Eat Well Australia

An Agenda for Action for Public Health Nutrition

2000 2010

Developed by the
Strategic Inter-Governmental
Nutrition Alliance of the National Public
Health Partnership

Acknowledgements

The National Public Health Partnership would like to acknowledge the contribution of the Strategic Inter-Governmental Nutrition Alliance (SIGNAL), the EWA Project Team, and all those involved in the consultation and development of this strategy and action plan.

The Australian Health Ministers Conference of 1 August 2001 endorsed the national public health nutrition strategy, *'Eat Well Australia'* and its Indigenous component the *'National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan* (NATSINSAP)', developed by the Strategic Inter-Governmental Nutrition Alliance of the National Public Health Partnership.

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Foreword

Eat Well Australia (EWA) is a vital resource to guide Australia's investment in public health nutrition over the next decade. It has been developed by the Strategic Inter-Governmental Nutrition Alliance (SIGNAL), the nutrition arm of the National Public Health Partnership.

The *EWA Strategic Framework* provides broad direction for the many partners from different sectors who make individual contributions to the health of Australians through improving our nutrition. This *EWA Agenda for Action* supports the *EWA Strategic Framework* with a detailed coordination mechanism. By addressing national issues it adds to the many valuable programs of state and territory Governments, in many cases detailing their good practice to assist other jurisdictions. It provides a focus for the non-government organisations that have been working in their areas of special interest and for private companies in the food system, individually and through their associations. *EWA* gives our research and teaching institutions a vision of the issues for which their expertise will be needed for the coming decade and beyond. It provides community and consumer organisations with the information they need to see how their interests are addressed and their involvement is facilitated.

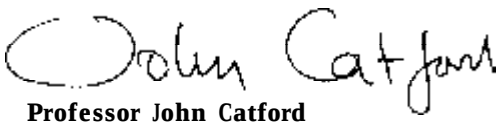
EWA is a 'whole-of-population' document which includes the *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan* (*NATSINSAP).* Indigenous nutritional health is such an important issue that both the *EWA* initiatives and those of *NATSINSAP* are needed. *NATSINSAP* has been developed by the *NATSINSAP* Working Party, following extensive consultation with Indigenous people and health organisations. Other groups who are vulnerable due to low income, remoteness, illness or other causes are also given special attention.

EWA takes forward the strategic directions of 'Acting on Australia's Weight' and refines them to those that will give best return for an initial investment. SIGNAL has prioritised increased consumption of vegetables and fruit as a focal point for the first three years of the decade. This focus will generate the greatest returns in the national health priority areas of cardiovascular disease, cancer and diabetes. Periodic evaluation of these initiatives will assist decisions about where the priorities should lie in the longer term. Maternal and child health has also been assigned a priority.

EWA also gives prominence to infrastructure and capacity building to ensure we create the new knowledge and systems to support our goals, that we review and reinvent these initiatives as circumstances change, and that the community and health workforce are kept up to date.

EWA has been built on a comprehensive consultative process across all sectors and jurisdictions, including submissions, seminars and interviews involving hundreds of stakeholders.

Spanning a decade of investment in Australia's nutrition, *EWA* has the capacity to bring substantial returns in the social and economic life of the country, and in the personal well being of all Australians.



Professor John Catford
Chairperson
Strategic Inter Governmental Nutrition Alliance (SIGNAL)

Preface

EWA has been designed to provide government and other sectors with a strategic framework and an agenda for action on public health nutrition for the first decade of the twenty first century. This document provides the detailed *EWA Agenda for Action*, as outlined in the summary *EWA Strategic Framework* document.

EWA has inherited previous work completed under the 1992 Food and nutrition policy, and aims to build on the broad intersectoral support that policy received. It has been developed over 1999 – 2000 with two rounds of consultations, public submissions and seminars in major centres. *EWA* has benefited from the experience and expertise of a wide range of professional interests, in all sectors: governments, private industry, non-government organisations, research and teaching centres, community and Indigenous organisations. It has also been able to build on other national public health strategies, including 'Acting on Australia's Weight', 'Active Australia', the National Breastfeeding Strategy and the National Action Plan on Vegetables and Fruit. Most importantly, *EWA* sets out to learn from, build on, support and extend the existing state and territory food and nutrition strategies. The SIGNAL *EWA* Working Group, the Vegetables and Fruit Working Group and the National Obesity Prevention Group have all contributed to a set of 26 'whole of population' initiatives covering priorities in health gain and capacity building.

The *NATSINSAP* has been developed in conjunction with *EWA*. *NATSINSAP* has been developed by an Indigenous working party in consultation with Indigenous health organisations and state and territory agencies. *NATSINSAP* sits partly within and partly additional to *EWA*, reflecting the urgent need for action to improve the health and nutrition of Australia's Indigenous population.

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Acknowledgements

SIGNAL wishes to acknowledge the assistance of all those who helped in the development of *EWA*.

Appendix 1 describes those who responded to the initial mail survey, made submissions, attended seminars, or gave expert advice on specific topics, including SIGNAL and DHAC personnel.

Those who assisted *NATSINSAP* are recognised in the *NATSINSAP* document.

Sincere apologies if anyone has been missed.

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List of acronyms

AADT	Australian Association of Dental Therapists
ABA	Australian Breastfeeding Association
ABS	Australian Bureau of Statistics
ACA	Australian Consumers Association
ACF	Anti-Cancer Foundation
ACHPER	Australian Council for Health, Physical Education and Recreation Inc
ACMI	Australian College of Midwives Incorporated
ACOSS	Australian Council of Social Services
ADA	Australian Dental Association
AFFA	Agriculture, Fisheries and Forestry Australia, Department of
AFGC	Australian Food and Grocery Council
AFISC	Australian Food Industry Science Centre
AHC	Australian Horticultural Corporation
AHMAC	Australian Health Ministers Advisory Council
AHPA	Australian Health Promotion Association
AIEH	Australian Institute of Environmental Health
AIHW	Australian Institute of Health and Welfare
AIFST	Australian Institute Food Science and Technology
AJFN	Australian Journal of Food and Nutrition
ALCA	Australian Lactation Consultants Association
AMA	Australian Medical Association
ANTA	Australian National Training Authority
ANF	Australian Nurses Federation
ANZFA	Australia New Zealand Food Authority
ANZJPH	Australian New Zealand Journal of Public Health
APD	Accredited Practising Dietitian
APMAIF	Advisory Panel for Marketing of Australian Infant Formula
ARC	Australian Research Council
ASI	Australian Supermarket Institute
ASSO	Australasian Society for the Study of Obesity
ATSIC	Aboriginal and Torres Strait Islander Commission
AUF	Australian United Fresh
BFHI	Baby-friendly Hospital Initiative
CCA	Cancer Council of Australia
CHD	Coronary Heart Disease
CHF	Consumers Health Forum

CODEX	Codex Alimentarius Commission
CSIRO	Commonwealth Scientific and Industrial Research Organisation
CVD	Coronary Vascular Disease
CWA	Country Women's Association
DA	Diabetes Australia
DAA	Dietitians Association of Australia
DALY	Disability Adjusted Life Year
DFaCS	Department of Family and Community Services
DHAC	Commonwealth Department of Health and Aged Care
DRDC	Dairy Research and Development Corporation
EWA	Eat Well Australia
FANO	Federation of Australian Nutrition Organisations
FNP	Food and nutrition policy
FOCIS	Federation of Canteens in Schools
FRDC	Fisheries Research Development Corporation
GRDC	Grain Research Development Corporation
GST	Goods and Services Tax
HACC	Home and Community Care
HCA	Horticultural Corporation Australia
HEIA	Home Economics Institute of Australia
HRDC	Horticultural Research Development Corporation
ITC	Industry Training Councils
MLA	Meat and Livestock Australia
MOU	Memorandum Of Understanding
NA	Nutrition Australia
NACCHO	National Aboriginal Community Controlled Health Organisations
NATSINSAP	National Aboriginal & Torres Strait Islander Nutrition Strategy and Action Plan
NESB	Non-English Speaking Background
NFNMS	National Food and Nutrition Monitoring System
NGO	Non-government Organisation
NHAC	National Health Advisory Committee
NHF	National Heart Foundation
NHMRC	National Health and Medical Research Council
NHPA	National Health Priority Area
NNS	National Nutrition Survey
NOPG	National Obesity Prevention Group
NPHNS	National Public Health Nutrition Strategy
NPHP	National Public Health Partnership

NRA	National Registration Authority for Agriculture and Veterinary Chemicals
NT	Northern Territory
NTD	Neural Tube Defect
NZ	New Zealand
OATSIH	Office for Aboriginal and Torres Strait Islander Health
PGA	Pharmacy Guild of Australia
PH	Public Health
PHAA	Public Health Association of Australia
PHEBAM	Public Health Evidence Base Advisory Mechanism
PHERP	Public Health Education Research Program
PHN	Public Health Nutrition
PHPPF	Public Health Planning and Practice Framework
PSA	Public Service Association
PAA	Pharmacists Association Australia
QFVG	Queensland Fruit and Vegetable Growers
RACP	Royal Australian College of Peadiatricians
RACGP	Royal Australian College of General Practitioners
RDI	Recommended Dietary Intake
RIRDC	Rural Industries Research and Development Corporation
SAAP	Supported Accommodation Assistance Program
SIGPAH	Strategic Inter-governmental Forum on Physical Activity and Health
SIGNAL	Strategic Inter-governmental Nutrition Alliance
TAFE	Technical and Further Education
TGA	Therapeutic Goods Administration
THS	Territory Health Services
TOR	Terms of Reference
WHO	World Health Organisation

The National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan

Indigenous health continues to be a major issue for Australia, and poor nutrition is a significant contributor to the problem.

EWA provides a 'whole of population' framework which includes initiatives that can benefit Indigenous people, in both health gain and capacity building, and many initiatives in *EWA* have a reference to Indigenous health. More specifically, it has a number of initiatives addressing population groups more vulnerable to poor nutrition, including Indigenous people.

But more is needed.

NATSINSAP is both part of, and additional to, *EWA*. It is part of the overall national public health strategy for the next decade, and it is additional to the 'whole of population' strategy. It has been created by and for Indigenous people and will have its own reference group, support and accountability. It reflects the community base that is at the core of successful interventions in Indigenous health, and the structures, such as NACCHO and OATSIH, in place to address Indigenous health issues.

The two documents are published side by side, and each constantly refers to the other. Together they can achieve more than either can by itself.

Part 1 EWA Action Plan: Background and Structure

1.1 A national framework for action in public health nutrition

Australia's safe and nutritious food supply is an important national asset. It is a source of health, pride and wealth for the nation. Despite this, the level of diet-related illness and premature death continues to be of great concern. Particularly disturbing is that some groups in the community experience much higher levels of illness than others and that such illness, and early death, is largely preventable using existing knowledge. It is an issue of national importance that many Aboriginal and Torres Strait Islander peoples suffer from poor nutrition and its consequences, warranting a specific and integrated focus within this framework. Access to a sound and varied diet is a human rights issue.

EWA is a coherent national approach to the underlying causes of the preventable burden of diet-related disease and early death, providing a set of interlinked initiatives for the prevention and management of these diseases.

Building on the food and nutrition policy

The 1992 'Food and Nutrition Policy' set a benchmark for national and State/Territory programs over the period to 1995. Following evaluation of its implementation, the National Public Health Nutrition Strategy was initiated, with Phase 1 (1997) setting out a platform for governments including SIGNAL.

Stage 2 involves the implementation of *EWA*.

There is irrefutable evidence that good nutrition can enhance quality of life and contribute to health and to a general sense of wellbeing. It is particularly significant to the health of infants and children and is a key factor in optimal physical and cognitive growth and development. Under-nutrition in young children is suspected of contributing to an increased risk of abdominal obesity, diabetes, hypertension, cardiovascular disease, and renal disease in adult life. This association is strongest when under-nutrition occurs in intra-uterine life, and the effect varies depending on the timing of the nutrition shortfall. However, the associations with adult disease also extend to under-nutrition in the first years of life. Aboriginal mothers are twice as likely to give birth to low birth-weight babies than other Australian mothers.

Nutrition issues must be considered across the lifespan, looking at the needs of people of all ages, and considering the effects on future generations. Associated issues such as smoking and physical activity must also be considered. Complex inter-relationships exist between nutrition and other factors, and often in particular in the lives of Aboriginal and Torres Strait Islander peoples.

Eating a varied and healthy diet and keeping physically active can help people to maintain independence in their later years, contributing to vitality and energy levels and to mental health and social functioning.

Sound nutrition can have major economic and social benefits. A well-nourished and healthy population is essential to economic development and to social and community cohesion. Investing in nutrition can help to contain costs in the health care system by reducing pressure on the acute care sector through reduced rates of illness and disease.

National public health strategies have been a key mechanism for responding to public health issues in Australia over the last 20 years. There are currently over twenty such strategies. In 1996, health ministers established the National Public Health Partnership - a working arrangement between the Commonwealth

Government and the states and territories - to plan and coordinate national public health efforts. To address national public health nutrition issues, the National Public Health Partnership created SIGNAL: the Strategic Inter-Governmental Nutrition Alliance, bringing the governments together for a coordinated response. Sound national public health nutrition policy and vigorous and sustained action are both important.

EWA applies a 'partnership' model in the context of current public health policy, structures and practice. To address areas where greatest impact can be achieved, *EWA* is focused largely on the partnership model, with priorities being:

- a major health issue: overweight and obesity;
- a critical food group: vegetables and fruit;
- strategic population/target groups: women, infants and children;
- the nutrition of vulnerable groups, especially Indigenous people; and
- capacity building, that is, building and strengthening the basic infrastructure required for effective action, including strategic management, funding and resources, research and development, workforce development, communication, monitoring and evaluation.

EWA combines a series of initiatives in both health gain and capacity building to provide a flexible and dynamic framework for co-operative national action. It stands with, and complements, other related national public health strategies such as 'Active Australia' and intersects with or incorporates initiatives such as 'Acting on Australia's Weight' and the National Diabetes Strategy. In particular, *EWA* offers an integrated approach to address the important area of Indigenous nutrition. It also supports work under way in the National Health Priority Areas of cardiovascular health, cancer and diabetes, in line with the World Health Organization's 'Global strategy for the prevention and control of non-communicable diseases'.

EWA provides both a context and support for the food and nutrition policies and strategies of State and Territory Governments. It provides a mechanism for industry, government and the non-government and community sectors to work together for the benefit of all Australians.

Sound nutrition as the basis for a healthy life

Nutrition is fundamental to health and to the prevention of disease and disability.

Proper and adequate nutrition is closely related to optimal growth, good education outcomes and health throughout life, and contributes to the economic and social wellbeing of society. The prevention of nutrition-related diseases includes strategies to manage both over-nutrition and under-nutrition. Together with physical activity, nutrition is core to the management of overweight and obesity, an issue of increasing concern in first world countries and a common underlying risk factor for major non-communicable chronic diseases such as Type 2 diabetes, cardiovascular disease and some cancers. Under-nutrition is related to the nutritional density of the diet and remains a significant issue for some groups, including the aged, people with a chronic disability, some Aboriginal and Torres Strait Islander communities, the poor, the homeless, and those who suffer from substance abuse, alcoholism and some chronic illnesses.

The clustering of poor nutrition (both under and over-nutrition) with smoking, physical inactivity and socioeconomic factors in Aboriginal and Torres Strait Islander communities, presents a complex array of nutrition-related issues to address across the life cycle. Cigarette smoking is of particular concern in the health of Indigenous peoples, and has been shown to be an important negative factor on intrauterine growth and birth weight of infants. When mothers smoke more than half a packet of cigarettes a day, their babies have three times the risk of having a low birth weight. Clearly, nutrition cannot be addressed in isolation from other lifestyle issues. Aboriginal and Torres Strait Islander peoples suffer from poor nutrition in many ways and the high burden of diet-related diseases in Indigenous communities poses a particular challenge.

The greatest public health nutrition challenges are those associated with the prevention of these 'lifestyle' related conditions.

Recently, science has highlighted two areas in nutrition which may offer significant health gains. These are attention to early nutrition and the importance of plant foods in our diets.

A relationship between both ends of the nutrition spectrum – under-nutrition and over-nutrition – has been made by linking the importance of sound nutrition in the early years, to health outcomes in later life. It is argued that poor nutrition during the foetal development of the child in particular, has been shown not only to affect the growth and development of the child, but also to increase the risk of abdominal obesity, Type 2 diabetes and cardiovascular and renal disease as an adult. It has been argued that this is the result of physiological adaptations made during development of the foetus in response to the nutrient insufficiency in early life. Under-nutrition is related to poor nutrient density in the diet, rather than shortage of food per se. Both are linked to other factors such as smoking or alcohol, and to income levels. In Australia they are of particular concern in Indigenous health.

Secondly, it has consistently been found that diets rich in plant foods are associated with a lower incidence of cardiovascular disease, Type 2 diabetes, some cancers and cataract and macular degeneration of the eyes. A number of substances that are found in plants such as antioxidant nutrients, non-nutrient novel substances (including bioflavonoids, phytoestrogens and indole carbinols for example) and some minerals are thought to protect against these diseases.

The importance of early nutrition and plant foods is supported in advice given by the National Health and Medical Research Council (NHMRC) in its three sets of dietary guidelines. The guidelines expound and emphasise the significance to health of variety and balance in the diet. Strategies that enable this advice to become practice for the majority of Australians remain a challenge for population health. For many groups, this requires careful consideration of cultural issues and food preferences. For Indigenous Australians, the value of traditional foods from both the land and sea should also be acknowledged.

Public investment in nutrition

A decade ago, it was calculated that the direct cost of health care services consumed in treating diet-related diseases, was $1.520 billion per year. Adding the indirect costs of lost earnings and premature death brought the figure to over $2.25 billion. This does not translate into savings available from improving our diet, but it is an indication of the scale of the impost on society and the economy.

More recent studies in Australia also demonstrate the important role nutrition plays. A major study of the burden of disease and injury in Australia, by the Australian Institute of Health and Welfare (AIHW), shows that diet is a significant factor. Using the Disability-Adjusted Life Year (DALY – equivalent to a lost year of healthy life) to assess the burden of disease, the study found that cardiovascular diseases (20%) were the leading cause of overall disease burden, followed by Type 2 diabetes (3%) and colorectal cancer (3%). These are all diet-related.

Major risk factors contributing to the overall burden of diseases include lack of physical activity (6.7%) obesity (4.3%), inadequate consumption of vegetables and fruit (2.7%) and high blood cholesterol (2.6%).

Creating a vision

The vision of *EWA* is that by 2010, the nutrition-related health of all Australians will be measurably improved, with marked improvements for Indigenous Australians and other vulnerable groups.

To achieve this vision, *EWA* provides a detailed framework for a national effort in public health nutrition over this first decade of the new century.

EWA has been developed by consulting with hundreds of interested people from all over Australia. With input from public, private, community and non-government sectors, it has taken the current thinking and experiences of Australia's nutrition practices and focused it on SIGNAL's priority areas.

EWA has employed the expertise of practitioners where the best evidence is not yet conclusive. It has taken note of the concerns of the industry figures whose role is to find a commercially viable way to deliver nutritious food to the Australian market. It has kept the public benefit uppermost in promoting partnerships as the basis of action.

SIGNAL

The Strategic Inter-Governmental Nutrition Alliance is the nutrition arm of the National Public Health Partnership to coordinate action to improve the nutritional health of Australians.

SIGNAL is made up of representatives or nominees of:

- the Commonwealth Department of Health and Aged Care (DHAC);
- all eight State/Territory Government Health Departments;
- the Australian Institute of Health and Welfare (AIHW);
- the Australia New Zealand Food Authority (ANZFA);
- the National Health and Medical Research Council; and
- the New Zealand Ministry of Health (with observer status).

The committee also includes four independent members with expertise in nutrition and public health, including Aboriginal and Torres Strait Island Nutrition.

EWA carries a vision of a decade to improve food and nutrition practices through research and innovation. Through interrelated initiatives, it will scan the world for new research and practice and bring it to Australia. *EWA* will seek out good practice in Australia and disseminate it. It will generate the background information, the practice improvement and the data needed for evaluation.

Innovation

Innovation is at the heart of *EWA*.

Under key initiatives, SIGNAL and other partners will seek out and build on the innovations of State and Territory jurisdictions, and of the non-government and private sectors. Innovation is built into *EWA*'s priorities as a fundamental component of capacity building. Innovation, supported by research, will be reviewed, evaluated, communicated and disseminated.

EWA itself has used an innovative structure to address one of the dilemmas of effective planning, how to structure initiatives in such a way as to bridge the gap between broad strategies and concrete actions. Each of its fields of activity is focused on several initiatives. Each initiative is based on a unique matrix that summarises its rationale, its objectives and the proposed actions needed. Responsibilities are indicated, evaluation indicators, risks and funding implications noted, along with the main potential partners and the capacity requirements.

Resources

EWA is built on partnerships and leverage. Every initiative is predicated on the involvement of stakeholders in their area of interest – both current and new. SIGNAL will need a small team to provide overall brokerage, marketing, coordination and support where required.

Partnerships will bring in-kind resources to *EWA*, and governments will be looking at the investment needed to gain the benefit of joint initiatives. The partnership model can add value to the investments of various stakeholders through joint initiatives, good practice advice and wider dissemination. Partners in different sectors have much to offer and much to learn from each other. Mutual agreement on outcomes and resources will help focus initiatives to gain the most from each partner's investment.

EWA provides the framework for directing food and nutrition resources from across sectors towards the public benefit of improved health through improved nutrition.

It does this by setting a ten year agenda and detailing frameworks for action as the basis for negotiating resources, both financial and in kind from governments and other interested parties.

In particular, *EWA* lays out for public, private and non-government sector consumption the arenas in which they can find mutual benefit through mutual action. It fills the gap many contributors have expressed concern about: a coherent set of options within which to negotiate the common ground.

1.2 EWA in context

EWA is unique but not alone.

It represents Australia's contribution to the global battle with non-communicable diseases, and by including *NATSINSAP*, the increasing recognition of the needs of the Indigenous peoples of the world. It supports and is in turn supported by other national initiatives in public health from all sectors. *EWA* reflects, and will enhance, the initiatives of state and territory governments in public health nutrition, including their pivotal role with communities.

The global context

The World Health Organization (WHO) estimates that non-communicable diseases now contribute to almost 60% of world mortality and 43% of the global burden of disease. These figures are expected to rise to 73% and 60 % respectively by 2020. In response, WHO has developed its global strategy for the prevention and control of non-communicable diseases.

The WHO Global strategy for the prevention and control of non-communicable diseases':

In December 1999 the WHO called on member states to join a global strategy to address heart disease, cancer, and Type 2 diabetes through:

1. generating local information bases for action;
2. establishing national prevention programs;
3. tackling non-health sector issues that impact on non-communicable diseases; and
4. tailoring health sector reforms to include effective management of non-communicable diseases.

International research and initiatives in public health nutrition need to be translated into the Australian context. Our diet and foods reflect our Australian environment, culture and history, as do the political structures within which we address public health issues. *EWA* needs to address our nutrition-related health status in our national context.

This includes the sustainability of the natural resources upon which all our foods depend. In research, innovation and education, a national nutrition framework can be mindful that long-term strategies need to conserve and renew the resources upon which they depend. Using science for developing new foods needs to be balanced with the capacity of the environment to sustain current or increased use. Environmental issues must also be considered in relation to facilitating access to valued traditional foods by Aboriginal and Torres Strait Islander peoples.

The national context

Nutrition is an emerging field where scientific evidence and good practice is still evolving. Because of the large amount of conflicting advice and information given to the public about food and nutrition, the Commonwealth government provided an authoritative reference in the form of a Food and nutrition policy as early as 1979. As new evidence became available the policy was updated or modified and in 1989 a

summary document and a set of eight dietary goals and guidelines for Australia were developed. The principal responsibility for such scientific evaluation and associated publication of nutrition statements continues to rest with the NHMRC.

Although the policy statements were collated to provide an authoritative reference on up-to-date issues on nutrition for health professionals, educators, home economists, industry and the community in general, the principal users have been those with a particular interest in the area. Thus, despite this relatively long time period in which a food and nutrition policy initiative has been operating, the focus on scientific evidence and continuous review has meant that service delivery personnel, concerned with individual patient care and nutrition educators have been those most aware of the goals and guidelines. The need for a broader, population centred approach has driven much of the more recent nutrition policy initiative. In contrast to the past emphasis on 'at risk' individuals and nutrition behaviour counselling by dietitians and other health personnel, the 1990s have seen the growing recognition that primary prevention at the population level may provide greater benefits in the long term.

The WHO set out this philosophy in 1990: *"Public health interventions aim to lower the average level of risk to health of the whole population, either because the whole population is at risk, or because a strategy to identify the minority of individuals at greatest risk, even if available, would only contribute to a modest public health improvement, since much if not most of the disease in the population occurs in the more numerous individuals at moderate to low risks".*

In 1991 the government agreed to develop a national food and nutrition policy for Australia aimed at ensuring equitable access for all Australians to safe, nutritious and acceptable food. The policy was launched in September 1992 with the hope that the catch-cry of "healthy food choices being easy food choices" would become a reality for all Australians.

The Food and nutrition policy itself is not enforced by an Act, legislation or accompanying regulations and in effect aims to foster changes in food choices and eating behaviours at the individual and population level. However the then National Food Authority created in 1991 (now the Australia New Zealand Food Authority –ANZFA) does have responsibility for food standards.

The goal of the Food and nutrition policy is to improve health and reduce the preventable burden of diet-related early death, illness and disability among Australians. It was anticipated that the policy would be implemented through strategies, which support the Australian dietary guidelines, involve key sectors in the food system, and foster community participation. Environmental and social contexts were particularly emphasised through the five key policy issues or principles identified by the policy document:

- Social Justice: through policy aim to increase the availability of nutritious foods, especially in remote areas; increase affordability of nutritious food for economically disadvantaged people; increase understanding of good nutrition and foods;
- Quality of the food supply and food system;
- Community participation and accountability: emphasising intersectoral action and partnerships;
- Food and nutrition system and its wider interaction: particularly through attention to impacts of individual programs on the wider food and nutrition system; and

- Ecologically sustainable development: to manage resources and ensure good health for future generations.

