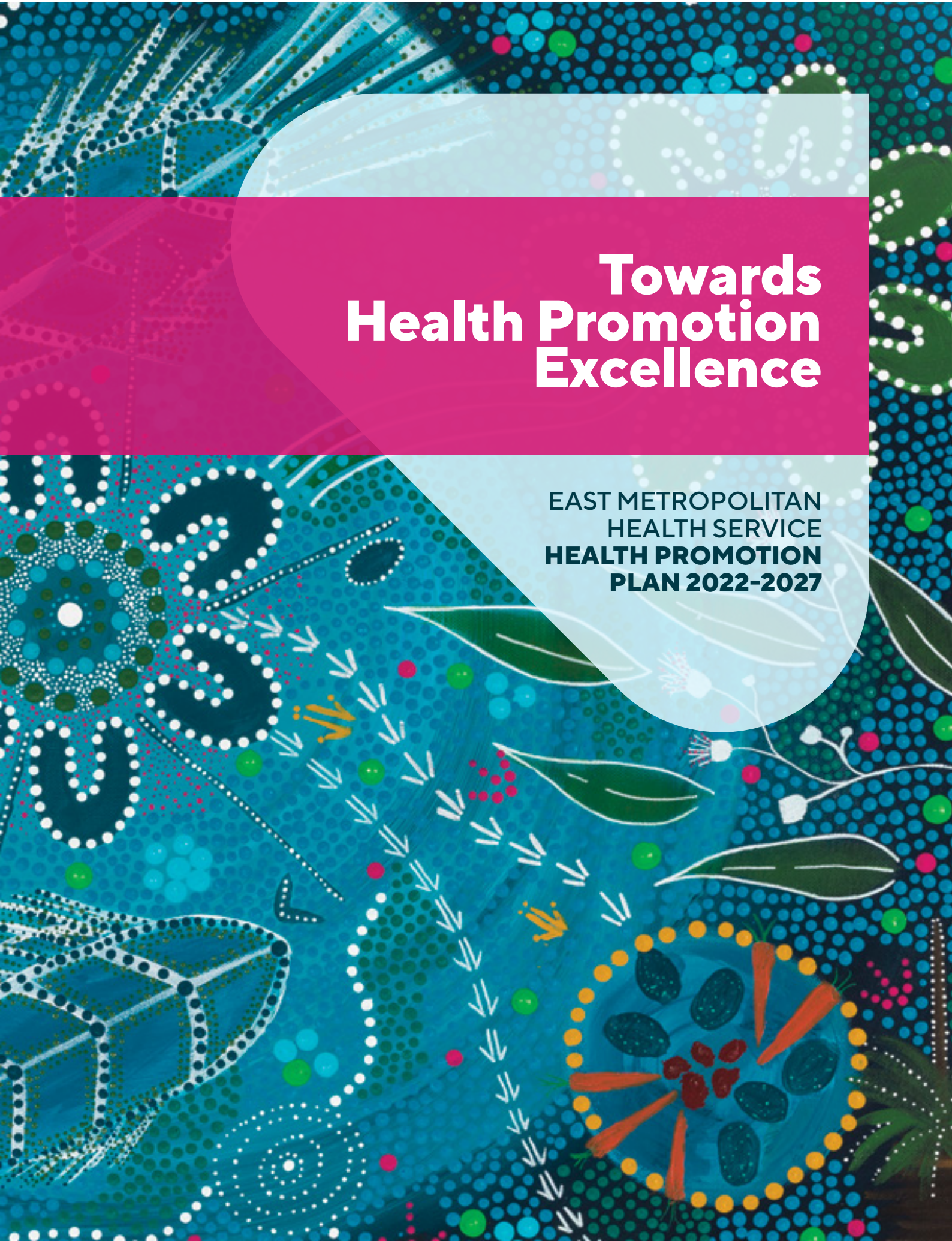
Government of Western Australia
East Metropolitan Health Service



Towards Health Promotion Excellence

EAST METROPOLITAN HEALTH SERVICE
HEALTH PROMOTION PLAN 2022-2027

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

CONTENTS

ACKNOWLEDGEMENT TO **ABORIGINAL PEOPLE**

Ngalak mornang Boorloo warlang Kataditj.
We at the East Metropolitan Health Service acknowledge the Traditional Owners of the land.

Ngalak djuripen Ngalak Moorditj Wirrin Katadjin.
We're happy, we're strong in spirit and knowledge.

Ngalak Kataditj boodja djuripen Moorditj Wadjuk boodja.
We acknowledge the land of the Wadjuk people of the Noongar Nation.

Ngala Wadjuk Bridiyas, Wadjuk Nyungar, Wadjuk Yoka and Kulungas moorditj yey.
Our Wadjuk Elders, Wadjuk men, Wadjuk women and children are strong today.

Ngalak djuripen Katadjin mornang Boorloo warlang.
We're happy to educate, learn and teach at the East Metropolitan Health Service.

Ngalak Katadjin Ngala Demban Dembart kaditj karni waankiny kura kura, Ngalak darbakarn kuliny.
We acknowledge our Elders, grandfathers and grandmothers and recognise truth telling (talking), and the journey they started long ago, we walk slowly together.

Noongar language and interpretation by Rohan Collard, Director, Dooga Waalitj Healing, June 2022.

OUR **ARTWORK STORY**

This artwork is about our Aboriginal people gathering together and starting their health journeys.

The artwork shows a continuous journey of learning from one another, sharing and paying close attention to the significant knowledge passed down from our ancestors to future generations. The artwork represents animals and plants that are local to Wadjuk country and were essential to Noongar people's survival and education.

