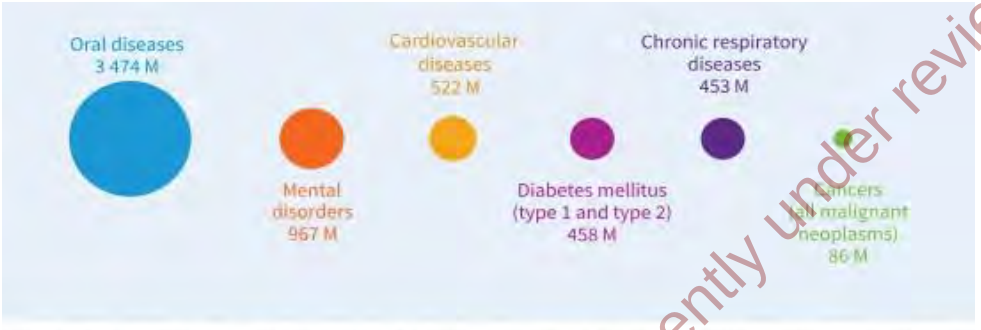
| **Priority** | **Strengthening oral health in the Grampians region** |
| **Program leads** | Aaron Bloch, Tara Purcell |

**Rationale/Problem:** Improving oral health in the Grampians region

Oral health is critical to health and well-being. It enables people to eat, breathe and speak and contributes to well-being by supporting self-confidence (WHO, 2022). Globally, there is a significant burden of disease due to oral conditions (WHO, 2022). The World Health Organisation has reported that the estimated number of cases of oral disease across the world is higher than other non-communicable diseases (*Figure 6.4_1*) (WHO, 2022).

*Figure 6.4_1 Comparison of estimated global case numbers for selected NCDs*




*Note.* Data are for all ages and both sexes from GBD 2019; oral diseases do not include lip and oral cavity cancer *(4)*. A standard method has been applied to incorporate the latest UN population estimates.

Although there has been improvement in oral health over the past few decades, there continues to be many Victorians that experience oral disease (DHHS, 2020). People in 9 of 11 Grampians region local government areas (LGAs) have higher rates of potentially avoidable admissions for oral disease than the rest of Victoria; 10 of 11 LGAs have higher percentage with at least one decayed missing or filled tooth and worse rates of caries and decay in children 0-12; and in seven of 11 LGAs adults report avoiding dental care due to cost (DHSV, 2020). Oral disease unequally impacts those vulnerable to the socioeconomic environment; children living in poverty are especially affected by poor oral health, with impacts on speech development (Anil et al 2017, Kambah 2019), school attendance (Jackson et al 2011), and self-esteem and social success in adolescents (Guarnizo- Herreno et al, 2012). Notably in 2019-20, of 67,000 avoidable admissions for preventable detail conditions to Australian hospitals, the rate was highest in those aged 5–9 years (8.6 per 1,000 population) (AIHW, 2022).

With respect to factors contributing to poor oral health, Victorian public health and well-being outcomes framework (VPHWOF) data show that in 10 of 11 Grampians region LGAs adults consume more sugar sweetened beverages than elsewhere in Victoria, and eat fewer serves of vegetables and fruit daily in seven of 11 LGAs. Good oral health is critical to healthy ageing (Patel et al, 2021), with poor oral health linked to numerous diseases (Seitz et al 2019) . Australians aged 15 or older living outside capital cities are more likely than people in capital cities to have complete tooth loss, less than 21 teeth, wear dentures, have missing teeth, have untreated disease and are more likely to avoid certain foods due to dental problems (AIHW, 2013), with malnutrition, acute illness and chronic disease impacts.

While Victoria provides public dental services and a range of dental health promotion programs as do other health providers in the community, given its impact across the life-course and on health services, oral disease remains a priority public health challenge in our region, for children and adults. By bringing a system science and value-based health care approach, our oral disease program of work aims to identify strategies which leverage existing programs and stakeholders to reduce the burden of disease and its consequent social, health and health service impacts.

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| ***Key objective*** | To support the implementation, evaluation and sustainability of one oral health intervention in Edenhope, with a view to scale, where possible, to elsewhere in the Grampians region. |
| ***What we want to achieve*** | • Improve the oral health of children<br>• Promote healthy environments<br>• Improve oral health literacy<br>• Improve oral health promotion, screening, early detection and preventions services |
| ***How might this be achieved?*** | Multiple action areas, as outlined in the Ottawa Charter for Health Promotion, can be utilised to achieve the goals described above.<br><br>Strategies aimed at health policy, health systems, the environments in which we live, work and play, and individuals will be needed to achieve equitable oral health outcomes across the Grampians region.<br><br>As described above, the initial work in the oral health stream has commenced in Edenhope, with a view to scale progressively in West Wimmera and across the Grampians region if demonstrated to be efficacious.<br><br>Consultation with community stakeholders and subject matter experts is in progress. The aim of the consultation process is to identify the system goal(s) and stakeholder driven interventions to achieve them. |
| ***Alignment with existing local, regional and/or state programs, initiatives and plans?*** | • Victorian Action Plan to Prevent oral disease 2020-2030<br>• Healthy Kids Healthy Futures<br>• By Five (Wimmera Southern Mallee Development Association) Wimmera Southern Mallee<br>• Municipal Health and Wellbeing Plans (see Section 6 References)<br>• National Preventive Health Strategy 2021-2030<br>• Victorian public health and wellbeing plan 2019–2023<br>• Dental Health Services Victoria Health Promotion Programs |
| ***How we will know if our plan is working?*** | The RE-AIM framework will be utilised to assess the reach, effectiveness, adoption, implementation and maintenance of the oral health interventions.<br><br>In partnership with stakeholders, a set of process, impact and outcome measures, comprised of both qualitative and qualitative indicators will be identified. |

# Appendix 6.5 Grampians Region Population Health Plan Strategic Priority Brief – Sexual and reproductive health

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| **Priority** | **Sexual and Reproductive Health and Viral Hepatitis in the Grampians Region** |
| **Program leads** | **Working Group**: Karen Worthington (BCH), Genevieve Lilley (BCH), Louise Feery (BCH), Dr Juliana Betts (GPHU)<br>**Steering Committee:** Dr Rob Grenfell (Grampians Health), Shannon Hill (WHG), Jo Labbett (BCH), Michelle Orr (BCH) |

**Rationale/Problem**

The Grampians Public Health Unit (GPHU) has worked closely with Ballarat Community Health (BCH) and a broad range of stakeholders, to understand the current sexual and reproductive health (SRH) landscape in the region including key strengths and resources, barriers to accessing sexual health care and possible solutions for improving outcomes, with a focus on improving health equity.

Sexual and reproductive health is a significant population health issue because it is fundamentally linked to the health, social and economic outcomes of communities. When viewed holistically and positively, sexual health is about well-being, not merely the absence of disease and involves respect, safety, and freedom from discrimination and violence (WHO, 2023).

Viral hepatitis has been incorporated into this stream of work, in line with the Victorian Government's *Sexual and reproductive health and viral hepatitis strategy 2022-2030,* which recognises the common element of "treatment as prevention" for viral hepatitis and sexually transmitted infections. A concerted effort to address health inequalities among priority population groups and counteract stigma is a common mechanism to improving both sexual health and viral hepatitis outcomes.

There are many strengths and assets to build upon within the Grampians region to improve sexual and reproductive health and viral hepatitis outcomes.

Some of these community strengths include:

- an effective sexual and reproductive health hub run by Ballarat Community Health (part of the strong, supported network of 11 Victorian Government funded SRH hubs throughout the state)
- a number of experienced sexual and reproductive health nurses and health promotion experts within the Grampians catchment region
- evidence that people living with Hepatitis C are engaging in treatment at rates above the state and national averages (WHO Collaborating Centre for Viral Hepatitis & The Doherty Institute, 2021)
- the presence and work of Women's Health Grampians – a strong local voice advocating for the health and wellbeing of Grampians women
- a commitment from all 11 Local Governments in the region to prioritise action to prevent violence against women and promote gender equity in their municipal public health and wellbeing plans.

Despite these strengths, the Grampians region as a whole, demonstrates a profound lack of accessible sexual and reproductive health services, particularly for the timely access to abortion and sexual health care. Recent media reports have highlighted the paucity of abortion services in the region (ABC, 2023). The rate of PBS claims for the prescription of medical termination drugs based on the patient's location was higher than state average in 9 of the 11 LGAs in our region. Despite this, the rate of PBS claims when based on the prescriber's location, was below the state average in 9 of the 11 LGAs in our catchment. This indicates that, despite significant demand within the region, people are likely to be seeking medical abortion services from outside of the region (Women's Health Atlas Victoria, 2023)

There has been a comprehensive enquiry conducted by Women's Health Grampians into access to abortion and other reproductive health services in the Grampians region. They have been a key informant in our investigation,

along with community nurses from maternal and child health, bush nursing centres, sexual health services, general practice, alcohol and other drug and the school nurse program, refugee health and maternity services.

We also spoke with community organisations working with migrants, Neighbourhood houses and medical services, among others. Key themes emerged around stigma, confidentiality, a lack of services, remoteness and barriers imposed by existing service models. Health literacy was commonly cited as contributing to people not accessing preventive care or delays in seeking help, which significantly affects outcomes, especially regarding abortion access.

Additionally, shared information in small communities has a powerful effect on the types of interventions people are happy to consider, leading to suspicion about best-practice contraception.

The prevention, detection, and management of Sexually Transmitted Infections (STIs) in the Grampians Region encounters similar barriers to unplanned pregnancy. If anything, stigma, fear about confidentiality, as well as concerns around competency are amplified.

For hepatitis services, knowledge of local health care providers of existing treatment and referral pathways appears to be limited in some areas, and access to care is challenging secondary to stigma, geographical distance and language barriers.

In addition to this, throughout every local government area in our region, higher than average rates of intimate partner violence have been demonstrated which has significant ramifications for sexual health and wellbeing (Women's Health Atlas, 2023).

In order to improve sexual and reproductive health and viral hepatitis outcomes it is essential that a population health approach focusing on the principles of co-design, equity and sustainability is adopted, which builds on existing community strengths.

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| ***Key objective*** | **Goal 1:** To build a responsive sexual health service that will meet the needs of our population<br><br>**Goal 2:** To build capacity in the health and community sector through partnerships, networks and education<br><br>**Goal 3:** To develop a designated sexual and reproductive health and viral hepatitis health promotion program focusing on primary and secondary prevention |
| ***How might this be achieved?*** | **Goal 1:** To build a responsive sexual health service that will meet the needs of our population<br>• Provision of care navigators for unplanned pregnancy<br>• Facilitated provision of state-wide referral tools<br>• Targeted support and up-skilling of existing provider networks<br><br>**Goal 2:** To build capacity in the health and community sector through partnerships, networks and education<br>• Region wide service provider education<br>• Establishment of relationships with key workers and community members<br>• Build network of supportive services: GP, LiverWELL, LINC-B, etc., telehealth<br><br>**Goal 3:** To develop a designated sexual and reproductive health and viral hepatitis health promotion program focusing on primary and secondary prevention<br>• Provision of a Sexual and Reproductive Health and Viral Hepatitis |

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| | health promotion officer<br>• Development of a comprehensive health promotion program<br>• Prevention and treatment awareness health promotion |
| ***Alignment with existing local, regional and/or state programs, initiatives and plans?*** | • Victorian public health and wellbeing plan 2019–2023<br>• All 11 LGAs in the Grampians catchment region prioritised the **prevention of violence and the promotion of gender equity** in their municipal public health and wellbeing plans, and 2 LGAs (Moorabool and Horsham) prioritised SRH specifically<br>• Victorian sexual and reproductive health and viral hepatitis strategy 2022-30, includes 6 sub-plans:<br>o Victorian Aboriginal sexual and reproductive health plan<br>o Victorian Hepatitis B plan<br>o Victorian Hepatitis C plan<br>o Victorian HIV plan<br>o Victorian sexual transmissible infections plan<br>o Victorian women's sexual and reproductive health plan<br>• Gender equality action plan 2022-2025<br>• Community health reform plan |
| ***How we will know if our plan is working?*** | **Process** measures may include:<br>• Collaborative networks of key stakeholders established to co-design effective interventions<br>• Increase in the number of schools participating in sexual health and relationships education professional development<br>• Changes to the number and types of schools participating in sexual health education<br>• Increases in the number of students participating and the number of sessions delivered<br>• Delivery of sexual health and viral hepatitis health promotion and training sessions in social service organisations (e.g. out of home care)<br><br>**Impact** measures may include:<br>• Increased self-reported knowledge and awareness of students regarding healthy relationships and safe sexual practices<br>• Increased knowledge of local referral pathways for workers at social care organisations<br>• Increased knowledge of local health care providers regarding best practice sexual and reproductive health care<br><br>**Outcome** measures may include:<br>• Increases in the rates of medical abortion prescriptions in the region based on patient and provider locations<br>• A decrease in waiting list time for public surgical abortion services<br>• An increase in the rate of contraceptive implant and IUD insertion in the region<br>• An increase in the rate of screening for chlamydia, gonorrhea and syphilis in target groups in general practices and other settings<br>• Increased rates of viral load testing for patients living with hepatitis B in the region<br>• Increased proportions of people with hepatitis C receiving treatment in the region<br>• Sustained change in the above outcome indicators tracked over time. |

# Appendix 6.6 Grampians Region Population Health Plan Strategic Priority Brief – Thriving children

| | |
|---|---|
| **Priority** | **Thriving Children** |
| **Program leads** | Radhika Krishnan, Alicia Williams |

**Rationale/Problem**

In 2020 data from several sources showed that in almost every Grampians LGA children 12 and under are experiencing outcomes poorer than the Victorian average across a range of indicators including smoking in pregnancy 1.75 times the Victorian rate, a 10% higher rate for low birthweight babies compared with Victorian average, and a higher proportion of children vulnerable in two or more domains in the 2018 Australian Early Development Census with double the Victorian rate for Ararat, and higher for Ballarat, Hindmarsh, Horsham, West Wimmera and Yarriambiack LGAs. Additionally we have seen higher than Victorian average rates of child protection substantiations in the cities of Ballarat, Ararat and Horsham, and Moorabool, Pyrenees, Hindmarsh, and West Wimmera Shires; higher than Victorian average rates of potentially preventable hospitalisations in children 0-14 in Ballarat, Pyrenees, Hindmarsh Horsham, West Wimmera and Yarriambiack LGAs; higher than Victorian average rates of admission for accidental injuries in children 0-14 in Pyrenees, Horsham and Yarriambiack LGAs, and higher than Victorian average rates of children 0-17 years affected by reported incidents of family violence in Ararat, Northern Grampians, Pyrenees, Hindmarsh, Horsham, West Wimmera and Yarriambiack LGAs.