Following the launch of the Food and nutrition policy, there was an initial implementation phase guided by the Food and nutrition policy program at a Commonwealth government level. These first phase initiatives were evaluated in 1995 and the emphasis for further implementation broadened to renew the critical partnerships and whole of system issues identified in the original policy. This was the core of the 1996 Stage 1 National Public Health Nutrition Strategy (NPHNS), culminating in the report of Health Strategies Deakin, 'Building a National Public Health Nutrition Strategy: a Framework for Government Health Authorities', which recommended SIGNAL and developed the blueprint for *EWA*.

EWA culminates Stage 2 of the NPHNS.

Related national public health developments

EWA will contribute to a range of national health policy issues.

At the national level, these issues are addressed around the National Health Priorities. Australia has a well-researched set of national public health priorities:

- Cardiovascular health;
- Cancer control;
- Injury prevention and control;
- Mental health;
- Diabetes; and
- Asthma.

EWA contributes to at least three of the National Health Priority Areas. Action plans for addressing the national health priorities are under development, and a section of DHAC has been specifically created to address the health priorities of cardiovascular health and Type 2 diabetes.

Active Australia

The Strategic Inter-Governmental forum on Physical Activity and Health (SIGPAH) is parallel to SIGNAL, but addresses physical activity.

Active Australia aims to improve the health and well-being of all Australians by promoting increased levels of moderate-intensity physical activity.

'Acting on Australia's Weight' pointed to the need for individuals to achieve healthy weights by both reducing energy intake and increasing energy output.

EWA, especially the initiative on Promoting healthy weight, is a companion strategy to Active Australia

EWA is closely aligned with a number of other Commonwealth Government-sponsored national strategies addressing diet-related health issues. Some are integrated into *EWA*:

- *NATSINSAP* is a major component of *EWA* as well as having its own structures;
- 'Acting on Australia's Weight' is the basis of the Healthy weight initiative;
- The National Action Plan on Vegetables and Fruit is included as an initiative;
- The National Breastfeeding Strategy is supported under an *EWA* initiative for maternal and child health;

- Active Australia is integrated into 'Acting on Australia's Weight' with the need to do exercise paralleled by the need for a healthy diet;
- The National Alcohol Action Plan provides opportunities for synergy since food and alcohol are consumed in similar settings, and excessive alcohol consumption is also an issue for the groups vulnerable to poor nutrition;
- The National Mental Health Plan includes issues of eating disorders, and people with mental illnesses are vulnerable to poor nutrition; and
- The National Diabetes Strategy and the Framework for Action on Diabetes.

In addition, DHAC is doing important work that is relevant to *EWA* including:

- The Office of Aboriginal and Torres Strait Islander Health has carriage of Indigenous health issues;
- The Food Policy Section is concerned with food safety, including labelling and genetically modified or functional foods;
- The Population Health Strategies Section addresses the issues of specific population groups;
- The General Practice Branch works with GPs and GP organisations, and GPs offer a unique channel for disseminating nutrition information; and
- The National Health Priorities and Quality Branch.

Other national institutions, such as the NHMRC, ANZFA and AIHW have roles that position them as strategic partners with various aspects of *EWA*.

Other sector partners operate numerous national programs under their various agendas, including public education, promotion, research and other capacity building.

NHMRC Dietary Guidelines

- Dietary guidelines for Australians, 1991
- Dietary guidelines for children and adolescents, 1995
- Dietary Guidelines for Older Australians, 1999

State and Territory initiatives

All state and territory governments have policies and programs to address public health nutrition. Three have developed Aboriginal and Torres Strait Islander specific nutrition policies: Queensland, the Northern Territory and Western Australia.

These were developed in light of the 1992 Food and nutrition policy, and have adapted its principles to address their main concerns and policy directions. Each of these is unique to its own jurisdiction and each state or territory provides the essential people and the resources for its public health nutrition programs. Each has provided the leadership and the models upon which *EWA* will rely.

EWA is a national framework that will support all state and territory jurisdictions by providing national level resources and coordination for public health nutrition. It will expand the national capacity for addressing health gain priorities, through research, dissemination, workforce development, communication and information resources. It will, for example, provide each jurisdiction with the examples and insights of good practices in other areas, and with nationally comparable nutrition and related health data. *EWA* will provide opportunities for state/territory actions to be part of national initiatives, reinforcing the value of their actions by making it apparent that they are contributing to a national imperative. It will also facilitate some partnerships, such as sponsorships, which are only feasible on a national scale, but which will have benefit within each jurisdiction. Examples of such partnerships might include the promotion of increased consumption of vegetables and fruit or investment in public and private sector research.

Each state and territory government has its own infrastructure for food and nutrition policy and programs. *EWA* recognises the autonomy of the jurisdictions and aims to add value to their work. They will continue to have the major role in public health nutrition program delivery and capacity building, and will work with regional stakeholders including local government. National initiatives require interpretation and implementation in each jurisdiction, while good practice models from one jurisdiction can be disseminated to others.

At the same time, national co-ordination and multi-jurisdictional programs provide the state and territory public health agencies with a role in facilitating national collaboration and consistency, networking and dissemination, and strategy monitoring. As well as constituting SIGNAL, they are each partners in their own right, and managers in their own jurisdiction.

Intersectoral partnerships

SIGNAL itself is built on the principle that effective partnerships can add value to the efforts of individual agents. It recognises, as appropriate, that community, non-government and private sector organisations may each take the lead in some areas of public health nutrition, especially where they have the capacity to affect critical points in the food supply. These organisations include community groups, local governments, national foundations, councils or associations, research and teaching organisations, industry bodies and individual companies.

EWA reflects the need for an approach that seeks public health benefit from interventions, which involve cooperation between sectors. In doing so it recognises that partnerships need to be primarily in the public interest, but built on respect for mutual interests, sound and transparent processes and dialogues that enhance mutual understanding. Particular recognition needs to be given to working with Indigenous communities to address their health issues, since improvements to Indigenous nutrition will only be achieved through community driven processes.

Just as *EWA* is based on partnerships, so other initiatives have been based on private or non-government sectors. The larger NGOs such as the National Heart Foundation of Australia and the Cancer Councils have been initiating and maintaining programs for many years, some in partnership with industry. More recently the Dietitians Association of Australia has teamed up with one national retailer to promote vegetables and fruit, and other companies have undertaken other programs or linked nutrition to the promotion of cereals, meats, or dairy products.

Emerging issues

Issues will continue to emerge during the period covered by this strategy. *EWA* does not seek to fix 'these issues, but to build frameworks for their resolution in the best interests of the health and wellbeing of the public. It seeks to find a way to balance sometimes competing interests - in the public interest.

New nutrition-related issues are arising as the framework is developed. Three that are currently under wide consideration are:

- Health claims: what should food producers be able to say about the potential health benefits from their products?
- Genetic modification: what are the potential risks or benefits of genetically modified food species and are there nutrition issues for consideration as well as food safety issues?
- Functional foods: what are the potential benefits or problems with the creation of new foods targeting specific nutritional issues?

EWA highlights innovative practices, nutrition literacy and monitoring and evaluation initiatives, which can help to address these emerging issues. These emerging issues also require further resolution at the policy and legislative levels of ANZFA and DHAC.

The Australian Guide to Healthy Eating

The Commonwealth Department of Health and Aged Care funded the development of the *Australian Guide to Healthy Eating*. Rather than replacing the five food groups, or the healthy diet pyramid, the guide has been designed to clarify and build upon the tools that are already available. The materials are based on the *Core Food Groups* and provide practical advice on how to implement Australia's dietary guidelines.

The Australian Guide to Healthy Eating provides information about the amounts and kinds of foods that are needed each day to get enough nutrients essential for good health and wellbeing. The resource package contains an educator's manual providing background information, posters, a consumer information booklet and a summary brochure.

For a healthy diet, the *Australian Guide to Healthy Eating* recommends:

1. Eat enough food from each of the five food groups every day;
2. Choose different varieties of foods from within each of the five food groups from day to day, week to week and at different times of the year; and
3. Eat: plenty of plant foods (bread, cereal, rice, pasta, noodles, vegetables, legumes and fruit); moderate amounts of animal foods (milk, yoghurt, cheese, meat, fish, poultry, eggs); drink plenty of water to quench your thirst.

For additional information visit the website:
http://www.health.gov.au/publhlth/strateg/food/guide/index.htm

1.3 EWA – a framework for a decade of improvement in public health nutrition

The goal of EWA

The goal of EWA is to improve the health of all Australians through improving nutrition and reducing the burden of diet-related disease.

EWA will achieve this through health gain and capacity building initiatives that are:

- **national** in scope, with recognition of the importance of state/territory, regional and local actions;
- based in **public health** practices, addressing underlying determinants of health in the population as a whole as well as high-risk groups; and
- focused on measurable actions within broad **nutrition** issues, including the food system from production to consumption, consumer demand and the health system itself.

EWA is built on a set of initial **priorities**, each of which is addressed by several **initiatives**, with **objectives** specific to each of the initiatives. Broad aims are to:

- support health gains in the context of the National Health Priorities Areas;
- improve the capacity of Australians to choose a healthy diet in line with the Australian Guide to Healthy Eating ’and NHMRC Dietary guidelines;
- support improved nutrition at all points in the food system in partnership with stakeholders in relevant sectors;
- provide targeted resources to those groups more vulnerable to poor nutrition; and
- monitor the food and nutrition system and seek opportunities for improvement.

Approach

As a national framework, *EWA* both extends and adds to existing investments in public health nutrition. It balances:

- support for the current work under Commonwealth, state and territory Government strategies;
- promotion of current good practices to other sectors and jurisdictions; and
- development of new knowledge and practices for national dissemination.

Many innovative programs have been developed by state or territory agencies, in cross-sectoral collaboration, or by industry or other stakeholders. Many of these are based on the 1992 Food and nutrition policy. *EWA* will build on the best of these and develop them at the national level.

In providing national coordination and support, *EWA* emphasises a range of capacity-building initiatives. These address the operational requirements of a national effort and provide the infrastructure for sustainability. Information for planning and evaluation is critical to this process and is both built into *EWA* and provided by other elements of the health system. Agencies such as the AIHW, NHMRC, Australian Bureau of Statistics and work being undertaken on behalf of DHAC towards a national food and nutrition

monitoring and surveillance system (NFNMS), provide the critical evidence base for planning, monitoring and evaluation. Researchers in all sectors are developing both our depth of understanding of nutrition and the diversity of our approaches to applying this new knowledge.

An active planning tool

EWA is an active planning tool: each initiative sets out the proposed actions for potential strategic partners to address in order to achieve clear objectives. It has been specifically developed to help intersectoral partners work together, so that effective partnerships will be the main vehicle for results. *EWA* promotes the autonomy of partners within set objectives. It recognises that the food system is largely in the private sector and that the range of national stakeholders and interests is wide. Collaborative initiatives already underway, demonstrate that the time is right for this approach.

EWA also recognises that the ideal level of evidence for launching public health strategies is rarely available, and that waiting for it can lead to inaction, even paralysis. At the same time, researchers, educators and other practitioners provide a wealth of qualitative information to support initial actions. To counter the evidence gap, *EWA* includes the explicit creation of knowledge, the promotion of innovation, progress towards a national food and nutrition monitoring system and the dissemination of good practice models.

EWA has been built so as to manage its own change process, in the knowledge that it needs to take advantage of new strategic opportunities, to learn from and replicate its successes, and to limit its risks.

Initiatives

EWA will begin the decade with a first set of capacity building and health gain initiatives designed to:

- improve our knowledge of the benefits of nutrition and what makes a better diet;
- educate and skill our population to be able to choose a healthy diet;
- support the food industry to make healthy choices easier;
- pay special attention to the nutritional needs of disadvantaged groups, including Indigenous Australians;
- monitor the food and nutrition system;
- establish the infrastructure and capacity needed for *EWA* to succeed; and
- review progress and create future initiatives.

In evaluating and renewing the strategy, SIGNAL and its partners will review these initiatives and they are expected to change over time. As an agent for change, *EWA* is based on the assumption that its purposes, as well as its structures, will evolve.

A ten-year national framework

EWA provides a national perspective for the decade 2000 - 2010. It also recognises that a useful

framework must support innovation and review, and that change is part of the implementation process. A ten-year framework involves monitoring the food and nutrition environment and adjusting the initiatives over three triennia, with a full review in 2010.

The ten-year period is constructed as:

2000 - 2002 Address priority areas and review progress made and continuing relevance of priorities at 2002;

2003 - 2005 Continue implementation on the basis of progress review; introduce new priorities as needed; review progress at the end of 2005;

2006 – 2008/9 Continue on basis of review; introduce new priorities; evaluate at 2009 for restructuring as needed for 2010 - 2020 framework.

Initiatives have timeframes set out for the first three years. Part of the task of the evaluation in 2002 will be to assess the progress of each initiative and suggest timeframes for the next triennium. Funding, other resources and upcoming priorities will also have an impact on timeframes for each triennium. These timeframes may change, but in 2009 a major review will be needed to assess the health gains made under *EWA* and its role for the future.

NATSINSAP operates on a similar time scale but will specify its own priorities and time lines.

EWA is built upon, and adds value to initiatives of strategic partners. While it remains a government strategy in the sense of providing a national framework for action, its implementation is essentially intersectoral.

The underlying base for effective partnerships is **capacity**:

- for effective program response to health issues;
- for effective dissemination of intervention and models; and
- for long-term sustainability in changing circumstances.

Capacity includes:

- information development;
- dissemination and communication;
- research and development;
- innovation;
- workforce development, including increasing the available public health nutrition workforce;
- practice improvement; and
- management of alliances and partnerships.

Health gain priorities

Health gain priorities derive from 'Building a National Public Health Nutrition Strategy: a Framework for Government Health Authorities 'commissioned by the Commonwealth Government and authored by Health Strategies Deakin. This analysis also led to the establishment of SIGNAL by the National Public Health Partnership, and recommended focusing public health nutrition resources for optimum gain from the available investments. It considered that this gain would be greatest where previous investments had already created a basis for higher returns, ie where the groundwork had already been done.

These 'margin benefits 'lie in areas where previous planning ('Acting on Australia 's Weight ') or private/ public sector marketing (Vegetables and Fruit) or other social programs (Vulnerable Groups) have been in place for some time. Health Strategies Deakin also recommended balancing priorities on two critical dimensions: health gain priorities versus capacity building, and initial implementation versus longer term health gain.

The *Framework* report set health gain priorities for *EWA* and clarified that capacity building and nutrition promotion were both integral.

From this and other work done by Health Strategies Deakin, including wide consultations over 'Acting on Australia 's Weight ', from the common directions of the state or territory policies and from the available evidence of health and nutrition patterns, the Framework report set out four priority areas to bring the greatest return from the initial investment:

- preventing **overweight and obesity** (building on 'Acting on Australia 's Weight ');
- increasing the consumption of **vegetables and fruit** (fresh and processed, as part of a balanced diet);
- promoting optimal nutrition for **women, infants and children** (building on strategies for folate and breastfeeding); and
- improving nutrition for **vulnerable groups**, including rural and isolated populations, low income groups and Indigenous Australians. An Indigenous strategy needs to be linked but should remain relatively autonomous.

SIGNAL has adopted these as the national priorities for the first triennium of *EWA*. They will be reviewed periodically and may continue to be priorities for following cycles, or may be superseded by other issues. Older people, for example, are an emerging priority, as evidenced by the recent publication of 'Dietary Guidelines for Older Australians '. Future reviews may well see older people become a priority area for *EWA*.

By focusing resources on these priority areas SIGNAL aims to maximise health gains for its investment in the initial years of *EWA*.

Synergy

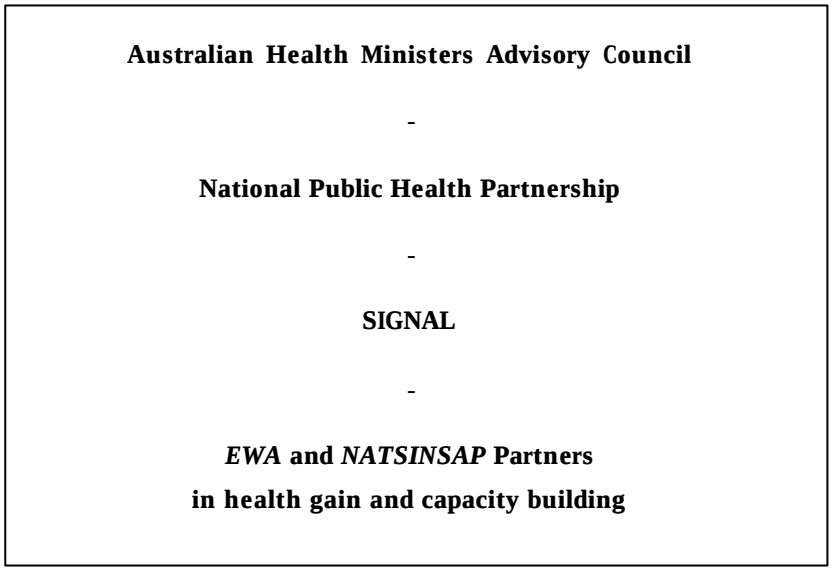
These priorities are not isolated arenas for action, but interlocking fields for initiatives that will support each other. For example, by prioritising a condition that affects major non-communicable diseases (obesity), a food group which impacts on both (vegetables and fruit), and specific target groups (vulnerable groups), *EWA* can achieve more than with either broad promotional actions or a limited 'silo 'approach.

Linkages amongst the initiatives are noted within each one, but generally speaking there are additional gains when one initiative supports another. This is not duplication or overlap but a synergistic approach to the complex issues of achieving long term health gains through health promotion. It will be especially important for the achievement of health gains for Indigenous Australians under both *EWA* and *NATSINSAP*.

Accountability

The National Public Health Partnership advises the governments of Australia through the Australian Health Ministers Advisory Council. SIGNAL is the nutrition arm of the NPHP. Other advisory or action groups can be set up as needed. These relationships are illustrated in Figure 1.

Figure 1:* EWA *in relation to its accountability structure



Operating principles

EWA reflects the 1992 Food and nutrition policy in the context of the policies and programs of each state or territory nearly a decade later. During this period there have been shifts in philosophy and policy about the role of government and its relationship to the private and non-government sectors. In this context, the National Public Health Partnership (NPHP) and the Strategic Inter-Governmental Nutrition Alliance (SIGNAL) provide national coordination and strategic management structures.

The operating principles *of EWA* are to:

- work with non-health government sectors, and non-profit, community, special needs and private sector stakeholders in the achievement of its objectives;
- maintain a focus on public health benefits;
- include a social justice component;

- facilitate partnerships based on clear ethics and protocols;
- provide for the capacity required to achieve the objectives of individual initiatives and *EWA* as a whole;
- base initiatives on the available evidence and develop that evidence where it is needed;
- promote nutrition in a 'healthy eating - healthy lifestyle' model; and
- recognise that a sustainable strategy and food supply requires continuing research, innovation, evaluation and renewal.

These operating principles underlie the *EWA* initiatives, set out below.

EWA: summary of initiatives

Strategic management

1 Steering the implementation of *EWA* and *NATSINSAP* 2 Developing nutrition policy 3 Establishing criteria for resource allocation 4 Managing partnerships	Government health departments will have to develop mechanisms to work with partners in implementing *EWA* and *NATSINSAP* initiatives, to promote consistent public policy, and to develop criteria for cost-effective resource allocation.

Health gain initiatives

Promoting healthy weight 1 Promoting healthy weight	Addressing overweight and obesity, taking 'Acting on Australia's Weight' as a starting point, by coordinating action between national strategies to focus on healthy lifestyles and by developing guidelines for professionals on healthy weight management and obesity prevention.
Vulnerable groups 1 Promoting organisational change in services 2 Influencing broad social policy 3 Addressing structural barriers to safe and healthy food	Specific initiatives targeting population groups more susceptible to poor nutrition practices, improving service delivery in the government and non-government sectors, food supply, social policy, research and health promotion activities.
Vegetables and fruit 1 Undertaking vegetables and fruit promotions 2 Addressing underlying structural factors which influence vegetables and fruit consumption 3 Enhancing research	Working with sector partners to increase the consumption of vegetables and fruit, with a national campaign, programs to address structural barriers and building the evidence for future initiatives.

Maternal and child health

1 Improving nutrition for pregnant and lactating women

2 Promoting breastfeeding and improving infant nutrition

3 Improving nutrition for children

Building on the National Breastfeeding Strategy, the National Folate Initiative, the National Child Nutrition Program and other practices and programs to address nutrition issues from pregnancy through to age five, for older children and for life-long benefit.

Capacity-building initiatives

Research and development

1 Investing in public health nutrition research

2 Disseminating research evidence

3 Promoting private sector investment in research

4 Promoting innovation

Government health departments can work with public agencies such as the NHMRC to enhance research into effective nutrition intervention, and with the private sector to develop collaborative research models. They can also oversee actions to assess and promote innovative solutions to national nutrition issues.

Workforce development

1 Building human resource requirements

2 Expand and extend tertiary education

3 Training primary health care professionals

4 Training the non-health workforce

Government health departments can seek to improve the infrastructure for delivery of public health nutrition programs, with the tertiary sector to increase the number and skills of qualified personnel, and with both the health and non-health workforces to develop their capacity to provide effective nutrition-related programs and services.

Communication

1 Disseminating *EWA*

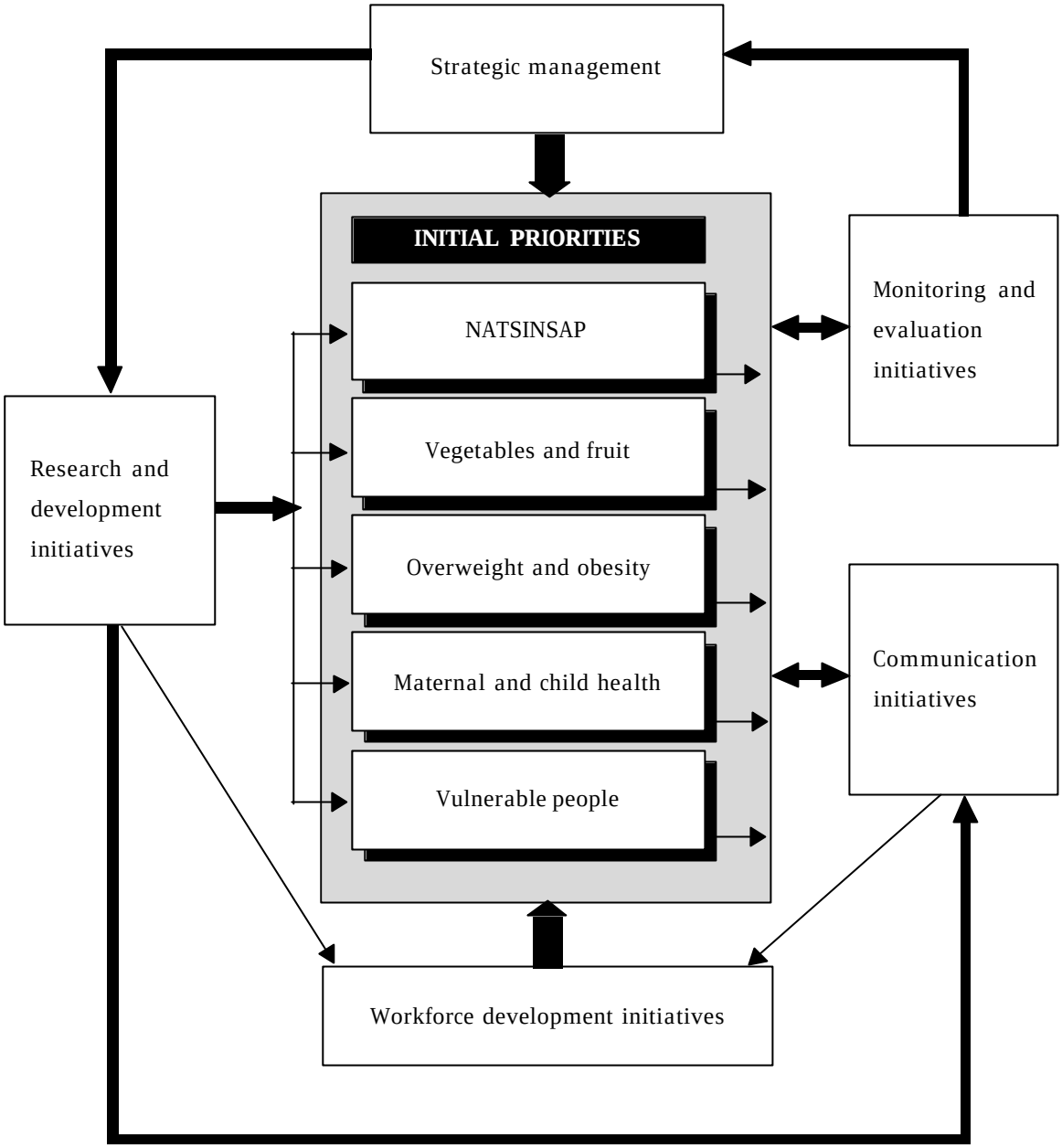
2 Communicating with the public

Government health departments can ensure *EWA* is promoted and to enlarge and speed the dissemination of nutrition research. Governments can also work with a wide range of partners to disseminate consistent nutrition messages to the Australian community to enhance their capacity to interpret nutrition information.

Monitoring and evaluation	
1 A national food and nutrition monitoring system 2 Evaluating *EWA*	Aspects of a national food and nutrition monitoring system are already under way but need to be extended and expanded. SIGNAL will work with key partners to ensure that the impacts of individual *EWA* and Indigenous health initiatives, and the strategy as a whole are able to be effectively monitored and evaluated, and that essential national nutrition data is collated.

Figure 2 illustrates the relationships among these initiatives:

Figure 2: EWA and relationships between priority areas



1.4 Implementing EWA

The heart of EWA is effective partnerships

The strategic framework and agenda for action are built on the knowledge that implementation involves the whole food and nutrition system, with the different sectors having their own interests, and roles according to those interests. *EWA* is a strategic framework for governments, but requires that governments work with other sector partners to achieve its goal.