These images remind us how important it is to understand seasonal change. Seasonal changes would signal to the Noongar community of hunting habits and dietary changes. Wetj (emu), yongka (kangaroo), djildjit (fish), kwordiny (wild carrots), eucalyptus, red gum and balga bush have medicinal and nutritional properties, and here represent Noongar connection to country, strength, wisdom and knowledge. Knowledge is significant to a holistic approach for health and wellbeing, and this means to focus on our spiritual, emotional, mental and physical state.

The Health Promotion team is shown in the centre, learning and growing together and travelling out connecting with community. The tracks represent us on a health journey together. We are building that strong community around health for our future generations. Our work as a Health Promotion team with the community grows and improves as our journey continues.

Artist Biography:
Sarah Humphries

"I am Sarah Humphries a mother of three, Nyoongar Yorga and Perth based Aboriginal Artist. Growing up I have watched both my grandmothers, Sheila Humphries Taylor and Doreen Creed Yarran Kickett, and my parents (Shirleen and Bill) paint. They are the ones that have inspired me to become an Aboriginal Artist. It was not until I had my three kids that I decided to take my art seriously and created Djinda Dreaming. Djinda Dreaming is a space where I can create, carry on what I have been taught and pass it down to my children. Being able to create paintings that not only represent the story I am telling but also the beauty of our culture and heritage is important to me. That is why I love doing this. We have a strong culture and there is a lot to be shared".

CONTEXT OF OUR HEALTH PROMOTION PLAN IN **POLICY & LEGISLATION**

The *Public Health Act 2016* protects and promotes the health of Western Australians. East Metropolitan Health Service (EMHS) is legislated to work with local governments through the following agreements:

- *Western Australian State Local Government Agreement,* signed by the Minister of Health.
- Agreed roles and responsibilities for the provision of public health planning support to local government; Part 5, Public Health Act 2016 (endorsed by EMHS CE in August 2019).

The *WA Health Public Health Policy Framework* mandates EMHS to deliver chronic disease and health promotion services through the following policies:

- *WA Health Promotion Strategic Framework 2017 – 2021*
- *Smoke Free Policy - MP 0158/21*
- *Healthy Options WA Food and Nutrition Policy - MP 0142/20*

The EMHS Health Promotion team supports implementation of the *EMHS Strategic Plan 2021-2015*, achieving deliverables for the following EMHS activities:

- *Obesity Prevention Strategy*
- *Clinical Services Plan*
- *Aboriginal Health and Wellbeing Implementation Action Pl25*
- *Cancer Services Plan*
- *EMHS wide Smoke Free Project*
- *Byford Health Hub*

The *Sustainable Health Review* outlines 8 Enduring Strategies and 30 Recommendations to guide the direction of the WA health system to deliver a healthier, and more sustainable future for all Western Australians.

"Our Plan is underpinned by current health promotion literature and evidence, and is informed by global, national and local health promotion context."

ALIGNMENT OF OUR PLAN

Towards Health Promotion Excellence

The *East Metropolitan Health Service (EMHS) Health Promotion Plan 2022 – 2027, Towards Health Promotion Excellence,* (our Plan) seeks to influence the way in which EMHS strategies are developed and implemented across EMHS, its community and partners to ensure that improving the health outcomes for priority populations in our catchment is everybody's business.

The *WA Health Public Health Policy Framework* is binding and mandatory for each health service provider. The Policy Framework specifies public health requirements that East Metropolitan Health Service must comply with, including chronic disease prevention and health promotion. The purpose of the Policy Framework is to ensure consistent services across the health system to prevent disease before it occurs.

The *WA Health Promotion Strategic Framework 2017 – 2021* (the Framework), is the guiding policy document for Health Promotion across the State's health system. The Framework identifies a set of guiding principles and priority areas to improve the health and wellbeing of the Western Australian population. As such, our Plan adopts the relevant Strategic Directions of the Framework:

- Healthy eating
- A more active WA
- Making smoking history
- Reducing harmful levels of alcohol use.

The *Draft WA Health Promotion Strategic Framework 2022 – 2026* has also been considered and the adoption of its priority areas will be included in the planning and implementation phases of our Plan. Implementation of our Plan will be supported with the development of our Road Map. This will be a co-designed process with our community and stakeholders to explore and summarise key actions of our Plan.

Our Plan is also closely aligned to the:

- Department of Health, *WA Sustainable Health Review* - Strategy 1: Commit and collaborate to address major public health issues.
- *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025* to reduce the incidence and prevalence of mental health problems and delay the uptake and reduce the harmful use of alcohol and other drugs and associated harms.
- *National Health Preventive Strategy 2021-2030* released in December 2021.
- *WA Aboriginal Health and Wellbeing Framework 2015-2030*, specifically the prevention and early intervention strategic directions.
- *National Obesity Strategy 2022 – 2032*, a framework for action to prevent, reduce, and treat overweight and obesity.

Within EMHS there are several organisational plans and frameworks with which we align, including:

- *EMHS Strategic Plan 2022-2025*
- *EMHS Obesity Prevention Strategy 2020-2025*
- *EMHS Clinical Services Plan – Towards 2024*
- *EMHS Aboriginal Health and Wellbeing Framework Action Plan 2022-2024*

There are many synergies between the EMHS Obesity Prevention Strategy and our Plan, and both require the collective efforts of stakeholders within EMHS and the broader community. The EMHS Health Promotion team and the EMHS Nutrition and Policy team will work together, harnessing key strengths to address the leading risk factors and determinants for physical activity, nutrition and overweight and obesity.