While Victorian Public Health and Wellbeing Outcomes Framework (VPHWOF) data show that across rural Victoria a slightly larger proportion of children 10-17 consume sufficient vegetables and fruit than the rest of Victoria, and in 2011-2012 children 5-17 were less likely to be obese, these statistics likely or do vary by remoteness: Australian Institute of Health and Welfare, (2017, p. 13) data show a 40% relative increase in obesity in children 2-17 in outer regional/ remote compared with inner regional. Given that obesity is a risk factor for a range of chronic diseases, interventions across the region to create environments and support households to be safe, loving, provide nutritious food to children and ensure adequate activity among children will deliver health and well-being benefits including reductions in levels of obesity and its chronic disease sequelae into the future.

Importantly, national and international evidence has shown what children need to thrive (ARACY, n.d.), that investment in early years yields outcomes for later in life (Molloy et al., 2021), and that it is possible to alter the life-course trajectory of children (Goldfeld et al., 2019) using a system science approach (Knight & Baldwin, 2022). *Thriving children* will build on joined-up work already underway in seven of the 11 LGAs in our region (*ByFIVE* – Wimmera Southern Mallee, *Every Child Every Chance* in Central Goldfields, and *Ballarat4Kids* in City of Ballarat) to reduce the burden of chronic disease risk factors in children and create a region where all children can thrive using the below strategies.

| | |
|---|---|
| ***Key objective*** | • Apply system science to develop a stakeholder driven plan for stakeholder driven interventions as part of the Grampians Region Population Health Plan 2023-2029, by working with LGAs to align priorities for child health and well-being<br>• Use improvement methodology and tools for equity focus to redesign service ecosystem, strengthen households and build social connectedness |
| ***What we want to achieve*** | Where they exist, reduce the gaps between children in Grampians region LGAs and the Victorian average in relation to a range of indicators including*<br>• Living in loving and safe environments<br>• Having access to material basics<br>• Access to appropriate health services<br>• Proportion of children enrolled in 4-year-old kinder<br>• Developmental readiness for school<br>• School achievement<br>• Participating in sport, and families participating in maternal and child health services<br>• Have access to culturally safe services and support<br>• *Note: all indicators align to *The Nest* (ARACY, n.d.) |
| ***How might this be achieved?*** | • Engagement from LGA CEOs and their staff in the Thriving Children program<br>• Development of governance structures across Ararat Rural City and Moorabool, Hepburn and Pyrenees Shires including providers for children's health and wellbeing, housing agencies, sports organisations and schools<br>• Local stakeholder driven identification of system goals and feasible interventions, being enacted and monitored<br>• Feasible evaluation methods in place for monitoring impacts (with partners Murdoch Children's Research Institute MCRI, Deakin University, Federation University)<br>• Joining with Best Start Improvement Advisors and other trained coaches to scale use of improvement methods in redesign<br>• Work to establish Re-stacking the Odds (MCRI, 2021) (if desired by stakeholders) in Ararat Rural City and Moorabool, Hepburn, Pyrenees Shires<br>• VPHWOF data regarding children with obesity and/or proportion of children eating sufficient serves of fruit and vegetables, stratified by rurality and LGA where available |

| | |
|---|---|
| ***Alignment with existing local, regional and/or state programs, initiatives and plans?*** | • Healthy Kids Healthy Futures<br>• Grampians Health Services Plan<br>• Victorian public health and wellbeing plan 2019–2023<br>• INFANT \| Healthy eating and active play<br>• *Ballarat4Kids*<br>• *By Five* (Wimmera Southern Mallee Development Association)<br>• *Go Goldfields – Every child every chance* (Central Goldfields)<br>• MCRI's *Re-stacking the odds*<br>• Australian Research Alliance for Children and Youth's (ARACY) *The Nest*<br>• *Early Years Catalyst* program<br>• Scotland's *Children and Young People Improvement Collaboration (CYPIC)* |
| ***How we will know if our plan is working?*** | We will utilise the RE-AIM framework to assess the reach, effectiveness, adoption, implementation and maintenance of the thriving children interventions. In partnership with stakeholders, a set of process, impact and outcome measures, comprised of both qualitative and quantitative indicators will be identified.<br><br>**NB** – Further refinement and development of measures to be finalised upon development of the evaluation plan, following further consultation with stakeholders, which will include:<br>• Short term localised indicators of intervention progress<br>• Feasible evaluation methods for monitoring impacts |

# Appendix 6.7 Grampians Region Population Health Plan Strategic Priority Brief – Tackling climate change and health

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| **Priority** | **Tackling climate change and its impact on health in the Grampians region** |
| **Program leads** | Rosemary Aldrich |

**Rationale/Problem**

Climate change is the greatest threat to public health of the 21st century (Watts et al 2019). Climate change health and well-being impacts are distributed unequally (Friel 2022). In the Grampians region, like many locations, increasingly frequent and intense climate events threaten health, livelihoods, infrastructure and services; since 1890 heatwaves have caused more deaths than all other natural disasters combined (Hughes et al 2016); with the number of hot days recorded in Australia doubling since 1960. Figures *A6.7_1* to *A6.7_5* below set out the projected climate changes to the Grampians region; without urgent action the risks of widespread disruption from extreme climate events are ever increasing.

In March 2023 the Intergovernmental Panel on Climate Change (IPCC) released its Synthesis Report of its sixth assessment cycle: Summary for Policy Makers, with very high confidence stating that there is a "rapidly closing window of opportunity to secure a liveable and sustainable future for all" (paragraph C.1) and that "deep, rapid, and sustained mitigation and accelerated implementation of adaptation actions in this decade would reduce future losses and damages related to climate change for humans and ecosystems" (paragraph C.2), while "Implementing both mitigation and adaptation actions together and taking trade-offs into account supports co - benefits and synergies for human health and well-being (paragraph C.4.3)

Globally the health care sector contributes 4-5% to global emissions (Tennison et al 2021, Karliner et al 2019). In Australia this figure has been calculated to be 7% (Malik et al 2018). Action to reduce carbon emissions and their impacts as a nation and locally including by health services of the Grampians region (through sustainability-focused and equity-focused actions for climate change mitigation and adaptation) can have health co-benefits for staff and community, and for the health system itself (Beggs et al 2022). Additionally, examining and stewarding the use of resources which contribute to the carbon footprint of health services in our region can translate into more efficient and effective use of those resources, liberating dollars which can be redirected to patient care.
It can be done. England's National Health Service (NHS) established its Sustainable Development Unit in 2008. In 2020 it transformed into Greener NHS, an organisation-wide philosophy underpinning all policy, planning and service delivery. With a stated ambition to deliver the world's first net zero health service and respond to climate change, now and for future generations, numerous programs completed, sustained or underway by 2021 had reduced emissions by 26% since 1990, decreased emissions per inpatient episode by 64% (Tennison, et al 2021); between 2007 and 2015 patient episodes of care increased by 11% while saving of £90million per year (Kiang and Behne, 2021).

Grampians Health's *Health Resource Stewardship* program is a local example of work underway to reduce waste and consequently reduce emissions. The program commenced in 2018 targeting 16 sources of waste arising from energy and product supply and use, models and patterns of care, and human factors-linked waste such as adverse events. More than 300 members of staff have been trained to take stewardship action in their daily work setting. Employing circular economy thinking and sourcing local supply where possible, reducing resource waste both reduces emissions and delivers health co-benefits, as well as helps constrain unnecessary spending.

Victorians want businesses and community leaders to act on climate change. Climate action must be realistic, pragmatic, and local and engage people where they are, recognising that attitudes to action on climate change do vary. Climate change threatens every sector and affects everyone.

The Victorian public health and well-being plan 2019-2023 lists tackling climate change and its impacts on health as the first of 10 key priority areas. Responding to the imperative to take action are the Victorian Climate Action Strategy, Victoria's Health and Human Services Climate Change Adaptation Action plan 2022-2026, and, locally, the

Grampians Region Climate Adaptation Strategy 2021-2025; work by health services is critical to achieving Victoria's strategic goals.

Importantly, work by health services to respond to the imperative of climate change cuts across at least five Sustainable Development Goals (SDGs). These include, 3 health, 10 effecting equity, 12 responsible consumption, 13 climate action and 17 working in partnership to achieve goals, and capitalises on our region's health services' shared values regarding providing high quality care with equitable health outcomes for all regardless of age, gender, location, income, capacity or cultural identity.

| | |
|---|---|
| ***Key objective*** | • Apply system science to develop stakeholder driven plan for climate response interventions as part of Grampians Region Population Health plan 2023-2029, in relation to mitigation and adaptation imperatives and action, inside and beyond the health sector<br>• Ensure mechanisms are in place to bring equity and sustainability lenses to all plans, programs and service decisions. |
| ***How might this be achieved?*** | • For health sector leaders and teams to learn from exemplars (such as the NHS, the successes of other Australian health organisations) and from the wisdom and experience of Australia's First Peoples in caring for country and people<br>• Development of sustainability, mitigation and adaptation strategy/strategies for Grampians Region health services, including by using circular economy principles across health services and by training staff to steward precious supply and human resources<br>• Identify and support training of staff as to lead or champion those strategies<br>• Promote an action at all levels approach in health organisations so that staff, visitors, clients and community can be confident that their health services are engaged and acting for their safety into a future with a changing climate<br>• Support health leaders to help lead their local communities in mitigation and adaptation efforts across the Wimmera Southern Mallee, Grampians Pyrenees Goldfields and Central Highlands. In doing so we will join with communities and other agencies (inside and outside health and inside and outside government) to grow adaptive capacity, and reduce vulnerability<br>• Support development of sustainable services given projected increase in frequency and severity of extreme weather events. We will give particular attention to actions around prevention, preparedness, disaster risk reduction, and to building resilience, response and recovery capacity to extreme climate events such as drought, fire, storms, floods and their direct and indirect, immediate and delayed impacts<br>• Support and build capacity to make equity- and sustainability-focused service and workforce decisions. |

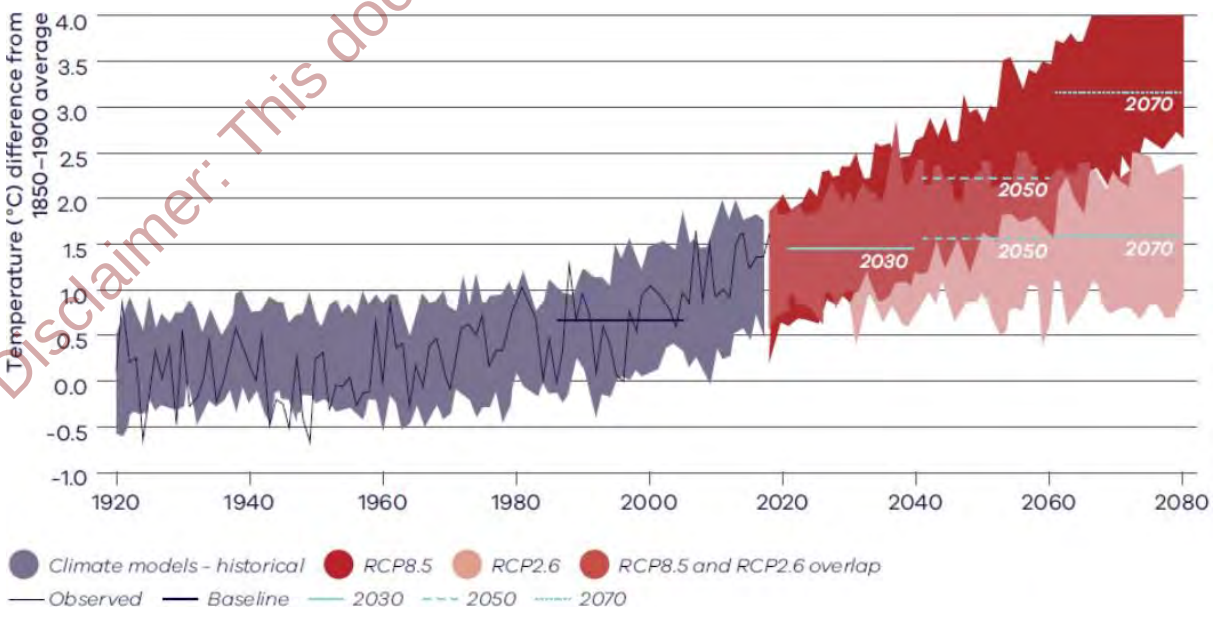
| | |
|---|---|
| ***Alignment with existing local, regional and/or state programs, initiatives and plans?*** | • Victorian public health and well-being plan 2019-2023<br>• Victorian Climate Change Strategy 2021<br>• Victoria's Health and Human Services Climate Change Adaptation Action plan 2022-2026<br>• Grampians Region Climate Adaptation Strategy 2021-2025<br>• Victoria's Climate Science Report 2019<br>• CSIRO DELWP Climate projections for Wimmera Southern Mallee 2019<br>• CSIRO DELWP Climate projections for the Central Highlands 2019 |
| ***How we will know if our plan is working?*** | • Health leaders in our region reached, engaged and acting to grow adaptive capacity across and reduce vulnerability in the organisations they lead<br>• Effectiveness of strategy shows measurable improvements in efficient use of human and other resources, as well as acceptability to staff and community<br>• Strategy is adopted as intended, and broadens scope and reach over time<br>• Implementation of program leads to demonstrable change in emissions and transitions to business as usual<br>• Program is sustained and continues to engage and demonstrate change and increased adaptive capacity is demonstrating through responses to extreme events<br>• Near net zero emissions by 2040 in health services. |



Projected changes in the climate of the Grampians region in four graphs (all sourced from Victoria's Climate Science Report 2019) and two boxes (sourced from Grampians Region Climate Adaptation Strategy 2021-2025).