Initiating and fostering these partnerships is a public sector responsibility, leading to implementation by cross-sectoral partners. The national body with the potential to coordinate implementation is SIGNAL, constituted by the Commonwealth and state/territory government health departments. SIGNAL is not separate or additional to the other jurisdictions, but is the vehicle for them to take concerted national action, through the National Public Health Partnership.

SIGNAL has a central facilitating role in the implementation of *EWA*, but as the facilitator, not the owner, of the process. Industry has a major investment in researching, producing and marketing food. Researchers are developing the evidence for sound nutritional practice. Educators are disseminating current scientific knowledge and nutrition practices to the public health profession, which in turn passes on good practice to the whole food and nutrition system. State and territory governments have well established nutrition programs. Non-government organisations are researching and promoting improved nutrition relevant to disease prevention. Community groups are involved in promoting better health including nutrition. All sectors have activities addressing issues of vulnerable groups. National programs address related issues such as physical activity, tobacco and alcohol or breastfeeding.

Implementing *EWA* is about developing partnerships that coordinate the investments of the different sectors to improve the nutrition and reduce the burden of diet-related disease amongst Australians.

SIGNAL's role: central but limited

SIGNAL members, and SIGNAL's role in the National Public Health Partnership (NPHP), provide *EWA* with the essential links for a national strategy. SIGNAL has the potential to facilitate the partnerships within and across sectors that are the real force for implementing *EWA*, and provides the round table for negotiating inter-governmental agreements.

Consultations suggested one way to effectively implement *EWA* would be to establish a small, entrepreneurial team to work with SIGNAL to:

- coordinate the implementation of specific initiatives under *EWA*;
- facilitate partnerships and national programs in collaboration with organisations from the public, non-government and private sectors;
- communicate, and advocate for, *EWA*;
- provide a forum for issues of intersectoral collaboration;
- monitor, and report on, the impact, effectiveness and efficiency of the implementation of *EWA*;

- oversee the periodic reviewing and renewal of *EWA* over its 10 year span, and address the issue of its evaluation in 2010; and
- provide accountability to the NPHP.

An EWA/NATSINSAP implementation team

Governments will need to have a highly innovative role in the implementation of *EWA*.

Partnerships need to be 'marketed' around the initiatives, with equitable arrangements that bring clear public benefit. Action planning and budgeting for each initiative will require project management resources. Funding will require developing cases, making proposals, and negotiating contracts with funders and partners. Monitoring and evaluation will require effective data collection and management, and accountability and reporting will require a consistent financial and performance management regime.

Consultations have suggested a small team could drive the implementation of the strategic framework with dedicated resources working with SIGNAL. The task is well beyond the current arrangement of a SIGNAL secretariat provided by the Commonwealth Department of Health and Aged Care. A team with input from the array of strategic partners could provide both resources and the multi-sector interest at the heart of implementing *EWA*.

Some potential partners indicated they were concerned that implementation could be overly constrained by administrative requirements. An implementation team might need to have the right mix of administrative freedom and accountability to operate in the highly commercial environment of the food system.

One option is the current arrangement for the management of the National Public Health Partnership – funded by the Commonwealth government and contracted to the Victorian government. Another would be for SIGNAL to auspice a corporation with each jurisdiction, as a shareholder, supporting it under agreed arrangements. Support could include in kind contributions of staff, expertise or physical resources, allowing intersectoral participation. A third model would be for the implementation team to be contracted to another sector partner or consortium, for example a university or an NGO, again with both financial and in-kind cross-sectoral support. In-kind support offers the twin benefits of practical resources and the growth of cross sector expertise and mutual understanding.

The best model for implementing *EWA* is an issue for governments to resolve in its discussions with stakeholders. This document only reflects the input of some stakeholders that the implementation of an ambitious strategy such as *EWA* needs an entrepreneurial team with an entrepreneurial culture and structure.

Gaining the commitment of potential sector partners

Consultations with numerous cross-sector stakeholders in the development of *EWA* indicated that many are open to partnerships in initiatives where there is mutual interest, and where they can see a satisfactory operating basis.

Developing partnerships is a key initiative in the Strategic management 'field of the *EWA*.

Some will take major, leadership roles in some initiatives; others will take minor roles, or target specific initiatives. Involvement of a range of partners will contribute enormously to the success of both *NATSINSAP* and *EWA*.

Resources for implementation

One of the first tasks for governments is to work through *EWA* with assigning priorities and drawing up project budgets for the actions indicated in each initiative. This will involve extensive negotiations with potential partners, since cost sharing (cash or in kind) could be an important aspect of the partnership.

Each initiative has considerable potential variation in how the proposed actions are taken, over what period and with what level and type of support from partners. No initiatives are able to begin without some investment, although there are some actions, which governments could initiate in advance, for example simply by letter to other agencies.

Costing of each initiative will be part of the project management activity. This will also involve some prioritisation of initiatives for the first triennium, and decisions about the seeking and managing of partnerships.

Governments will need to gain the necessary agreement at the NPHP and ministerial level, and at that point the implementation, including costing, can begin.

Change management

As a ten-year strategy, *EWA* will need periodic evaluation, a full review and constant renewal. Each initiative has the capacity for evaluation built into it. At the end of the decade, the whole strategy will need to be reviewed.

Monitoring, evaluation and innovation provide the basis for constant renewal. This is not a strategy fixed in concrete for a decade, but an active charter for action that assumes that change will happen, some efforts will not succeed and new issues and ideas will arise and need to be incorporated.

SIGNAL can take a lead role in overseeing the implementation, monitoring and evaluation of the initiatives, and make recommendations as to the adaptations necessary. Through constant monitoring and reporting and periodic evaluation, SIGNAL can ensure that new opportunities are taken advantage of, effective practice is built on and replicated, and any initiatives that need modification are addressed.

1.5 Reading EWA: An Agenda for Action

EWA is an agenda for action and is structured for effective implementation. It is not a linear text. It uses an innovative format to present the critical information needed to act on each initiative. This matrix structure bridges broad strategy and itemised activity. It has been designed for utility: concrete actions with clear objectives, with potential partners indicated, and with the requisite machinery of capacity, potential indicators, milestones, risks and links to other initiatives. Each initiative is based on a rationale, and each is presented in a two-page matrix.

The main structural unit is the **Initiative**. *EWA* is composed of a series of initiatives, each of which is laid out as a **Rationale** and an **Initiative Matrix.**

The **Rationale** sets out:

The issue

A summary of the issue the initiative is addressing

Evidence and context

Articulates the main contextual factors and the evidence behind the issue being addressed

What is already being done?

Acknowledges programs or activities already addressing the problem, upon which *EWA* can build

What more is needed?

Points to the gaps which *EWA* can most usefully address, or which may need further work in the future

Scope of EWA response

Describes briefly the level and type of initiative *EWA* is able to extend to, given its mandate and the role of SIGNAL and a public health nutrition approach.

Partnerships

Suggests the type of intersectoral partnerships, which may be appropriate for the initiative.

The **Initiative Matrix** uses two or three pages to summarise the essential components of the proposed actions in addressing the issue, given all the above. This is modelled on the next page. Importantly, the modelling format is not a table: the all-important þproposed actions ’are at the centre, and the supporting components surround them. Each is worded to be self-contained, but linkages to other initiatives and to essential capacity components are noted. Each is actionable once partnerships are negotiated and resources identified. *NATINSAP* uses a slightly modified version.

Name of the Initiative

<table>
<tr><td rowspan="2">Potential sector partners
Organisations in various sectors which could potentially be involved in the initiative.

The first one(s) listed and bolded are seen as potentially taking a lead role</td><td>Objective
The output or outcomes the initiative sets out to achieve, and against which it will be evaluated.</td><td>Target groups
If the initiative has target groups - primary or secondary - they are listed here.</td></tr>
<tr><td colspan="2">Proposed actions

What can be done to implement this initiative?

(The processes and outputs at the centre of the initiative).</td></tr>
<tr><td colspan="2">Funding implications
Main items of the initiative that will need to be costed and funded in the implementation of EWA.</td><td>Potential indicators
Measures of input, process, output or outcome, which can be used in monitoring or evaluating the initiative.</td></tr>
<tr><td colspan="2">Risks
What are the significant threats to the initiative achieving its objectives?</td><td>Links to other initiatives
Cross references to other initiatives in EWA that usefully intersect with this one.</td></tr>
</table>

Capacity Components

The infrastructural and capacity building requirements of the initiative.

They may be at short/term program level; medium term/ dissemination level; or longer term/ broad capability level

Part 2 Strategic management

This section addresses the implementation of EWA and NATSINSAP, its policy and resource environments. It consists of four initiatives:

- Steering the implementation of EWA and NATSINSAP;
- Developing nutrition policy;
- Establishing criteria for resource allocation; and
- Managing partnerships.

Strategic management

Initiative no. 1: Steering the implementation of EWA and NATSINSAP

The issue

SIGNAL is charged with overseeing the implementation of *EWA* and *NATSINSAP*. As major new initiatives, dedicated strategic management resources are required to ensure action at the national, state/territory government and local levels. Current resources available to SIGNAL are not sufficient for this.

Evidence and context

High level ministerial and intergovernmental support will be needed to successfully implement *EWA* and *NATSINSAP*. States and territories already have programs that will contribute to improving nutritional health and it is not the role of SIGNAL or the Commonwealth government to oversee these programs.

A wide range of public sector agencies and institutions, non-government organisations, professional organisations and industry groups, have a role to play in improving the nutritional health of Australians. *EWA* and *NATSINSAP* will also benefit from the support of these key sectors, and *NATSINSAP* in particular needs to be implemented through community consultation, input and 'ownership'.

SIGNAL needs to take a leadership/coordination role to foster the formal consultative links with other sectors, on which both *EWA* and *NATSINSAP* are substantially based. A national coordination role will add value to the work of the state and territory agencies, non-government organisations, food industry and other stakeholders. SIGNAL is one option for providing national coordination of *EWA* and *NATSINSAP*; other mechanisms may be more appropriate.

What is already being done?

The FNP and NPHNS (Stage 1) provide policy and structural backgrounds. SIGNAL is a sub-committee of the National Public Health Partnership Group. It has a secretariat located in the Commonwealth Department of Health and Aged Care. Membership includes senior staff with responsibility for nutrition from all states and territories, representatives from ANZFA, NHMRC, NZ Ministry of Health and Department of Health and Aged Care, as well as independent experts.

Framework agreements exist for cooperative planning between the Commonwealth government, state/ territory governments, ATSIC, NACCHO and state affiliates and the Torres Strait Regional Authority.

State and Territory food and nutrition policies: Food and Nutrition Directions for NSW 1996-2000; Qld Outcome Area Plan and Aboriginal And Torres Strait Islander Food and Nutrition Strategy 1995; NT Food and Nutrition Policy; SA Food and Health Policy; Tasmanian Food and Nutrition Policy; Victorian Food and Nutrition Policy and Implementation Strategy; Nutrition WA and Public Health Nutrition Business Plan 1997-2000.

What more is needed?

Consultations have proposed the establishment of a highly skilled entrepreneurial management team or taskforce which has the resources and motivation to drive the implementation of *EWA* and establish formal relationships with government and non-government partners. This team would include members specifically dedicated to managing *NATSINSAP*, with advice from an Indigenous nutrition steering group. While the task force could be outsourced along the lines of the NPHP secretariat, it would be accountable to SIGNAL. This is one of several options possible.

Scope of *EWA* response

SIGNAL can facilitate key structures, but these will need resource support from lead partners such as DHAC and OATSIH at the Commonwealth level and health and other agencies at the state/territory level. In-kind sponsorship from other partners is also an option.

Partnerships

SIGNAL and major national funding bodies; other potential in-kind sponsors.

Steering the implementation of EWA and NATSINSAP

Potential sector partners

Government health departments;

ANZFA**;**

AFGC;

DA;

NHF;

NA;

ASI;

HCA;

PHAA;

DAA;

FANO;

ABA;

MLA;

NACCHO;

CCA;

OATSIH;

AFFA,

Community Services, Transport departments;

Health Foundations.

Objectives

Manage the implementation of *EWA* and *NATSINSAP;*

Establish the formal networks needed for *EWA* and *NATSINSAP* to be sustained.

Proposed actions

1 Develop priorities for implementing *EWA;*

2 Establish dedicated strategic management team with support of lead and other partners or other mechanism;

3 Establish an Aboriginal and Torres Strait Islander Steering Committee or other mechanism;

4 Address *NATSINSAP* first phase 'priorities;

5 Establish formal mechanisms to consult with food industry and NGO representative bodies;

6 Establish working relationships with government departments responsible for agriculture, transport, community services and environment;

7 Establish working relationships with national peak bodies responsible for regulation and policy development;

8 Establish a partnership development process within and across initiatives.

Capacity components

Accountability and responsibilities of management team agreed;

Framework agreements

Partnership principles and protocols;

Secretariats for steering committee/consultative groups/committees;

Agreed outcomes, accountability and reporting mechanisms;

MOU between health and other government departments;

Review partnership protocols at 1 year;

Review consultative mechanisms at 3 years;

Review management arrangements at 5 and 10 years.

Funding implications

Management team;

Secretariat committees;

Reviews.

Potential indicators

Management team employed;

Extent stakeholders perceive the strategy as effectively managed;

Extent stakeholders perceive that networks function as intended.

Risks

Insufficient funding for management team or intergovernmental support for *EWA* and *NATSINSAP;*

State jurisdictions have insufficient resources to support implementation;

NGOs and industry consider level of representation inadequate.

Links to other initiatives

Strategic management

2 Developing nutrition policy.

4 Managing partnerships.

Communication

1 Disseminating *EWA.*

***NATSINSAP* management provisions.**

Strategic management

Initiative no. 2: Developing nutrition policy

The issue

Food and nutrition issues that require a policy response from the health sector are increasing in number and complexity as a result of developments in scientific research, food technology and changing environmental and social factors. Existing policies and instruments need to be continually revised and updated in light of these issues. Whilst government health departments can identify nutrition-related public policy issues, it must have the capacity to respond appropriately to new issues and research information.

Up-to-date public policy is essential for stakeholders to pursue their roles effectively. Ambiguity or gaps in policy result in conflicting actions and create barriers to intersectoral activity and confusion in the community.

Evidence and context

Examples of emerging food and nutrition issues include food security and poor nutrition in disadvantaged groups, increasing prevalence of obesity and Type 2 diabetes and the importance of breast feeding for long term health. The issues of genetically modified foods, health claim labelling, and functional foods have been prominent in the public arena and are of particular interest to both consumers and the food industry.

The range of responses by government health agencies involved in policy development may result in inconsistency and a lack of coherence in providing effective policy responses. Public policy affecting the community's nutritional health is developed by the Commonwealth Department of Health and Aged Care (DHAC), which includes the NHMRC, the Australia and New Zealand Food Authority (ANZFA) and the Therapeutic Goods Administration (TGA) and by state/territory health agencies.

Commonwealth government agencies have separate management structures with distinct business plans and jurisdictions. Non-government stakeholders are increasingly seeking consistent policy responses across agencies.

What is already being done?

DHAC Food Policy Section coordinates government policy, established in 1999.

DHAC developing non-communicable disease framework to better integrate action on common risk factors.

State and territory health departments developing and implementing nutrition policy as appropriate in their jurisdictions.

NHMRC Health Advisory Committee translates scientific research into health advice.

Policy instruments - Dietary guidelines, Recommended Dietary Intakes.

National Public Health Priorities Strategy 1999-2000.

Staff of agencies have regular meetings and may be co-members of committees on particular issues.

What more is needed?

An integrated approach across all agencies to develop and revise policy that addresses emerging and continuing public health nutrition issues.

One option is the establishment of a scientific reference group placed within an institution/organisation/ government department. This committee can review and update the evidence to ensure that national policy development is timely and effective.

Scope of *EWA* response

Limited to Commonwealth and state/territory government health departments and agencies. Essentially, this initiative will increase governments 'capacity to develop and implement healthy public policy.

The scientific reference group would also have a role in increasing investment in public health nutrition research.

Partnerships

Commonwealth and state/territory government health departments and agencies.

Developing nutrition policy

<table>
<tr><td rowspan="2">Potential sector partners
Government health departments;
NHMRC;
ANZFA;
AIHW;
TGA;
Codex;
AFFA;
Community Services, Transport departments.</td><td colspan="2">Objectives
Identify public policy needs that impact on nutritional health and develop appropriate and timely public policy;
Achieve consistency and/or complementarity between the activities of major Commonwealth government and state/territory health agencies.</td></tr>
<tr><td colspan="2">Proposed actions
1 Identify policy issues for review or development;
2 NHMRC establishes a standing committee on nutrition;
3 Relevant government health agencies clarify the roles and responsibilities of each agency in relation to policy development and deliver consistent and timely health policy advice to governments;
4 ANZFA to develop a policy on the effects of regulatory changes on public health nutrition;
5 DHAC/NHMRC reviews and revises the Dietary guidelines and Recommended Dietary Intakes as needed.</td></tr>
<tr><td>Funding implications
Research;
Revision of guidelines and RDIs.</td><td>Potential indicators
Specific policy tasks completed;
Extent to which key stakeholders perceive policies as consistent and complementary;
Extent to which key stakeholders perceive policies are developed in a timely fashion in response to emerging issues.</td><td rowspan="3">Capacity components
MOUs between ANZFA and both NHMRC and DHAC;
Scientific research supported by NHMRC funding;
Research on impact of advertising and labelling on consumers;
Research on/ analysis of effect of regulatory changes on public health nutrition.</td></tr>
<tr><td>Risks
Communication difficulties between government agencies;
Agencies restructured.</td><td>Links to other initiatives
Strategic management
1 Implementing EWA and NATSINSAP.
Research and development
1 Investing in public health nutrition research.
4 Promoting innovation.</td></tr>
</table>

Strategic management

Initiative no. 3: Establishing criteria for resource allocation

The issue

The public health system needs to improve its capacity to make rational, well-informed, evidence-based decisions about resource allocation in public health nutrition. This is becoming increasingly important, as there is strong competition for scarce government resources. Decisions need to take into account allocative and technical efficiency without losing sight of equity considerations.

Evidence and context

There is an overwhelming body of evidence that suggests that the burden on the community of diet-related disease is substantial. However, investment in measures to prevent diet-related disease is historically low and inadequate to halt major public health threats. There is little evidence that quantifies the benefits of investing in public health nutrition interventions or assesses the cost effectiveness of specific interventions.

Resource allocation decision making should focus on: assessing and managing risks to health, preventing chronic disease, promoting good health and reducing the isolation of public health interventions through collaboration and co-ordination. One of the few definitive pieces of work that quantified the benefits of investment in nutrition was by Steve Crowley and colleagues, 1992. Under the notion of 'attributable risk', the authors estimated the proportion of various conditions (heart disease, cancers etc) attributable to nutrition. This data needs to be expanded to cover a wider range of diseases, especially chronic diseases.

The NHMRC in its report 'Acting on Australia's Weight' estimated the direct cost of obesity to the Australian health system at $800m per annum.

The AIHW 'Burden of Disease and Injury in Australia report' 1999 estimates the contribution to the burden of disease and injury for a selection of diet-related risk factors: hypertension 5%; high blood cholesterol 3%; overweight and obesity 4%. Only one dietary factor, the inadequate consumption of vegetables and fruit was estimated, accounting for nearly 3% of the total burden of disease.

A WA study in 1998 by Codde and Unwin, found that on average per year, diet-attributable diseases accounted for 18% of all deaths and 3.2% of all hospital admissions in WA.

The 'Victorian Burden of Disease Study' also estimated that both obesity and physical inactivity make significant contributions to the mortality burden. For Indigenous communities this burden is significantly greater. In young and middle aged people, for example, mortality from cardiovascular disease is 10 – 20 times higher than for the rest of the Australian population. Type 2 diabetes is 7-8 times higher, is worse in remote areas, and occurs earlier in the lives of Indigenous Australians.

What is already being done?

DHAC is:

- formulating guidelines and criteria for the evaluation of evidence on public health interventions – the Public Health Evidence Base Advisory Mechanism (PHEBAM);
- contracting with a consortium to provide health economics advice;

- funding an analysis of the feasibility of applying priority setting and resource allocation tools to public health programs at the national level;
- funding an investigation of the returns on investment in public health; and
- funding an analysis for Active Australia on the economic costs of physical inactivity in national priority areas.

NPHP is testing the viability of the Public Health Planning and Practice Framework.

What more is needed?

Identify, quantify and disseminate the potential benefits of public health nutrition interventions for reducing health costs, especially through prevention of chronic non-communicable diseases.

Information on the effectiveness of interventions.

Scope of *EWA* response

EWA will build on and extend existing work on economic modelling by the NPHP and DHAC. It will apply this work to public health nutrition resource allocation decisions.

Partnerships

AIHW; NPHP; NHMRC; Commonwealth and state/territory government departments and agencies; health NGOs; universities; industry and transport.

<table>
<tr><td rowspan="2">Potential sector partners

Government health departments;
ANZFA;
NPHP;
SIGPAH;
NGOs i.e. DA; NHF;
Universities e.g. Centre for Evidence Based Practice;
CSIRO;
NHMRC;
AIHW;
Industry;
OATSIH;
Indigenous organisations.</td><td colspan="2">Objectives
Improve the measurement of the social and economic benefits of investments in public health nutrition;
Improve the effectiveness of resource allocation to nutrition and other public health interventions by providing health planners, public health nutritionists and public health decision makers with updated advice based on economic modeling.</td></tr>
<tr><td>Proposed actions
1 Review and expand work on 'attributable risk';
2 Identify and apply a range of economic measures, such as burden of disease, capacity to benefit, and Program Budgeting Marginal Analyses to planning EWA initiatives;
3 Through the Public Health Evidence Base Advisory Mechanism, investigate opportunities for assessing public health nutrition/physical activity interventions and initiatives;
4 Pilot the Public Health Planning and Practice Framework on vegetables and fruit initiatives, and further refine the methodology for other fields;
5 Disseminate the Public Health Planning and Practice Framework to public health nutrition practitioners;
6 Explore potential applications of economic modelling to Indigenous health.</td><td rowspan="3">Capacity components
Policy mandate within DHAC and states/ territories;
Evaluation of the impact of economic tools on programs, particularly community-based programs.</td></tr>
<tr><td>Funding implications
Reviews;
Economic planning and assessment tool pilots.</td><td>Potential indicators
Extent economic tools such as PHPPF and PHEBAM are used to plan and assess initiatives;
Public health nutrition funding allocation demonstrates optimal investment.</td></tr>
<tr><td>Risks
Complexity of nutrition issues makes using economic analyses difficult;
Resource techniques place too much emphasis on efficiency vs. equity;
PHN loses social/community support.</td><td>Links to other initiatives
Research and Development
1 Investing in public health nutrition research.
2 Disseminating research evidence.</td></tr>
</table>

Strategic management

Initiative no. 4: Managing partnerships

The issue

There is considerable potential to foster partnerships that both promote the public good and achieve benefits for the partners involved. Successful implementation of *EWA* will depend on maintaining strong and flexible partnership arrangements. Governments should seek to expand their capacity to facilitate partnerships amongst stakeholders.

Evidence and context

Partnerships between stakeholders in the food and nutrition system are increasingly important for combining expertise and resources. However, there are concerns in each sector that the interests of other sectors not dominate the national nutrition agenda, and that interests represented in *EWA* are within its scope.

The effective management of partnerships combines fields such as negotiation, ethics, risks, contracts and agreements, business planning and project monitoring. Few people in public health nutrition have formal training in all such fields, nor are there readily available models, protocols or guidelines for managing partnerships. In NSW, health promotion experts are currently developing indicators for assessing the value and effectiveness of partnerships and intersectoral action.

What is already being done?

Existing partnerships involve many groupings, examples include:

- industry and professional groups (Coles and DAA);
- NGOs and industry (NHF, Shell roadhouses and edible oil manufacturers, Anti-Cancer Council LifeTrak program with industry partners); government and industry (Tasmania's Eat Well Tasmania Campaign, Sydney's Fresh Food Bowl);
- industry and research (Sanitarium and its Australasian Nutrition Advisory Council);
- government, industry and NGOs (GO GRAINS); and
- food service industry and government (WA Healthy Choices Award and Foodsafe Program).

Effective management of partnerships is an issue for government:

- the NPHP has published advice ('Issues for Consideration in Industry Partnerships for Public Health Initiatives'); and
- the Tasmanian Government has issued a Partnership Framework for project managers.

In 1999, SIGNAL developed draft partnership protocols for working with the vegetables and fruit sector. NSW Health has published 'Indicators to help with capacity building in health promotion' (1999) by Hawe P, King L, Noort M, Jordens C and Lloyd B.

Forums exist in every state and territory to work on Framework Agreements for Aboriginal and Torres Strait Islander Health. The Agreements are signed by the Commonwealth government, Aboriginal

Community Controlled Health Organisations, the Aboriginal & Torres Strait Islander Commission and state/territory health departments.

What more is needed?

An agreed policy framework for partnerships.

Models and training in managing partnerships made available to potential partners in public health nutrition. These resources should be applicable across a range of organisations and types of partnerships.

Scope of *EWA* response

EWA can provide guidelines and resource material to refer to in creating partnerships with realistic goals when implementing *EWA.* These resources could be incorporated into professional development and accessed on a needs basis by all relevant groups.

Potential sector partners

NPHP;

Government health departments;

ANZFA;

CSIRO;

Indigenous organisations;

Peak Industry;

AFGC;

AUF;

MLA;

Universities with public health nutrition programs;

NGOs i.e. DA, NHF, ACA, NA;

Health promotion foundations;

Environmental health.

Objective

Identify, foster and effectively manage the partnership arrangements needed to implement *EWA and NATSINSAP*.

Target groups

Public health nutrition practitioners;

Organisations involved in the food and nutrition system.