Accompanying documents

Our Plan is underpinned by current health promotion literature and evidence, and is informed by global, national and local health promotion context. It is recommended our Plan is read in conjunction with *East Metropolitan Health Service Health Promotion Evidence in Context Paper* for full context.

OUR HEALTH PROMOTION **TEAM**

EMHS vision **Healthy people, amazing care.**
Koorda moort, moorditj kwabadak.

We do this by creating and maintaining community environments that support optimal health, wellbeing and belonging.

Our mission

We put health first
We promote environments that support people to thrive physically, culturally, emotionally, and socially in their community.

We make health visible
We connect and collaborate with community, health and non-health partners to make small and sustainable changes that create healthier communities.

We engage and advocate
We engage with people with lived experience and empower them to address population health issues. We strengthen community action, value and amplify the voices of priority populations to reduce health inequities.

We partner and empower
We build collective capacity and partner with service providers to create healthier environments. We put health on the agenda in multi-agency environments.

Our guiding principles

These guiding principles are a core part of our team and essential to our decision-making processes.

We support the well and at-risk
Our expertise is in primary prevention to reduce the likelihood of disease developing.

We work at population level
Small shifts in populations' behaviour can have high impact, effecting large overall reductions in the burden of chronic disease.

We connect and collaborate
It is necessary to work in partnership to enact sustainable change. We support a collective impact approach, with partnership and communication as the foundation of our work.

We use systems thinking
Focussing on individual behaviour is not enough.
It is necessary to focus on the environment people live in and how this interacts with their choices and behaviours.

We are informed by evidence
We are committed to evidence-based and evidence-informed practice in the planning, implementation and evaluation of our work.

We support equity
We will work to reduce the health gap between population groups. We focus on populations where risk factors are high, and interventions will have most impact.

OUR PLAN - **SUMMARY**

EMHS vision
Healthy people, amazing care.
Koorda moort, moorditj kwabadak.
We do this by creating and maintaining community environments that support optimal health, wellbeing and belonging.

Priority populations

- Aboriginal people
- Culturally and linguistically diverse (CALD) people
- Lesbian, gay, bisexual, transgender, queer or questioning, intersex and/or other sexuality and gender diverse people (LGBTQIA+)
- People with mental illness
- People of low socio-economic status
- People with disability
- Women and young people

Goals	Objectives
1. Increasing physical activity	• Increase in shared spaces for social sport, active recreation and play. • Increase in programs and supportive built environments for walking and active mobility.
2. Improving access to and consumption of nutritious food and drink	• Increase availability and promotion of healthy food and drink in selected food environments. • Support population-based initiatives to enable people to eat a healthier diet.
3. Preventing and minimising harm from alcohol use	• Increase programs and supportive environments that minimise alcohol-related harm. • Improve timely and equitable access to organisations that provide alcohol-related support services in community and hospital settings.
4. Reducing tobacco and e-cigarette use	• Reduce exposure to second-hand smoke and e-cigarette aerosol. • Create supportive environments for people to stop smoking and improve access to smoking cessation support across hospital, primary care and community sectors.

Co-benefits

Improving mental health

Preventing injury and creating safer communities

Addressing climate change

Next Steps: Developing a Road Map for action

Horizon 1: 2022-2024 Action Plan
Co-design process with community and service provider stakeholders to develop this action plan.

Horizon 2: 2025-2027 Action Plan
A mid-cycle review will inform our planning for this horizon.

Our community faces a growing burden of chronic disease and health inequity; smart investment to halt this rising burden is urgently required. The evidence [1] suggests that some of the best investments to address this growing burden of disease and its significant economic impact are underpinned by:

- the achievement of health equity for specific priority populations in our catchment area
- investment in co-designed and co-implemented primary prevention interventions
- addressing the leading and modifiable risk factors for chronic disease in Western Australia.

Supporting equity for specific priority populations in our catchment area

There are groups of people within our community who experience a disproportionate burden of disease, leading to differences in their health and wellbeing [2].

Our Plan aims to support equity for priority populations, who will benefit the most from addressing the four modifiable risk factors. This includes but is not limited to:

- Aboriginal people
- Culturally and linguistically diverse (CALD) people
- Lesbian, gay, bisexual, transgender, queer or questioning, intersex and/or other sexuality and gender diverse people (LGBTQIA+)
- people with mental illness
- people of low socio-economic status
- people with disability
- women and young people.

It is important to note that some people identify with more than one priority population group, and this intersectionality can compound their health and wellbeing issues [2].

We are committed to supporting equity in each of our health promotion goals and objectives. This will be done by working with partners and community (including priority populations) to implement sustainable, collective action for systemic changes to our social and physical environments and the creation of tailored participation opportunities that make it easy and affordable to prioritise healthier behaviours. Together, we will use a three-pronged approach to:

- strengthen, develop, trial, and adopt systems-based interventions that address the social and economic inequities to enable the adoption of healthier behaviours
- co-design and co-implement interventions with community that provide relevant and meaningful ways to improve and promote healthier behaviours
- measure the impact of our work to improve environments in our geographic catchment area.

Investment in co-designed and co-implemented primary prevention interventions

Our Plan fits within the prevention spectrum with a key focus on primary prevention actions for people in our community that are:

- well and would benefit from whole-of community strategies that improve factors to avoid developing chronic disease
- are at increased risk of developing chronic disease and would benefit from targeted population-wide strategies that prevent disease and illness.