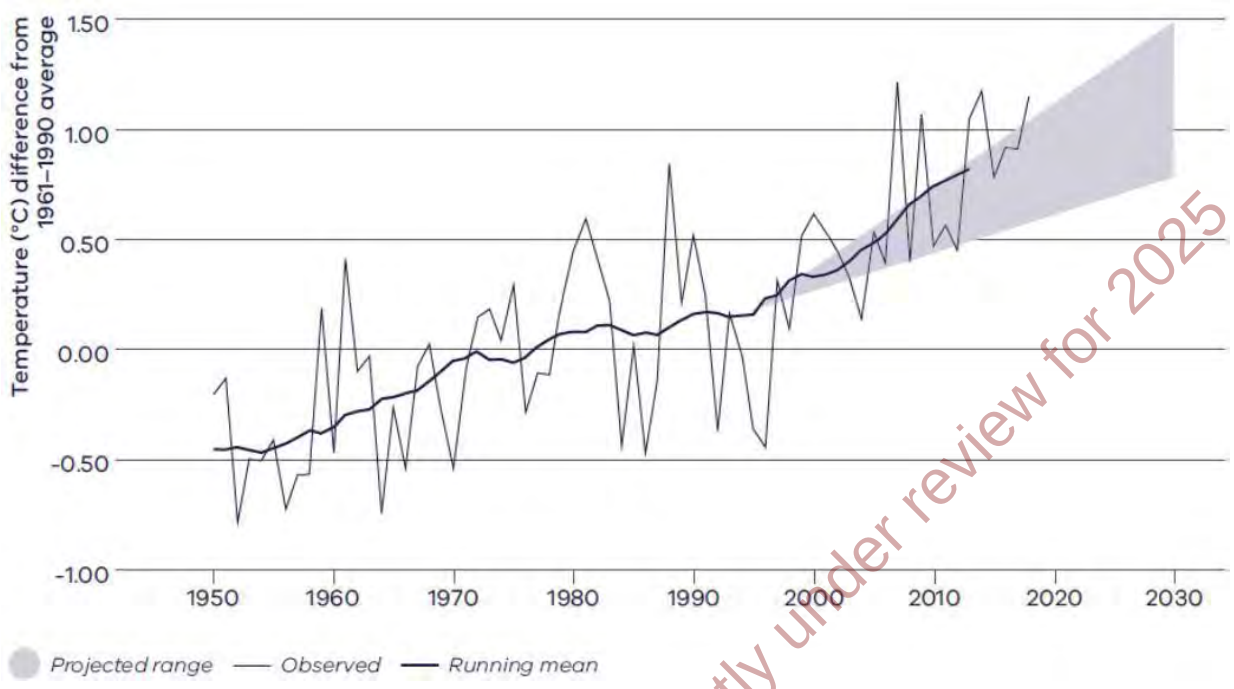
**1) Victoria is expected to continue to get warmer**

*Figure A6.7_1 Average annual temperature of Victoria in observations and models relative to the pre-industrial era, showing the highest emissions pathway (RCP 8.5) and the lowest (RCP 2.6) separately. (CSIRO, 2019).*



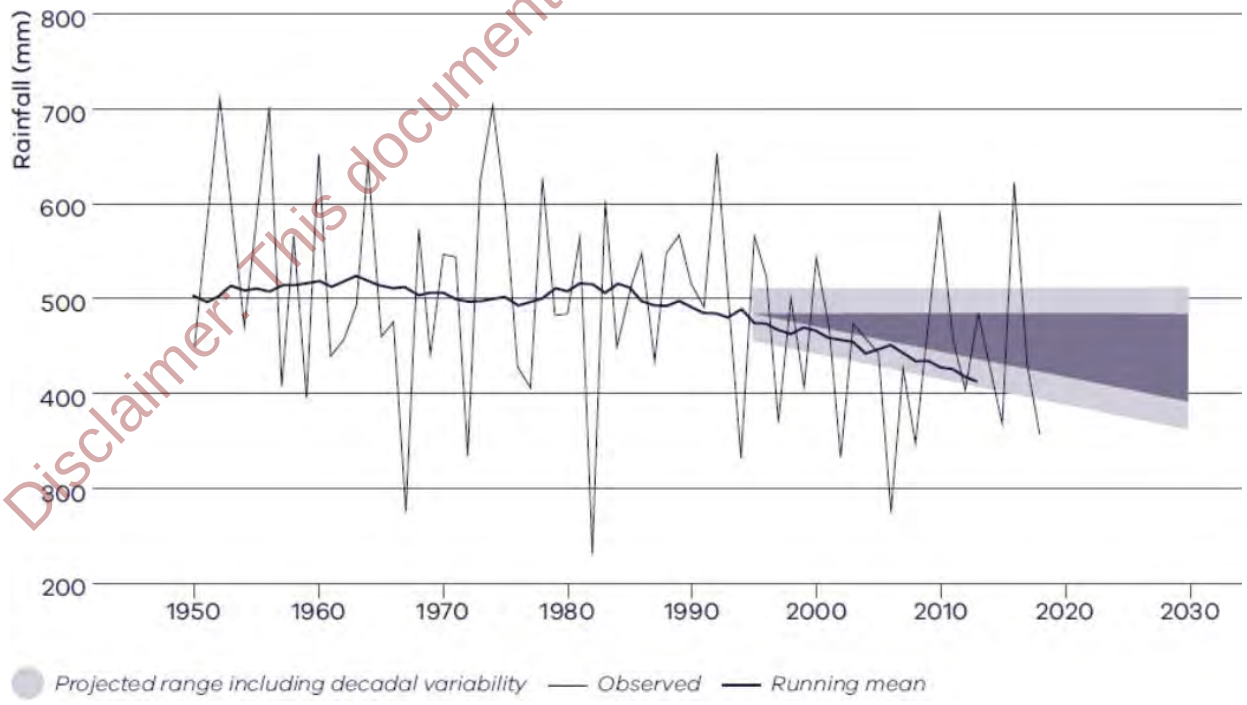
**2) Observed temperature in Victoria is tracking towards upper limit of projections**

*Figure A6.7_2 Comparison of the observed average annual temperatures for Victoria with the projected range of change. (CSIRO, 2019)*




**3) Observed winter rainfall in Victoria is tracking towards drier end of projections**

*Figure A6.7_3 Observed averaged rainfall in Victoria and projected rainfall change to 2030 across climate models and emissions scenarios (CSIRO, 2019)*

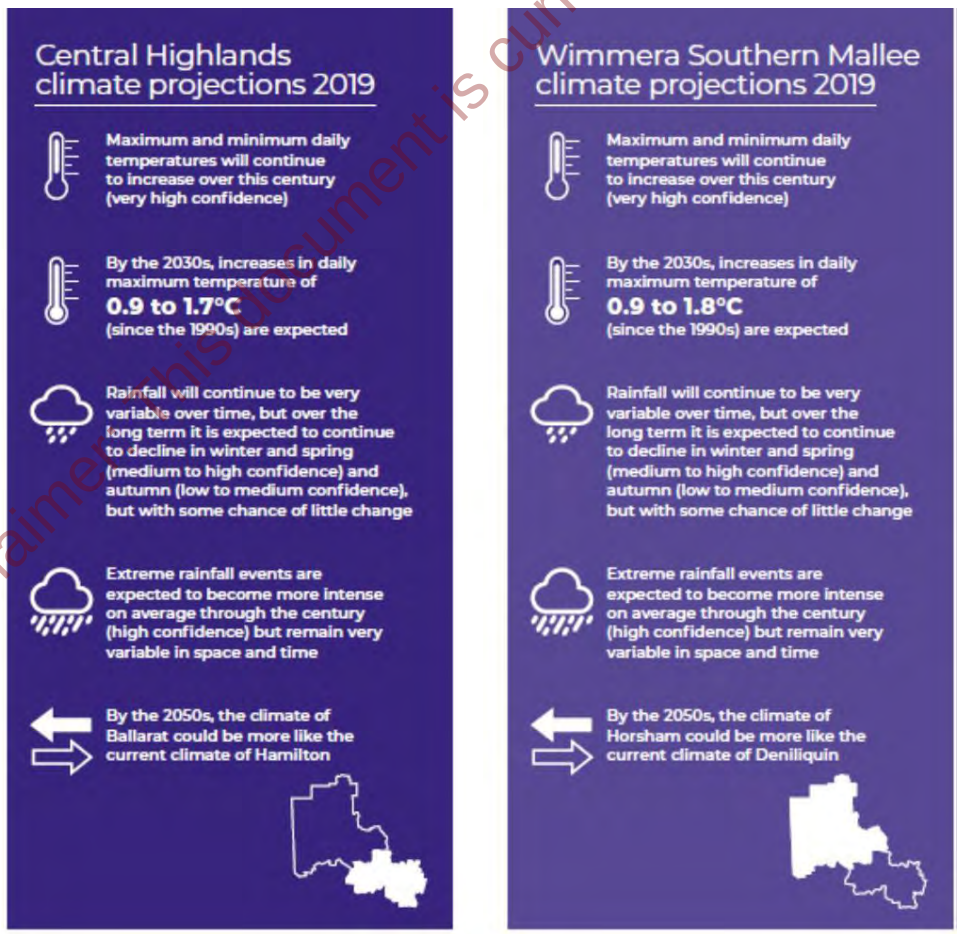


**4) Leading to a projected annual rainfall decline by the 2050s**

*Figure A6.7_4 Average decline in annual rainfall in percent for locations across Victoria for the 2050s under high emissions scenario (RCP 8.5) compared to 1986-2005 (CSIRO, 2019)*


**5) Resulting in a changed climate, environmental changes and population level impacts**

*Figure A6.7_5 CSIRO climate projections for Central Highlands and Wimmera Southern Mallee (Source: Grampians Region Climate Adaptation Strategy 2021-2025)*



# Appendix 6.8 Grampians Region Population Health Plan Strategic Priority Brief – E2E Integrating cardiac care

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|---|---|
| **Priority** | **Integrating prevention, primary care and acute care into the value-based health care continuum** |
| **Program leads** | Sharon Sykes, Director Planning and Innovation, Grampians Health |

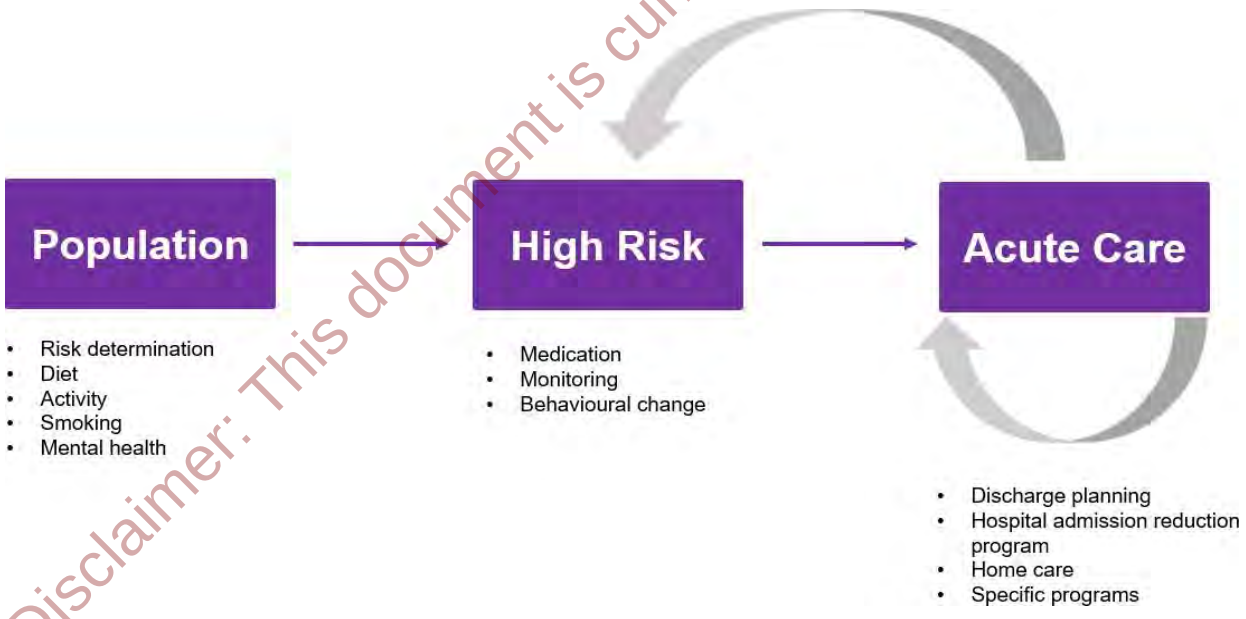
## 6.8.1 Opportunity

Cardiovascular disease is one of the principal causes of morbidity and mortality in our region at levels greater than State averages. This is manifested in the unfortunate levels of severe disease at the time of first presentation to hospital. Improvement in the identification and management of high-risk individuals will lead to overall improvement in the health and quality of life for members of the community.

## 6.8.2 Problem Definition

It is proposed that we will develop an end-to-end approach to the detection, treatment and management of cardiovascular risk and disease across the Grampians region. This will require a multifaceted effort, with a range of strategic actions on different parts of the continuum. It is intended that when all parts are connected that we will achieve a shift the reduction of adverse cardiac outcomes in our region. The three components of the approach are outlined in the following diagram. Each of the domains will require synchronised approaches as sub-programs of the integrated program.

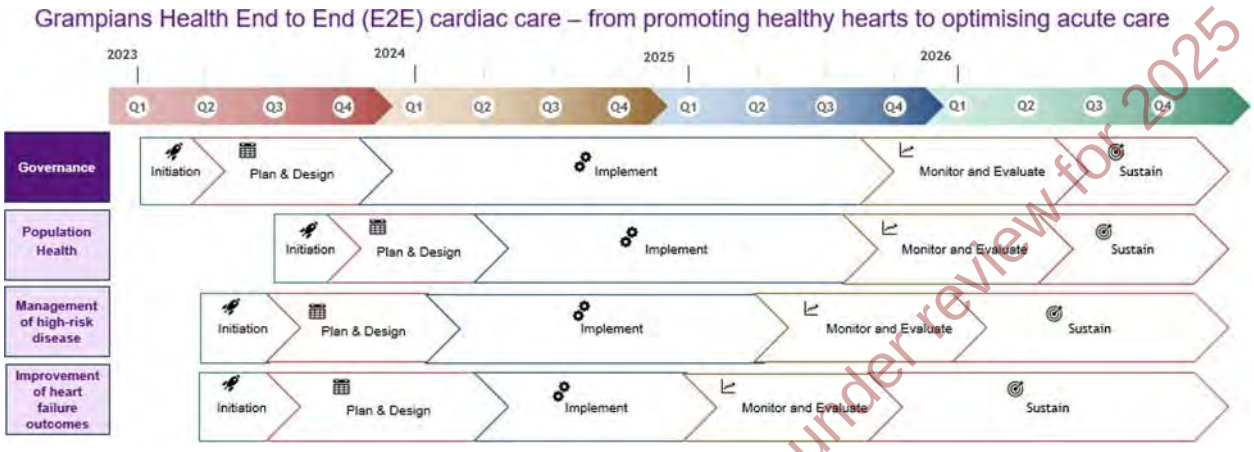
*Figure A6.8_1 E2E model of integrating cardiac care in Grampians region to optimise outcomes and value-based health care*



## 6.8.3 Alignment to strategic objectives

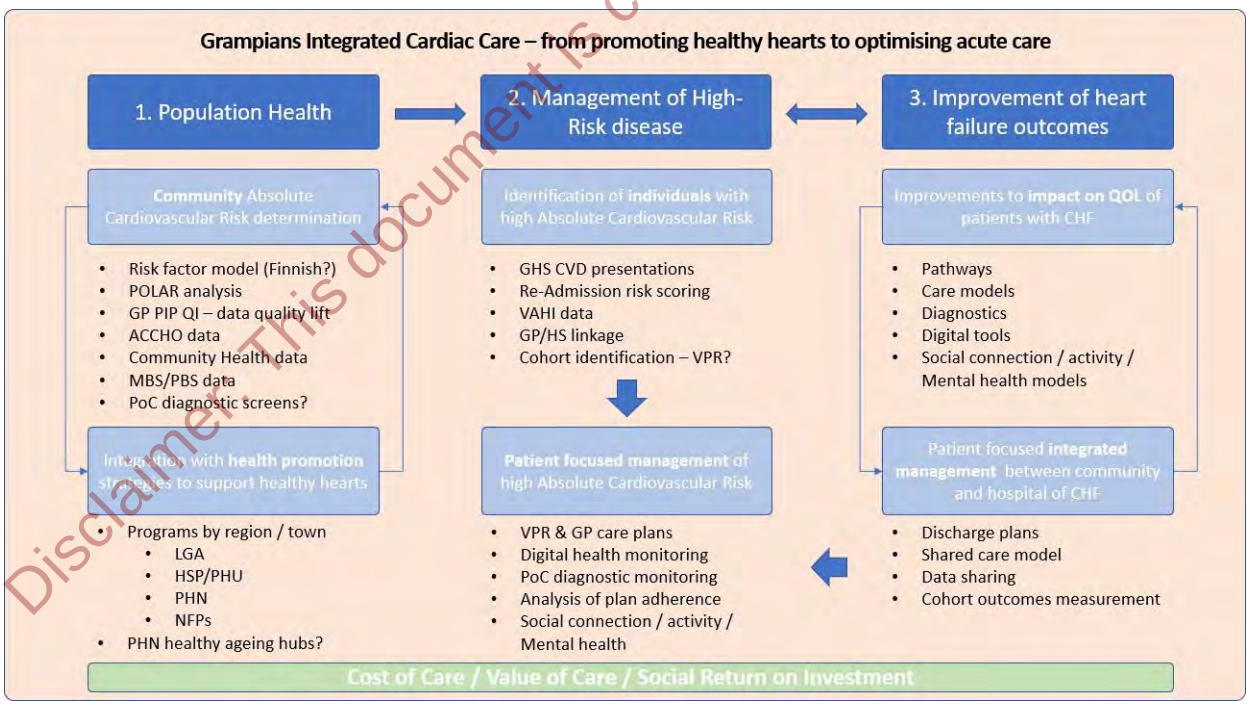
Integrated care with optimised clinical outcomes is a strategic imperative for all levels of the health care system. There are a number of strategic drivers for a whole of system approach, which can be categorised into the various headings; patient experience, preventive health, risk management, clinical demand, clinical outcomes, healthcare expenditure, and health policy. Value-based care is a key State health policy and cardiovascular health and care has been a priority.