Proposed actions

1 Review current materials and best practices in partnerships, and develop national protocols, guidelines and resources accordingly;

2 Promote use of guidelines and resources in tertiary public health nutrition education, continuing education and professional development;

3 Disseminate partnership models and protocols to stakeholders at all levels;

4 Investigate the feasibility of developing a national nutrition promotion group to promote effective management of partnerships across sectors;

5 Disseminate partnership protocols to state and local stakeholders and public health nutrition workforce;

6 Use Framework Agreements to progress Indigenous nutrition related health measures.

Capacity components

Effective dissemination of the resources will require some needs analysis;

Existing resources provide a running start, requiring national application;

Diverse products are needed to meet types of demand;

Evaluation to focus on stakeholder assessment of resources.

Funding implications

Protocols/guidelines;

Secretariats for partnerships which implement initiatives;

In-service courses;

Funding sponsorship sought from private sector sources and government health departments.

Potential indicators

Extent stakeholders perceive improved partnership capacity and practices;

Uptake of formal partnership arrangements with the private sector;

Range and types of partnerships formed;

Number of MOUs signed between partners.

Risks

Resources are general enough for wide use.

Links to other initiatives

Strategic management

1 Implementing *EWA* and *NATSINSAP*.

Workforce development

1 Building human resource requirements.

Part 3 EWA Health gain initiatives

This section contains initiatives covering

- Vulnerable groups
- Promoting healthy weight
- Vegetables and fruit
- Maternal and child health

Vulnerable groups

Some groups in the community are especially vulnerable to food insecurity. That is, they are unable to consistently access an adequate amount of food to live active and healthy lives, or have the assured ability to acquire acceptable foods in socially acceptable ways. At least four studies of low-income households in NSW and Victoria describe instances where low-income households limit their food purchasing and intake, either periodically or chronically. The 1995 National Nutrition Survey found that 10% of men and women aged between 19 and 24 reported that at some time in the previous 12 months they had run out of food and had no money to buy more.

Low income combined with high food costs results in many Aboriginal and Torres Strait Islander people spending a large percentage of their income on food and contributes to concerns among Indigenous Australians of going without food. Thirty percent of Aboriginal adults worry at least occasionally about going without food. Concern about food security was greater among people who were aged 25-44 years old, lived in rural areas, lived in a household where no-one was working and who were living in households with one or more dependent children.

Additionally, the misuse of substances such as alcohol and tobacco usage may also divert money away from food and other necessities. For example, a study in remote communities indicated more than 50 percent of resources spent were on tobacco and beer, in contrast to less than 20 percent being spent on these commodities in the general community.

There are many possible causes of food insecurity - poverty, remoteness and limited physical access to food, frailness, social isolation and chronic illness. Causes can readily compound as is the case for Indigenous Australians who are on low incomes and living in remote communities, sometimes cut off from services, and for older people living alone with a chronic illness. People with disabilities often face extra costs as a result of the disability.

The lack of reliable access to food may be constant, cyclical or temporary and linked to specific events or crises such as unavoidable financial crises.

For the purposes of *EWA*, groups within the community who are considered more vulnerable to poor nutrition because of structural, and financial constraints include:

- people on low-incomes;
- people with disabilities (physical, intellectual and developmental);
- chronically ill people (including people with mental health problems);
- people with dementia;
- frail older people;
- refugees;
- alcohol or drug abusers; and
- homeless people.

Families or carers of some vulnerable groups can themselves become vulnerable. Some ethnic groups may be included where they are departing from traditional diets but not taking up nutritious alternatives or where they have limited access to culturally appropriate services or have limited incomes. People who consume excessive amounts of alcohol are susceptible to poor nutrition and at risk of nutrition deficiency diseases such as Wernicke Korsakoff Syndrome. Strategies to minimise the consequences of alcohol-related harm for vulnerable groups are detailed in the Commonwealth government's National Alcohol Action Plan.

Nutrition issues for Indigenous communities are addressed in a range of initiatives in *EWA* and, to ensure adequate resources are dedicated to addressing the serious nutrition problems faced by Indigenous communities, more specifically, in *NATSINSAP*.

The following initiatives aim to address many of the fundamental social, organisational and economic factors that deny individuals and particular groups in the community access to a variety of affordable nutritious foods. Ensuring vulnerable people obtain adequate nutrition is a complex issue. Groups vary in their ability to access services. Where services exist, they may not have adequate resources to provide social as well as nutrient needs. Developing local solutions in partnership with the community and local providers and the private sector is important.

To address the problems of food insecurity and poor nutritional status, governments at all levels need to provide leadership through pro-active social policy and through funding of community organisations and services. Where possible, joint programs with related government initiatives such as the National Drug Strategic Framework and Action Plans should be undertaken.

Vulnerable people need to be provided with sufficient income to purchase food and be able to access affordable food from retail outlets or emergency food relief when necessary. Some groups of vulnerable people (frail and disabled and homeless) rely on others to provide meals in the home or in organised settings. Support and assistance is required for those living in organised settings who share cooking, such as mental health residential services and Supported Accommodation Assistance Program and Substitute Care Services. These organisations need to be adequately funded.

Vulnerable groups

Initiative no. 1: Promoting organisational change in services

The issue

Government and non-government agencies that provide services for vulnerable groups are generally unaware of the short and long- term effects of an inadequate diet on nutrition and health. This leads to the failure of government and non-government agencies to sufficiently support the provision of food and nutritional resources at the service level.

Evidence and context

There are increasing numbers of people who are socially disadvantaged and find it difficult to obtain a sufficient, and nutritionally adequate, supply of food. Although some food and nutrition problems are due to poverty, people living in poverty may be well nourished. Alternatively, some people receiving government services have significant food and nutrition problems that are unrecognised.

An array of government agencies provide services to vulnerable groups in the community, for example, the Supported Accommodation Assistance Program (SAAP), aged care services such as Home and Community Care (HACC), disability services, alcohol and drug services and Meals-on-Wheels. At the end of June 1996, 5,092 not-for-profit organisations were involved in the direct provision of community services. Volunteers also provide many services.

There is increasing pressure on this sector to respond to growing disadvantage. Most agencies, health workers, community workers and welfare organisations do not have sufficient resources or expertise in food and nutrition. Studies indicate that the meal services for many groups of vulnerable people do not meet nutrition recommendations. For many organisations it is not core business and they rarely consider food and nutrition issues at the policy, infrastructure or service delivery levels.

What is already being done?

Welfare agencies struggle to provide food in the form of free or subsidised meals, food that clients can use to prepare meals themselves, food budgeting advice, food parcels and food vouchers.

State food banks distribute 4,000 tonnes of food nationally every year through a myriad of community support agencies to Australians in need.

Youth and homelessness food programs exist in larger cities and towns.

Meals on Wheels services operate at the local and regional level.

WA Food Cent$ Program uses the salience of a budgeting message to promote nutritious food to people on low incomes and train welfare workers in nutrition.

Food service in organised settings encompasses nursing homes, Meals on Wheels services, boarding houses, gaols and community residential centres for people with disabilities. Their management is fragmented, with a mosaic of funding bodies, government and non-government agencies responsible for services.

The NSW Standards for Substitute Care and SAAP are being reviewed for nutrition content.

US Department of Agriculture's Food and Nutrition Resource Guide for Homeless Shelters, Soup Kitchens and Food Banks.

Review of national competency standards for community services through Community Services and Health Training Australia, due mid 2001.

What more is needed?

EWA can provide leadership for agencies that have contact with vulnerable people to identify and change services, work practices and policies which impact on food and nutrition. Further, it can build the capacity of agencies to recognise the impact of nutrition on the client's life and promote good practice models. Nutrition competencies need to be included in the training of community workers.

Scope of *EWA* response

EWA has a catalyst role and should work with government and non-government agencies with expertise in relevant fields, eg dealing with families or individuals on very low incomes. This initiative is closely linked

to 'Influencing broad social policy'. The scope also allows for opportunities to train welfare workers in nutrition.

Validated food security indicators to be developed as part of a national food and nutrition monitoring system.

Measures addressing Indigenous health will need to be culturally appropriate and specific training may be needed.

Partnerships

By working with government and non-government agencies in the welfare and community services sector, government health departments can facilitate the development of effective model food and nutrition programs as part of a healthy life for vulnerable groups.

Promoting organisational change in services

Potential sector partners

Government health departments;

DFaCS;

Peak welfare and advocacy groups;

Food banks;

Private sector;

NPHP;

HACC;

Non-health government agencies;

Community Services and Health Training Australia;

Education sector.

Objective

Ensure that vulnerable groups have access to sufficient and nutritionally adequate food by bringing about organisational change in government and non-government services where these services impact on food and nutrition needs, and by developing effective model programs that address food and nutrition issues for a range of groups.

Target groups

Providers of services to groups defined as vulnerable.

Proposed actions

1 Review the range of existing services, identify where services impact on food and nutrition and recommend what organisational changes and training are needed to improve food and nutrition;

2 Encourage the development of partnerships at a local level to increase the nutrition capacity of welfare organisations;

3 Identify and disseminate resources and models of effective food and nutrition initiatives for vulnerable groups (such as FOOD Cent$ Program) across jurisdictions and sectors;

4 Set up a nutrition information service for welfare providers;

5 Develop nutrition guidelines for agencies that provide meal services for vulnerable groups and recommend ways to ensure they are adopted;

6 Provide expert advice on nutrition training needs to the community services training and education sector as opportunities arise.

Capacity components

Partnerships for review and dissemination;

Existing food services for vulnerable groups;

Background information on vulnerable groups;

Partners to jointly resource initiative;

Validated food security indicators.

Funding implications

Review and dissemination will require resources from partners, possibly in-kind;

Sponsorship to sustain information service;

Development of validated measurement tools.

Potential indicators

Extent of changes to key services that impact on food and nutrition; Extent of uptake of models/nutrition standards; percentage of people defined as food insecure 'using a range of validated measures; Extent groups using emergency food sites.

Risks

Service agencies lack expertise and resources to take leadership role in nutrition matters;

Complexity of issues facing vulnerable groups reduces importance of nutrition;

The intersectoral nature of problems creates difficulties.

Links to other initiatives

Vulnerable groups

2 Influencing broad social policy.

3 Addressing structural barriers to accessing safe and healthy food.

Monitoring and evaluation

1 A national food and nutrition monitoring system. *NATSINSAP*.

2 Food security.

Communication

1 Disseminating the *EWA* strategies.

2 Communicating with the public.

Vulnerable groups

Initiative no. 2: Influencing broad social policy

The issue

Government policy can affect the affordability and accessibility of food. Vulnerable groups are particularly affected by policy which impacts on their income, the cost of food or their ready access to safe, nutritious and culturally appropriate food.

Evidence and context

Government policies relating to taxation, pensions, sustainable agriculture, transport, trade, labeling and advertising can influence buying patterns or prices, and affect consumption in low-income households. Government funding and taxation strategies also impact on the delivery of community services. For example, government policies that encourage food manufacturers and wholesalers to dispose of surplus food through food banks, whether through tax concessions or other means, increase the range and variety of food available to those in need. The remote community unemployment benefit includes a remote area allowance of 5%, but the cost of food is up to 50% higher than in coastal and metropolitan Australia. The disability pension does not cover the high costs of special diets, if needed.

The proposed National Principles for SAAP Service Standards and the existing NSW Standards for Substitute Care and SAAP Services offer the opportunity to influence the provision of food to homeless people.

At a local level, policies that impact on town planning can impact on local food costs and access. Many policy decisions are made without considering their impact on public health nutrition, often because information is not available.

There is limited research information on the nutritional impact of poverty and other disadvantage. Systematic research is needed to describe the situation and establish appropriate policy responses. A 'whole of government' response will include commitment by government agencies to improve vulnerable people's ability to purchase and access healthy food.

What is already being done?

The Goods and Services Tax (GST) is not applied to fresh foods;

New food labelling standards may influence food prices;

1999 Commonwealth government's Enhanced Primary Care Package;

National Principles for SAAP Service Standards;

NSW Standards for Substitute Care and SAAP Services currently being reviewed;

1998 Food Regulation Review;

Consumer Health Forum reference to ANZFA on unit pricing (1999);

National Drug Strategic Framework and National Alcohol Action Plan and National Tobacco Strategy 1999 to 2002-03.

What more is needed?

Policies and actions that improve access to an adequate supply of healthy food. Policies and actions need to take a whole of government approach and to be based on good information. Further research is needed to inform policy.

Scope of *EWA* response

EWA can provide initial assessment of the situation and set the scene for inter-governmental negotiation and activity.

Policy change should support organisational changes to service delivery and other structural changes and individual behaviour change. Where policy affects the mainstream, special notice should also be taken of the effect on Indigenous communities.

The initiative 'Implementing *EWA*' sets up mechanisms for encouraging a whole of government approach.

Partnerships

Government and non-government organisations in the welfare and community sector.

Influencing broad social policy

Potential sector partners **Government health departments;** NPHP; ANZFA; ACOSS; OATSIH; ACA; ANZFA; Non-health government agencies; Australian Local Government Association; State/territory governments; Peak advocacy groups eg Disability Councils; Private transport sector; Food industry; Food retail sector.	**Objective** Influence broad social policy to make food affordable and accessible for vulnerable groups. **Proposed actions** 1 Account of nutrition issues in public health responses to vulnerable people; 2 Conduct feasibility studies into the potential impact of relevant non-health government policies, eg tax or pensions or other economic instruments, on consumption of foods that meet dietary guidelines; 3 Identify research needs around the nutritional impact of poverty and other disadvantage; 4 Develop policy positions based on the feasibility and research studies; 5 Consider policy modifications as a result of studies.	**Target groups** Low income people; People on pensions; Older people; Indigenous Australians; Remote populations. **Capacity components** Resources for feasibility study; Policy model, precedent or framework; High level support needed for successful negotiations at policy level, to ministerial level.
Funding implications Feasibility studies; Research.	**Potential indicators** Number of feasibility studies completed; Extent and type of research funded; Extent NPHP policy/statements take account of nutrition; Extent beneficial policy modifications identified; Extent new policy/ies implemented.	
Risks Health interests may not prevail over others, eg revenue.	**Links to other initiatives** **Strategic management** 1 Implementing *EWA* and *NATSINSAP*. 2 Nutrition policy development and reform. **Vulnerable groups** 1 Promoting organisational change in services. 3 Addressing structural barriers to accessing safe and healthy food. **Research and development** 1 Investing in public health nutrition research. 2 Disseminating research evidence. **Communication** 1 Disseminating the *EWA* strategy. 2 Communicating with the public. ***NATSINSAP*** 2 Food security.	

Vulnerable groups

Initiative no. 3: Addressing structural barriers to safe and healthy food

The issue

Food choice is not just a matter of knowledge but is also influenced by physical, economic, cultural and other structural factors. Vulnerable groups have less personal and economic resources to overcome structural barriers.

Evidence and context

Activities aimed at changing behaviour and knowledge will struggle against underlying structural factors that affect equitable access to food. Some of these forces are town planning norms and regulations, public transport, food supply systems, competitive prices for food and user friendly shopping. Food has been shown to be more expensive in locations with high concentrations of disadvantaged people, particularly Indigenous Australians and some rural communities (Market Basket Survey). The food choices are often limited in these locations and barriers to Indigenous Australians access to traditional foods exacerbate their disadvantage.

Lack of resources in higher population areas (for example, car ownership) or poorly organised public transport to retail centres, confines disadvantaged people to buying food locally where there may be less choice or higher prices. Public infrastructure in metropolitan areas, such as public transport and its affordability, also influence access to food.

Food supply structural factors such as transport practices and costs, and handling and promotion at the retail level affect the cost and range of foods available. The cost of freight is a major impediment to wider implementation of food assistance programs, especially in rural areas. Government support through subsided freight or carriage on government rail networks (where available) would greatly assist these programs.

There is a lack of community and professional awareness of structural factors that affect access to food.

What is already being done?

Fresh foods are not taxed under the Year 2000 Goods and Services Tax. However, the impact of the GST compliance system on small business and flow-on costs to small communities is not yet known.

Local government food policies eg Penrith and South Sydney Councils 'policies address local structural barriers.

New Zealand Network Against Poverty Report – 'Hidden Hunger: Food and low income in New Zealand ' (1999).

Food Share Australia program provides a food package for a low fee, and community service with Nutrition Australia providing education resources to recipients

What more is needed?

Actions that engage the private sector in practices that lead to greater availability of safe and healthy food, and which encourage local government to address local structural problems.

Remove barriers to Indigenous Australians access to traditional foods.

Scope of *EWA* response

EWA recognises that other issues impact on food access and it is a particular problem for Indigenous communities. *NATSINSAP* has several initiatives that address various aspects of access.

Access to food is also influenced by income, which in turn is influenced by broader social policies. Nutrition knowledge and food preparation skills are addressed in the 'Communication' section.

Partnerships

Transport and government; Food retail industry and government; Government health departments.

Potential sector partners

Government health departments;
ANZFA;
ACOSS;
Community transport groups;
AFGC;
ASI ;
Local governments;
State/territory governments;
Private transport sector;
Food retail sector;
Non-health government agencies;
Community food service providers.

Objective

Ensure that vulnerable groups have equitable access to foods, which are safe, nutritious, affordable and culturally appropriate.

Target groups

Low income people;
Pensioners and older people;
Indigenous Australians;
Remote populations.

Proposed actions

1 Commission studies into non-policy based structural barriers and promoters that impact on the consumption of healthy foods by at risk groups;
2 Develop policy positions based on the feasibility and research studies 'results;
3 Bipartisan government support for government and non-government initiatives that address structural barriers to food access;
4 Identify actions that retailers, food manufacturers and private transport can take;
5 Recognise retail, transport and food manufacturers who change their practices toward increasing the availability of affordable and nutritionally desirable food;
6 Develop and implement a remote food subsidies program in collaboration with non-health government agencies and the private sector;
7 Improve access to healthy food including traditional foods for Indigenous Australians;
8 Review and disseminate evidence to practitioners on the role of local government food policies in addressing local structural barriers and promoters which impact on the consumption of healthy food.

Capacity components

Resources for feasibility;
Policy model, precedent or framework;
High level support needed for successful negotiations at policy level, to ministerial level;
Private sector and government coalition.

Funding implications

Cost of feasibility study.

Potential indicators

Studies completed; Extent of bipartisan support;
Extent of actions taken by private sector to address structural barriers to access; Extent remote subsidies program implemented;
Range of affordable and nutritious food available in disadvantaged locations.

Risks

Health interests may not prevail over others, eg revenue;
Intersectoral problems create difficulties.

Links to other initiatives

Strategic management
1 Implementing *EWA* and *NATSINSAP*.
2 Nutrition policy development and reform.

Vulnerable people
1 Promoting organisational change in services.
2 Influencing broad social policy.

Research and development
1 Investing in public health nutrition.
2 Disseminating research evidence.

Communication
1 Disseminating the *EWA* strategy.
2 Communicating with the public.

NATSINSAP
1 Food supply in rural and remote areas.
2 Food security.

Promoting healthy weight

The World Health Organisation has identified the increasing prevalence of obesity as a major public health problem for developed countries and an increasing number of developing countries. In Australia, the proportion of the population classified as obese (measured as a Body Mass Index of 30 or more) has doubled in the ten years to 1995 (from 9% to 18%), (Ref: Australian Institute of Health and Welfare. Unpublished analysis of the 1995 National Nutrition Survey. 1999. Canberra) and there is every indication that this trend will continue to increase over the coming decades.

Obesity is a major health issue for Aboriginal and Torres Strait Islander peoples, with some 25% of men and 28% of women over 18 years classified as obese in 1995 (Ref: Australian Bureau of Statistics. *1995 National Health Survey: Aboriginal and Torres Strait Islander results*. Australian Bureau of Statistics, 1999. Canberra) compared with the national Australian prevalence of around 18% (people aged 19 years and over) identified in the 1995 National Nutrition Survey (Ref: Australian Bureau of Statistics and Commonwealth Department of Health and Aged Care. National Nutrition Survey: Nutrient intakes and physical measurements, Australia, 1995. Australian Bureau of Statistics, 1998, Canberra).

While the promoting healthy weight issue has been identified as one of the four major priority areas of *EWA*, it is not an issue that can be addressed in isolation. It has a strong interrelationship with the other major priority areas in the framework (the promotion of vegetables and fruit and addressing the nutritional needs of vulnerable groups, women and children) and needs to be an integral component of the activities developed for these areas, including the strategies developed in *NATSINSAP*.

It is also important that *EWA*'s initiatives on overweight and obesity link with Australia's National Health Priority Area strategies and other national health strategies relating to chronic non-communicable disease. Of particular importance are strategies to promote regular physical activity in the population.

More broadly, acknowledging the complex and multi-factorial nature of the aetiology and management of overweight and obesity, *EWA* reflects the necessity for a wide range of sectors (including those not traditionally associated with health) to work together to address this important issue.

Acting on Australia's Weight'

Australia is a world leader in addressing overweight and obesity issues at a population level.

In 1997, the National Health and Medical Research Council (NHMRC) released a report entitled Acting on Australia's Weight: a strategic plan for the prevention of overweight and obesity. The report was prepared by the NHMRC Working Party on the Prevention of Overweight and Obesity - a joint activity of the NHMRC Environmental Health and Nutrition Standing Committee and the Health Advancement Standing Committee.

The report:

- set out the evidence for focussing on the prevention of overweight and obesity to complement the already significant amount of effort being directed towards management and treatment;

- recommended changes in the environments in which people live to make it easier for them to be physically active and consume a healthy diet; and
- set a goal, for the recommended 10 year implementation period, to prevent further weight gain in adults and eventually reduce the proportion of the adult population that is overweight or obese, and to ensure the healthy growth of children.

Following the release of 'Acting on Australia's Weight' in 1997, the Commonwealth Department of Health and Aged Care commissioned the development of a detailed implementation strategy. This work, completed in January 1999, was undertaken by the Health Strategies Deakin group at Deakin University, working in association with the National Heart Foundation (Victoria).

Among its recommendations, the report emphasised the critical need for implementation to be underpinned by strategic management and high-level leadership; the building of effective partnerships; and the need to ensure promoting healthy weight maintains a high profile on public, private and government agendas.

To facilitate this, the report recommended the establishment of a group of experts to advise governments and the Strategic Inter-Governmental Nutrition Alliance (SIGNAL) on promoting healthy weight issues. The National Obesity Prevention Group (NOPG) was subsequently convened in June 1999, operating under the auspices of SIGNAL.

The key focus areas of NOPG during 1999 were to investigate the development of guidelines for the prevention and management of overweight and obesity in adults and to investigate issues relating to childhood obesity. NOPG members also contributed to the development of *EWA*.

Early in 2000, the NOPG was restructured, with members forming part of a broader informal network of experts to address issues relating to chronic non-communicable disease.

Initiative no. 1: Promoting healthy weight

The issue

The prevalence of obesity in Australia doubled in the 10 years to 1995 from 9% to 18%. For Aboriginal and Torres Strait Islander peoples, about 25% of males and 28% of females were classified as obese in 1994. Unhealthy weight gain is a major contributor to ill health and places a heavy burden on individuals and on social, economic and health systems. Urgent action to reverse this trend is required.

Evidence and context

The causes of overweight and obesity are complex and include inherited characteristics, aspects of lifestyle, eg diet and activity, and psychological factors. Increasing rates of obesity are probably the result of small decreases in physical activity and small changes in food intake by many, rather than extreme inactivity and excessive food intake among a few. Treatment and management remain important but preventing unhealthy weight gain in the population, together with promoting the healthy growth of children offer the best hope of addressing these current Australian trends.

Lack of sound scientific evidence for successful public health interventions specifically targeting overweight and obesity prevention makes setting priorities for action difficult.

The current evidence suggests that tackling overweight and obesity requires a high degree of sensitivity, long term commitment, inter-sectoral collaboration and action and environmental modification to make it easy for people to be active and eat a healthy diet in their everyday settings.

What is already being done?

Internationally, overweight and obesity are recognised as serious health, social and economic problems. The WHO has called for urgent action to address this 'global epidemic'.

In Australia, the NHMRC developed 'Acting on Australia's Weight' to focus on healthy eating and regular moderate physical activity for all, and on the healthy growth of children.

Scientifically valid guidelines for health professionals and consumers for the treatment and management of overweight and obesity are also being developed by the NHMRC.

Structures have been established to advise governments, eg the Strategic Inter-Governmental Nutrition Alliance (SIGNAL), the Strategic Inter-governmental Forum on Physical Activity and Health (SIGPAH) and the national obesity network of experts.

In addition, various government, industry and non-government bodies promote physically active lifestyles and healthy eating habits.

What more is needed?

Key decision makers in relevant sectors who understand the societal implications of the current trends in overweight and obesity and are committed to leading action on reversing them.

The capacity to monitor and evaluate trends effectively, particularly in children.

Action-oriented research to guide policy and program development.

Improving access to a healthy diet at an affordable price, including improving the quality of takeaway foods and foods eaten outside the home.

In particular, there is a need to develop, implement and evaluate a range of settings based, and/or specific population group interventions.

Scope of *EWA* response

EWA sets out a number of concrete steps that drive the urgent action that is needed to reverse the current trend. *EWA* also gives further impetus to implementing priorities outlined in 'Acting on Australia's Weight' and the subsequent implementation plan.

The attached activities were selected on the basis of their capacity to have a strong initial impact in the first phase of *EWA*. Further rounds of the strategy will need to review these choices, and reformulate the initiative as needed.

Actions based on 'Acting on Australia's Weight' are also linked to other *EWA* initiatives for vulnerable people, *NATSINSAP*, the vegetables and fruit initiatives and child and maternal health initiatives.

Partnerships

Build on and develop partnerships between governments, industry, and non- government organisations.

Potential sector partners

Government health departments;

NHMRC;

Research sector;

Food industry, including fast food industry;

Weight loss industry;

Private and public transport sector;

Media sector;

Peak industry and advocacy groups, including DA and NHF;

NGOs, including social welfare groups;

Non-health government departments (Commonwealth and state/territory).

Objective

Halt the trend of increasing overweight and obesity by giving added impetus to implementing the NHMRC strategic plan 'Acting on Australia's Weight', by coordinating action between national strategies to focus on promoting healthy lifestyles and by developing guidelines for professionals on healthy weight management and obesity prevention.