Primary prevention interventions aim to prevent disease or injury before it ever occurs (see Figure 1). This is done by preventing exposures to risks that cause disease or injury, altering unhealthy or unsafe behaviours that can lead to disease or injury, and increasing resistance to disease or injury should exposure occur.

Although health promotion action can occur across the whole prevention spectrum, our Plan does not deliver secondary and/or tertiary prevention goals, objectives or actions which may sit within scope for other teams across EMHS, the community and our partners. The EMHS Health Promotion team will work alongside our primary and secondary prevention colleagues and partners to ensure a comprehensive approach to prevention.

Achieving our health promotion objectives will be most effective with participation by and partnerships between community, private, non-profit and government partners at the state and local levels. We aim to implement a collective impact approach, engaging partners across multiple sectors and reach beyond the traditional boundaries of public health to include the transport network, planning agencies, Aboriginal health and wellbeing providers, clinical and community providers, and community service organisations. This focuses on communication, a shared common agenda and mutually beneficial outcomes. In addition, to stay grounded in day-to-day realities, we will aim to involve people from priority population groups at all stages of planning, implementation and evaluation.

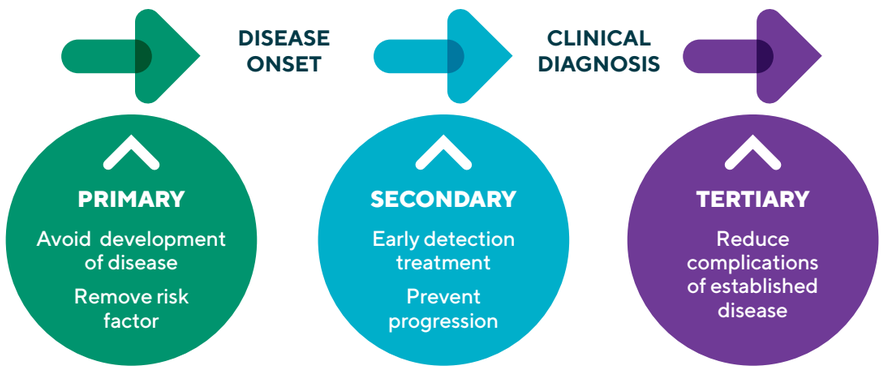


Figure 1. Levels of prevention strategies
Adapted from: Primary Care Online Resources and Education: Preventive Services [3].

ABOUT OUR PLAN

Next steps: Developing a Road Map for action

Horizon 1: 2022 – 2024 Action Plan

The Horizon 1 Action Plan will be developed within 12 months of our Plan's release and will focus on initial actions and measures to address the EMHS Health Promotion objectives.

To develop the Horizon 1 Action Plan, the EMHS Health Promotion team has identified goals and objectives for leading and modifiable risk factors. In addition, the team has also identified potential actions to prioritise our efforts against each health promotion objective and will use a conceptual framework (see Figure 2) to guide the development of the Horizon 1 Action Plan.

Horizon 2 Action Plan: 2025 - 2027

The Horizon 2 Action Plan will be informed by a mid-cycle review. This will build on the Horizon 1 Action Plan and continue to drive action to achieve the EMHS Health Promotion objectives.