*Figure A6.8_2 E2E Integrating cardiac care in Grampians region- time frame for implementation*




## 6.8.4 Program model

*Figure A6.8_3 E2E Integrating cardiac care in Grampians region: detail of project components*



### 6.8.5 Key Partners

Western Victoria Primary Health Network (WVPHN), Grampians Health Executive and Leadership, Victorian Agency for Health Information (VAHI), Department of Health (DH), Deakin University (DU), Community Advisory Committee (CAC), Clinical, Allied, Primary Health; Grampians Public Health Unit (GPHU).

**Aim:** To establish an end-to-end integrated cardiovascular model with:

- Translatable methodology,
- Detailed economic analysis of methodology,
- Demonstrated impact on regional health.

### 6.8.6 Sub-programs (and lead agencies)

**Population health** – Grampians Public Health Unit

**Aim:** To improve cardiovascular Population health through:

- Community Absolute Cardiovascular Risk determination,
- Integration with health promotion strategies to support healthy hearts.

**Management of high-risk disease** – Western Victoria Primary Health Network

**Aim:** To improve management of individuals at high risk of heart disease through:

- Identification of individuals with high Absolute Cardiovascular Risk,
- Patient focused management of high Absolute Cardiovascular Risk.

**Improvement of heart failure outcomes** – Grampians Health

**Aim:** The development of an integrated Chronic Heart Failure management system across the hospital and community interface to:

- Improve the quality of life of patients with Chronic Heart Failure,
- Patient focused integrated community and hospital management of Chronic Heart Failure.

*Table A6.8_1 E2E Integrating cardiac care in Grampians region: evaluation measures*

| Component | Measures |
|---|---|
| **Governance** | • Detailed cost benefit analysis |
| **Population health** | • Burden of disease – QALY and population impact |
| **Management of high-risk disease** | • Rates of AR determination<br>• Adherence to CVD management guidelines for AR, IHD and CHF<br>• Improved patient quality of life<br>• Reduction in readmission of Chronic Heart Failure over 30 days |
| **Improvement of heart failure outcomes** | • Improved patient quality of life<br>• Reduction in readmission over 30 days |
| **Experience of care measures** | • Cultural safety<br>• Barriers to or enablers of access to care<br>• Others as nominated by consumers |

# Appendix 6.9 Grampians Region Population Health Plan Strategic Priority Brief – Regionalising early diagnosis and cancer care

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|---|---|
| **Priority** | **Integrating prevention, screening for those at high risk and acute care into the value-based health care continuum** |
| **Program leads** | Kerry Davidson, Director Grampians Integrated Cancer Services |

## 6.9.1 Opportunity

Lung cancer continues to be the leading cause of cancer death in Australia, and survival rates remain low as many people with lung cancer have advanced stage disease at diagnosis (*Figure A6.9_1*). Improving survival and quality of life requires earlier diagnosis and treatment. Currently the five-year relative survival for stage IV lung cancer is 3.8%, compared to 67.7% for stage I lung cancer. A National Lung Cancer Screening Program intending to deliver earlier detection of lung cancer in Australians was announced by the Australian Government in May 2023, with screening to commence in July 2025.

*Figure A6.9_1 Cancer Data by stage of diagnosis. Source: https://www.aihw.gov.au/reports/cancer/cancer-data-in-australia/contents/cancer-incidence-and-survival-by-stage-data-visualisation last updated October 2022*

## 6.9.2 Problem Definition

Aboriginal and Torres Strait Islander peoples and people living in remote, very remote areas and areas of greatest socioeconomic disadvantage are disproportionately affected by lung cancer, with higher lung cancer incidence and mortality in these groups. Data for the Grampians region, set out in *Table A2.4_17* Incidence, prevalence and premature death rates associated with cancer, by Local Government Area show that the age- adjusted incidence for lung cancer in every LGA exceeds the rate for the whole of Victoria - by more than three times in West Wimmera LGA - and that in general the rates worsen with distance from Melbourne.

There are many complex reasons for these statistics, including higher rates of smoking in populations experiencing disadvantage, as well as lower levels of access to primary care making later diagnosis more likely, and structural and socio-economic barriers to optimal care once diagnosed.

## 6.9.3 Alignment to strategic objectives

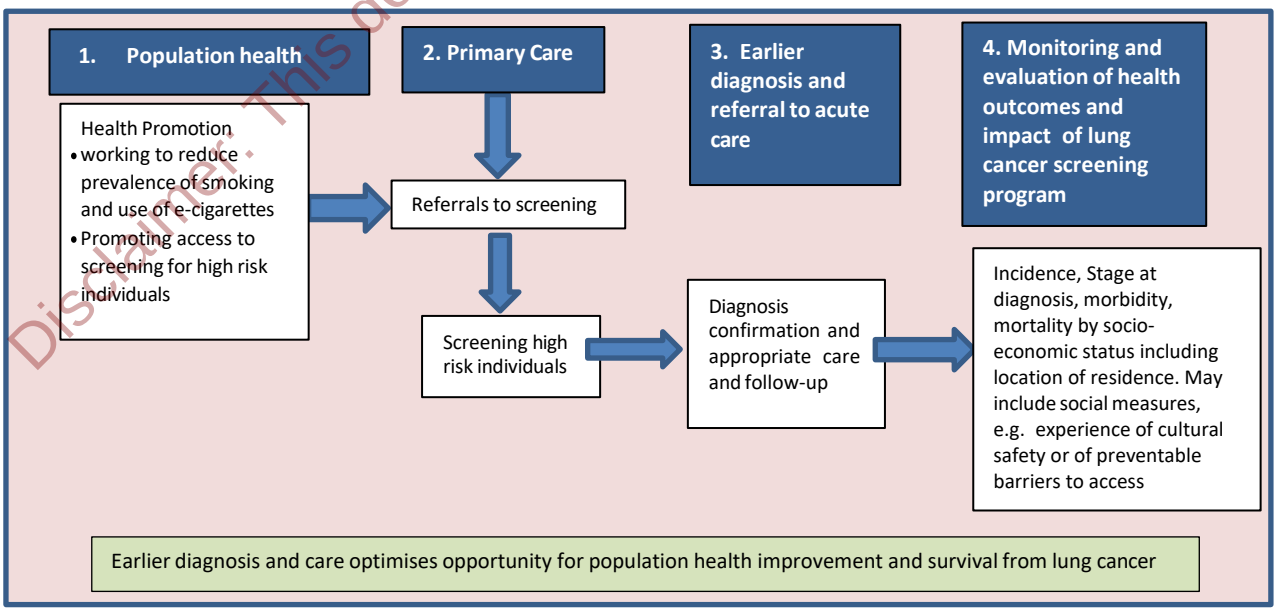
Integrated care with optimised clinical outcomes is a strategic imperative for all levels of the health care system. Value-based care is a key State health policy and cardiovascular health and care has been a priority. The best value care is preventing the need for care in the first instance. Screening for high-risk individuals to effect earlier diagnosis gives an individual an opportunity for a better outcome and potentially avoids high acuity care by treating disease before it becomes systemic.

## 6.9.4 Program model

Screening high risk populations in order to deliver earlier diagnosis is not useful unless there are usable pathways to receiving appropriate care in ways and locations acceptable to the person identified on screening. For this reason, the Grampians Integrated Cancer Service aims to, with partners, implement a program of work in the first instance to optimise the regional lung cancer care pathway, so that when screening begins identified individuals can get timely access to the diagnostics and care they need. In this way the program will have two components:

- Public health and primary care initiatives to identify individuals eligible for screening when screening commences
- Ensuring inclusive, feasible and acceptable pathways to optimal care for individuals requiring care.

*Figure A6.9_2 Promoting referrals to lung cancer screening improves opportunity for early diagnosis and care: schematic model*



Grampians Integrated Cancer Services in 2023-24 is undertaking work to first optimise the care pathway for lung cancer across the Grampians region in order to be ready to receive and manage individuals identified with early lung cancer once screening commences in 2025. Key partners in this work are the Western Victoria Primary Health Network (WVPHN), Grampians Health, Grampians Public Health Unit (GPHU), Goolum Goolum, Budja Budja and Ballarat and District Aboriginal Co-operatives; Victorian Agency for Health Information (VAHI); GH Community Advisory Committee (CAC); Clinicians. Potential outcome measures for this program of work are set out in *Table A6.9_1.*

*Table A6.9_1 E2E Regionalising early diagnosis and lung cancer care in the Grampians region: evaluation measures*

| Component | Measures |
|---|---|
| **Governance** | • Detailed cost benefit analysis |
| **Population health** | • Burden of disease – QALY and population impact |
| **Detection of early disease** | • Stage of cancer at diagnosis |
| **Management of high-risk disease** | • Adherence to lung cancer management guidelines<br>• Improved patient quality of life |
| **Improvement of lung cancer outcomes** | • Improved patient quality of life<br>• Improvement in survival and cancer free years |
| **Experience of care measures** | • Cultural safety<br>• Barriers to or enablers of access to care<br>• Others as nominated by consumers |


Disclaimer: This document is currently under review for 2025

# Appendix 7

## Tools and resources for program implementation

# Appendix 7.1 LETTERS template for program planning, implementation and sustainability[1]

| Name of program or project: | Team leader/ Contact person: | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *(Add or delete rows as required)* Week or month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| **Leadership and governance** | | | | | | | | | | | | | | | | | | |
| • Confirm Authority for program and its sustainability | | | | | | | | | | | | | | | | | | |
| • Identify leadership team including community stakeholder members | | | | | | | | | | | | | | | | | | |
| • Identify who will have responsibility for program sustainability into the future | | | | | | | | | | | | | | | | | | |
| • Establish accountability and governance structure (+/- Terms of Reference) | | | | | | | | | | | | | | | | | | |
| • Draft program aims including sustainability of program | | | | | | | | | | | | | | | | | | |
| • Scope equity and mental health considerations, including through gender impact assessment | | | | | | | | | | | | | | | | | | |
| • Ensure inclusion of Aboriginal and Torres Strait Islander Peoples voice | | | | | | | | | | | | | | | | | | |
| • Identify core or guiding policies and procedures | | | | | | | | | | | | | | | | | | |
| • Evaluate key risks, develop risk management plan and undertake regular review | | | | | | | | | | | | | | | | | | |
| • Regular iterative review of emerging process, impact and outcome evidence | | | | | | | | | | | | | | | | | | |
| • On-going review of aims and strategies | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Engaging with people, processes and evidence** | | | | | | | | | | | | | | | | | | |
| • Identify the Position to have responsibility for engagement sustainability into the future | | | | | | | | | | | | | | | | | | |
| • Identify stakeholders | | | | | | | | | | | | | | | | | | |
| • Identify and review evidence to inform strategy | | | | | | | | | | | | | | | | | | |
| • Seek consumer and stakeholder input into strategy planning and sustainability | | | | | | | | | | | | | | | | | | |
| • Undertake gap analysis re current situation and goal outcome | | | | | | | | | | | | | | | | | | |
| • Map known processes (diagnostics) regarding alignment around strategy aims | | | | | | | | | | | | | | | | | | |
| • Evaluate relevant existing processes | | | | | | | | | | | | | | | | | | |
| • Identify process changes required | | | | | | | | | | | | | | | | | | |
| • Identify barriers and enablers to success and sustainability (local and from literature) | | | | | | | | | | | | | | | | | | |
| • Identify strategies to overcome barriers and strengthen enablers | | | | | | | | | | | | | | | | | | |
| • Identify processes for sustaining engagement and use of new evidence | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Training and education** | | | | | | | | | | | | | | | | | | |
| • Identify the Position to have responsibility for training and education sustainability into the future | | | | | | | | | | | | | | | | | | |
| • Identify training needs | | | | | | | | | | | | | | | | | | |
| • Develop training plan for sustainable training using variety of strategies and platforms | | | | | | | | | | | | | | | | | | |
| • Implement training plan | | | | | | | | | | | | | | | | | | |