Proposed actions

1 Strategic research on issues relating to overweight and obesity;

2 Develop guidelines for the prevention, management and treatment of obesity in clinical settings and for community-based programs;

3 Develop a strategy to reduce the prevalence of childhood obesity;

4 Develop systems and tools to monitor overweight and obesity, particularly for children;

5 Design and develop model multi-strategy regional or population level interventions to guide national policy and planning on overweight and obesity;

6 Increase awareness of the health impact of overweight and obesity.

Capacity components

SIGNAL;

SIGPAH;

NHMRC;

Network of experts in overweight and obesity;

GP networks;

Research networks, including PHERP;

Workforce programs, including the Post-graduate Public Health Program for Clinicians;

Active Australia Alliance;

Inter-sectoral partnerships;

Reviews at 1, 3 and 5 years.

Funding implications

Guidelines;

Model intervention projects;

Communication strategy;

Monitoring systems;

Research.

Potential indicators

Guidelines developed by type;

Communication strategy developed & implemented;

Extent key decision makers recognise the implications of trend to overweight and obesity;

Number of intervention projects implemented and evaluated;

The prevalence of overweight and obesity by target group.

Risks

Failure to secure industry commitment and inter-sectoral action;

Inappropriate actions by some consumers as result of media ie increase in prevalence of eating disorders, or;

Inadequate communication strategy could result in complacency by decision-makers and individuals - ie failure to see obesity as a health risk.

Links to other initiatives

Strategic management

1 Implementing *EWA* and *NATINSAP*.

2 Nutrition policy development and reform.

Communication

1 Disseminating *EWA*..

2 Communicating with the public.

Vulnerable people

1 Addressing structural barriers to safe and healthy food.

2 *NATSINSAP*.

Monitoring and evaluation

1 A national food and nutrition monitoring system.

Child and Maternal Health

National Child Nutrition Program, and others.

Vegetables and fruit

Initiative no. 1: Undertaking vegetables and fruit promotions

The issue

On average, Australians do not consume enough vegetables and fruit for optimal health. We eat four to five serves or less a day, while epidemiological studies show strong health benefits from eating seven serves a day.

Evidence and context

Epidemiological and clinical studies indicate that an adequate consumption of vegetables and fruit protects against diseases such as coronary heart disease, hypertension, stroke, Type 2 diabetes and many forms of cancer. The 1995 National Nutrition Survey shows that patterns of vegetables and fruit consumption vary and reflect the socio-economic characteristics of consumers, their geographical location and differences in age and sex.

Consumers have said that their intake is influenced by high prices, especially of fruit, time taken to prepare vegetables, lack of or limited supply, poor quality, and concerns about pesticide. Social and domestic changes have resulted in families having less time to prepare food and a decline in cooking skills, which may further limit consumption of vegetables and fruit.

Consumption is also influenced by wholesale and transport practices and costs, particularly in remote areas, and handling and promotion at the retail level. Fruit competes with snack foods, and more needs to be known about the competitors for vegetables in the commercial environment.

What is already being done?

CSIRO report for SIGNAL: 'An issues paper on barriers to the consumption of fruit and vegetables, and previous efforts to promote an increased consumption of fruit and vegetables '(1999).

Examples of state/territory activities:

- WA, Food Cent$ and state frut and vegetable campaigns 1990-2000;
- SA, Eat Well SA ';
- Vic, Healthy Eating Communications Strategy ';
- NSW, Fruit and Vegetable Tool Kit 'for health professionals and Sydney Fresh Food Bowl Project ';
- Qld, Research on effective practice and monitoring tool to assess intake ';
- NT, Improving food supply in remote communities '; and
- Tas, Eat Well Tasmania '.

Examples of retail sector promotions:

- Coles 7 a Day '; five year national campaign with DAA, launched in 1999; Other retailers also promote vegetables and fruit;

Peak grower groups marketing campaigns:

- Queensland Fruit and Vegetable Growers;
- Australian United Fresh, 'Vegies for Aussie Kids 'and Vegies are fun';
- Sydney Markets with NSW Education, School Sports 2000';
- ANZFA & AFGC: Pilot folate and neural tube defect health claim;
- GO GRAINS Partnership Project funded by GRDC;
- Nutrition Australia promotional activities.

Diabetes Australia produces diabetes specific information on vegetables and fruit for Woolworths and general community education, Supermarket Sleuth Tours, and support state programs.

What more is needed?

A nationally integrated and long-term campaign to increase vegetables and fruit consumption, which includes private, non-profit and government sector partners.

Scope of *EWA* response

EWA can support research to address issues in the Australian context.

The promotional campaign must also be supported by policy changes that address the underlying structural barriers to increased vegetables and fruit consumption (see 'Vegetables and fruit 'initiative 2).

Specific activities for children are linked with the maternal and child health initiative for school-aged children.

EWA can also support food supply initiatives identified in *NATSINSAP* to improve the supply of affordable, high quality vegetables and fruit to Indigenous Australians, particularly those living in remote areas.

Partnerships

Vegetables and fruit grower groups, retail sector, health agencies, NGOs, non-health government departments, government health departments.

Potential sector partners

Government health departments;
State/territory agriculture;
AHC;
National Chamber of Food Industry eg Canned Food Information Service;
AUF;
QFVG;
NHF;
Cancer Councils;
Local government;
Education sector;
Retail sector;
MLA;
DA;
GRDC;
ATSIC;
OATSIH.

Objectives

Increase the proportion of the population who consume vegetables and fruit every day;

Increase the proportion of the population who consume vegetables and fruit at or above the recommended level.

Target groups

General population;
Young people;
Low-income groups;
Indigenous Australians;
Remote and rural communities.

Proposed actions

1 Establish long-term national and state-based partnerships with industry, vegetables and fruit peak groups, non-government and sector partners;
2 Parameters of social marketing and promotional programs defined by social marketing research as outlined in the National Vegetables and Fruit Action Plan;
3 Disseminate best practice models across jurisdictions, including seed funding of local initiatives;
4 Address issues of supply to remote communities;
5 Develop guidelines (recommended intake, messages) for the promotion of vegetables and fruit;
6 Public health nutrition professionals build partnerships with the community to develop local solutions and programs that support promotional campaigns.

Capacity components

Vegetables and Fruit Working Group;
Protocols for management of partnerships;
Research data for program development and long-term evaluation;
Training and Development for program workforce;
Monitoring and evaluation plan.

Funding implications

Promotional costs via sponsorship;
Seed funding for adaptations;
Research and evaluation costs.

Potential indicators

National Vegetables and Fruit Action Plan process indicators;
Consumption patterns show correlation with promotional activities;
Level of funding committed by partners.

Risks

Partnerships are inadequately managed;
Campaign may not have same reach to some target groups;
Changes to grower levies may influence the amount of money available for cross-sectoral promotion;
Vegetables and fruit promotion does not attract media interest;
Vegetables and fruit access in remote areas doesn t improve.

Links with other initiatives

All other vegetables and fruit initiatives

Communication

2 Communicating with the public.

Promoting healthy weight.

Maternal and child health

4 Nutrition for school-aged children.

NATSINSAP

1 Food supply in rural and remote areas.

Vegetables and fruit

Initiative no. 2: Addressing underlying structural factors which influence vegetables and fruit consumption

The issue

Improvements in vegetables and fruit consumption as a result of promotional activities will struggle against underlying structural factors - social, physical and economic.

Evidence and context

Consumption is influenced by structural factors such as wholesale and transport practices and costs, particularly in remote areas, and handling and promotion at the retail level nationally. Cost components of accessibility can include imposts throughout the value chain: costs of production, processing, transport, marketing and sale. Changes in cost components can have an impact on either final price or cost effectiveness of selling in marginal locations.

Government policies relating to taxation, transportation, import/export, labelling and advertising can affect consumption. A 'whole of government' response will include commitment by agencies along the whole value chain. It will also address affordability issues for vulnerable groups, for example through taxation or pension schemes.

Many policy decisions are made without full consideration of the impact of policy change on public health nutrition. This is often because information is not available. Also, decisions affecting Indigenous communities are often made without reference to them.

What is already being done?

Goods and Services Tax does not apply to staple and fresh foods.

Qld Remote stores policy, and food supply and promotion initiatives in remote communities.

Local government food policies; planned state investment in improved remote store infrastructure in Qld up to 2010.

WA State Fruit and Vegetable Campaigns 1990-2000

What more is needed?

Policies and actions that support local communities' capacity to readily access an adequate supply of high quality vegetables and fruit.

Policies and actions need to be based on good information, in order to understand better the social, physical and economic barriers to eating more vegetables and fruit.

Partnerships between the private and government sectors.

Scope of *EWA* response

EWA can provide an initial assessment of the situation and set the scene for inter-governmental and intersectoral negotiation and activity.

Policy change should support promotional activities aimed at effecting individual changes in behaviour (see 'Vegetables and fruit' initiative 1).

Access to vegetables and fruit is particularly an issue for remote communities and is addressed in *NATSINSAP* and in the vulnerable groups initiative 3 'Addressing structural barriers to safe and healthy food'.

Other barriers such as food preference, knowledge and food preparation will be addressed in a vegetables and fruit campaign.

Partnerships

Inter-government, state and regional development and the private sector and community organisations.

Addressing underlying structural factors which influence vegetables and fruit consumption

<table>
<tr>
<td rowspan="2">Potential sector partners

Government health departments;
ANZFA;
TGA;
OATSIH;
Vegetable and fruit grower groups;
Non-health government agencies;
Private wholesale sector;
Local government;
State/territory health departments;
Private transport sector;
Food retail sector;
Peak welfare and advocacy groups;
Trade departments</td>
<td>Objective
Increase vegetable and fruit consumption through modification of social, physical and economic factors and policies, which impact on consumption.</td>
<td>Target groups
General population with some stress on vulnerable groups; Indigenous, remote populations.</td>
</tr>
<tr>
<td>Proposed actions
1 Research the potential impact of non-health government policies, for example tax or pensions, or of other economic instruments, on the consumption of vegetables and fruit;
2 Commission studies into non-policy based structural barriers and promoters which impact on consumption of vegetables and fruit;
3 Develop policy positions based on research results;
4 Review and disseminate evidence to practitioners on role of local government food policies in addressing local structural barriers and promoters;
5 Public health nutrition professionals build partnerships with the community to develop local solutions and programs address barriers to safe and healthy food.</td>
<td>Capacity components
Resources for feasibility;
Policy model, precedent or framework;
High level support needed for successful negotiations at policy level, to ministerial level.</td>
</tr>
<tr>
<td colspan="2">Funding implications
Feasibility studies.</td>
<td>Potential indicators
Feasibility studies completed;
Beneficial policy modifications identified;
Extent modifications agreed to by sector.</td>
</tr>
<tr>
<td colspan="2">Risks
Health interests may not prevail over others, eg revenue.</td>
<td>Links to other initiatives
NATSINSAP
1 Food supply in remote and rural areas.
Vulnerable groups
3 Addressing structural barriers to safe and healthy food.
Promoting healthy weight
Maternal and child health
4 Nutrition for school-aged children.
Strategic management
2 Nutrition policy development and reform.</td>
</tr>
</table>

Initiative no. 3: Enhancing research

The issue

More evidence is needed on the efficacy and cost effectiveness of strategies to increase vegetables and fruit intake.

Evidence and context

There is sound evidence to link the consumption of vegetables and fruit to health benefits. Many state/ territory governments as well as private sector organisations have implemented campaigns to increase the consumption of vegetables and fruit among different segments of the community. These campaigns have been evaluated and strategies tested with varying levels of rigour. Until now, there has been no coordinated national effort and only a few examples of systematic evaluation of strategies.

A greater evidence base is needed for future government and industry activities. Industry sees a major role for government in providing research to establish objective data. In addition, industry sees itself as a source of consumer data. Public campaigns need to be based on both sound health benefit data and evidence of the effectiveness of intervention.

What is already being done?

CSIRO report for SIGNAL on barriers to the consumption of fruit and vegetables, and previous efforts to promote an increased consumption of fruit and vegetables (1999).

WA Evaluation of fruit and vegetable campaign 1990-2000.

Qld Health and Griffith University review of evidence for Cancer Prevention Program (1999).

NSW Cancer Council Review of evidence linking cancer and diet.

Queensland Fruit and Vegetable Growers Market Studies: Qld healthy food access basket survey.

What more is needed?

Testing of vegetable and fruit interventions and strategies under ideal conditions.

Identification of the conditions for successful implementation.

Research into how strategies can be widely implemented and sustained.

Research on effective vegetables and fruit monitoring tools and quality assessment tools for remote areas.

Scope of *EWA* response

EWA can support research to address issues in the Australian context. Such research is necessary to support ongoing vegetables and fruit social marketing campaigns (see initiative 1) and interventions to address structural barriers to increased vegetable and fruit intake (see initiative 2).

This initiative also links with the research and development initiatives, which considers investment in public health research and dissemination of research evidence, and with the establishment of a national food and nutrition monitoring and surveillance system.

Partnerships

Grower organizations, horticultural and vegetables and fruit statutory bodies, state governments and NGOs.

Enhancing research

Potential sector partners	**Objective** Develop effective interventions for the promotion of vegetables and fruit.	**Target groups** Research provided for industry and public health sectors.
Government health departments; NHMRC; Grower groups; F&V and horticulture statutory groups; NGOs; Research sector; DA.	**Proposed actions** 1 Provide resources for systematic evaluation of campaigns; 2 Fund health promotion researchers to test interventions; 3 Disseminate research results and base funding decisions for future interventions on research; 4 Reach consensus on development of tools to assess intake of vegetables and fruit and assess quality.	**Capacity components** Grants process; Appropriate review structure and funding criteria; Protection of intellectual property; Research consortia; Dissemination model.

Funding implications	**Potential indicators**
Intervention research; Evaluation components.	Funding for evaluation; Extent campaign elements evaluated; Extent intervention research tools developed; Extent stakeholders perceive research enhances intervention.
Risks Limitations on public funding	**Links to other initiatives** **Research and development** 1 Investing in public health nutrition research. 2 Disseminating research evidence. **Monitoring and evaluation** 1 A national food and nutrition monitoring system.

Maternal and child health

Initiatives to improve the nutritional health of pregnant and lactating women, infants and children cover:

- Improving nutrition for pregnant and lactating women
- Promoting breastfeeding and improving infant nutrition
- Improving nutrition for children.

The approach

The rationale for choosing particular approaches to improving nutrition for children and mothers is summarised for each of the following initiatives and is based in current practice and issues identified by nutrition experts through the consultation process.

Overall, *EWA* recognises that food has a wider role than just the provision of nutrients and it is important that children explore the social aspects of food as well as learning practical food preparation skills. The role of the family in providing and teaching about food is also acknowledged as important, especially for young children who rely on care-givers for all their food and social needs. Culturally specific practices may be important for some groups, for example Indigenous Australians and it is important that intervention programs acknowledge and support the role of the family. The *NATSINSAP* provides the framework for developing programs for improving the nutrition of Indigenous mothers and babies within the context of the community and family.

Also important is to build partnerships with the community and private sector, to develop local solutions and programs to address barriers to safe and healthy food for children and their communities.

The Commonwealth government, through the National Health and Medical Research Council, has developed food and nutrition guidelines for parents, educators and other caregivers. These guidelines include the 1995 Dietary guidelines for children and adolescents and the 1996 Infant feeding guidelines for health workers. These guidelines are important references for health professionals and the following initiatives. The 1995 Dietary guidelines for children and adolescents identifies three nutrients as especially important to normal development of all children: energy, iron and calcium.

Monitoring nutritional status of children

The importance of monitoring growth is recognised across all three maternal and child health initiatives. Australia has no centralised system for monitoring the growth and weight of infants and older children. Therefore, it is difficult to identify individuals and groups with specific problems. Overseas experience has shown that growth monitoring and promotion programs are effective in decreasing malnutrition and improving growth in at-risk groups.

Recent studies have found that the growth pattern of breastfed babies is different from that of formula-fed babies. Current growth charts are based on formula-fed babies; and do not account for the decrease in

growth velocity of breastfed babies at 3 months. This perceived failure to grow at the normal rate leads women to give up or supplement breastfeeding. In Australia, breastfeeding studies have not always been comparable, as there is no standard methodology for defining breastfeeding, or for measuring its initiation and duration. This creates problems in monitoring rates of breastfeeding, evaluating programs and identifying the relationships between breastfeeding and health.

Maternal and child health

Initiative no. 1: Improving nutrition for pregnant and lactating women

The issue

The health and nutrition of mothers is integral to the health of infants and children. In at-risk communities, poor maternal nutrition transmits disadvantage through the generations. Breaking the cycle is important for the individual and the community.

Evidence and context

Maintaining optimal nutrition during pregnancy is essential for the future of the child, even into adulthood. Women require nutrient-dense diets during pregnancy and when breastfeeding. A diet low in micronutrients, if combined with smoking and low levels of physical activity before and during pregnancy, affects the health of the child and the mother over the short and long term. The nutritional status of mothers influences the development of the foetus, and ultimately the birth weight of babies (a measure of foetal growth). Infants born at both extremes of the normal birth weight range may be at increased risk of chronic disease as adults. High birth weight babies are often born to mothers with poorly controlled Type 2 diabetes.

Aboriginal women, particularly those living in remote communities, have a higher prevalence of low birth weight infants than the general community. Fewer Aboriginal women, teenage mothers and women of low socio-economic status use antenatal services and poor attendance at these services is associated with low birth weight.

Two nutrients, folate and iron, are particularly important prior to and during pregnancy. Evidence shows that 7 out of 10 cases of neural tube defects in infants can be prevented by increasing the intake of folate at least one month before conception and during the first three months of pregnancy. Each year in Australia 400-500 babies are born with a neural tube defect. Recent evidence suggests that folate may also reduce the risk of low birth weight, cleft palate, Downs Syndrome and congenital heart disease. Iron requirements during pregnancy are high, and women risk becoming iron deficient or anaemic.

The 'National Nutrition Survey '(1995) found that the average intake of iron was below the RDI for women of childbearing age. Calcium requirements are increased during pregnancy and lactation. The median calcium intake for adult women of 663 mg remains less than the RDI ('National Nutrition Survey ' (1995). Many parents at this stage in their lives have an increased interest in their health and in protecting the health of their child. This gives health professionals the opportunity to provide effective health and nutrition education programs to a motivated group.

What is already being done?

Numerous programs address maternal and child nutrition issues, commonly in a community health or clinical context. NT and WA programs linking clinic-based care with family and cultural support have improved maternal and child health outcomes in Indigenous communities. Qld Health has reviewed maternal nutrition interventions. GPs and community nurses routinely give nutritional advice to women.

Folate strategies and campaigns:

- Voluntary fortification of breads and cereal products with folate;
- ANZFA Folate Neural Tube Defect Health Claims Pilot, 1999-2000;
- State-based folate promotional campaigns, eg WA Folate campaign;
- Industry/NGO campaigns eg Northcott Society/Kellogg folate education program, and WA Fruit and Vegetable education campaigns 1990-2000; and
- Commonwealth government Folate Campaign with Pharmaceutical Society Australia, 1998.

Australian Iron Status Advisory Panel produces information on iron for health professionals.

Meat and Livestock Australia has supported professional and consumer education on iron since 1993 including consumer advertising, GP education and nutrition professional campaigns and a range of brochures on iron for consumers.

The Dairy industry provides educational information on calcium intake for pregnant and lactating women.

What more is needed?

Programs for high-risk women that promote optimal nutrition during pregnancy and lactation, including Indigenous women, based on social marketing principles.

Antenatal services that are accessible, culturally appropriate and staffed by informed professionals who are able to provide authoritative nutrition advice.

Further research into poor maternal nutrition as a cause of poor health in later life, with a focus on at-risk groups.

Consumer guidelines on the prevention of listeriosis.

Scope of *EWA* response

This initiative, together with *NATSINSAP*, provides a national focus. Related initiatives encompass monitoring systems, policy development, and opportunities for new research, disseminating research evidence and development of health professional workforce.

Partnerships

Industry, NGO and health combine to promote awareness of the benefits of a nutritious diet and nutrients such as folate, lean meat (iron) and dairy foods (calcium). Aboriginal community controlled health organisations provide services to Indigenous women. Nutrition and QUIT smoking programs.

Potential sector partners

Government health departments;

ANZFA;

OATSIH;

NACCHO;

NHMRC;

NGOs eg Northcott, DA, NA;

Regional Indigenous health and women's health organisations;

Child care sector;

State/territory health workforce;

Professional organisations, eg RACGP, DAA, PHAA, PSA, ANF

MLA, obstetricians;

Dairy industry;

Vegetable and fruit industry;

Women's hospitals.

Objectives

Increase the proportion of babies born within the healthy weight range by promoting high quality diet among pregnant women at risk;

Reduce the prevalence of iron-deficiency anaemia of attributable to poor nutrition through monitoring and promotion of high quality diet among women at risk;

Reduce the incidence of birth defects by increasing average folate intakes and the proportion of pregnant women who meet the recommended intake of 400 mcg through promotion of fortified foods, supplement use and intake of natural dietary folate sources;

Increase the proportion of lactating women with adequate intakes of energy/calcium; and

Decrease the exposure of pregnant women to foods contaminated with listeria through education about high-risk foods, and training of food handlers.

Target groups

Women of child bearing age, particularly Indigenous women and teenagers;

Relevant health professionals.

Proposed actions

1 Report on the incidence, trends and distribution of birth weight;

2 Fund studies to document circumstances where inadequate diets are likely to contribute to the incidence of low birth weight, high birth weight and iron deficiency;

3 Develop criteria for assessing dietary interventions or programs for pregnant and lactating women at risk; identify programs for evaluation; and recommend further program development based on reviews and other new information;

4 Disseminate effective community-based programs to appropriate local health organisations and service deliverers;

5 Develop and evaluate Indigenous access and participation in antenatal and postnatal care programs;

6 Review folate fortification program and other national and international approaches to increasing folate awareness;

7 Investigate the need for dietary guidelines for pregnant and lactating women;

8 Assess the links between adult health and maternal nutrition, disseminate results and recommend further research.

Capacity Components

Current research in Indigenous or other communities;

NHMRC research funding capacity;

OATSIH; Indigenous health resources;

Secretariat and expenses available for expert panel;

Consultation mechanism re dietary guidelines;

Dissemination mechanism;

Education of health professionals;

Reorientation of antenatal health services;

Active Australia programs;

National Tobacco Strategy.

Funding implications

Reviews;

Guideline development;

Community-based programs.

Potential indicators

Development/dissemination of successful programs/new dietary guidelines;

Awareness of folate and NTDs link among health professionals, and women of childbearing age; Awareness of research findings re maternal nutrition and health, among health professionals; Nutritional status of pregnant and lactating women by key nutrients.

Risks

Nutrition addressed in isolation of other factors that impact on pregnancy eg smoking, drugs, gestational diabetes;

Nutrients promoted to consumers in a piece-meal, single-issue fashion, confusing women about important dietary behaviours.

Links to other initiatives

NATSINSAP

3 Communication and dissemination of 'good practice' programs in public health nutrition.

Research and development

2 Disseminating research evidence.

Vegetables and fruit

1 A vegetables and fruit promotional campaign.

Workforce development

3 Training primary health care professionals.

Monitoring and evaluation

1 A national food and nutrition monitoring system.

Initiative no. 2: Promoting breastfeeding and improving infant nutrition

The issue

Children in early life need appropriate food, physical activity and social experiences to grow and develop. Some infants are at greater risk of under- or over-nutrition, particularly Indigenous children and those of certain ethnic groups. Breast milk is the preferred first food for infants and WHO recommends breastfeeding up to two years of age and beyond. Breastfeeding rates remain well below the National Breastfeeding Strategy target of 80% of all infants to be at least partially breastfed at six months by the Year 2000. In 1995, 80% of all infants were breastfed at birth, but only 40% at six months.

Evidence and context

Breastfeeding protects against infectious diseases and childhood malnutrition and there is evidence that breastfeeding may give long term protection from coronary vascular disease (CVD), cancer, Type 2 diabetes and asthma. Health service decision-makers are generally unaware of the evidence to support the health benefits of breastfeeding and have not made it a priority issue for intervention and resource allocation.

There are many societal and personal barriers to initiating and continuing breastfeeding. Women returning to work find breastfeeding difficult. Few workplaces have policies in place to support breastfeeding and this contributes to early weaning. Studies show that particular groups of women - urban Indigenous women, women in families with low incomes and teenage mothers – have lower rates of both initiation and duration of breastfeeding. These groups of women are less likely to access antenatal and early childhood services, and therefore receive less advice on breastfeeding.

Overweight/obesity in early childhood is associated with physical activity levels and high intakes of energy -dense food. By contrast, in rural and remote areas, a substantial proportion of Indigenous children have an unacceptable level of malnutrition (e.g. 20% Indigenous children in Darwin area, Territory Health Service data) which can limit development and predisposes a child to infectious diseases.

The introduction of solid foods to infants is a critical stage and poor practices can result in nutrient deficiency, for example iron deficiency. Iron plays an important role in normal neurological development in early life. Efforts to ensure that young children receive optimal diets have centred on providing advice and training for caregivers in formal childcare settings (long day and family day care) and for parents through child and family services.

What is already being done?

National Breastfeeding Strategy 1996-2000 initiatives e.g. family education, national standards for infant care services, employer support, health professional education, Indigenous health and data collection.

The Australian Breastfeeding Association, formerly Nursing Mothers Association of Australia, continues to promote breastfeeding via an array of strategies.

State/territory community-based health services provide antenatal and postnatal nutrition advice to mothers in a variety of settings, eg WA The Child and Antenatal Program; Tas Breastfeeding Coalition; WA Breastfeeeding Policy and Action Group; NSW Strategies to promote breastfeeding 'document and Caring for Infants Program; Tasmania, SA, NSW recognise breastfeeding-friendly businesses; 'Breastfeeding and Infant Nutrition - A Plan for Qld to 2005 '.

WHO Baby-friendly Hospital Initiative (BFHI)- National Advisory Council & accreditation of 19 hospitals up to Dec 1999.