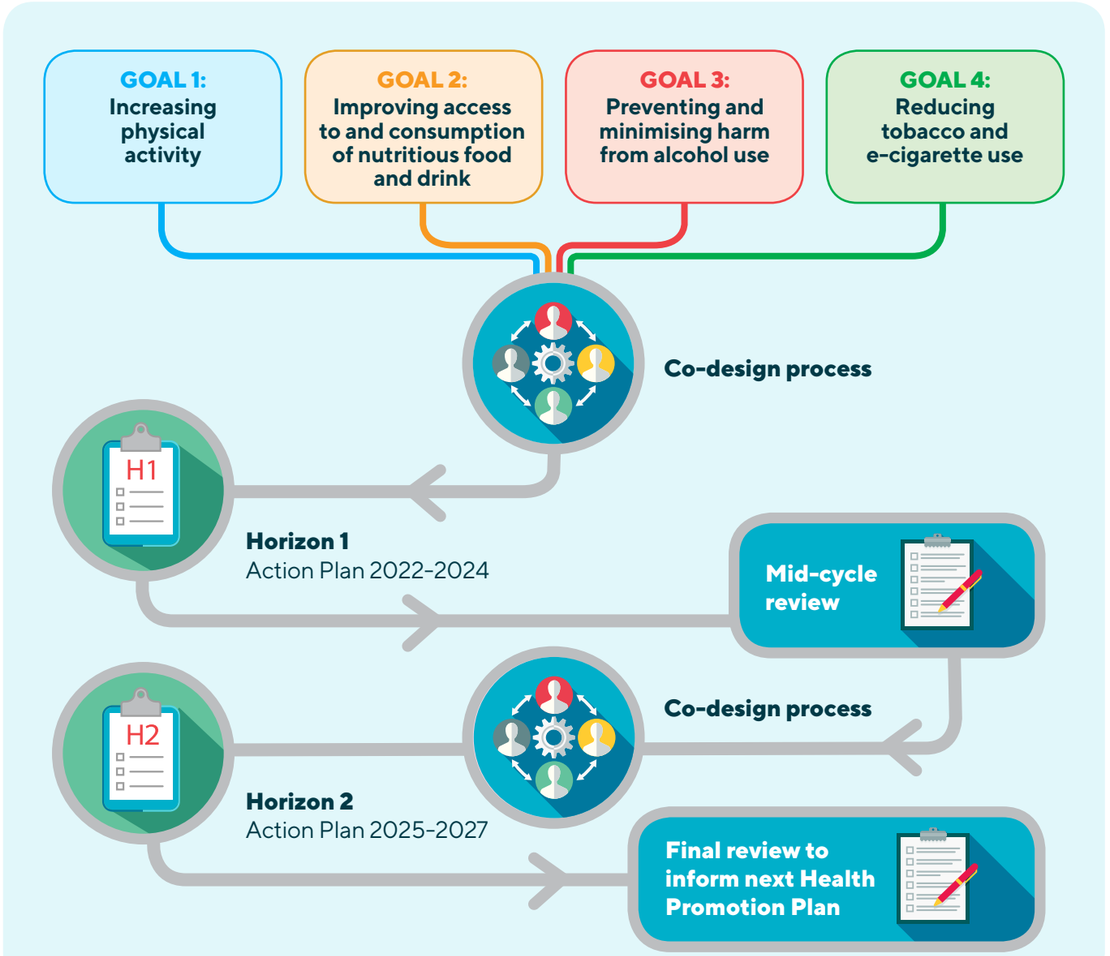


Figure 2. Conceptual framework to develop our Road Map
Adapted from: Alzheimer's Association and Centers for Disease Control and Prevention [4]

ADDRESSING THE **FOUR LEADING AND MODIFIABLE RISK FACTORS**

The four leading and modifiable risk factors for chronic disease in Western Australia are: physical inactivity, poor dietary intake, harmful alcohol use, and tobacco use [5].

	Conditions									
Behavioural risk factors	Cardio-vascular diseases	Type 2 diabetes	Mental illness	Chronic kidney disease	Some cancers	Injury	Musculo-skeletal	Respiratory infections and diseases	Oral diseases	Neurological conditions†
Tobacco use	●	●	●	●	●	●	●	●	●	●
Physical inactivity	●	●	●	●	●	●	●			●
Harmful alcohol use*	●		●		●	●	●	●	●	●
Poor dietary intake	●	●	●	●	●	●	●		●	●

*Drinks more than 2 standard drinks/day, †includes dementia

Table 1. Associations between behavioural risk factors and selected chronic diseases and injury
Adapted from: Draft WA Health Promotion Strategic Framework 2022-2026

Our goals and objectives address these four risk factors, focusing on priority populations, environmental change and working in partnership with community and stakeholders. The evidence shows that addressing these four leading and modifiable risk factors makes good business sense because they:

- place a significant burden on our economy and it is estimated that this burden will continue to rise if we do nothing [6]
- can deliver significant economic benefits when their related social determinants of health are addressed [6-8]
- can contribute to important community-wide co-benefits when a population health approach is taken [9,10].

In addition, we will work with the 13 local governments in the EMHS geographic area to support the development, implementation and review of local public health plans, with a focus on the four leading risk factors.

The case to address the four leading risk factors:

Known economic burden

$66.8 BILLION estimated **cost of alcohol use** in Australia in 2017–2018 [8].

$136.9 BILLION estimated **social cost for tobacco use** in 2015–16 [8].

$805 MILLION **total annual cost of physical inactivity** to the Australian economy in 2013 [7].

Estimated potential economic benefits of actions addressing social determinants of health in Australia

$2.3 BILLION **savings in hospital expenditure** due to 60,000 fewer people needing to be admitted to hospital annually [6].

$184.5 MILLION **annual savings** due to 5.3 million fewer Pharmaceutical Benefit Scheme scripts needed to be filled each year [6].

Addressing these risk factors can lead to co-benefits:

Example: Shifts towards universally healthy and sustainable diets can lead to co-benefits, such as minimising food system-related greenhouse gas emissions and land use degradation, reducing the environmental footprint, aiding in climate change mitigation, and improving population health [9].

Example: More active urban planning and design supports more people to be active more often, making the healthy choice easier and more accessible for all. Healthy and active neighbourhood design contributes to increased social safety and inclusion, increased road safety and increased social capital from more vibrant streets, spaces and places [10].

Our goals and objectives for the four leading risk factors are detailed in the next section.

GOAL 1: INCREASING PHYSICAL ACTIVITY

KEY **FACTS**

1 in 2 Australian adults **do not meet** Australia's **physical activity guidelines**[11].

Physical activity is lower among people from lower socio-economic groups: 37% are sufficiently active, compared to **52%** from the highest socio-economic groups[12].

Aboriginal Australians are less likely to be physically active than non-Aboriginal Australians[13].

A higher proportion of **women (44%)** reported **insufficient activity levels** compared to men **(34.5%)** in the EMHS area[14].

Regular physical activity has major health benefits, including reducing the risk of heart disease, type 2 diabetes, cancer[15, 16] and mental illness[17], and positively influencing academic results, social connection, gender equality, and the ability to live independently, live well for longer, and have increased access to places and services[18]. Physical inactivity places a significant burden on the economy and investing in population-level physical activity actions can reduce potentially preventable hospitalisations[7].

We aim to increase physical activity levels across the population with a particular focus on people who are not achieving physical activity guidelines, those with the lowest levels of physical activity, those at highest risk of discontinuing physical activity based on life cycle stages, and those living with the most disadvantage.

OUR **OBJECTIVES**

- **Increase in shared spaces for social sport, active recreation and play.**
- **Increase in programs and supportive built environments for walking and active mobility.**

OUR **POTENTIAL ACTIONS**

- Work with community, local government, state government (e.g. planning and transport sectors) to develop physical activity policies that improve the design and use of public spaces for recreation, play and neighbourhood walking.
- Co-design evidence-based policies and programs in a range of local settings within EMHS catchment area that encourage cycling, walking and public transport access to local destinations.
- Co-design physical activity programs with priority populations to create welcoming, inclusive and culturally secure environments.