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| • Plan and evaluate training | | | | | | | | | | | | | | | | | | |
| • Adjust and expand training strategies as needed from establishment to embedded program | | | | | | | | | | | | | | | | | | |
| • Plan mechanisms for sustainable evaluation and modification of training | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Tools and resources** | | | | | | | | | | | | | | | | | | |
| • Identify the Position to have responsibility for tools and resource sustainability into the future | | | | | | | | | | | | | | | | | | |
| • Identify existing tools, evaluate their usefulness for the program | | | | | | | | | | | | | | | | | | |
| • Develop additional tools as necessary | | | | | | | | | | | | | | | | | | |
| • Ensure access to tools beyond implementation phase by establishing web-based portal if possible | | | | | | | | | | | | | | | | | | |
| • Identify sustainable process for updating or adding new tools as available | | | | | | | | | | | | | | | | | | |
| • Identify process for on-going periodic review of tools and guides | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Evaluation and audit** | | | | | | | | | | | | | | | | | | |
| • Identify the Position to be responsible for evaluation and audit sustainability into the future | | | | | | | | | | | | | | | | | | |
| • Scope and identify auditable process elements of program | | | | | | | | | | | | | | | | | | |
| • Develop process, impact and outcome measures that reflect program aims | | | | | | | | | | | | | | | | | | |
| • Include Key Performance Indicators that will remain relevant to program into the future | | | | | | | | | | | | | | | | | | |
| • Identify where data are or can be collected in routine processes to inform sustainable auditing | | | | | | | | | | | | | | | | | | |
| • Develop evaluation and audit plan which uses opportunistic data where possible | | | | | | | | | | | | | | | | | | |
| • Assess evaluation plan with RE-AIM to ensure data collected can answer RE-AIM questions | | | | | | | | | | | | | | | | | | |
| • Implement evaluation plan | | | | | | | | | | | | | | | | | | |
| • Adjust program informed by evidence | | | | | | | | | | | | | | | | | | |
| • Apply RE-AIM Framework to inform scale and sustainability decision | | | | | | | | | | | | | | | | | | |
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| **Reporting and communication** | | | | | | | | | | | | | | | | | | |
| • Identify the Position to be responsible for reporting sustainability into the future | | | | | | | | | | | | | | | | | | |
| • Identify reporting requirements across implementation and beyond implementation phase | | | | | | | | | | | | | | | | | | |
| • Develop communication strategy to include each stakeholder group | | | | | | | | | | | | | | | | | | |
| • Implement communication plan across platforms | | | | | | | | | | | | | | | | | | |
| • Provide reports and updates to leadership team or sponsoring Committee and stakeholders | | | | | | | | | | | | | | | | | | |
| • Identify sustainable reporting mechanisms for program beyond implementation phase | | | | | | | | | | | | | | | | | | |
| • Undertake wider dissemination of program outcomes | | | | | | | | | | | | | | | | | | |
| • Tell stories of diffusion and celebrate successes | | | | | | | | | | | | | | | | | | |
| • Present and publish about lessons learnt | | | | | | | | | | | | | | | | | | |
| • Permit and promote opportunities for wide dissemination | | | | | | | | | | | | | | | | | | |
| • Make plans, tools and resources available to others | | | | | | | | | | | | | | | | | | |

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| • Ensure stories of success and the new norm become part of orientation for newcomers | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| **Sustainability** | | | | | | | | | | | | | | | | | | |
| • Consider planetary sustainability in planning and implementation | | | | | | | | | | | | | | | | | | |
| • Plan sustainability strategy for training, measuring, audit, improvement, sustaining the gains | | | | | | | | | | | | | | | | | | |
| • Ensure the Position identified as responsible for program sustainability has capacity to take carriage | | | | | | | | | | | | | | | | | | |
| • Seek agreement of stakeholders in sustainability plan | | | | | | | | | | | | | | | | | | |
| • Work towards ensuring all aspects are self-sustaining | | | | | | | | | | | | | | | | | | |
| • Develop measures and key performance indicators of sustainability | | | | | | | | | | | | | | | | | | |
| • Track second and third generation diffusion | | | | | | | | | | | | | | | | | | |
| • Do regular tests of sustainability | | | | | | | | | | | | | | | | | | |
| • Incorporate KPI measures beyond program implementation into usual organizational reporting | | | | | | | | | | | | | | | | | | |

1 First developed by and reported in Aldrich R, Ford J 2012 *ISBAR in our Communication* Final Report Hunter New England Local Health District.
For more information please contact Professor Rosemary Aldrich, Grampians Public Health Unit, Victoria. *Email*: rosemary.aldrich@gh.org.au

Appendix 7.1.1 Example use of the LETTERS template

| **Program:** *Tackling climate change and its impact on health in our region*<br>Plan for 2023-2024: developing the GRPHP ***Climate Action Framework*** | *Contact person:* Rosemary Aldrich rosemary.aldrich@gh.org.au 0428176633 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 7/23 | 8/23 | 9/23 | 10/23 | 11/23 | 12/23 | 1/24 | 2/24 | 3/24 | 4/24 | 5/24 | 6/24 |
| **Leadership and governance** | | | | | | | | | | | | |
| • Confirm Authority for program and its sustainability | | | | | | | | | | | | |
| • Identify leadership team including community stakeholder members | | | | | | | | | | | | |
| • Identify who will have responsibility for program sustainability into the future | | | | | | | | | | | | |
| • Establish accountability and governance structure (+/- Terms of Reference) | | | | | | | | | | | | |
| • Draft program aims including sustainability of program | | | | | | | | | | | | |
| • Scope equity and mental health considerations, including through gender impact assessment | | | | | | | | | | | | |
| • Ensure inclusion of Aboriginal and Torres Strait Islander Peoples voice | | | | | | | | | | | | |
| • Identify core or guiding policies and procedures | | | | | | | | | | | | |
| • Evaluate key risks, develop risk management plan and undertake regular review | | | | | | | | | | | | |
| • Regular iterative review of emerging process, impact and outcome evidence | | | | | | | | | | | | |
| • On-going review of aims and strategies | | | | | | | | | | | | |
| **Engaging with people, processes and evidence** | | | | | | | | | | | | |
| • Identify the Position to have responsibility for engagement sustainability into the future | | | | | | | | | | | | |
| • Identify stakeholders | | | | | | | | | | | | |
| • Identify and review evidence to inform strategy | | | | | | | | | | | | |
| • Seek consumer and stakeholder input into strategy planning and sustainability | | | | | | | | | | | | |
| • Undertake gap analysis re current situation and goal outcome | | | | | | | | | | | | |
| • Map known processes (diagnostics) regarding alignment around strategy aims | | | | | | | | | | | | |
| • Evaluate relevant existing processes | | | | | | | | | | | | |
| • Identify process changes required | | | | | | | | | | | | |
| • Identify barriers and enablers to success and sustainability (local and from literature) | | | | | | | | | | | | |
| • Identify strategies to overcome barriers and strengthen enablers | | | | | | | | | | | | |
| • Identify processes for sustaining engagement and use of new evidence | | | | | | | | | | | | |
| **Training and education** | | | | | | | | | | | | |
| • Identify the Position to have responsibility for training and education sustainability into the future | | | | | | | | | | | | |
| • Identify training needs | | | | | | | | | | | | |
| • Develop training plan for sustainable training using variety of strategies and platforms | | | | | | | | | | | | |
| • Test and implement training plan | | | | | | | | | | | | |
| • Plan and evaluate training | | | | | | | | | | | | |
| • Adjust and expand training strategies as needed from establishment to embedded program | | | | | | | | | | | | |
| • Plan mechanisms for sustainable evaluation and modification of training | | | | | | | | | | | | |
| **Tools and resources** | | | | | | | | | | | | |
| • Identify the Position to have responsibility for tools and resource sustainability into the future | | | | | | | | | | | | |
| • Identify existing tools, evaluate their usefulness for the program | | | | | | | | | | | | |
| • Develop additional tools as necessary | | | | | | | | | | | | |

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| • Ensure access to tools beyond implementation phase by establishing web-based portal if possible | | | | | | | | | | | | | |
| • Identify sustainable process for updating or adding new tools as available | | | | | | | | | | | | | |
| • Identify process for on-going periodic review of tools and guides | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| **Evaluation and audit** | | | | | | | | | | | | | |
| • Identify the Position to be responsible for evaluation and audit sustainability into the future | | | | | | | | | | | | | |
| • Use RE-AIM to identify evaluation requirements of program | | | | | | | | | | | | | |
| • Develop process, impact and outcome measures to be able to answer RE-AIM questions | | | | | | | | | | | | | |
| • Include Key Performance Indicators that will remain relevant to program into the future | | | | | | | | | | | | | |
| • Identify where data are or can be collected in routine processes to inform sustainable auditing | | | | | | | | | | | | | |
| • Develop evaluation and audit plan which uses opportunistic data where possible | | | | | | | | | | | | | |
| • Implement evaluation plan | | | | | | | | | | | | | |
| • Ask RE-AIM questions at agreed intervals | | | | | | | | | | | | | |
| • Adjust program informed by evidence and RE-AIM answers | | | | | | | | | | | | | |
| • Apply RE-AIM framework to inform scale and sustainability decisions | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| **Reporting and communication** | | | | | | | | | | | | | |
| • Identify the Position to be responsible for reporting sustainability into the future | | | | | | | | | | | | | |
| • Identify reporting requirements across implementation and beyond implementation phase | | | | | | | | | | | | | |
| • Develop communication strategy to include each stakeholder group | | | | | | | | | | | | | |
| • Implement communication plan across platforms | | | | | | | | | | | | | |
| • Provide reports and updates to leadership team or sponsoring Committee and stakeholders | | | | | | | | | | | | | |
| • Identify sustainable reporting mechanisms for program beyond implementation phase | | | | | | | | | | | | | |
| • Undertake wider dissemination of program outcomes | | | | | | | | | | | | | |
| • Tell stories of diffusion and celebrate successes | | | | | | | | | | | | | |
| • Present and publish about lessons learnt | | | | | | | | | | | | | |
| • Permit and promote opportunities for wide dissemination | | | | | | | | | | | | | |
| • Make plans, tools and resources available to others | | | | | | | | | | | | | |
| • Ensure stories of success and the new norm become part of orientation for newcomers | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| **Sustainability** | | | | | | | | | | | | | |
| • Consider planetary sustainability in planning and implementation | | | | | | | | | | | | | |
| • Plan sustainability strategy for training, measuring, audit, improvement, sustaining the gains | | | | | | | | | | | | | |
| • Ensure the Position responsible for program sustainability has capacity to take carriage | | | | | | | | | | | | | |
| • Seek agreement of stakeholders in sustainability plan | | | | | | | | | | | | | |
| • Work towards ensuring all aspects are self-sustaining | | | | | | | | | | | | | |
| • Develop measures and key performance indicators of sustainability | | | | | | | | | | | | | |
| • Track second and third generation diffusion | | | | | | | | | | | | | |
| • Do regular tests of sustainability | | | | | | | | | | | | | |
| • Incorporate KPI measures beyond program implementation into usual organizational reporting | | | | | | | | | | | | | |

# Appendix 7.2 Impact assessment

## Appendix 7.2.1 Equity-focused health impact assessment

In 2005 the Australasian Collaboration for Equity Impact Assessment (ACHEIA) reported the development and use of its **equity-focused health impact assessment** framework (EFHIA) (Mahoney et al 2004, Aldrich et al 2005). An early tool for applying an equity "lens" (Pauly et al 2016), the EFHIA framework set out six steps to assess any policy, planning or service decision for its potential to generate unintended consequences, specifically in relation to increasing the health inequality gap. The EFHIA tool can be used retrospectively or prospectively, identifying opportunity for altering the policy, plan or service to reduce the risk of making health inequalities worse. Its six steps are:

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| **Scoping**<br><br>Determining the suitability of the policy or practice for an EFHIA and the feasibility of undertaking it. | This step includes consideration of<br>• the nature of policy, planning or service decision multiplied by the potential for population impact,<br>• a preliminary assessment to determine the possible populations affected and the potential equity dimensions<br>• identification of appropriate stakeholders |
| **Screening**<br><br>Setting the scope of the EFHIA, including | • establishing terms of reference (including First Nations aspects)<br>• clarifying dimensions of equity (access, resources, outcomes)<br>• agreeing definitions such as search terms, and elements of socio-economic position or socioeconomic status<br>• brainstorming for likely or possible impacts of the policy<br>• identifying outcome measures and consideration of how these could be used for monitoring, and<br>• planning for the EFHIA e.g. timing, management, reporting and accountability aspects. |
| **Impact identification**<br><br>Detailed analysis of policy or practice to include: | • Identification of policy context<br>• Identification of target population(s)<br>• Data collection on relevant population groups or subpopulations (included and excluded)<br>• Identification of policy or practice variable(s) of interest<br>• Search literature for evidence of relationship between populations group, socioeconomic position and variable of interest<br>• Consult with stakeholders, target population, key informants on the relationship between the variable of interest, the potential or actual impacts, differential impacts and population group(s) |
| **Impact assessment** | Weighting and synthesis of evidence and consideration of equity impacts in this setting at this time (such as the nature of impact versus the likelihood of impacts occurring). Produce a statement of potential impacts on policy on equity. |

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| **Recommendations** | Recommend changes based on the identified likely equity impacts and links to health. |
| **Monitoring and evaluation** | Strategies for monitoring uptake and impact of EFHIA recommendations and systems for evaluating outcomes and EFHIA. |

*Source: Mahoney et al 2004, p9*

EFHIA can be undertaken to whatever depth of inquiry the decision requires and resources permit, and has been used in relation to local (Rashid et al 2021), jurisdictional (Harris-Roxas et al 2014, Cohen et al 2016) or global (WHO, 2015) programs and policy.

In essence an EFHIA asks:

- Are the benefits of the policy, program or service likely to be unequally distributed along socioeconomic, sociodemographic or sociocultural lines? Who benefits and who does not?
- Does the program as designed or implemented contain sociodemographic, socioeconomic or sociocultural barriers to access/ outcome/ opportunity to benefit for some?
- How can these structural barriers by mitigated or compensated for to ensure we do not widen the health inequalities gap in outcome or benefit?
- After making changes to the program and/ or its implementation, how will we know that there has been no widening of the health inequalities gap? What will we measure to be sure?

## Appendix 7.2.2 Gender impact assessment

A gender impact assessment (GIA) is a critical tool for ensuring that policies, programs, and services prioritise the diverse needs and experiences of women, men and gender diverse people. It not only helps in addressing gender inequality but also in highlighting intersectional factors such as Aboriginality, age, disability, ethnicity, gender identity, race, religion or sexual orientation. These factors may create overlapping forms of discrimination and marginalisation, leading to amplified barriers to services, heightened risk of social isolation, and exacerbated social and economic disadvantage, including housing insecurity (The Equality Institute, 2022).

The Grampians Region Population Health Plan acknowledges the significance of GIA in identifying and mitigating any potential impacts of gender inequality on health outcomes. This process is mandated by the *Gender Equality Act 2020 Victoria* (the Act), which requires defined entities[i] to conduct GIA when developing or reviewing policies, programs, or services with a significant impact on the public.

Embracing GIA in our health planning and decision-making processes brings several notable benefits including improved policy making & service delivery, achieving gender equality and a better use of resources. We commit to incorporating gender impact assessments throughout our planned work as part of the Grampians Region Population Health Plan 2023 – 2029, ensuring that our programs place inclusivity and equity at the core.

Gender impact assessments conducted under the Act must involve the following key components (The Equality Institute, 2022):

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| **Assessment** | How will the policy, program or service affect people of different genders? |
| **Explanation** | How will you design or change the policy, program or service to better meet the needs of people of different genders?<br><br>How will it address gender inequality and promote gender equality? |
| **Apply an intersectional approach** | Consider how the end user's experience of gender inequality may be shaped by other aspects of their identity including: Aboriginality; age; disability; ethnicity; gender identity; race; religion; sexual orientation. |

In order to incorporate GIA into our decision-making processes, each intervention will be assessed against the following criteria outlined in the GIA Toolkit (The Equality Institute, 2022):

*Figure A7.2 Overview of the four steps for conducting a gender impact assessment (The Equality Institute 2022).*


By systematically incorporating these steps into our planning processes, we can ensure that our health policies and programs are gender-sensitive and contribute to the overall well-being and equity of our diverse population.