WHO International Code of Marketing Breastmilk substitutes; Australian agreement and Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF).

ANZFA control composition and labelling of Infant Formula, advise on labelling that breast milk is best.

Maternal and Infant Care Standards for hospitals, 1999. 1999 NHMRC Review of Child Health Screening; NHMRC Infant Feeding Guidelines.

Extensive food industry education campaigns sponsored by, for example, baby food manufacturers, dairy, meat and vegetables and fruit industry peak bodies.

Nutrition Australia's Childcare Advisory Service.

What more is needed?

Reorient health services to ensure they support and promote breastfeeding including intersectoral action to improve workplace policies and practices.

Evaluate and sustain effective breastfeeding strategy programs.

Support existing service deliverers (including training in lactation for non-specialist staff) to extend their role with families, business and industry.

Establish effective monitoring tools and systems of growth monitoring.

Build on state initiatives in childcare services and disseminate effective programs and education materials nationally.

Develop health promotion programs to address childhood obesity that encompass education, training and environmental activities.

Scope of *EWA* response

Governments have a role to identify effective interventions and to promote these models through existing agencies and partners.

This initiative is linked with 'A national food and nutrition monitoring system', the *NATSINSAP* initiatives and with 'Workforce development for health professionals'.

Partnerships

Australian Breastfeeding Association with Maternity Services and lactation consultants, state and private sector on developing workplace policies and breastfeeding-friendly environments, and state partnerships with child-care sector, NGOs and food industry.

Potential sector partners

Government health departments;

NHMRC;

AIHW;

ANZFA;

ABA;

ACMI ;

OATSIH;

State/Territory health services, family health care & community providers;

Maternity services;

RACGP;

Royal College of Nursing;

Obstetricians and Paediatricians;

ALCA;

PSA ;

Employer groups;

Network of Australian Lactation Colleges;

Child care sector;

Professional groups: DAA, AMA, ADA;

NGOs eg National Council of Women, CWA, NA, NHF;

Food industry eg MLA, dairy boards;

Training bodies.

Objectives

Increase the proportion of mothers who breastfeed to at least six months of age by reducing cultural, structural and economic barriers to breastfeeding;

Increase the proportion of mothers who introduce solid foods consistent with NHMRC Infant feeding guidelines;

Increase health system policies that encourage and support breastfeeding to at least six months;

Introduce, implement, maintain and monitor policies, practices and facilities in the community that encourage mothers to decide to breastfeed and support breastfeeding to at least six months.

Proposed actions

1 Evaluate and expand effective National Breastfeeding Strategy activities;

2 Review policies and practices that influence breastfeeding decisions and make practices/policies more supportive;

3 Review progress and identify ways to accelerate the uptake of the Baby-friendly Hospital initiative in all maternity hospitals;

4 Review the current status of Australia's implementation of the WHO Code of Marketing of breast-milk substitutes;

5 Reach consensus on standard methods for measuring duration and initiation rates of breastfeeding;

6 Review and recommend growth standards for use in assessment of breastfed babies;

7 Review previous strategies (across sectors) for disseminating information on nutrition, first foods, social aspects and active lifestyles for children in early life to parents and other caregivers and recommend future directions.

Target groups

Nursing mothers and their families, particularly teenage mothers, Indigenous, low income and NESB women and families;

Parents and care-givers;

Health professionals;

Employers;

Pregnant women and partners

Capacity components

Existing research base and programs;

National Child Nutrition Program;

1996-2000 National Breastfeeding Strategy products;

DHAC coordination and funding of the National Breastfeeding Strategy;

DHAC/ABA Five Year Plan for Breastfeeding

Existing National committees, BFHI and APMAIF;

Anti-discrimination legislation;

BFHI Administration through Australian College Midwives Inc and adequate funding;

A national food and nutrition monitoring system;

Increased understanding by policy makers of health benefits of breastfeeding;

Increased knowledge and skills of health professionals.

Funding implications

National Breastfeeding Strategy activities;

Evaluation of Breast Feeding Strategy;

Development of methods/ tools;

Growth monitoring systems;

Program implementation.

Potential indicators

National rates of breastfeeding initiation and duration, particularly low socio-economic groups and teenage mothers; Number of workplaces participating in 'breastfeeding friendly' practices; Number of hospitals that are accredited BFHIs; Extent of coalitions formed ;

Extent WHO Code implemented; Proportion of mothers who introduce solid foods consistent with NHMRC Infant feeding guidelines; Monitoring tools developed; Extent growth monitoring system established; Extent take-up of effective infant nutrition programs and materials available nationally.

Risks

Breastfeeding emotional issue for some sections of the community makes implementing difficult;

Health care decision makers continue to regard breastfeeding as a low priority;

State-based materials programs not transferable.

Links to other initiatives

NATSINSAP

3 Communication and dissemination of 'good practice' programs in public health nutrition.

Workforce development

3 Training primary health care professionals.

Research and development

1 Investing in public health nutrition research.

2 Disseminating research evidence.

Communication

2 Communicating with the public.

Initiative no. 3: Improving nutrition for children

The issue

Children need good nutrition in order to develop and grow to their potential, and to be protected against chronic disease in later life. Food has a wider role than just nutrition. Educating children about healthy eating, social aspects and preparing food can promote good eating habits into adulthood. Nutrition issues affecting Indigenous children are particularly complex.

Evidence and context

More Australian children are overweight and obese than at any time in our recorded history, with prevalence of obesity among children aged 12 to 15 increasing from 5.3% in 1985 to 6.8% in 1995. The National Nutrition Survey (1995) found that 23% of children of this age were considered at risk of becoming overweight. In certain Indigenous communities the prevalence of overweight and obesity amongst children aged 7-18 has been found to exceed 17%. There is evidence that the number of children with a distorted body image is also increasing and that this problem is affecting both sexes earlier.

Childhood obesity is associated with high-energy diets, low levels of physical activity and television watching habits. Family, school and social factors such as television advertising and peer norms influence children's eating habits and body image. There are fewer opportunities to learn to cook in schools than in the past. Studies have shown that "junk" food ads dominate children's peak viewing periods.

Nutrition issues and approaches to intervening may differ with age, for example, early nutrition is linked to dental health. Promotion of healthy eating in schools is increasingly implemented within a Health Promoting Schools framework, which takes account of curriculum content, school policies, social and physical environments, school health services, and links with the community. Nutrition may be addressed at the same time as physical inactivity.

Recent work has focused on increasing the range of foods available in childcare centres, family day care and school canteens that meet the cost and taste preference of children. Industry has been developing new products for canteens for this purpose. Regulations and licence systems for childcare services are peculiar to each state/territory and this has limited the dissemination of programs nationally and the practitioners' capacity to respond to national policy issues.

What is already being done?

1995 Dietary guidelines for children and adolescents.

National Child Nutrition Program, $15M available for local community programs.

National Family Strategy.

Local area health promotion nutrition programs in schools.

Pilot programs in WA, Tasmania and NSW aimed at improving body image and preventing eating disorders.

State-based school canteen associations accredit schools providing healthy canteen food, register food products and give advice on training for canteen personnel.

Federation of Canteens in Schools has developed nutrient criteria for the registration of foods.

Health Promoting Schools Association encourages partnerships between health, education and the community.

Variety of state education syllabuses and education resource kits.

Vic 'Body Image and Health Inc'.

NSW Healthy Body and Image and Disordered Eating Association.

PHAA Policy on TV Advertising to Children.

SA Children's Health Development Foundation activities.

WA 'Kids in the Kitchen' Project and Children's Fruit and Vegetable Campaign 1995-2000.

Qld trial programs with youth nurses & oral therapists.

Many resources and programs developed by NGOs and food industry.

Improving the nutritional standards of food in childcare settings has been a focus of state/territory public health/community health workforces, eg:

- NSW Caring for Children Program;
- Qld Maternal & Child Nutrition Resource Package;
- SA Childcare Nutrition Partnership;
- WA Start Right Eat Right Award Scheme;
- Tas Childcare Workshops;
- QLD 'There's more to food than eating';
- NT Growth Assessment and Action Program for remote health workers and Food and Nutrition Information System monitors nutritional status of children 0-5 years in remote communities; and
- Tasmania's 'Tucker Talk'.

Kidsgrub@ email group (1999) acts as a clearing house for State-based practitioners.

National Accreditation Standards include nutrition standards for Long Day Care Centres.

What more is needed?

Build on and disseminate state-based initiatives that encourage healthy eating and teach children food preparation skills.

Provide support to canteen associations and encourage monitoring of food sold.

Promote cross-government initiatives to address eating disorder issues, which tie in with National Mental Health Strategy initiatives.

Address current advertising practices.

Scope of *EWA* response

EWA can add value to state-based programs by disseminating best practice programs.

The *EWA* also includes initiatives to address overweight and obesity in children, supported by Active Australia initiatives to increase activity levels of children. Training for food service staff is addressed in 'Workforce development'. Specific actions for Indigenous children are addressed in *NATSINSAP*. Monitoring tools and systems are addressed in 'Child and maternal health' initiative, and in 'Promoting breastfeeding and improving infant nutrition'.

Partnerships

NHF, School Canteen Associations & State health departments. Education, childcare & health sectors.

Potential sector partners

Government health departments;

NHMRC;

Health Promoting Schools Association of Australia;

State School Canteen Associations;

FOCIS;

DA;

HEIA;

Area health services;

Education sector;

Parent associations;

Advertising Federation Australia;

ACHPER;

Australian Sports Commission;

ACA,CHF;

NGOs ie NA, NHF

PHAA;

DAA;

AIEH;

Peak sporting groups;

ADA ;

Association of Dental Therapists;

Youth associations;

Child Health Development Foundation;

Publishing industry;

Child care sector.

Objectives

Increase the proportion of children within the healthy weight range, through improved growth monitoring, and promotion of good eating habits and physical activity.

Increase the availability of healthy meals and snacks for children from institutional food services (canteens, pre-schools, day care) through policies, training, incentives and by working with industry.

Promote a wide range of food experiences and positive attitudes to food and body image among children.

Target groups

Children aged 1-16 years;

Families, parents, care-givers;

School canteen staff;

Childcare staff;

School teachers;

Oral health therapists;

School health nurses;

Health professionals;

Indigenous families.

Proposed actions

1 Develop criteria, identify best practice programs/materials across a range of settings, issues and age groups, disseminate these programs;

2 Review research on food advertising and adequacy of TV Advertising Code for Children and recommend future directions;

3 Review food supply strategies for school canteens and identify appropriate national approaches, funding mechanisms and structures;

4 Review recommendation by state groups on preventing eating disorders and distorted body image, and fund pilot initiatives;

5 Identify specific groups in the community whose children are at high risk and fund research and programs to address the problem.

Capacity

Components

National Child Nutrition Program;

Secretariat for

Health Promoting Schools Association;

National Mental Health Strategy collaborative working party ;

Existing programs/ resources and research;

National Mental Health Strategy Working Party;

Active Australia Program.

Funding implications

Secretariat for school canteen associations;

Pilot studies;

Reviews;

Health promoting schools programs paid for by States.

Potential indicators

Reviews complete and programs disseminated

Extent children ŝ diets meet Dietary guidelines for children and adolescents; Number/extent health promoting schools projects address nutrition issues; Extent food sold in school canteens fits dietary guidelines; Extent food provided in child-care meets nutrition standards; Prevalence of eating disorders/overweight/obesity; Proportion of ĵunk ’food ads in children ŝ peak viewing time

Risks

Social factors too large to be addressed adequately by Strategy;

National approach to school canteens unsupported at local level.

Links to other initiatives

All other maternal and child health initiatives.

NATSINSAP.

Promoting healthy weight.

Workforce development

4 Training the non-health workforce.

Research and development

1 Investing in public health research.

2 Disseminating research evidence.

Communication

2 Communicating with the public.

Vulnerable groups

1 Addressing structural barriers to safe and healthy food.

Vegetables and fruit

1 A national vegetables and fruit promotion campaign.

Part 4 EWA Capacity-building initiatives

This section contains initiatives covering

- Research and development
- Workforce development
- Communication
- Monitoring and eva**luation**

Research and development

Initiative no. 1: Investing in public health nutrition research

The issue

EWA and *NATSINSAP* need to be based on the best available research evidence throughout its 10-year lifespan. SIGNAL and other government agencies need access to reviews of research evidence to inform policy development. Stakeholders 'ability to effectively implement nutrition promotion programs will depend in part on the quality and availability of evidence that informs practice. Research into Indigenous health needs to be consultative and culturally appropriate.

Evidence and context

Agreed national research priorities are important to ensure funding bodies invest in public health nutrition research that informs practice and policy.

Public health nutrition research encompasses four broad categories of research:

1 aetiological research ie diet, nutrition and disease distribution, disease mechanisms;

2 influences on nutritional status including food supply and factors which influence consumer demands;

3 methods development; and

4 intervention research, related to policy and program development, priority setting, implementation and development.

Nutrition researchers report that funding for applied research and intervention research in nutrition is minimal because of the low status of applied research and the lack of familiarity of funding bodies with this type of research. Funding for the other categories of nutrition research is very competitive.

Funding bodies include the NHMRC, state/territory health departments, NGOs such as National Heart Foundation (NHF) and health promotion foundations. In 1999, the NHF funded 18 nutrition projects, all of which could be classified as aetiological research and the NHMRC funded few public health nutrition-related projects.

Agreement between the NHMRC, government and non-government health agencies and the research sector on priorities for research could make a significant difference. No one body will have the capacity to fund all the research needed or indeed the expertise or interest in all research areas.

Practitioners require reviews of existing evidence. Good practice guidelines provide evidence for practitioners developing strategies and programs. There are efficiencies to be gained by standardising approaches to guideline development.

What is already being done?

Public sector funding bodies include: the NHMRC and the ARC.

State and territory health departments, area/district health services, health promotion foundations and non-government organisations fund the bulk of practice research and program evaluation.

University researchers and practitioners conduct research, and the CSIRO Division of Health Sciences and Nutrition conducts nutrition research.

Food Science Australia is a joint venture between CSIRO and Australian Food Industry Science Centre to undertake research for the public good and for the food industry.

The Aboriginal and Torres Strait Islander Health Research Agenda Working Group is a joint working group of NHMRC and OATSIH and is developing a strategic research agenda for Indigenous health.

What more is needed?

Identify gaps and develop priorities for research as well as mechanisms for distributing the funds in an effective and coordinated way.

The establishment of scientific reference group/s to set research priorities in consultation with the research sector, health-based non-government organisations and other stakeholders.

Reviews of existing evidence. Systems for results of Indigenous health research to be fed back for community use.

Scope of *EWA* response

Establishment of links with funding bodies and mechanisms to encourage cooperative research.

The *EWA* also considers how the research evidence can be disseminated to the field; the role of research evidence in the development of policy; the review of the impact of changes to the food supply and food regulation and allocation of resources; and research skills needed by the practitioners.

Partnerships

NHMRC, Commonwealth, state and territory governments, universities, NGOs.

<table>
<tr>
<td rowspan="2">Potential sector partners

NHMRC;
Government health departments;
Health promotion foundations;
OATSIH;
DAA;
FANO;
PHAA;
CSIRO;
HRDC;
ANZFA;
Food Science Australia;
University sector;
NGOs ie state and territory
(anti) Cancer Councils/ Societies; NHF, DA.</td>
<td>Objective
Achieve an adequate level of appropriate public health research by establishing research priorities and increasing the proportion of government health research funding dedicated to public health nutrition research.</td>
<td>Target groups
Academic researchers;
CSIRO researchers;
State/territory health officers.</td>
</tr>
<tr>
<td>Proposed actions
1 Fund research to support the implementation of EWA including: identifying and setting priorities, funding key aspects of scientific and applied research relevant to EWA, developing practice based guidelines and building the capacity of government health departments in critical appraisal and evidence based approaches;
2 Conduct trials of national significance of practice guidelines and intervention programs;
3 Commission reviews of existing evidence to inform EWA nutrition promotion priorities;
4 Review range of research funding available (including overseas funding) and disseminate to researchers, practitioners and community health organisations;
5 Develop the research skills of public health nutrition workforce. Scholarships and fellowships related to the nutrition research should be evaluated, and if assessed as worthwhile, encouraged and expanded.</td>
<td>Capacity Components
Funding and priority setting criteria developed;
Collaboration between researchers on national trials;
Consultation with stakeholders re priority setting;
Dissemination of evidence.</td>
</tr>
<tr>
<td colspan="2">Funding implications
Research;
Reviews of evidence.</td>
<td>Potential indicators
Funding priorities and process established;
Funding allocated to type of research;
Amount and proportion of funding available from key funding bodies for public health nutrition research priority areas;
Number and type of coordinated national trials.</td>
</tr>
<tr>
<td colspan="2">Risks
Public health nutrition, especially intervention research remains under-funded;
Academic institutions fail to form consortia.</td>
<td>Links to other initiatives
Research and development
2 Disseminating research evidence.
3 Promoting private sector investment in research.
Strategic management
2 Developing nutrition policy.
3 Establishing criteria for resource allocation.
Workforce development
2 Expand and extend tertiary education.</td>
</tr>
</table>

Initiative no. 2: Disseminating research evidence

The issue

Research, which provides a scientific basis for identifying nutrition problems and possible solutions, needs to be disseminated to practitioners, policy makers and sector partners. For Indigenous health, this includes effective dissemination to community organisations.

Evidence and context

Practitioners and policy makers often under-use research. Model programs are developed in one state and re-invented in another. Researchers expand the evidence for successful nutrition interventions with no impact on usual practice. Programs are evaluated and the lessons lost. Timely research is either unavailable or not actively disseminated in a format suited to the needs of public policy makers and practitioners. Issues faced by practitioners often go unrecognised by researchers as there is limited contact between the two groups and research outcomes have limited capacity to improve practice.

A wide cross section of informants consulted for the development of *EWA* cited better access to Australia-wide research and information on programs developed by other organisations as a motive for becoming a partner in the implementation of *EWA*.

What is already being done?

Research is disseminated through the FOODCHAIN newsletter, a SIGNAL Website, peer journals (e.g. AJFN and ANZJPH) and presentations at conferences.

Existing Internet-based professional discussion groups eg Nutnet email listserve.

Existing professional, NGO, government and industry networks, newsletters/ position papers, special interest groups, seminars and forums.

What more is needed?

A dissemination strategy that creates links between researchers and practitioners, makes evidence accessible, and ensures that the research is interpreted to suit the information needs of the various target audiences.

Scope of *EWA* response

Dissemination of evidence needs to be ongoing and linked to completion of specific research products.

It is strongly linked to investing in public health nutrition research and evaluation plan initiatives and to training of the professional workforce to present practitioner research for peer review (see workforce development initiatives).

Partnerships

Government health departments and research sector.

Disseminating research evidence

Potential sector partners

Government health departments;

NHMRC;

ANZFA;

State-based nutrition networks;

AFGC Food Science Bureau;

Research community;

PHAA;

AHPA;

DAA;

AIFST;

AFISC;

NGOs ie DA,

NHF, State (Anti) Cancer Councils/ Societies, NA;

OATSIH;

Health Promotion Foundations;

Food industry;

Objective

Increase the use of research evidence in public health nutrition planning and practice by actively disseminating the results of research on *EWA* priorities to policy-makers, practitioners and researchers.

Proposed actions

1 Develop formal links between researchers and practitioners on an as needs basis;

2 Support biennial conferences to report progress and results of public health nutrition research and EWA initiatives;

3 Undertake reviews of evidence relating to priority initiatives and establish a process for conducting the reviews, types of evidence required and criteria for appraising evidence and setting priorities;

4 Use the reviews of evidence as a basis to develop good practice guidelines for *EWA* interventions;

5 Publicise completed reviews and other research such as successful intervention models and guides for best practice through established state/territory, professional and organisational networks, conferences, newsletters and by posting on SIGNAL/ NPHP website;

6 Develop policy for formal links between state-based nutrition networks and public health nutrition research consortia, eg practitioner representatives on consortia steering committees;

7 Encourage the inclusion of dissemination strategies as part of research, including progress reports and to community/Indigenous health organisations.

Target groups

Community nutritionists;

Health promotion officers;

State/territory planners;

Primary health care workforce;

Professional associations;

Research community.

Capacity components

Practitioner-researcher link policy;

Government research funding;

Conference sponsorship.

Funding implications

Biennial conferences

Reviews;

Publication of reviews

Website.

Potential indicators

Reach of national conferences; Number of reviews;

Extent reviews/other research actively publicized;

Extent evidence from trials and reviews is used by practitioners in planning *EWA* initiatives;

Extent practitioners and researchers perceive links strengthened.

Risks

Inadequate insight into relationship between supply and demand of information.

Links to other initiatives

Research and development

1 Investing in public health nutrition research.

4 Promoting innovation.

Workforce development

1 Human resource requirements.

2 Expand and extend tertiary education.

Monitoring and evaluation

1 Evaluating *EWA.*

2 *NATSINSAP* Best Practice 'initiative.

Research and development

Initiative no. 3: Promoting private sector investment in research

The issue

Both the food industry and NGO sector invest in public health nutrition research. There is potential for private sector funded research to complement government commissioned research. Increasing private sector investment in public health nutrition priority research areas is hindered by the lack of a mechanism for negotiating common interests between the private and government sectors.

Evidence and context

The non-government sector, and to a lesser extent the food industry, are interested in research that supports public sector policy. Industry organisations commission academic and government researchers such as CSIRO to conduct research on their behalf. Non-government organisations either commission research, do their own research or operate grant schemes available for researchers. Research done for the private sector is not always publicly available for confidentiality reasons.

Much of private food industry research is commercially oriented and not focused on public health nutrition issues.

What is already being done?

The private sector is investing in research that may be useful and available for public health nutrition purposes. Examples include product development research (individual companies), consumption patterns related to market research (companies and associations) and the association between diet and health (NGOs).

The private sector commissions academic researchers or establishes agencies to do the research. One example is Food Science Australia, a joint venture between CSIRO and Australian Food Industry Science Centre (AFISC) established to conduct research for the public good and for the food industry.

The private sector also supports capacity building initiatives for research, for example, Kellogg and NHF fund a research fellowship in the area of evaluation of health promotion activities.

While much research will be confidential, industry also commissions research to use in public policy debates for example, consumer attitudes to nutrition issues.

NGO research grant programs support public health nutrition research eg NHF, Cancer Council and Diabetes Australia.

CSIRO undertakes much of its research with private and industry funds and sets mutually agreed research goals with industry annually.

What more is needed?

Development of a mutually beneficial research agenda and platform for pursuing the agreed research topics between government and private sectors.

Protocols for conducting joint research to ensure the interests of both the public and private sector are met and useful outcomes disseminated: these can be articulated in partnership agreements.

Scope of *EWA* response

Protocols and partnership technology are discussed in the 'Strategic management' initiative, 'Managing partnerships'. Encouraging more public sector investment in research is covered in the 'Research and development' initiative, 'Investing in public health nutrition research'.

Partnerships

Private, NGO, public, such as CSIRO, and research sector.

Promoting private sector investment in research

<table>
<tr><td rowspan="2">Potential sector partners

Government health departments;
NPHP;
Industry groups eg AFGC;
Research sector;
Smart Food Centre;
RIRDC;
CSIRO;
MLA;
HRDC;
DRDC;
Pork Corporation;
GRDC;
NGOs eg NHF, DA;
NHMRC;
AFISC.</td><td colspan="2">Objective
Increase the level of private sector investment in public health nutrition research in priority areas by facilitating industry involvement and establishing protocols to maintain standards and credibility.</td></tr>
<tr><td>Proposed actions
1 Develop protocols for conducting joint research in consultation with stakeholders and linked to Partnership agreements;
2 Investigate the feasibility of a national foundation for nutrition which has public and private funding;
3 Establish joint research topics/areas of interests between governments, industry groups and peak NGOs;
4 Establish protocols for conducting joint research between governments, industry, NGOs and NHMRC.</td><td>Capacity components
Resources to establish and trial protocols;
Evaluation of protocols and pilots to inform future directions;
Dissemination to all sectors.</td></tr>
<tr><td>Funding implications
National nutrition foundation;
Short, medium and long term research projects.</td><td colspan="2">Potential indicators
Extent key stakeholders agree on protocols;
Amount spent on public health research priorities from industry and NGOs;
Proportion of total research funding from private sector;
Number of private sector research projects which make results available to public sector practitioners;
Extent stakeholders perceive research credible and useful.</td></tr>
<tr><td>Risks
Sectors unable to agree on protocols;
No credibility of research despite protocols.</td><td colspan="2">Links to other initiatives
Strategic management
1 Implementing EWA and NATSINSAP.
4 Managing partnerships.
Research and development
1 Investing in public health nutrition research.
2 Disseminating research evidence.</td></tr>
</table>

Research and development

Initiative no. 4: Promoting innovation

The issue

EWA and *NATSINSAP*, will become outdated and irrelevant unless it brings innovative solutions to both novel and recalcitrant problems, and develops a broad problem solving capability. Stakeholders in the *EWA* and *NATSINSAP* will need to be able to capitalise on innovations made by other groups.

Evidence and context

Effective strategic planning requires periodic assessment of initiatives and innovative measures where appropriate. *EWA* and *NATSINSAP* will benefit from an integrated component, which addresses innovation as a continuing need.

As a ten-year strategy, *EWA* will see numerous innovations at a community, agency or state/territory level, which could be promoted in other locations or settings. Public and private sector research can open up opportunities for innovative solutions to public health nutrition problems, but opportunities are lost if they are not broadcast.

Much innovation lies in cross-sectoral interaction, for example the application of new nutrition or health knowledge to food products or to nutrition promotion.

The public health nutrition community in Australia would also benefit from adopting innovative ideas and practices from other countries.

Innovation is also needed to address the challenges of Indigenous health problems.

What is already being done?

Current sources of innovation are:

- information about international research and practices;
- domestic research and practice development in the research/education, NGO and public sectors, for example the NHMRC currently encourages innovation by giving higher weighting in assessment to research proposals that are innovative; and
- private sector initiatives in product development or marketing.