GOAL 2: IMPROVING ACCESS TO AND CONSUMPTION OF NUTRITIOUS FOOD AND DRINK

KEY **FACTS**

In 2020, **only 7%** of the Western Australian population ate the **recommended number of serves of vegetables** [19].

Discretionary foods in Australia in 2018, contributed one third **(35%)** of total daily energy [20].

Less than half (43.2%) of the EMHS population meet the **recommended daily fruit intake** [14].

Australia's Food and Nutrition 2012 found that people from **lower socio-economic groups** (across all age groups) drank **significantly more sugary drinks (38%)** compared with those from higher socio-economic groups **(31%)** [21].

22% of Aboriginal people in Australia were living in a household that in the previous 12 months had **run out of food and had not been able to afford to buy more**, compared with **3.7%** of non-Aboriginal people [22].

Healthy diets are essential for promoting health and reducing the risk of obesity and diet-related chronic diseases such as heart disease, type 2 diabetes, and some cancers [23]. Yet most Australians do not eat a healthy dietary pattern that is consistent with recommendations [20]. Eating behaviours are influenced by a range of ecological factors including individual, social, physical, and macro-level, which is referred to as the food or nutrition environment [24]. There is evidence of a positive relationship between availability of healthy foods and better quality diets [25].

It is increasingly difficult for many people to eat healthily because food prices for healthy foods have risen faster than for unhealthy foods in the EMHS geographic area [26]; and communities are bombarded with misleading or inaccurate nutrition information and advertising and promotion of unhealthy products [27].

We aim to identify and implement actions that equitably improve population diets in our geographic area. We will do this by focusing on co-designing interventions to improve food environments in our geographic area to make healthier eating easier, especially for priority populations.

OUR **OBJECTIVES**

- **Increase availability and promotion of healthy food and drink in selected food environments.**
- **Support population-based initiatives to enable people to eat a healthier diet.**

OUR **POTENTIAL ACTIONS**

- With community and partners, develop and implement evidence-based policies and programs in a range of local settings within EMHS catchment area to increase availability and promotion of healthy food and drinks, improve access to free drinking water and restrict promotion of unhealthy food and drinks.
- Remove marketing of unhealthy food and drinks from EMHS and local government owned or managed assets, in collaboration with key partners.

GOAL 3: PREVENTING AND MINIMISING HARM FROM ALCOHOL USE

KEY **FACTS**

The **total cost of alcohol use** in Australia in the 2017/18 year was **$66.8 billion**[28].

Of the **young adults** (aged 16-30) admitted to the **Trauma Unit** at Royal Perth Hospital, **43% had consumed alcohol** prior to their injury (2010 – 2019)[29].

In WA, **males** are more likely than females to **drink at risky levels**: **32%** of men drink at long-term harm compared with **18%** of women; **13%** of men drink at short-term harm compared with **5%** of women[19].

After adjusting for differences in age, **lesbian, gay or bisexual people** were far more likely than the whole population to **consume alcohol in risky quantities**, with lifetime risk drinkers of **25.8%** compared with **17.2%** of heterosexual people[30].

Only **56% of men** and **28% of women** are aware of the quantity of drinks that can lead to long-term harm[30].

Drinking alcohol at risky levels causes a range of preventable diseases, including cancer, stroke and liver cirrhosis, along with the injury and violence experienced by communities across the state[31, 32]. Drinking alcohol at risky levels affects mental and emotional wellbeing[33] and can impact on relationships, productivity, social connections and anti-social behaviour[8]. Locally, alcohol-related presentations to the Royal Perth Hospital Emergency Department costs the WA community $7.5 million per year[34].

We aim to work with community and partners across sectors to comprehensively address alcohol-related harm and create positive changes in our community. We do this by increasing connection and integration of local community systems and increase supportive environments to prevent and minimise alcohol-related harm and injury.

OUR **OBJECTIVES**

- **Increase programs and supportive environments that minimise alcohol-related harm.**
- **Improve timely and equitable access to organisations that provide alcohol-related support services in community and hospital settings.**

OUR **POTENTIAL ACTIONS**

- Collaborate with Local Drug Action Groups to design and deliver targeted interventions for high risk populations.
- Co-design and develop policies and programs to reduce exposure of young people to alcohol use, marketing, and extend the reach of credible, evidence-based messages.
- Support learning and development opportunities for health and community service organisations to plan, deliver and action primary prevention strategies.

GOAL 4: REDUCING TOBACCO AND E-CIGARETTE USE

KEY **FACTS**

In Australia, up to **two-thirds of deaths** in people who smoke can be attributed to smoking [35].

In WA, **38% of Aboriginal people smoke** [36], compared to **12%** of the general population [30].

One in three **(32%)** Australian adults who smoked daily had a **mental health or behavioural condition**, compared with **18%** of people who had never smoked.

22% of Australians aged 18-24 years have used an **e-cigarette or vaping device** at least once.

Despite significant reductions in the rates of tobacco smoking among the general population, tobacco use continues to cause the highest burden of disease both nationally and in WA, including many respiratory diseases, cardio-vascular diseases, and cancer [37]. People diagnosed with a mental health and/or behavioural condition, those that identify as LGBTQIA+ and people from lower socio-economic areas continue to be more likely to use tobacco [30, 37, 38].

Creating smoke free environments de-normalises smoking behaviour, prevents uptake from young people, supports people who smoke to stop smoking and reduces non-smokers exposure to second-hand smoke [39].