[i] Meaning of defined entity (1) For the purposes of this Act, an entity is a defined entity on a particular day if it is, on the most recent 30 June before that day— (a) a public service body; or (b) a public entity; or (c) a special body; or (d) a Council; or (e) Court Services Victoria; or (f) a university within the meaning of the Education and Training Reform Act 2006; or (g) the Office of Public Prosecutions; or (h) a prescribed entity— that has 50 or more employees.

# Appendix 7.3 Using improvement methodology to improve health

Improvement in health outcomes is dependent upon improving the systems that exist to provide healthcare. With origins in the manufacturing industry, improvement methodology describes the systematic use of a range of tools and techniques to improve patient care and associated healthcare processes continuously.

Improvement methodology fits within systems change in terms of identifying leverage points and change strategies, and evaluating processes and interventions, and can be applied to the public health setting in targeting social determinants of health. It is important to apply an equity lens to all quality improvement to consider how diverse experiences and perspectives are included.

There are various frameworks to guide improvement work. One of the most widely adopted is the Model for Improvement, developed by the Associates in Process Improvement (Langley et al., 2009).

The Model for Improvement is based on three fundamental questions:

- What are we trying to accomplish?
- How will we know that change is an improvement?
- What changes can we make that will result in an improvement?

These three questions are combined with the Plan-Do-Study-Act (PDSA) cycle as the engine for developing, testing and implementing change in a system.

*Table A7.3_1* outlines key elements within the Model for Improvement, and associated tools and techniques. Further information and resources can be accessed from the Institute of Healthcare Improvement (IHI) website www.ihi.org

*Table A7.3_1 Key elements of the Model for Improvement and associated tools and techniques*

| Component of the Model for Improvement | Key Elements | Tools / Techniques |
|---|---|---|
| **What are we trying to accomplish?** | • Setting aims<br>• Establishing an aim statement | • SMART goals |
| **How will we know that change is an improvement?** | • Establishing measures: outcome, process and balancing<br>• Developing a measurement strategy | • Measurement strategy<br>• Data collection plan<br>• Run charts |
| **What changes can we make that will result in an improvement?** | • Developing change ideas<br>• Developing a theory of change | • Process mapping<br>• Fishbone diagrams<br>• 5 Whys<br>• Logical thinking<br>• Benchmarking<br>• Creative thinking<br>• Driver Diagram<br>• Prioritisation matrix |
| **Plan-Do-Study-Act Cycle** | • Testing change ideas | • PDSA planning forms |

# Appendix 7.4 Using system science to drive system change

In our daily lives numerous factors, processes and conditions exert swirls of influence on and around us in often unseen ways. These influences are part of a dynamic process which push and pull and shape and bend interactions, opportunities, and possibilities for change. These processes work with others to create a "system" - a complex arrangements of parts working towards a purpose (apparent or not).

Understanding what a system is, how systems function and how to change systems has long been the subject of scholarly inquiry (Knight and Baldwin, 2022). A system – such as the health and societal system which prevails in the Grampians region and drives the determinants of health outcomes for the people of the Grampians– has been defined as "a set of interconnected elements that is coherently organised in a way that achieves something" (Meadows, 2008). For the people of the Grampians region the current health and social system is driving increasingly unequal health outcomes. Because it is dynamic a system evolves as new drivers emerge or drivers change in their capacity to influence the system's character and outputs (Carey & Crammond, 2015; Birney, 2021). In theory therefore *understanding* the system permits identification of opportunities to change drivers and therefore create positive change (Birney, 2021).

Envisioning a health outcome future for the people of the Grampians region different from that suggested by current trends requires bold imagination and a belief that it is possible to change the system which has created the current trends. Systems *theory* provides a logic to deliver system change; *models* of system change can guide this process.

### *1) Applying a model of system change*

Many models of system change have features in common including the map the system, need to identify stakeholders, identify leverage points and change strategies, and iteratively evaluate process and interventions using a range of tools and methods (Knight & Baldwin, 2022).

For prevention and population health, and for the health sector more widely, two models explain principles and processes by which we may work to improve our population's health. The *Prevention Systems Change framework* (PSCF) (Pescud, et al., 2021) is helpful for two reasons. First it aims to generate change while ensuring change enacted does not lead to negative consequences; unintentionally reducing access to prevention approaches and programs which improve their health outcomes now would be catastrophic to the vulnerable in the Grampians region. Second, this model has social justice as an underpinning value which strongly aligns with a goal to optimise equity of outcomes in relation to prevention and population health programs. PSCF principles or "rules" to ensure keeping an equity focus on program design include seeking diverse perspectives, creating shared commitment to change, system mapping, implementing change and adapting quickly in response to on-going evaluation measures. *Systemic design* (Jones, 2014) adds to the PSCF principles by identifying a preferred future and strategising how to get there, and by including leadership reflexivity to understand and question normative patterns and drivers of why a system works as it does; this has great application in the Grampians region given its complex health and social care system workings have evolved slowly over decades, incrementally, and somewhat unchallenged with resulting inequity accepted as normal and inevitable.

A resulting hybrid model can be followed to enact the system change steps where stakeholders initially self-identify as stakeholders to map a system around an outcome or issue, resulting in identifying further stakeholders; seeking to have the wider stakeholder group identify a system goal and / or plausible potential outcomes for the system; mapping the system to identify driving forces of that goal and identifying leverage points or opportunities to change the drivers; working with stakeholders to reflect on why the systems works as it does, develop strategies for action at potent leverage points and chart a course for the future; implement those strategies, and evaluate the effectiveness of interventions. While system mapping can concern the factors influencing why an issue is the way it is, system mapping can also seek to understand the drivers influencing the achievement of a certain goal (which is pertinent to prevention and population health program planning), as described following.

***2) Identifying stakeholders***

System stakeholders comprise the "individuals, groups, organisations and institutions that influence and coordinate the actions of [a] system" (Knight & Baldwin, 2022). Given their contribution to the way a system works, any ambition to influence a system dynamic must engage its stakeholders.
Identifying stakeholders in an iterative process, and cannot be separated from mapping the system itself. System mapping provides a sound foundation by which to identity further stakeholders; by definition any driver individual or group identified in system map is a stakeholder.

A stakeholder with requisite knowledge and skills (capacity to build coalitions for change, to understand the system, to lead organisational reflexivity and to advocate for change) may be identified to lead the change (Drier, et al., 2019). Stakeholder characteristics such as the power they may have in the system, the nature of the connections with others, or the frames about and views of the system they bring, hold or perpetuate in the system (Vallis & Inayatullah, 2016) may determine a stakeholder's potential to influence the potency of opportunities for change in the system (Knight & Baldwin 2022). Stakeholders seeking to change a system need to identify the goal of system change before a process of change commence.

***3) Mapping the system goal***

Once stakeholders have identified a system goal, the work of system change commences by mapping the interactions and relationships between and toward drivers of a system goal. By placing the system goal at the centre of the system, stakeholders can then explore the factors which prevail upon the issue or goal, to make it better or worse, to achieve it or not.

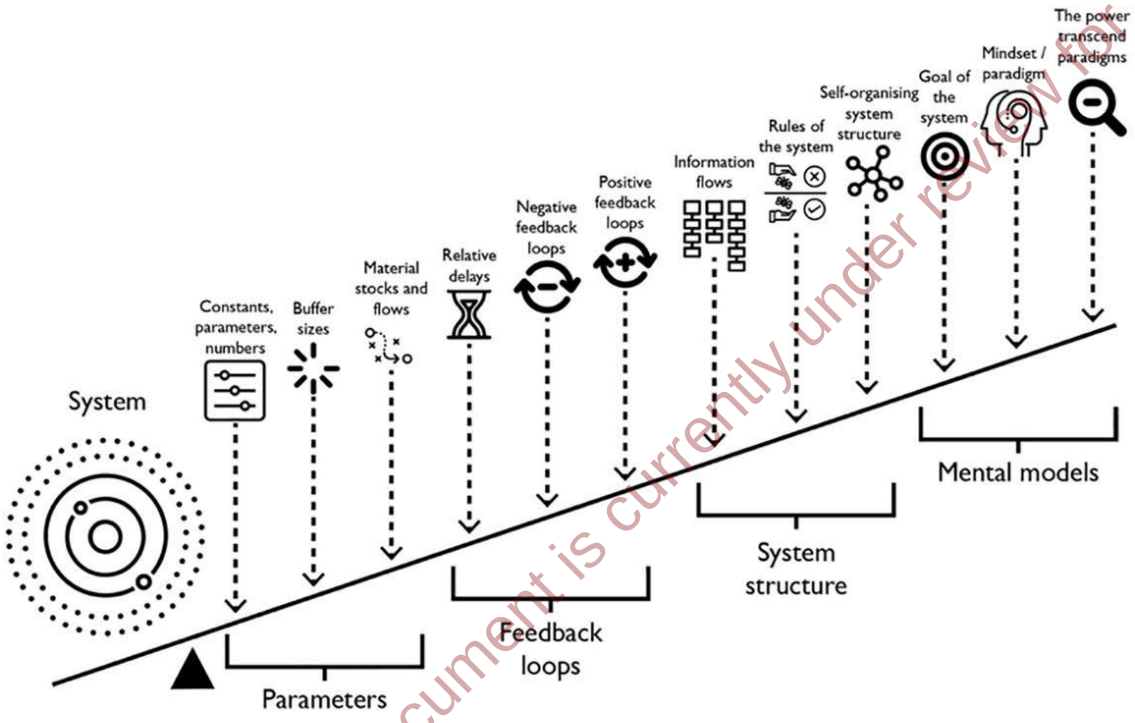
Some factors will drive the goal directly, an absence or deficit in these drivers will limit the achievement of the system goal. The system map needs to therefore fully identify the drivers of those direct drivers, and their drivers and interactions, positively and negatively, with other drivers, and so on, so that the complexity of what it takes to the achieve the system goal is understood.

The PESTEL framework prompts thinking about political, economic, social, technological, environmental and legal factors (Issa., et al, 2014) contributing to the drivers of the system issue or goal.

### *4) Changing a system*

There is a broad literature on system change. Influential theorists Meadows (1999) and Birney (2021) characterise opportunities for intervention to produce system change as leverage points or points of potential respectively. Meadows (1999) argues that acting to shift societal paradigms and discourses offers most potency for change by re-framing what is possible for society and therefore for the system operating in that society; responding to "numbers" is least potent (*Figure A7.4_1*). Being bold in ambition is a key powerful first step to imagining a stronger healthier future for the people in our region. Changing the conversation about what is possible is a key first step.

*Figure A7.4_1 Meadows, D. H. (1999). Leverage points: Places to intervene in a system.*

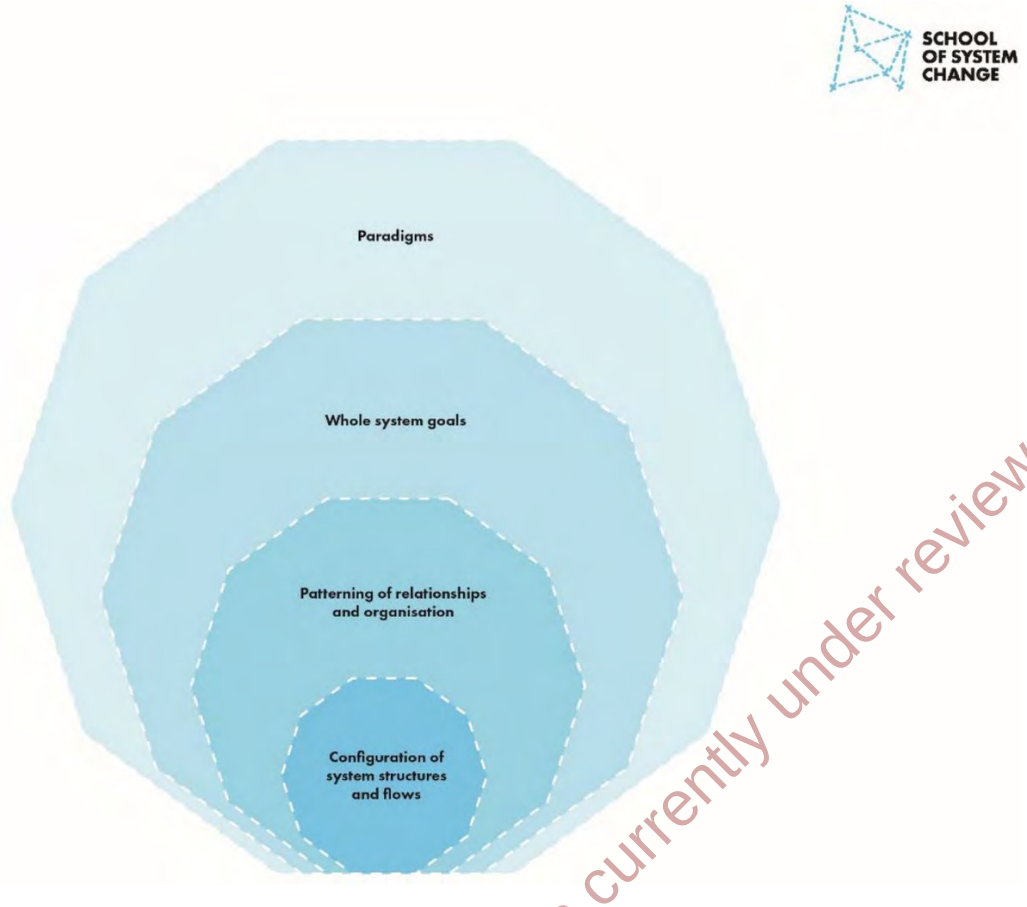



.

*Graphic sourced from:* Angheloiu, C., & Tennant, M. (2020). Urban futures: Systemic or system changing interventions? A literature review using Meadows' leverage points as analytical framework. *Cities*, *104*, 102808.

Aligned with Meadows' 12 leverage points but clustered into four levels, Birney (2021) describes points of potential as a nested pattern, with intervening at structures and process level having local impact but less potential to change the whole system, nested inside organisational patterns of functioning, nested within whole system goals, nested within paradigm shift (*Figure A7.4_2*).

*Figure A7.4_2 Birney, 2021. Nested patterns of systems – that indicate levels of potential in changing systems*






### *5) Measuring change*

System change is possible, and system change is necessary for population health outcomes, the collective result of a web of dynamic and diverse complex system interactions (entrenched or worsening in the Grampians region), to shift in positively.