Awards for innovative practice have been employed in public health nutrition, principally based on settings (eg school canteens), or state/territory jurisdictions (eg the NSW Better Health Awards for food manufacturers). The Public Health Association of Australia Public Health Impact Award is one example of professional awards that recognise good practice.

What more is needed?

A systematic collation of innovative research and practice development, both Australian and international which is nationally based and disseminated, accessible across sectors, and reflects current and potential issues for *EWA*.

A national award could assist promotion of innovation in public health nutrition and recognise groups with a track record for innovative practice.

Responsive funding channels to capture and reward innovations as they emerge. For example, the 'portfolio investment' approach would assist funding investment decisions and the consolidation of innovation into norms of good practice.

Grant conditions to allow for publishing data and to extend and further develop innovative ideas and incentives to actively disseminate information.

Scope of *EWA* response

EWA can provide the national coordination needed to both promote innovation and develop ways of building in the creation and consolidation of innovative approaches to public health nutrition. This initiative complements the other 'Research and development' initiatives, particularly, 'Investing in public health nutrition research' and 'Disseminating research evidence'.

Partnerships

All sectors are both producers and consumers of innovation.

Potential sector partners	**Objective** Resolve public health nutrition problems by promoting innovative solutions and providing practitioners with information on innovative research and practice development.	
Government health departments; Research and education institutions; Industry and industry associations; NGOs; All levels of government; NHMRC; ANZFA; CSIRO; OATSIH; NACCHO.	**Proposed actions** 1 Undertake a scan of national and international research and practice development and disseminate results; 3 Investigate the feasibility of funding a grants program for innovative research and practice development; 4 Create and promote a national award system for innovation in public health nutrition; 5 Disseminate new successful innovative practice to public health nutrition workforce using formal networks.	**Capacity components** Criteria for judging the success and wider applicability of innovations; Research and educational personnel with constantly updated knowledge of developments; Inclusion of Indigenous health expertise; Cross-sector knowledge of innovative practices; National food and nutrition monitoring system to track impact of innovations.

Funding implications	**Potential indicators**
Grants and awards schemes.	Grants scheme established; Award scheme established; Rate of innovation increases in priority areas, as judged by stakeholders.

Risks	**Links to other initiatives**
Innovation will challenge current practice and needs to be fostered in an open manner; Prescriptive or bureaucratic processes could flatten the innovation; Diversity of stakeholder interests could dissipate this initiative.	**Research and development** 1 Investing in public health nutrition research. 2 Disseminating research evidence. 3 Promoting private sector investment in research. **Monitoring and evaluation** 4 Evaluating *EWA*.

Workforce development

Initiative no. 1: Building human resource requirements

The issue

There is a need to improve the capacity of the public health nutrition and health promotion workforce, to implement public health nutrition initiatives. Capacity is defined as having an adequate infrastructure, and an appropriately sized and skilled workforce to deliver programs. *EWA* initiatives are at a strategic level, and sound operational planning and good management will be needed to successfully implement them.

Evidence and context

Programs often fail to produce desired outcomes because of poor implementation. Reviews of the literature suggest that staff selection, supervision and training, and the use of management information is critical in program effectiveness. A substantial responsibility for *EWA* outcomes will rest with the state/territory health workforces. Consultations indicate that this may place demands on the workforce beyond current capacity and that the specialist workforce is too small to achieve a major impact. This is particularly the case with Indigenous nutrition, as *NATSINSAP* points out.

The states/territories have different workforce infrastructures and approaches to delivering public health nutrition programs. It is unclear whether there is an optimum infrastructure. The optimum size of the workforce is similarly unclear. Non-nutritionists generally make decisions on resource allocation to nutrition programs.

Practitioners implementing public health nutrition programs encompass a diverse workforce, including public health nutrition specialists, community nutritionists and dietitians, private sector dietitians, university researchers, health promotion and public health generalists, and Aboriginal health workers. They need training to implement *EWA* initiatives.

What is already being done?

1999 NPHP, Public Health Workforce Development Working Group: The NPHP aims to develop a national approach to public health workforce development. This will include medium and long-term strategies for a public health workforce program, including the development of an adaptive capacity in the existing workforce and mechanisms for training to respond to planned programs and meet emerging issues.

1999 Review of Public Health Education and Research Program.

Mapping of public health training in NT.

Research into training needs in WA.

Qld Allied Health Taskforce Recruitment and Retention.

Proposed NSW Centre for Public Health Nutrition.

Public Health Nutrition PHERP Centre at Deakin University.

What more is needed?

A systematic approach to define the relevant workforces involved in public health nutrition and to assess their capacity to deliver *EWA* interventions. This information can be used to influence managers to give nutrition a higher priority and increase the capacity of the system to deliver initiatives.

Increased size of specialist workforce and regular reviews of workforce. Clarification of state and Commonwealth government funding responsibilities.

The development of training packages which are tied to the implementation of initiatives around operational planning and management, strategies for program targeting, partnership management and formative evaluation.

Scope of *EWA* response

Responsibility for basic training lies with universities and other training institutions, and funding of infrastructure lies with states/territories. *EWA* can provide needs assessment and information to influence these other jurisdictions.

NATSINSAP has separate initiatives for workforce development for Indigenous health workers, improving basic training and partnership management, and disseminating research evidence. Endorsement of the framework by state jurisdictions will help allocate resources to implementing initiatives.

This initiative is closely linked with other workforce initiatives, particularly initiatives for primary health professionals and non-health workforce.

Partnerships

Non health sectors such as education, employers, professional organisations, practitioners (urban and rural) and experts in workforce development.

Building human resource requirements

Potential sector Partners

Government health departments;
Universities with public health and nutrition courses;
DAA;
PHAA;
OATSIH;
NGOs;
Divisions of General Practice.

Objective
Improve the capacity of public health nutrition and health promotion workforces, including increasing the specialist nutrition workforce, to support and deliver *EWA* and *NATSINSAP* initiatives.

Proposed actions

1 Fund a needs assessment to investigate the workforce requirements and structural relationships necessary to deliver *EWA* initiatives and state/territory food and nutrition policies in light of current funding arrangements, workforce capacity and composition;
2 Fund adequate human resources to implement *EWA* initiatives;
3 Review, restructure and resource workforce infrastructure according to recommendations of needs assessment;
4 Include public health nutrition (including community level) training as part of a new monitoring system of public health workforce needs;
5 Offer training packages tied to implementation of *EWA* initiatives and core competency initiatives;
6 Examine outcomes of Public Health Education Research Program (PHERP) in relation to public health nutrition workforce.

Capacity components
NPHP workforce development committee;
Training packages developed by State/ Territories.

Funding implications
Needs assessment;
Restructure of workforce;
Training packages.

Potential indicators
Extent needs assessment and reviews completed by state/ territories;
Extent to which human resource capacity matches infrastructure needs over 10 years of program, by state/territory;
Stakeholders 'perception of quality of state/territory implementation of *EWA* interventions.

Risks
Recommendations to government and education institutions not implemented;
Courses do not meet workforce demands and/or are not accessible;
Workforce does not meet minimum National Training Council competency requirements.

Links to other initiatives
Workforce development
2 Expand and extend tertiary education.
Monitoring and evaluation
2 Evaluating *EWA*.
NATSINSAP

Workforce development

Initiative no. 2: Expand and extend tertiary education

The issue

Tertiary education and in-service training needs to be expanded and extended to the public health nutrition and public health (non-nutrition) workforces and the primary health care workforce. In particular, the public health workforce (non-nutrition) needs more training in aspects of public health nutrition relevant to their positions.

Evidence and context

All public health practitioners need to be competent and have a wide knowledge of both nutrition and public health practice. Practitioners 'access to further public health education is constrained by course delivery modes and geographic factors. Consultation identified a current debate about the relative benefits of specialist versus multi-disciplinary public health nutrition training.

Although the consultation process did not systematically assess training needs, respondents did identify a need for more training in public health management areas such as nutrition monitoring and surveillance; data analysis and bio-statistics; evaluation; committee management; partnership management; epidemiology; food regulation and policy; and health promotion.

Those working with Indigenous communities need acculturation and training in their particular issues and needs. The consultation also identified a perceived need for improving the generalist public health workforce's understanding of nutrition issues, and *NATSINSAP* has identified the need for greater knowledge of effective nutrition practice in Indigenous communities.

What is already being done?

There are many academic institutions in Australia that provide either nutrition and dietetic or public health undergraduate and post-graduate training. A few institutions offer specialist public health nutrition training. Each course has its own specialities and emphasis. Public health nutrition expertise also exists in other courses such as sociology and geography and medical/general practitioner training.

Public health nutrition (PHN) competencies under development in 1999, PHAA Food and Nutrition Special Interest Group/Griffith University.

Feasibility studies re PHN (registration PHAA/Griffith University) or accreditation system (Nutrition Society) 1999/2000.

Deakin PHN Specialities Program, 1995-1998 (PHERP).

The Public Health Education and Research Program (PHERP) is an NHMRC program that, to some extent, funds the development of public health courses in universities, for example, PHERP project for more diversity in nutrition/dietetics, Monash University, 1999; PHERP project re: distance learning, University of Qld,1999.

Master of Public Health Nutrition degree course, University of Newcastle/University of Qld, from 2001.

DAA accreditation of Nutrition and Dietetic courses.

States/territories offer public health cadetships/scholarships.

What more is needed?

Demonstrate the need and demand for more courses to tertiary sector.

Expand and extend tertiary education and in-service training in public health, including specialist training for the public health nutrition workforce.

Include public health nutrition modules in existing public health coursework, including specific components on Indigenous nutrition.

Scope of *EWA* response

Responsibility for basic training lies with universities and training institutes but state/territory employers can support enhancements. *EWA* takes the approach of providing information on problems in access and gaps in the types of training, to the suppliers of education, to encourage change as needed.

This initiative is linked with the needs analysis of workforce infrastructure recommended in the first Workforce development 'initiative. Expansion of training to the Indigenous health workforce is covered specifically in the *NATSINSAP*.

Partnerships

Universities often compete for funding but may also cooperate. Collaboration on course development and intellectual issues may require considerable negotiation.

Expand and extend tertiary education

<table>
<tr>
<td rowspan="2">Potential sector partners

Government health departments;
Tertiary sector;
NHMRC;
Nutrition Society of Australia;
DAA;
PHAA Food and Nutrition Special Interest Group;
RACGP and RACP;
FANO.</td>
<td>Objectives
Enhance the capacity of the public health nutrition workforce to plan, implement and evaluate public health nutrition programs through improvement to tertiary education;
Enhance the capacity of managers in public health to oversee public health nutrition programs.</td>
<td>Target groups
Public health nutrition workers;
Community nutritionists;
Specialist nutrition workers;
Public health and health promotion managers;
Indigenous health workers;
General practitioners.</td>
</tr>
<tr>
<td>Proposed actions
1 Conduct an annual survey of available courses, course content and disseminates on website/newsletter;
2 Review professional and tertiary studies which document levels and scope of current tertiary education of workforce as part of needs analysis of workforce requirements;
3 Identify the demand for different kinds/ modules of education;
4 Provide more PHERP funding to enhance tertiary training in public health nutrition, using a national approach;
5 Expand and extend flexible learning specialist public health nutrition courses and public health courses;
6 Further integrate effective public health nutrition approaches into existing general public health coursework;
7 Investigate the value of introducing a system of public health nutrition competencies;
8 Develop an implementation and action plan for introducing public health nutrition competencies, if warranted.</td>
<td>Capacity components
Support of the tertiary education sector;
Agreed definitions of recognised qualifications;
Grant systems to facilitate access to courses.</td>
</tr>
<tr>
<td colspan="2">Funding implications
Course development and additional implementation tasks;
Additional PHERP funding.</td>
<td>Potential indicators
Extent of agreement and introduction of competencies;
Number of courses/modules/case studies developed by type, student numbers, institutions and delivery mode;
Number of nutrition/dietetic graduates with public health qualifications, by year;
Number of public health nutrition workers with recognised qualifications in public health and/or public health nutrition, by year;
Use of nutrition examples in public health courses.</td>
</tr>
<tr>
<td colspan="2">Risks
Collaboration between tertiary institutions is unsuccessful;
Collaboration between professional associations is unsuccessful.</td>
<td>Links to other initiatives
Workforce development
1 Building human resource requirements.
NATSINSAP</td>
</tr>
</table>

Workforce development

Initiative no. 3: Training primary health care professionals

The issue

Primary health care professionals may include community nutritionists, general practitioners, community nurses, clinical dieticians, maternal and child health nurses, Indigenous health workers, physiotherapists, oral health therapists, occupational therapists and pharmacists. These professionals could potentially be involved in implementing aspects of *EWA* and *NATSINSAP*. However, to enable them to be involved, they will need access to nutrition information and program specific training.

Evidence and context

Primary health care settings provide opportunities for implementing nutrition prevention strategies. Research shows that interventions in the clinical setting have the potential to reduce morbidity and mortality. The one-to-one relationship between health care professionals and individuals can reinforce community-wide health promotion programs. For example, around 80% of all Australians visit their general practitioners at least once a year, so that there is scope for brief opportunistic interventions in advising people about diet and referring people to other health professionals or organisations. GP organisations are increasingly collaborating with others in the care of high-risk people and the broader community. However, primary prevention poses a challenge for primary health care practitioners, and studies have shown that general practitioners (for example) do not always provide optimal preventive services.

There are many barriers to the provision of primary prevention services in primary health care settings including lack of knowledge of effective counselling messages, time pressures and the fee for service environment.

Research shows the most effective way to engage primary health care professionals in preventative initiatives is to provide program-specific training. For example, the Canadian Task Force on the Periodic Health Examination recommends that prevention activities for general practitioners be based on case-finding, i.e. periodic health examinations, which target specific conditions for different age, sex and high risk groups.

What is already being done?

There is a wide range of local and statewide programs involving primary health care professionals. Examples include:

- 'HART Action in rural towns', an initiative between NHF and NSW Divisions of GPs;
- 'It Takes More than an Apple a Day', a detailing program for GPs, TAS;
- 'Lighten Up Healthy Life Style Program', health worker training program;
- GP Nutrition Manuals, West Morton Division of GPs and Toowoomba Division of GPs, QLD;
- 'Gut Busters', Shared Care Program with General Practitioners;
- Sanitarium Nutrition Information Service for GPs, Hornsby;

- Nutrition Australia nutrition seminars for health professionals;
- Canadian Task Force on the Periodic Health Examination, 'atlas 'of preventive interventions for use by GPs.

States/territories and NGOs, particularly Diabetes Australia offer training in nutrition to primary health care workers.

The NHF is working with peak training organisations to build nutrition information into existing training and activities.

Aboriginal Community Controlled Health Services are funded by the Office for Aboriginal and Torres Strait Islander Health to improve the access of Indigenous Australians to comprehensive primary health care services.

DHAC Public Health Clinicianship project.

What more is needed?

Primary health care professionals could be involved in the implementation of initiatives such as overweight, maternal and child health, vulnerable groups, and Indigenous Australians.

It will be essential to assess what nutrition knowledge and resources the different professional groups need, and to develop appropriate training strategies and resources.

For activities in this area to succeed, they must be closely linked to community and environmental activities and be supported by adequate infrastructure and specialists to reach the local level.

Management support for community programs is important.

Work with professional associations to reduce structural barriers and policy barriers.

Scope of *EWA* response

Primary health care professionals may be involved in the implementation of a number of initiatives, eg obesity, child growth, nutrition education for the prevention and management of CHD.

Linked initiatives include 'Disseminating research evidence ', 'Communicating with the public ', other 'Workforce development 'initiatives, and *NATSINSAP*.

Partnerships

Potential partnerships between: professional associations and training institutes; General Practitioner/ medical organisations such as the Royal Australian College of General Practitioners (RACGP); divisions of general practice and rural health training units.

Training primary health care professionals

<table>
<tr>
<td rowspan="2">Potential sector partners

Government health departments;
Divisions of General Practice;
Professional organisations i.e. RACGP, RACP, PGA, DAA, ANF, Australian Faculty of Public Health Physicians, ADA, AADT, ALCA, Pharmacists Society of Australia;
NACHO;
Higher education institutions (universities/ colleges/ TAFE);
Food industry;
NGOs ie NA, NHF, DA;
Private health care Organisations</td>
<td>Objective
Improve the capacity of primary health care practitioners to support the implementation of relevant EWA and NATSINSAP initiatives.</td>
<td>Target groups
Clinical/community Dietitians;
General practitioners;
Physiotherapists;
Pharmacists;
Community nurses;
Lactation consultants;
Indigenous health workers;
Dentists/Oral health therapists;
Diabetes educators;
Speech pathologists.</td>
</tr>
<tr>
<td>Proposed actions
1 Undertake training needs analysis for primary health care professionals when nutrition promotion action plans are being developed;
2 Develop training modules/strategies for nutrition;
3 Develop and disseminate best practice guidelines for training primary health care professionals;
4 Fund and evaluate general practice programs, which focus on EWA priorities.</td>
<td>Capacity Components
Sponsorship of strategies/training modules to meet the nutrition information needs of primary health professions involved in implementing EWA priorities;
Quality assurance standards for training modules;
Training linked to existing professional continuing education programs eg RACGP QA and CE, DAA APD,
lactation specialists;
Support of local management</td>
</tr>
<tr>
<td colspan="2">Funding implications
Training needs analysis and modules;
Training costs: must be established, possibly sponsored.</td>
<td>Potential indicators
Extent of need assessments completed by state/territory;
Extent training strategies developed;
Extent primary health care professionals involved in implementing initiatives by state/territory.</td>
</tr>
<tr>
<td colspan="2">Risks
Public health practice dominated by one-to-one practice;
Range of resources inadequate;
Capacity of primary health care professionals over-burdened.</td>
<td>Links to other initiatives
All health gain initiatives
Workforce development
1 Building human resource requirements.
4 Training the non-health workforce.
NATSINSAP
Monitoring and Evaluation
1 A national food and nutrition monitoring system.</td>
</tr>
</table>

Workforce development

Initiative no. 4: Training the non-health workforce

The issue

People working in non-health sectors can influence the nutrition of the population in both a positive and negative way. Such groups include technical and marketing staff in the food industry and in the retail sector; primary producers; those working in the health and fitness industry, the child care sector and the hospitality industry; local government employees; teachers and those managing school canteens. Community stores are critical in remote Indigenous communities. Many local and community groups and organisations are also involved in programs, which have, or could have, a nutrition focus.

Providing training and information for these workers to improve their nutritional influence on population groups is a cost effective way to increase the reach of *EWA* and improve the consistency of nutrition messages to the community.

Evidence and context

Public health nutrition practitioners and management already recognise the impact, and potential benefits, of working with the non-health workforce across a range of sectors. They have targeted key people outside the health sector involved in supplying food, i.e. those who formulate food products and people who prepare food for consumption outside the home. Given that many of the partners involved in implementing *EWA* initiatives are outside the health sector, links with many of these groups need to be maintained or in some cases established.

Giving the workforce from these other sectors opportunities to access education and training on nutrition and *EWA* initiatives will be essential to maintaining understanding between sector partners. This workforce will have less direct involvement in nutrition promotion than professional nutritionists or health sector workers.

What is already being done?

SMART Food Centre: Provides novel short nutrition courses and formal qualifications for food industry employees.

University of Sydney: training for fitness leaders in weight management.

TAFE: Canteen Operators Course provides a national training program for canteen managers.

TAFE: Catering Childcare Certificate (short) Course and Food Studies Course.

The Australian National Training Authority (ANTA) and the Industry Training Councils (ITCs): provide a national framework through which the health sector can influence training in agriculture, retail and transport. Nationally accredited healthy catering training plan and resources for chefs.

Various state/territory and locally based catering improvement and or education programs which target child-care settings, school canteens, gaols, sporting venues, farmers, take away sector and store managers.

NGOs (NA, DA, and NHF): provide training/resources for non-health sector workforce, particularly aimed at the education sector.

What more is needed?

Identify key groups to facilitate collaborative approaches such as training, funding and information and ensure they meet the needs of the non-health workforce for relevant initiatives.

An assessment of relevant course work and on-the-job training with sector partners, leading to improved nutrition training in areas of need.

Scope of *EWA* response

EWA provides a framework for linking the health and education sectors with industry, for exploring the state of nutrition training, and for potential improvements.

Partnerships

The public health sector in partnership with education, industry, professional associations and NGOs.

Training the non-health workforce

<table>
<tr>
<td rowspan="2">Potential sector partners

Government health departments;
ANTA;
TAFE;
AIFST;
AIEH;
ANZFA;
Local government associations;
State/Territory education departments;
NGOs ie DA, NHF, NA;
Industry training councils;
Professional and industry associations;
SMART Food Centre;
Consumers Health Forum;
WA, VIC, ACT Health promotion foundations;
Workplaces.</td>
<td>Objective
Improve the capacity of the non-health workforce to support the implementation of relevant EWA initiatives.</td>
<td>Target groups
All people working in sectors relevant to implementing EWA health gain initiatives.</td>
</tr>
<tr>
<td>Proposed actions
1 Undertake needs assessment/s of key non-health sector workforce (including food industry) which reviews current levels of involvement in public health nutrition activities and determine training needs for each health gain initiative as implemented;
2 Professional and food and other industry associations and NGOs to develop a nutrition component to on-the-job training and resource materials;
3 Audit and review nutrition course work and competencies across workforces relevant to EWA;
4 Tertiary training institutes to develop and offer short courses on EWA initiatives to food industry staff as needed;
5 Develop and provide accessible training packages for community and consumer groups such as sporting clubs.</td>
<td>Capacity Components
Personnel to carry out survey and work with partners in review;
Industry sponsorship for short training courses;
Practitioner-based delivery of identified training needs.</td>
</tr>
<tr>
<td colspan="2">Funding implications
Cost of course development is the responsibility of relevant sectors/ training institutions, with potential for sponsorship;
Development of locally based training packages.</td>
<td>Potential indicators
Number, type and quality of short courses offered to non-health workforce, which coincide with implementation of EWA initiatives;
Range of non-health sector offered training in EWA initiatives;
Extent nutrition coursework in place by sector.</td>
</tr>
<tr>
<td colspan="2">Risks
Complexity of training systems can resist change;
Diversity of needs may be difficult to meet;
Nutrition not a priority for targeted groups and not accommodated in work culture.</td>
<td>Links to other initiatives
All health gain initiatives
Workforce development
1 Building human resource requirements.
3 Training primary health care professionals.
Communication
2 Communicating with the public.
NATSINSAP
1 Food supply in remote areas.</td>
</tr>
</table>

Communication

Initiative no. 1: Disseminating the EWA strategy

The issue

To be effective, both *EWA* and *NATSINSAP* need to engage key stakeholders and maintain their involvement when planning implementation. Government health departments need to inform key stakeholders about the aims of *EWA* and opportunities for involvement, so that they become involved and stay involved in its implementation.

Evidence and context

The existence of *EWA*, the funding opportunities and achievements arising from it and major programs and achievements, need to be communicated to the many groups, organisations, businesses and individuals that could be involved in its implementation. This information should be easily accessible to all sectors. Different communication approaches will be required to reach the public and other stakeholders.

Communicating the aims and achievements of *EWA* will engender support from public health management, the community and political representatives; help secure resources for *EWA* over the long term; and ensure potential partners are engaged.

The contributions of partners need to be publicly acknowledged.

What is already being done?

Government health departments undertake ongoing communication strategies to promote good nutrition messages health professionals and the public.

Existing nutrition/public health/industry/NGO websites.

What more is needed?

A planned and sustained approach to communicating the aims, scope and specific initiatives to all stakeholders.

A planned approach to communicating programs and the outcomes to management and decision makers, especially to the ministerial level and to the general public.

Key stakeholders taking responsibility for communicating with their own constituencies.

Scope of *EWA* response

Communicating *EWA* requires short-term public relations activities, long-term dissemination infrastructure and periodic renewal.

A separate initiative addresses the need to communicate research and evaluation evidence to practitioners, the research sector and other stakeholders. Another initiative covers the communication of nutrition information and messages to the general public and a third the promotion of innovation.

Although *NATSINSAP* has a separate initiative for disseminating its aims and programs, its dissemination will be closely linked to *EWA*.

Partnerships

Government health departments to develop partnerships with media, professional organisations and peak organisations. Partners and key stakeholders to be encouraged to use their own communication networks to further disseminate *EWA* to other groups.

Disseminating the EWA strategy

<table>
<tr>
<td rowspan="2">Potential sector partners
Government health departments;
State/territory education departments;
ANZFA;
OATSIH;
Media organisations;
FANO;
PHAA;
DAA;
AFGC;
HCA;
ASSO;
AMA;
ABA;
NACCHO;
NGOs ie NA, DA, NHF;
Nutrition Society;
Peak organisations;
Tertiary institutions;
Food industry.</td>
<td>Objective
Ensure all current and potential stakeholders are aware of, and committed to, the aims and the scope of initiatives of EWA and NATSINSAP.</td>
<td>Target groups
State/Territory officers;
NGOs;
Private sector;
Research community;
NPHP/AHMAC;
Political representatives;
General public;
Community controlled Indigenous medical services.</td>
</tr>
<tr>
<td>Proposed actions
1 Undertake a communications strategy;
2 Develop website that provides up-to-date information on initiatives and links to sector partner sites suitable for both professionals and the general public;
3 Facilitate a biennial national conference to report on the progress of initiatives and encourage presentations at other national forums;
4 Disseminate EWA and NATSINSAP through established professional and organisational networks and consultative groups;
5 Report regularly through NPHP channels to the Australian Health Ministers Advisory Council;
6 Disseminate information on initiatives through state-based public nutrition networks;
7 Sector partners develop</td>
<td>Capacity
Components
Funding and dissemination policy;
Responsibility for website upkeep allocated;
State-based nutrition networks supported;
Conference sponsorship;
Review dissemination after periodic evaluations;
Simple reporting procedures</td>
</tr>
<tr>
<td colspan="2">Funding implications
Communication strategy;
Website design, list serve facility and upkeep;
Conferences.</td>
<td>Potential indicators
Extent EWA name is recognised and role understood by key stakeholders;
Extent initiatives are known to stakeholders with intersecting interests;
Extent initiatives are known to government representatives with responsibilities for health, agriculture, social welfare and Aboriginal affairs.</td>
</tr>
<tr>
<td colspan="2">Risks
Communication networks and mechanisms not maintained or sustainable.</td>
<td>Links to other initiatives
Strategic management
1 Implementing EWA and NATSINSAP.
Communication
2 Communicating with the public.
Research and development
2 Disseminating research evidence.
NATSINSAP</td>
</tr>
</table>

Communication

Initiative no. 2: Communicating with the public

The issue

The general public needs access to consistent nutrition information that is based on good science, is easily understood, regularly reviewed and readily available. Nutrition information assists people to choose healthy food and contributes to changing eating behaviour.