We aim to reduce smoking levels across the population with a particular focus on priority populations with higher smoking rates compared to the population average. This will include providing supportive environments to stop smoking and enabling environmental changes in collaboration with community and partners.

OUR **OBJECTIVES**

- **Reduce exposure to second-hand smoke and e-cigarette aerosol.**
- **Create supportive environments for people to stop smoking and improve access to smoking cessation support across hospital, primary care and community sectors.**

OUR **POTENTIAL ACTIONS**

- Deliver culturally relevant and responsive community-based primary prevention and smoking cessation education programs for priority populations.
- Co-design solutions to reduce exposure to second-hand smoke, such as increasing smoke free areas.
- Implement a coordinated approach for smoking cessation support in health service and community settings, including offering all inpatients and EMHS employees who smoke with brief advice, free access to combination Nicotine Replacement Therapy, a referral to Quitline and other behavioural support.

GLOSSARY

Co-benefit
Co-benefits are substantial and specific benefits to other sectors that can be gained by investing in health-related programs. These benefits are intended positive side effects of a policy or intervention. Co-benefits avoid imposing health objectives on other sectors and rather aim towards contributing to the other sectors objectives.

Co-design
Co-design is a participatory approach for problem-solving that brings those with technical expertise and lived experience together, on equal ground, to design solutions. Co-design brings citizens and stakeholders together to design new products, services and policies. It is a process, set of practical tools, and a set of principles. Co-design presents an entirely different approach to program development and delivery, however is a well-established approach to creative practice.

Co-implement
Co-implementing solutions means involving and working with people, stakeholders and partners, particularly local ones, in putting a co-designed solution into action. A measure is being co-implemented if representatives of services and community are involved in its delivery in a complementary and non-commercial way.

Community health
Community health services provide universal access as well as targeted services for priority population groups. Community health is part of the primary health sector. It includes non-residential health services offered to patients and consumers in an integrated and coordinated manner in a community setting, or the coordination of health services elsewhere in the community. Such services are provided by, or on behalf of, state and territory governments.

Conceptual framework
A conceptual framework includes one or more formal theories, in part or whole, as well as other concepts and empirical findings from the literature. It is used to show relationships among these ideas and how they relate.

Culturally secure
A commitment to the principle that the design and provision of programs and services offered by the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. Cultural security focuses primarily on systemic change that seeks to assist health professionals to integrate culture into their delivery of programs and services, and to adopt a cultural lens to view practices from the perspective of Aboriginal people and culture. The emphasis is that the responsibility for the provision of culturally secure health care lies with the system as a whole, and not just the individual health practitioner.

Culturally secure programs and services need to:
- identify and respond to the cultural needs of Aboriginal people
- work within a holistic framework that recognises the importance of connection to country, culture, spirituality, family and community
- recognise and reflect on how these factors affect health and wellbeing
- work in partnership with Aboriginal leaders, communities and organisations.

Intersectionality
Intersectionality refers to the ways in which different aspects of a person's identity, including social characteristics, can expose them to overlapping forms of discrimination and marginalisation. Attitudes, systems and structures in society and organisations can interact to create inequality and result in exclusion. When these aspects or characteristics combine systemic barriers are greater and risks increase.

Population health
The organised response by society to protect and promote health, and to prevent illness, injury and disability. Population health activities generally focus on:
- prevention, promotion and protection rather than on treatment
- populations rather than on individuals
- the factors and behaviours that cause illness.

It can also refer to the health of subpopulations, and comparisons of the health of different populations.

Primary care
Primary health care encompasses a range of services delivered outside the hospital that generally do not need a referral. This includes unreferred medical services, for example, general practitioner (GP) visits, dental, other health practitioner, pharmaceutical, and community and public health services. It is often the first point of contact people have with the health system.

Primary prevention
Strategies aimed at preventing illness by maintaining and/or enhancing the wellbeing of the general population.

Priority population
Specific groups within our population that experience disadvantages and higher rates of illness and death than the general population such as children and young people, mothers and babies, those who live in rural and remote Australia, Aboriginal people, older people, veterans, prisoners, men and women.

Public health
Public health is concerned with the big picture of how society is organised to maximise health and well-being; about what people can do for themselves as well as the role of institutions and government to ensure good health in our communities.

Secondary prevention
Secondary prevention is aimed towards individuals or groups that demonstrate early psychological or physical symptoms, difficulties, or conditions, which is intended to prevent the development of more serious dysfunction or illness. Secondary prevention includes screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.

Tertiary prevention
Tertiary prevention is managing disease post diagnosis to slow or stop disease progression and to reduce the effect of the disease, for example with measures such as chemotherapy, rehabilitation and screening for complications.