System change will take the aligned efforts of many stakeholders, and it is critical that impact and outcome evaluation capture change (or not). However, effort without evaluation is like writing in invisible ink (Aldrich, 2022). Evaluating system change is equally complex. Potential methods for evaluating interventions to change a system are set out in *Table A.7.4_1.*

*Table A.7.4_1 Potential methods and measures for outcome-focused system change over time (using equity of access to healthcare as an example of system change goal)*

| **Methods** | **Process measures** Is the system change intervention operating as planned? | **Impact measures** Are the interventions having an impact on antecedent drivers? | **Outcome measures** Has the outcome of interest been achieved? |
|---|---|---|---|
| **Quantitative** | • Structures established, working and effective yes/no<br>• Number stakeholders engaged<br>• Number forums held/ attendance<br>• Processes for capturing data in place<br>• # Staff trained in equity-focused impact assessment<br>• Equity consideration embedded in processes for service design and innovation decisions<br>• Capacity available to undertake quantitative and qualitative evaluation | • Occasions of consumer participation in governance and decision-making structures<br>• % Services designed with equity-focused impact assessment (Simpson, et al., 2005)<br>• + Pre and post implementation service data collection and analysis | • Numbers of people accessing care x place of residence, age, gender, socioeconomic quintile<br>• Waiting list persons x socioeconomic status; time on waiting list by socioeconomic status<br>• % Left emergency department without being seen<br>• Stage of cancer presentation x socioeconomic status<br>• Reduction in number of adverse events due to delayed care |
| **Qualitative** | Diverse qualitative methods are used for system evaluation:<br>• Survey, focus groups, feedback<br>• Discourse analysis (Fairclough, 1995)<br>• Reflexivity analysis and monitoring (Rijswijk, et al., 2015)<br>• Stakeholder stories<br><br>Processes are occurring:<br>• System mapping + stakeholder experience with identifying leverage points<br>• Meaningful stakeholder engagement (Aguilar-Gaxiola, et al., 2022)<br>• Nature of barriers to accessing care<br><br>Baseline data:<br>• Level of cultural safety assessed<br>• Leadership/ workforce values and beliefs about the care equity gap | Discourse analysis of organisational environment: goals, policies, reports<br>• Change in quality of relationships between stakeholders<br>• Quality and impact of equity-focused decision discussions – team interviews<br>• Cultural Safety assessment using validated methods (Elvidge, et al. 2020)<br>• Experience with access and consequences<br>• First Nations peoples' perception and experience of cultural safety and likelihood to seek care<br>• Examining the role of intermediaries[1] in change | • Stakeholder stories / experience regarding inclusiveness and access<br>• Health care provider/ staff experience in managing care demands<br>• Feedback to GH about quality and access to care |

[1] Intermediaries are "organisations that support, influence and complement the efforts of 'social innovators' (such as service delivery groups, grassroots activists, social enterprises, post-secondary institutions and policy makers) already working to" effect a goal. (Knight & Baldwin, 2022, p26)

Source: Aldrich, 2022

# Appendix 7.5 The STICKE program for systems mapping

## STICKE: Systems Thinking In Community Knowledge Exchange

**Victorian communities are seeking answers to a number of complex problems, particularly in the area of population health and wellbeing.**

**Complex** or **'wicked' problems** are influenced by many interacting factors and can therefore be difficult to address in a simplistic manner. These problems:

- are difficult to clearly define
- have many causes and interdependencies
- are often evolving – a 'moving target'
- have no clear solution
- are socially complex.

Solutions to complex problems are usually beyond the capacity of a single organisation or sector to address and require a holistic and coordinated approach[1].

"We are really trying to get away from the idea that complex problems can be solved with linear thinking."

**STICKE researcher**

Obesity, for example, is considered a "complex, multifactorial disease, with genetic, behavioural, socioeconomic and environmental origins"[2]. Acknowledging and navigating with this sort of complexity through multiple strategies at multiple levels, delivered through locally-based initiatives, may represent the most promising approach to prevention[3].

**Systems thinking** is a way of understanding complex problems and the interactions between the factors that perpetuate them. Systems thinking can be used collaboratively with communities to design interventions to improve complex problems[4]. Other sectors have used this type of approach before, but its potential in health and community-led prevention of disease is yet to be fully realised.

**Complex problems are influenced by many interacting variables: multiple strategies at multiple levels, delivered as community-based interventions, may represent the most promising approach.**

### KEY POINTS

STICKE is an easy to use, cloud-based software platform that supports a 'systems thinking' approach to tackling complex problems. It can be used by individuals looking to explore wicked problems, or by facilitators looking to bring together multiple perspectives from a large number of people. The software guides users through the creation of a system 'map' that can then be used to help explore the problem and potential intervention points.

STICKE can support communities in mapping a complex problem and its drivers at all levels of policy and decision-making authority and identify appropriate and feasible locally-led responses.

STICKE has been developed in collaboration with Victorian communities through research undertaken by Deakin University, and continues to be used in an increasing number of health promotion and other settings.

If you are interested in learning more about STICKE and how you can access the platform, contact sticke@deakin.edu.au.

STICKE SYSTEMS THINKING IN COMMUNITY KNOWLEDGE EXCHANGE

IISRI INSTITUTE FOR INTELLIGENT SYSTEMS RESEARCH AND INNOVATION

GLOBE GLOBAL OBESITY CENTRE

VicHealth vichealth.vic.gov.au



Source: Excerpt from https://apo.org.au/sites/default/files/resource-files/2019-12/apo-nid275376.pdf
*Reproduced with permission*
For further information https://sticke2.deakin.edu.au/

# Appendix 7.6 Risk Management Framework for the GRPHP

Enacting the GRPHP is an unprecedented undertaking in the Grampians region, and will necessarily involve numerous organisations, agencies, members of our community, and other stakeholders such as media. Identifying and managing the risks presented by the ambitious plan is critical to its leadership and governance. This document describes, for the GRPHP Steering Committee, GPHU and implementation partners, an approach to the development of a Risk Register so that these risks of implementation can be managed, including by articulating risk management principles and proposed categories of risk (*Table A7.6.1*) and a strategy for assessing risk (*Table A7.6.2*).

*Table A7.6.1 Risk management principles and proposed categories*

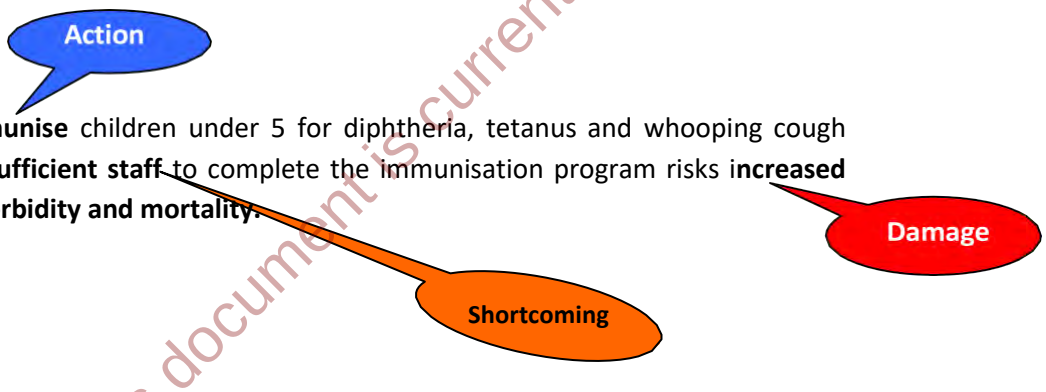
<table>
<tr><th colspan="4">Definitions</th></tr>
<tr><td>Risk</td><td colspan="3">The chance of something happening that will have an effect on objectives.</td></tr>
<tr><td>Risk Statement</td><td colspan="3">POTENTIAL ‘cause and effect’ statement –link between POTENTIAL root cause and POTENTIAL undesirable outcome</td></tr>
<tr><td>Risk Rating</td><td colspan="3">Risk will have been evaluated and prioritised according to Risk Rating Matrix.<br>Likelihood x Consequence = Risk Rating</td></tr>
<tr><td>Consequence</td><td colspan="3">Outcome or impact of an event</td></tr>
<tr><td>Likelihood</td><td colspan="3">Used as a general description of probability or frequency</td></tr>
<tr><td>Control</td><td colspan="3">A…process, policy, device, practice or other action that acts to minimize negative risk. The ‘Hierarchy of Controls’ in priority order of effectiveness:
<table>
<tr><th>Strong</th><th>Intermediate</th><th>Weak</th></tr>
<tr><td>Elimination (stop doing something therefore eliminating the risk associated with)</td><td>Eliminate or reduce distractions</td><td>Double checks</td></tr>
<tr><td>Engineering (do it differently with physical barriers or controls for protection)</td><td>Eliminate look & sound like</td><td>Administration (e.g. policy or procedure)</td></tr>
<tr><td>Substitution (replace hazardous process by non- or less-hazardous process)</td><td>Increase staffing / decrease workload</td><td>Alerts, labels or warnings</td></tr>
<tr><td>Simplify the process &/or remove unnecessary steps</td><td>Checklist or other cognitive aid at point of care</td><td>Training & education</td></tr>
<tr><td>Standardise equipment or process for doing something at point of program delivery</td><td>PPE (goggles, masks, gloves, ear plugs, hats, metal tipped boots etc.)</td><td>Additional advice, analysis, audit, review or study</td></tr>
</table></td></tr>
<tr><td>Risk Treatment</td><td colspan="3">Risk treatment involves identifying the range of options (controls) for treating risk, assessing those options, preparing risk treatment plans and implementing them…Risk treatment plans may involve the re-design of existing controls, the introduction of new controls or monitoring of existing controls. Low impact risks require only periodic monitoring while major risks are likely to require more intense management focus. Risk treatment plans include considerations of resourcing and timing.<br>Response to risk:<ul><li>Reduce the likelihood</li><li>Reduce the consequence/s</li><li>Transfer/share the risk</li><li>Avoid the risk</li><li>Accept the risk</li></ul></td></tr>
</table>

| | |
|---|---|
| **Monitoring / Review** | Organisations must monitor not only the risks, but also the effectiveness of the associated risk treatment plans and the management processes for controlling their implementation. |
| **Assurance** | A process that provides confidence that planned objectives will be achieved within an acceptable degree of residual risk. Achievement of this target would indicate that the risk has been managed to an acceptable degree thus providing assurance to GRPHP Steering Committee. |

| | |
|---|---|
| **Risk Acceptance** | **Some risks may not be able to be engineered or treated to a degree. If this is the case then discussion must be undertaken within the SC regarding 'risk acceptance'. The reasons why a risk may be accepted are:**<br>1. The level of the risk is so low that specific treatment is not appropriate within available resources;<br>2. The risk is such that there is no treatment available;<br>3. All feasible treatments are in place yet the rating remains unchanged; or<br>4. The opportunities presented outweigh the threats to such a degree that the risk is justified.<br>**If risks cannot be avoided or transferred, and if measures have been taken to limit the consequence and prevent the risk from occurring, the residual risk must be accepted.** |
| **Residual Risk** | **Risk remaining after implementation of risk treatment.** |

Conventionally a risk statement contains three elements: an **action (or inaction)**, a **shortcoming** and the **damage** anticipated.

For example:




Conventionally risk statements are rated according to likelihood and consequence (*Table A7.6.2*), and strategies and controls put in place to reduce the likelihood or consequence or both from occurring:

*Table A7.6.2 Risk assessment likelihood and consequence matrix*

| RISK MATRIX | CONSEQUENCE | | | | |
|---|---|---|---|---|---|
| LIKELIHOOD | Catastrophic | Major | Moderate | Minor | Insignificant |
| Frequent (Almost Certain) | 1 - Extreme | 1 - Extreme | 2 - High | 3 - Medium | 3 - Medium |
| Probable (Likely) | 1 - Extreme | 1 - Extreme | 2 - High | 3 - Medium | 3 - Medium |
| Occasional (Possible) | 1 - Extreme | 2 - High | 2 - High | 3 - Medium | 4 - Low |
| Uncommon (Unlikely) | 1 - Extreme | 2 - High | 3 - Medium | 4 - Low | 4 - Low |
| Remote (Rare) | 2 - High | 3 - Medium | 3 - Medium | 4 - Low | 4 - Low |

*"Risk" Type Phrases and Risk Categories*

Risk Categories can assist in identifying, categorising and reporting risks in the implementation of the GRPHP. The following categories may be used to risk- evaluate the GRPHP and its implementation:

*Suggested Risk Categories*

| | |
|---|---|
| **1** | Leadership and governance |
| **2** | Engaging with people and processes |
| **3** | Training and education |
| **4** | Tools and resources |
| **5** | Evaluation and measurement public health outcomes |
| **6** | Reporting and communication |
| **7** | Sustainability of gains |

The following examples could help in developing sound risk descriptions to then aid consideration for management.

1) **Leadership and Management** – Partnerships, governance, strategic direction, legislative compliance, structures
    - Failure to partner genuinely in program implementation …which results in…
    - Non compliance with legislative requirements due to … which results in …
    - Loss of funding due to ….. which results in …..
    - Increased risk of litigation due to ….. which results in …..
    - Inadequate management systems in place to achieve the strategic and operational objectives due to ….. which results in …. which results in …..
    - Inability to establish and monitor contractual arrangements due to ….. which results
    - Preventable adverse event due to….. which results in …..

2) **Engaging with community**
    - Failure to engage widely ….which results in …
    - Consumer annoyance due to expectations not being met which will results in ..
    - Failure to consider equity impacts of public health interventions…. Which results in…
    - Failure to consider sustainability (capacity to maintain gains made)…. Which results in
    - Failure to consider sustainability (program impact on environment)… which results in

- Failure to consider First Nations voices in program planning… which results in….
- Public outrage due to ….. which results in …..
- Loss of public confidence in the work of the GPHU and GRCPH Plan partners …which results

**3) Training and Education Human Resource Management**

- Preventable incidents due to….. which results in …..
- Inadequate level of security due to ….. which results in …..
- Inability to attract and retain staff due to ….. which results in …..
- Insufficient or inadequately trained staff due to ….. which results in …

**4) Tools and Resources**

- Budgetary demands are greater than existing funds due to ….which results in
- Inadequate Infrastructure due to ….. which results …..

**5) Evaluation and measurement of public health outcomes**

- Failure to consider unintended consequences of public health interventions…which results in…
- Failure to plan for and/or undertake short, medium and long term evaluation….which results in
- Confidential information is inappropriately disclosed due to ….. which results in …..

**6) Reporting and Communication**

- Failure to meet DH reporting deadlines due to ….which results in
- Loss of critical information due to ….. which results in …..
- Delay in communicating critical information due to ….. which results in …..
- Information systems breakdown due to ….. which results in ….
- Failure to communicate with our community as needed, including positive stories… which results in….