Evidence and context

The general public is very aware of the importance of healthy diets to their well being. However, many Australians are confused by the diversity of advice they receive (some of it misinformed or conflicting) and the changing nature of nutrition facts. Some groups, such as people from diverse cultural and linguistic backgrounds or those with specific diseases, receive inadequate advice. There are varying opinions as to the kinds of resources consumers want and need and how to deliver them effectively.

The development of consumer friendly messages requires a significant amount of market research to gauge true beliefs and knowledge. On the other hand, informants consulted for the development of *EWA* agreed that it is important that all partners promulgate consistent nutrition messages.

The Commonwealth government provides policy and practical guidelines for organisations to develop nutrition education materials and messages in the form of dietary guidelines. Consumers largely judge nutrition information by the perceived credibility of its authors or source. Dissemination of nutrition education materials is often passive, except when the materials are being used to support a particular program, public health information campaign or product marketing campaign. Organisations meet consumer demand for information using internet websites, by the production of print resources, and some provide telephone services. Consumers also receive nutrition information at school, through health professionals, via electronic and print media and when they read food product labels.

The Australia and New Zealand governments are currently reviewing the prohibition on health claims on food product labels and in related advertising. If health claims are introduced, it will be necessary to educate consumers on how to interpret them. It is important to identify the different sectors, their possible roles and responsibility for delivering and sustaining education strategies around any health claims that may be introduced.

What is already being done?

Nutrition information resources based on:

- Core Foods Groups;
- Dietary guidelines for Australians;
- Dietary Guidelines for Older Australians;
- Dietary guidelines for children and adolescents;
* the Australian Guide to Healthy Eating;
* Australian Drinking Water Guidelines.

Nutrition education resources/consumer information services/campaigns:

- local state/regional health service campaigns;
- individual food companies;
- peak industry and primary produce organisations;
- Nutrition Australia; NHF; Diabetes Australia;
- Cancer Council Australia;
- professional organisations;
- State/territory governments; and
- GP organisations.

ANZFA Food Standards:

- voluntary use of nutrition information;
- mandatory use when nutrition claim made;
- mandatory ingredient listing; proposal for foods containing more than 1.15% alcohol be labelled advising that the food be kept out of reach of children; and pilot health claim on folate and neural tube defects.

What more is needed?

Market research on effective dissemination of nutrition messages.

For all stakeholders to agree to actively disseminate consistent nutrition education messages.

A planned approach to educating consumers on how to interpret food labelling and associated advertising in accord with legislative changes.

Identify all discipline specific/health professional groups that regularly give nutrition advice and ensure that state/territory targets these groups to give consistent messages.

To develop and promote nutrition education materials for people from diverse backgrounds and Indigenous communities.

Develop nutrition messages for individuals at high risk of specific diseases.

Scope of *EWA* response

Dissemination of program messages which support the dietary guidelines.

Consideration of the role of food labelling.

Related initiatives include workforce training, maternal and child health initiatives and the vegetables and fruit promotion campaign.

Partnerships

Potential partnerships across and between all sectors, particularly industry and government, education and tertiary sector of other identified disciplines, relevant professional organisations.

Communication with the public

Potential sector partners

Government health departments;

NHMRC;

State/territory area health services;

GP organisations such as RACGP, divisions of general practice;

Food industry;

FANO;

NGOs;

Professional organisations such as DAA;

Peak organizations;

Curriculum Corporation;

NHMRC;

ANZFA;

OATSIH.

Objectives

Expose the Australian community to consistent and readily understood nutrition messages;

Provide consumers with clear, concise information about the composition of foods and key nutrients of public health significance.

Target groups

Australian community;

School teachers;

School children;

Health professionals.

Proposed actions

1 Disseminate authoritative information on high profile public health nutrition issues;

2 Disseminate government nutrition guidelines and materials through professional networks and public meetings;

3 Ensure website information is consumer-friendly and linked to other credible websites;

4 Develop culturally appropriate resources based on the Australian Guide to Healthy Eating, for large ethnic minorities;

5 Gain agreement on nutrition messages and then develop consumer-friendly messages and resources for programs and general education purposes as needed;

6 Review research into effective delivery of nutrition information, and disseminate results;

7 Review education materials as needed;

8 Develop regulations relating to food in response to new scientific knowledge, particularly in relation to food labelling;

9 Develop a plan for educating the public and health practitioners on matters relating to food regulation, particularly food labelling.

Capacity components

Nutrition promotion priority project teams;

Key stakeholders;

ANZFA;

Quackwatch.com (audits quality of nutrition information on websites).

Funding implications

New culturally appropriate guides;

Website.

Potential indicators

Culturally appropriate guidelines developed;

Extent Australian community exposed to messages by target groups;

Extent messages are perceived as consistent by key stakeholders and target groups;

Extent nutrition guidelines are understood by key professional groups and consumers.

Risks

Nutrition messages are changed or used out of context;

Reaching agreement on modes and content of messages impossible;

Various bodies remain autonomous and continue to send various messages to the public.

Links to other initiatives

All initiatives.

Communication

1 Disseminating EWA.

Child and maternal health

4 Nutrition for school-aged children.

Vegetables and fruit

1 Undertaking vegetable and fruit promotions.

Workforce development

3 Training primary health care professionals.

4 Training the non-health workforce.

Monitoring and evaluation

Initiative no. 1: A National Food and Nutrition Monitoring System (NFNMS)

The issue

Currently, monitoring of the food and nutrition situation in Australia is neither consistent nor nationally coordinated. Lack of long term commitment to monitoring has resulted in the failure to retain and develop a critical mass of expertise. Data collections are not adequate to meet the needs of *EWA* and are not linked or always compatible. This is a handicap for policy development, program planning and evaluation and reporting.

Evidence and context

A coordinated national food and nutrition monitoring system is needed to provide appropriate data for;

- policy development;
- coordination and review;
- program planning and evaluation;
- reporting against national goals and targets; and
- reporting internationally.

Such a system could provide the long term continuity of collection of key data sets needed to track changes and identify trends. The development of standard methods and procedures for collecting data will improve comparability of data collected by different organisations, in different locations and at different times. At present, a range of data are collected by many groups, both nationally and in jurisdictions, but methods are not standardised and data-sets cannot be linked.

Monitoring and evaluation of both individual initiatives and *EWA* as a whole will not be possible without appropriate indicators. In addition, indicators, analyses and evaluations are required for assessing existing food and nutrition programs. Specific initiatives may require long-term national data. Studies suggest that data are more likely to be used if the users are involved in the design of studies, if the data are timely and are interpreted to fit the information needs of the user.

What is already being done?

In 1999, DHAC funded a project to progress the establishment of a national food and nutrition monitoring system.

ABS/DHAC ongoing analysis of 1995 National Nutrition Survey Data.

AIHW Development of National Public Health Indicators Discussion Paper1999.

OZNUT Food Composition Database.

DHAC project on incidence of food borne illness.

What more is needed?

A national food and nutrition monitoring system needs to be:

- placed on a long-term footing and requires a strategic plan for beyond 2000; adequately funded to maintain core data collecting activities and to develop linkage systems between data-bases;
- able to include mechanisms for identifying emerging monitoring issues and coordinating methods of data collection; and
- integrated into *EWA*.

Indicators need to be refined and methods of measurement in place to track progress under *EWA* and areas of public health nutrition importance. These need to include local level information support for policy and planning.

The data needs to be disseminated in a useable form to researchers, the Commonwealth government and state/territory-based decision-makers and other *EWA* stakeholders.

Scope of *EWA* response

EWA can focus the collection of strategic public health nutrition information and link this with food borne illness data, and house the initiative for funding and management purposes.

Ways of actively disseminating the data to users is also part of the scope of *EWA* and is discussed in the Disseminating research evidence 'initiative.

Partnerships

Existing partnerships between consortium and others including industry. Partnerships with groups planning implementation of initiatives.

Potential sector partners

Government health departments;
AIHW;
ANZFA;
ABS;
NRA;
NHMRC;
CSIRO;
Research and education sectors;
Industry;
State/territory management and workforce;
NGOs;
Agriculture/ environmental/ biotechnology/ industry sectors.

Objectives

Establish an on-going national food and nutrition monitoring system;

Provide policy makers and practitioners with timely information upon which to evaluate current practice and plan for the future;

Identify emerging trends and work with jurisdictions to address information requirements;

Ensure that *EWA* and component initiatives have a firm evidence base for planning, and evaluation.

Proposed actions

1 Resource continuing evaluation of *EWA* over 3, 6 and 10 years;

2 Identify indicators and data sources for assessing *EWA* short and long term impacts and other monitoring needs;

3 Make long term plans for a national food and nutrition monitoring and surveillance system;

4 Ensure current and new monitoring and surveillance reports are developed, data is collected as required and of sufficient quality and usability to fit users needs;

5 Consult with different sectors to assess data needs;

6 Disseminate information to policy makers, the research sector, practitioners and other stakeholders as needed and interpret to fit the information needs of the specific user;

7 Maintain an updated Australian food composition database.

Capacity components

Resources to provide continuous and adequate data and monitoring services;

Partnerships to effect required outputs efficiently;

Mechanisms for ongoing consultation and review of users 'needs;

Evaluation of the outcomes of a monitoring system;

Strategic communication/ information and management plans;

ANZFA.

Funding implications

Long term funding of a national food and nutrition monitoring system;

Publication of data.

Potential indicators

Extent information required by stakeholders is provided over the long term;

Extent long-term sustainability of a national food and nutrition monitoring system is assured;

Extent data is available to monitor trends of specific priorities;

Extent key users perceive data meets their needs.

Risks

Long period required to demonstrate health gains may reduce attraction of investment in data;

Short-term funding arrangements threaten long-term data requirements;

Data does not meet diverse needs of users, in particular decision makers;

Failure to get agreement between jurisdictions on indicators and use of comparable measurements.

Links with other initiatives

Monitoring and evaluation

1 Evaluating *EWA*.

Research and development

2 Disseminating research evidence.

Strategic management

3 Establishing criteria for resource allocation.

NATSINSAP

Monitoring and evaluation

Initiative no. 2: Evaluating EWA

The issue

EWA, including *NATSINSAP*, is a new and complex strategic framework, therefore ongoing evaluation will be necessary to direct appropriate, effective and efficient implementation.

Evidence and context

Over the next ten years, *EWA* will be implemented in a changing environment. Large investments from government and the private sector are at stake. Evaluation is essential to protect these investments. *EWA* needs to remain relevant and consistent with current scientific evidence. Improved data will be available through the establishment of a national food and nutrition monitoring system.

Individual initiatives will need timely information on their effectiveness and efficiency, including the progress of implementation, achievement of outcomes, unintended consequences and impacts of external factors.

EWA will need reviews of its continuing appropriateness, including the interaction between different initiatives, and its ongoing relevance as priorities change and new issues emerge.

What is already being done?

Continuing development of *EWA*, including consultations with a wide range of stakeholders and developing initial indicators for monitoring progress and outcomes.

Work towards a national food and nutrition monitoring system is enhancing data and related capacity in the field of public health nutrition.

What more is needed?

An annual evaluation plan and mechanism which covers:

- regular internally monitoring and evaluation of each initiative, based on an agreed framework and guidelines;
- priorities and specifications for the review of selected initiatives every three years, including definition of acceptable short, intermediate and long term outcomes and baseline data;
- specifications for the review of *EWA* overall, possibly at six and certainly at ten years, covering the appropriateness of priorities, the effectiveness of the mix of initiatives, the working of intersectoral partnerships and the management of the strategy; and
- resource requirements and timeframe for the production of reports.

The reviews should be conducted by independent evaluators, involve more than one team, adopt transparent processes and make the results publicly available.

Scope of *EWA* response

Significant resources are needed for early reviews, but these should reduce over time, except for major reviews.

NATSINSAP evaluation may need its own timetable.

Partnerships

Ensuring that evaluation occurs is the business of government health departments but reviews will need to involve all sectors.

Evaluating EWA

<table>
<tr><td rowspan="2">Potential Sector partners

Government health departments;
All sectors.</td><td colspan="2">Objectives
Ensure the ongoing relevance and effectiveness of EWA and NATSINSAP;
Ensure accountability of contributions from all partners for the implementation of EWA and NATSINSAP.</td></tr>
<tr><td>Proposed actions
1 Develop guidelines for incorporating monitoring and evaluation activities into all initiatives;
2 Partners leading each initiative need to develop suitable evaluation plans agreed to by government health departments and other funding partners;
3 Identify priority areas for review every 3 years and commission reviews to reassess priority status;
4 Commission external evaluation of EWA after 5/6 and 10 years, and NATSINSAP on its schedule, to review overall appropriateness and effectiveness;
5 Report annually to all partners on the progress of implementation and outcomes achieved;
6 Update food and nutrition policies using evidence from EWA evaluations and reviews.</td><td>Capacity components
Guidelines for evaluation activities;
Baseline performance information;
TOR for evaluation of initiatives, priority areas and reviews;
Flexibility for evaluation of NATSINSAP in appropriate timetable;
Consultation mechanism for 5/6 and 10 year reviews;
National PHN Priority Setting Framework.</td></tr>
<tr><td colspan="2">Funding implications
3 year priority reviews;
5/6 and 10 year major review of EWA.</td><td>Potential indicators
Evaluation guidelines developed;
Annual reports produced;
Reviews completed;
Extent stakeholders perceive that evaluations produce credible and useful findings;
Stakeholders have sufficient information to assess whether EWA is relevant and effective and make changes in light of information.</td></tr>
<tr><td colspan="2">Risks
Findings from evaluation not seen as credible;
Recommendations from evaluations not taken into account;
Review results alienate key partners.</td><td>Links to other initiatives
Monitoring and evaluation applies to all initiatives under EWA and NATSINSAP.
All initiatives will need to have an evaluation plan appropriate to the type and scale of processes and outcomes involved.</td></tr>
</table>

Part 5 Appendices

This section contains the appendices:

- Key informants
- Commonwealth Department of Health and Aged Care responses to drafts

Appendix 1: EWA Key informants

Geoffrey Annison, Australian Food and Grocery Council

Sue Amanatidis, University of Sydney

Pat Anderson, Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation

Susan Anderson, National Heart Foundation

Russell Antcliffe, Woolworths Pty Ltd

Veronica Arbon, Batchelor Institute of Indigenous Territory Education

Tim Armstrong, Australian Institute of Health and Welfare

Bronwyn Ashton, National Heart Foundation

Sophie Atkin, Lower Great Southern Health Service

Elaine Attwood, National Council of Women of Australia Ltd

Bernie Auricht, National Heart Foundation

Brenda Austin, Central Australian Aboriginal Congress, Alice Springs

Rachael Avard, Western Sydney Health Services

Bernie Ayers, Diabetes Australia

Bruce Bevin, Australian Supermarket Institute

Belinda Brandon, Commonwealth Department of Health and Aged Care

Lynette Brown, ACT Health and Community Care

Katrine Baghurst, CSIRO Division of Health Sciences and Nutrition

Jeanette Baldwin, Diabetes Australia

Liz Balmer, Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council

Judith Barbour, Child and Youth Health

Adrian Bauman, University of New South Wales

Noel Baxendell, Aboriginal and Torres Strait Islander Commission

Gracia Baylor, National Council of Women of Australia

Elaine Bennett, Family Child and Youth Services

Mary Bent, Tasmanian Department of Health and Community Services

Colin Binns, Curtin University

Tony Blackwell, Department of Human Services

Sue Booth, Health Promotion SA

Lillian Bovell, Western Australian Municipal Government Association

Robyn Bowcock, Kimberley Public Health Unit

Shirley Bowen, ACT Health and Community Care

Sharron Bowers, Commonwealth Department of Health and Aged Care

Debbie Brealey, QLD Southern Public Health Unit

Marlene Brell, Council on the Ageing (NSW Inc)

Julie Brimbecomb, Territory Health Services

Helen Broad, Eat Well SA

Robin Bromley, WA School Canteen Association (Inc.)

Louise Broomhead, Commonwealth Department of Health and Aged Care

Toni Brown, Devonport Community and Health Services Centre

Wendy Brown, University of Newcastle

Des Buchhorn, Community Health Centre, Tweed Heads

Simone Burgharott, Anti-Cancer Foundation of South Australia

Adele Butler, Adelaide Hills Community Health Centre

Cathy Campbell, Health Department of Western Australia

Heather Campbell, Tangentyere Council

Sandra Capra, Dietitians Association of Australia

Addy Carroll, Healthway

Patricia Carter, Eat Well SA

Karen Cashel, University of Canberra

Sue Cassidy, Dietitians Association of Australia

Ian Caterson, University of Sydney

John Catford, Victorian Department of Human Services

Paula Cauduro, Territory Health Services

Ronis Chapman, Commonwealth Department of Health and Aged Care

Denise Chapman, NSW Health services

Kim Chute, W.A. School Health Organisation

Allan Clements, Tangentyere Council

Michelle Coad, Commonwealth Department of Health and Aged Care

Alan Coates, Australian Cancer Society

Ian Coffey, I A Coffey and Associates Pty Ltd

Fiona Collins, Bunbury Community Health Service

Clare Collins, Hunter Area Health Service (NSW)

Judy Congrieve, Tasmanian Nutrition Promotion Taskforce

Graham Cook, ALPA

Graeme Cooksey, Education Programs Branch

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David Crawford, Deakin University

Heather Crawford, Home Economics Institute of Australia

Kim Crawley, Midwest Health Service

Anne Croker, Australian Breastfeeding Association

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Giordana Cross, Children's Development Foundation (SA)

Linda Croucher

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Gail Cummins, Central Great Southern Health Service (WA)

Margaret Curran, Office of Aboriginal and Torres Straight Islander Health

Truus Daalder, Council on the Ageing

Leanne Daley, National Aboriginal Community Controlled Health Organisation

Camille Damaso, Northern Territory Health Services

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Lynda Davies, Northern Area Health Service

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Rosemary Davis, NSW Department of School Education

Vicki Deakin, University of Canberra

Catherine Deeps, Commonwealth Department of Health and Aged Care

Kelly Dematta, Penrith City Council

Clive Deverall, Cancer Foundation of WA

Helen Dixon, Anti-Cancer Council of Victoria

Annette Dobson, Women's Health Australia Project

Jon Doole, Kingborough Council

Veronique Droulez, Nutrition Solutions

Helen Duckett, North Metro Region

Janet Duke, The Royal Australian and NZ College of Obstetricians and Gynaecologists

Susan Dumbrell, Northern Sydney AHS

Sophia Dunn, Tropical Public Health Unit (QLD)

Karen Edmond, Territory Health Services

Gary Egger, Centre for Health Promotion Research (NSW)

David Ellement, MD96 Market City

Michelle Elwell, Tropical Public Health Unit (QLD)

Geoff Fairbrother, Australian Chicken Meat Federation Inc

Josephine Farley, Catering Institute Of Australia (WA)

Efi Farmakalidis, Berri Ltd.

Tania Feriot

Karol Fiddy, Well Womens Project, Adelaide Prison

Jill Finch, Australian Breastfeeding Association

Ruth Foley, Dietitians Association of Australia (WA)

Wendy Foley, University of Queensland

Jonathon Fowler, Small Business Association of Australia

Virginia Fox, Queen Elizabeth Hospital

Don Fraser, Charleville Western Areas

Michelle Fraser, Office of Aboriginal and Torres Straight Islander Health

Shirley Frizzell, Healthway

Ros Gabriel, Tropical Public Health Unit (QLD)

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Colleen Glasson, QLD Southern Public Health Unit

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Michael Gracey, WA Office of Aboriginal Health

Penny Graham, Commonwealth Department of Health and Aged Care

Kathleen Graham, Commonwealth Department of Health and Aged Care

Gordon Gregory, National Rural Health Alliance

Heather Grieve, Territory Health Services

Trish Griffiths, Bread Research Institute Australia Limited

Jill Grogan, Australian Divisions of General Practice Ltd

Anita Groos, QLD Central Public Health Unit

Rod Hall, Australian Fresh Fruit and Vegetable Association

Robert Halliday, Perth Market Authority

Cindy Hamill, Woolworths (QLD)

Cathy Harper, Southern Public Health Unit

Diane Harvey, International Diabetes Institute

Noel Harvey, Queensland Fruit and Vegetable Growers

Kate Hawking, Lower Great Southern Health Service

Margaret Hayes, Nutrition and Physical Activity Progam

Jenny Hazelton, ACT Health and Community Care

Anna Hebron, NT Women's Advisory Council to the Chief Minister

Michele Herriot, Health Promotion, South Australia

Paul Hewitt, Board of Studies, Curriculum Branch

Lesley Hewitt, North Metro Region

June Hicks, Nutrition Australia

Andrea Hickert, Bunbury Regional Hospital

Chris Higgins, Franklins Pty Ltd

Leonne Hiscutt, Australian United Fresh

Vivienne Hobson, Territory Health Services

Alison Hodge, Anti-Cancer Council of Victoria

Cheryl Hogarth, Tasmanian Dairy Industry Authority

David Hooper, Australian United Fresh

Emma Hopley, SMART CHOICE

Aloysa Hourigan, Springwood Medical Centre

Peter Howe, University of Wollongong

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Roger Hughes, Griffith University

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Amanda Justice, Territory Health Services

Pam Jupp, Australia New Zealand Food Authority

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Monica Kelly, Territory Health Services

Leanne Kennett, Adelaide Central Community Health

Heather Kent, Tasmanian Nutrition Promotion Taskforce

Sarah Kepert, Warren Blackwood Health Service

Joanne Kesteven, Meals on Wheels Association of NSW

Lesley King, NSW Cancer Council

Julie King, NSW Dept of School Education

Judy Kirkwood, Queensland Health

Jill Kleiner, Territory Health Services

Erin Lally, Goldfields Public Health Services

Michelle Lane, Disability Services Commission

Josephine Lang, Curriculum Development and Learning Technologies, Department of Education

Nadine Laschko, Commonwealth Department of Health and Aged Care

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Libby Lawler, Katherine West Health Board

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Ilona Lee, NSW Multicultural Health Communication Service

Mandy Lee, Queensland Health

Simone Lee, Australian Cancer Foundation of SA

Stephen Leeder, University of Sydney

Dympna Leonard, Queensland Health

Janine Lewis, Australia New Zealand Food Authority

Pam Lincoln, Lower Great Southern Health Service

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Leonnie Manns, Disability Council of NSW

Geoff Marks, University of Queensland

Patricia Marsh, Sanitarium Health Foods Co.

Patricia Marshall, Australian Diabetes Educators Association

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Eugenia Matherson, National Heart Foundation

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Marian McAllister, Noarlunga Health Service

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Leisa McCarthy, Territory Health Services

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Jo Meederyn, Eat Well SA

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Des Rogers, Red Centre Produce

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Graham Taylor, Food Industry Conference of Australia

Adam Tedesco, Territory Health Services

Carol Theobold, Environmental Health Branch

Denise Thompson, Diabetes Australia (WA)

Jennifer Thomson, Australian Medical Association

Maxine Toogood, Macquarie Health Service

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Carrie Turner, Territory Health Services

Richard Uglow, Retail Traders Association of Victoria

Kathy Usic, NSW School Canteen Association

Sandra Vale, National Heart Foundation

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Glen Vawser, Easy Slim

Philip Vita, NSW Health

Anna Voloschenko, Queensland Cancer Fund

Jan von See, Ravenswood Community Health Centre

Margaret Waight, Commonwealth Department of Health and Aged Care

Rae Walker, National Stroke Foundation

Patricia Walker, Top End Division Of General Practice

Anne Warburton, Royal Australian College of Physicians

Alison Ward, Devonport Community and Health Services Centre

Rowland Watson, Victorian Department of Human Services

Ross Weaver, Department of Commerce and Trading

Karen Webb, University of Sydney

Leanne Wells, Commonwealth Department of Health and Aged Care

Judy Wellins, NSW Southern Health Service

Barbara Wheeler, ACT Health and Community Care

Jo White, Health Centre Numbulwar

Leticia White, Commonwealth Department of Health and Aged Care

Krista Williams, Chronic Disease and Health Enhancement Branch

Peter Williams, Kellogg (Australia) P/L

Julie Williams, Tasmanian Department of Health and Human Services

Helana Willls, Swan Health

Elizabeth Wilson, Australian Breastfeeding Association (Tas)

Mike Wilson, Agriculture, Fisheries and Forestry - Agrifood Business Environment

Megan Wingrove, Territory Health Services

Marilyn Wise, National Centre for Health Promotion (NSW)

Beverly Wood, Consultant

Julie Woods, Public Health Association of Australia

David R Woodward, University of Tasmania

Alison Worrell, Batchelor Institute of Indigenous Territory Education

Marilyn Yates, Education Department

Heather Yeatman, University of Wollongong

Appendix 2 - Commonwealth Department of Health and Aged Care responses to drafts

Department of Health & Aged Care responses were received from:

Division	Branch	Section
Health Services	General Practice	Population Health
Health Services	Mental Health	Promotion & Prevention
OATSIH	Health Strategies & Research	Branch Executive
Office of NHMRC	National Health Priorities and Quality	Asthma & Cancer
Office of NHMRC	National Health Priorities and Quality	CVD & Diabetes
Population Health	Communicable Diseases & Environmental Health	Food Policy
Population Health	Drug Strategy & Population Health Social Marketing	Tobacco & Alcohol
Population Health	Primary Prevention & Early Detection	Population Health Strategies

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