**7) Sustainability of gains**

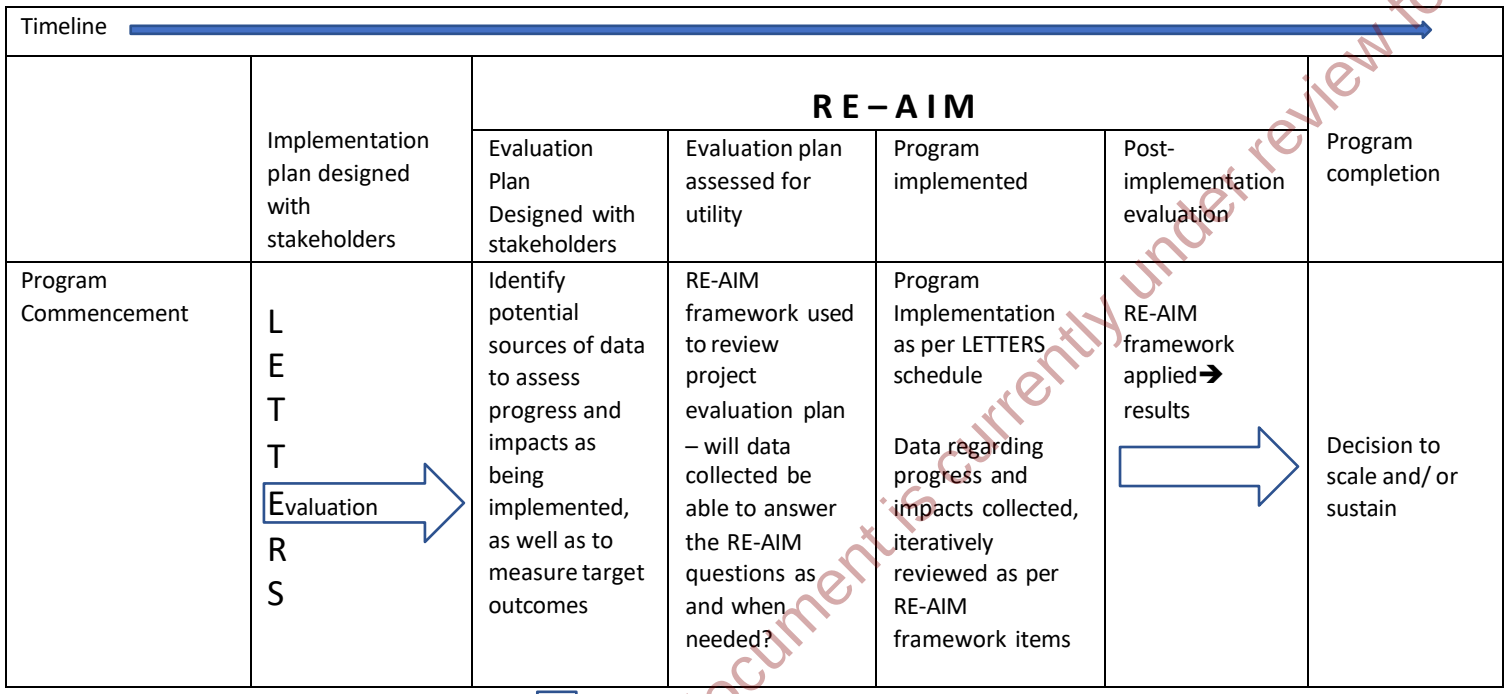
- Failure to think about sustainability from the start due to…which results in…
- Failure to plan to track outcomes into the future due to… which results in …
- Failure to track outcomes into the future due to… which results in
- Failure to adapt to changing funding, demographic and organisational landscape in the future
  due to… which results in…

# Appendix 8

## Schematic model for evaluation

# Appendix 8.1 Grampians Region program evaluation plan using RE-AIM framework

*Figure A8.1 RE-AIM framework*




*Data may measure*

| *Data may be* | **Processes** | **Impacts** | **Outcomes** |
|---|---|---|---|
| **Quantitative** | | | |
| **Qualitative** | | | |

# Appendix 9

## Sources of data used and useful links

# Sources of data used and useful links

*Table A9_1 Data Sources used in the report*

| Data Source (including link) | Author/Source | Main topics covered |
|---|---|---|
| 1800 My Options | 1800 My Options | Mapping of local abortion service providers |
| Australian Dental Association Victorian Branch Inc - Public dental waiting times (adavb.org) | ADA Victoria | Provides waiting times for general dental care in months by LGA. |
| 2033.0.55.001 - Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016 (abs.gov.au) | ABS | Socio-economic advantage and disadvantage by postal area, suburb, LGA |
| Disability, Ageing and Carers, Australia: Summary of Findings, 2018 \| Australian Bureau of Statistics (abs.gov.au) | ABS | Modelled estimates of people living with a disability, by LGA |
| Search Census data \| Australian Bureau of Statistics (abs.gov.au) | ABS | Key social, economic, demographic and health characteristics from the Australian census |
| Deaths in Australia, Life expectancy - Australian Institute of Health and Welfare (aihw.gov.au) | AIHW | Key health statistics – Victorian and national levels |
| Oral health data by area \| dhsv.org.au | Dental Health Services Victoria | Oral health profiles, by LGA |
| Victorian Population Health Survey 2017 | Department of Health (Victoria) | Social determinants of health and health risk and outcome data, by LGA |
| Victoria, local public health areas and local government areas surveillance summary report' | Department of Health (Victoria) | Notification data by LGA for infectious diseases and other notifiable conditions |
| Settlement Reports - Dataset - data.gov.au | Department of Home Affairs | Data on migration by visa stream, by LGA. |
| Data downloads \| NDIS | NDIS | Data on NDIS participation, by LGA, including participation locations, goals, outcomes, providers, budgets, and more |
| Data Workbooks - Phidu (torrens.edu.au) | PHIDU, Torrens University | Health, demographics, disadvantage, housing |
| Ambulance attendances for alcohol and drug-related events - AODstats | Turning Point – Eastern Health | Ambulance attendances and hospitalisation data for alcohol and drug-related events |
| VHISS - VHISS (dhhs.vic.gov.au) | Victorian Agency for Health Information | Burden of Disease, avoidable mortality and life expectancy by LGA |
| Victorian Women's Health Atlas (victorianwomenshealthatlas.net.au) | Women's Health Atlas | Maps by priority health areas – by LGA, disaggregated by gender |
| Viral Hepatitis Mapping Project - ASHM | World Health Organization Collaborating Centre for Viral Hepatitis | SA3 – level data: modelled prevalence and treatment for chronic hepatitis B and hepatitis C |

1800 my options. (2023). *1800 my options: online search for abortion services.* https://pubgeomapping.1800myoptions.org.au/#7,-37.02448395075963,145.13488769531253

Akil, L., Ahmad, H. A., & Reddy, R. S. (2014). Effects of climate change on Salmonella infections. *Foodborne pathogens and disease*, *11*(12), 974-980.

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Australian Bureau of Statistics. (2020). *Disability, Ageing and Carers, Australia; 2018 SAD LGA modelled estimates.* [data download]. https://www.abs.gov.au/statistics/health/disability/disability-ageing-and-carers-australia-summary-findings/latest-release

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*Australian Bureau of Statistics. (2023). Search Census Data.* https://www.abs.gov.au/census/find-census-data/search-by-area

Australian Institute of Health and Welfare. (2019). *Analysis of cervical cancer and abnormality outcomes in an era of cervical screening and HPV vaccination in Australia* [report]. https://www.aihw.gov.au/reports/cancer-screening/analysis-of-cervical-cancer-and-abnormality/summary

Australian Institute of Health and Welfare. (2022). *Deaths in Australia*. https://www.aihw.gov.au/reports/life-expectancy-deaths/deaths-in-australia/contents/life-expectancy

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Turning Point, Eastern Health. (2023). Ambulance attendances: Local Government Areas (LGA) Alcohol and drug-related ambulance attendances in Victoria. https://aodstats.org.au/explore-data/ambulance-attendances/

Victorian Agency for Health Information (2020). *The health and wellbeing of the lesbian, gay, bisexual, transgender, intersex and queer population in Victoria: Findings from the Victorian Population Health Survey 2017.* https://vahi.vic.gov.au/sites/default/files/2021-12/The-health-and-wellbeing-of-the-LGBTIQ-population-in-Victoria.pdf

Victorian Agency for Health Information (2022a). *Victorian Health Information Surveillance System (VHISS).* https://vhiss.reporting.dhhs.vic.gov.au/ViewContent.aspx?TopicID=1

Victorian Agency for Health Information (2022b). *Victorian Population Health Survey 2020 – Dashboards.* https://vahi.vic.gov.au/reports/population-health/victorian-population-health-survey-2020-dashboards

Western Victoria Primary Health Network (2023) *Western Victoria Health Pathways: Termination of Pregnancy.* https://westvic.communityhealthpathways.org/

Women's Health Atlas Victoria. (2023). *Maps by priority health area.* https://victorianwomenshealthatlas.net.au/#!/

World Health Organization Collaborating Centre for Viral Hepatitis, The Doherty Institute (2021) *Viral Hepatitis Mapping Project: Online Portal* [database] https://ashm.org.au/resources/viral-hepatitis-mapping-project/

# Appendix 10

## People involved in the development of the GRPHP

## 10.1 Members Grampians Health Primary Care and Population Health Advisory Committee

| *Name* | *Organisation* |
|---|---|
| Marie Aitken | Grampians Health Board (Chair) |
| Bill Brown | Grampians Health Board |
| Rowena Clift | Western Victoria Primary Health Network |
| Dale Fraser | Grampians Health |
| Dr Robert Grenfell | Grampians Health |
| Dr Matthew Hadfield | Grampians Health |
| Leanne Hodder | Department of Health |
| Amelia Kingston | Grampians Health Community Advisory Committee |
| Nicholas Jones | Grampians Health Board |
| Prof Anna Peeters | Institute for Health Transformation, Deakin University |
| Andrew Saunders | Grampians Region Health Service Partnership |
| Cora Trevarthen | Grampians Health Board |
| Prof Rosemary Aldrich | Grampians Public Health Unit |

## 10.2 Members Grampians Region Population Health Plan Steering Committee

| *Name* | *Organisation* |
|---|---|
| Dr Rob Grenfell | Grampians Health (Chair) |
| Prof Rosemary Aldrich | Grampians Public Health Unit |
| Ritchie Dodds | West Wimmera Health Service |
| Sean Duffy | Ballarat Community Health |
| Suzanne Ryan-Evers | Ballarat Regional Multicultural Council |
| Marianne Hendron | Womens Health Grampians |
| Leanne Hodder | Department of Health |
| Amelia Kingston | Grampians Health Community Advisory Committee |
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| Jim Nolan | Pyrenees Shire Council |
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Joanne Richie

Caylee Sandwith

Tanya Schipp

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Naomi Ziebell

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Heather Parker

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Katrina Hetherington
Paul Kochschamper
Amanda Ryan
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Genevieve Lilley
Tashkah Lloyd
Michelle Orr
Karina Vila
Karen Worthington

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Jayde Ringin

**Budja Budja Aboriginal Co-operative**
Roman Zwolak

**Central Goldfields Shire Council**
David Leatham

**Central Highlands Rural Health**
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**Child and Family Services (CAFS), Ballarat**
Bridie Bunworth

**City of Ballarat**
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**Dental Health Services Victoria**
Robyn Alexander

**Department of Education**
Jeanette Trembearth

**Department of Families, Fairness and Housing**
Dianne Stewart

**East Grampians Health Service**
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Sue McAdie

**East Wimmera Health Service**
Maddison Hendy
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**Gippsland Region Public Health Unit**
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**Go Goldfields**
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**Goolum Goolum Aboriginal Co-operative**
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Josh Koenig
Liz Rowe

**Hepburn Shire Council**
George Martin
Kate Procter

**Horsham Neighbourhood House**
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**Horsham Rural City Council**
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Mandy Kirsopp
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Mandi Stewart
Shayanah Vella

**LiverWELL**
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**Maryborough and District Health Service**

**Maryborough Community House Inc**
Jeannie Clark

**Melbourne Sexual Health Centre**
Lisa Kennedy

**Moorabool Shire Council**

**Murdoch Community Services Inc, St Arnaud**
Leigh Cooksley

**Murtoa and District Neighbourhood House**
Dee Schier

**Nhill Neighbourhood House Learning Centre**
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**Northern Grampians Shire Council**
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**NSW Health**
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**One Red Tree Resource Centre Inc.**
Tammie Meehan

**Pyrenees Shire Council**
Adam Boyle
Jerry Van Delf

**Rural Northwest Health**
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**Rural Outreach Program**
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**Sports Central**
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Andrew Milligan

**Sports Focus**
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**Springs Medical**
Lee Ann Potter

**The Orange Door**
Ramona Podasca

**The Peter Doherty Institute for Infection and Immunity**
Prof Ben Cowie

**The Royal Women's Hospital**
Catherine Hannon

**The Stephanie Alexander Kitchen Garden Foundation**
Lauren Dempsey
Ciel Lindley

**Tiny Pride**
Ange Elson

**UFS Dispensaries**
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**Uniting Wimmera**
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**Warracknabeal Neighbourhood House and Learning Centre**
Karen Fuller

**West Wimmera Health Service**
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Christine Dufty
Chantelle Fischer
Hamid Ghaderi
Dorothy McLaren
Rhys Webb
Darren Welsh

**West Wimmera Shire Council**

**Western Victoria Primary Health Network**
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Dr Kate Graham
Jamie Swann
Naomi White

**Wimmera Development Association**
Sara Baron
Jo Martin (By Five)

**Women's Health Grampians**
Claire Evans
Deb Harris
Shannon Hill
Melissa Morris
Mika Pediaditis

**Woomelang and District Bush Nursing Centre Inc**
Carol Paech

**WRISC Family Violence Support**
Libby Jewson

**Yarriambiack Shire Council**
Elysia Preston
Michelle Schilling

## Individual community members

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Tracey Chenoweth
Andy G
Cassy Lefler
Pauline Molloy
Mel Murphy
Jacinta W
Pam Young
Florence Schulz
Jyriah Rogers

## 10.6 Stakeholder participation

The GRPHP reflects the strong participation of stakeholders that occurred across a series of online and in-person forums and input via email. Some participants have chosen not to be listed above.

### 10.6.1 Online forums

*Table A10.6_1 Number of participants who attended online 'Data Snapshot' sessions*

| Grampians region | Number of participants |
|---|---|
| Central Highlands | 31 |
| Grampians Pyrenees Goldfields | 22 |
| Wimmera Southern Mallee | 11 |
| **Total participants across Grampians region** | **64** |

### 10.6.2 In-person workshops

Progressing through April, work continued around engaging building stakeholder engagement capability for our PPH and GPHU teams and preparing for stakeholder forums.

*Table A10.6_2 Number of participants who attended in person workshops*

| Grampians region | Number of participants |
|---|---|
| Central Highlands | 17 |
| Grampians Pyrenees Goldfields | 18 |
| Wimmera Southern Mallee | 19 |
| **Total participants across Grampians region** | **54** |

### 10.6.3 Stakeholder responses to invitations to identify interventions

Stakeholder survey were sent to a total of 730 stakeholders with 120 stakeholders who attended data workshops and forums and an additional 610 stakeholders. In Central Highlands one response was excluded as the responder and their responses were relevant to Wimmera Southern Mallee region and not the Central Highlands region.

*Table A10.6_3 Number of participants who responded to invitation to identify interventions*

| Grampians region | Number of participants |
|---|---|
| Central Highlands | 11 |
| Grampians Pyrenees Goldfields | 11 |
| Wimmera Southern Mallee | 14 |
| **Total responses across Grampians region** | **36** |



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Grampians Public Health Unit

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