REFERENCES

1. Department of Health. National Preventive Health Strategy 2021-2030. In: Health Do, editor. Canberra: Department of Health; 2021.
2. Australian Institute of Health and Welfare. Australia's health 2022. Canberra: Australian Institute of Health and Welfare; 2022.
3. Columbia University. Primary Care Online Resources and Education: Preventive Services New York: Columbia University; 2022 [Available from: https://edblogs.columbia.edu/pcore/prevention/prevention-preventive-services/.
4. Alzheimer's Association and Centers for Disease Control and Prevention. Healthy Brain Initiative, State and Local Public Health Partnerships to Address Dementia: The 2018-2023 Road Map. Chicago: Alzheimer's Association; 2018.
5. Chronic Disease Prevention Directorate. Western Australian Health Promotion Strategic Framework 2017-2021. In: Department of Health WA, editor. Perth: Department of Health, Western Australia; 2017.
6. Brown L, Thurecht L, Nepal B. The cost of inaction on the social determinants of health: National Centre for Social and Economic Modelling; 2012.
7. Ding D, Lawson KD, Kolbe-Alexander TL, Finkelstein EA, Katzmarzyk PT, van Mechelen W, et al. The economic burden of physical inactivity: a global analysis of major non-communicable diseases. Lancet. 2016;388(10051):1311-24.
8. Australian Institute of Health and Welfare. Alcohol, tobacco and other drugs in Australia. Canberra: Australian Institute of Health and Welfare; 2022.
9. Laine JE, Huybrechts I, Gunter MJ, Ferrari P, Weiderpass E, Tsilidis K, et al. Co-benefits from sustainable dietary shifts for population and environmental health: an assessment from a large European cohort study. The Lancet Planetary Health. 2021;5(11):e786-e96.
10. United Nations. United Nations sustainable development goals, 17 goals to transform our world New York: United Nations; 2018 [Available from: https://www.un.org/sustainabledevelopment/.
11. National Health Survey: First Results, 2017-18 [Internet]. 2019 [cited June 2022]. Available from: https://www.abs.gov.au/statistics/health/health-conditions-and-risks/national-health-survey-first-results/latest-release?msclkid=25736499ba2811ecb7f31de01344442b.
12. Australian Institute of Health and Welfare. Insufficient physical activity. Canberra; 2020. Report No.: Cat. no: PHE 248.
13. National Indigenous Australians Agency. Aboriginal and Torres Strait Islander Health Performance Framework: Tier 2 – Determinants of Health 2.18 Physical activity. Canberra; 2022.
14. Epidemiology Branch PaAHD, Department of Health WA in collaboration with the Coorperative Research Centre for Spatial Information (CRC-SI),. Summary of population characteristics and the health and wellbeing of residents of the East Metro Health Service. Perth; 2022.
15. Al-Mallah MH, Sakr S, Al-Qunaibet A. Cardiorespiratory Fitness and Cardiovascular Disease Prevention: an Update. Curr Atheroscler Rep. 2018;20(1):1.
16. Brenner DR, Shaw E, Yannitsos DH, Warkentin MT, Brockton NT, McGregor SE, et al. The association between recreational physical activity, sedentary time, and colorectal polyps in a population screened for colorectal cancer. Cancer Epidemiol. 2018;53:12-20.
17. Gordon BR, McDowell CP, Hallgren M, Meyer JD, Lyons M, Herring MP. Association of Efficacy of Resistance Exercise Training With Depressive Symptoms: Meta-analysis and Meta-regression Analysis of Randomized Clinical Trials. JAMA Psychiatry. 2018;75(6):566-76.
18. Gaskin DJ, Thorpe RJ, Jr., McGinty EE, Bower K, Rohde C, Young JH, et al. Disparities in diabetes: the nexus of race, poverty, and place. Am J Public Health. 2014;104(11):2147-55.
19. Epidemiology Directorate. Health and Wellbeing of Adults in Western Australia 2020, Overview and Trends. Perth; 2021.
20. Australian Health Survey: Consumption of food groups from the Australian Dietary Guidelines, 2011-12 [Internet]. 2016 [cited June 2022]. Available from: http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.012~2011-12~Main%20Features~Key%20Findings~1.
21. Australian Institute of Health and Welfare. Australia's food and nutrition 2012. Canberra: AIHW, Australian Government; 2012. Contract No.: Cat. no. PHE 163.
22. Australian Bureau of Statistics. Australian Aboriginal and Torres Strait Islander Health Survey: Nutrition Results - Food and Nutrients, 2012-13. Canberra: ABS; 2015. Contract No.: 4727.0.55.005.
23. National Health and Medical Research Council. Australian Dietary Guidelines. Canberra: National Health and Medical Research Council; 2013.
24. Glanz K, Sallis JF, Saelens BE, Frank LD. Healthy nutrition environments: concepts and measures. Am J Health Promot. 2005;19(5):330-3, ii.
25. Bauer UE, Briss PA, Goodman RA, Bowman BA. Prevention of chronic disease in the 21st century: elimination of the leading preventable causes of premature death and disability in the USA. Lancet. 2014;384(9937):45-52.
26. Pollard C, Savage V, Landrigan T, Hanbury A, Kerr D. Food Access and Cost Survey 2013 Report. Perth: Department of Health WA; 2015.
27. Ayoob K-T, Duyff RL, Quagliani D. Position of the American Dietetic Association: Food and Nutrition Misinformation. Journal of the American Dietetic Association. 2002;102(2):260-6.
28. Whetton S, Tait RJ, Gilmore W, Dey T, Agramunt S, Abdul Halim S, et al. Examining the Social and Economic Costs of Alcohol Use in Australia: 2017/18. Perth, WA: National Drug Research Institute, Curtin University; 2021.
29. East Metropolitan Health Service. Alcohol and Other Drug Related Injuries in Western Australia. Perth; 2020.
30. Australian Institute of Health and Welfare. National Drug Strategy Household Survey 2019. Canberra: Australian Institute of Health and Welfare 2020. Contract No.: PHE 270.
31. Gao C, Ogeil R, Lloyd B. Alcohol's burden of disease in Australia. Canberra; 2014.
32. Turning Point. Turning Point Annual Review 2019. Richmond, Vic: Eastern Health; 2019.
33. Alcohol. Think Again. Alcohol and Mental Health Perth, WA: Mental Health Commission; 2022 [Available from: https://alcoholthinkagain.com.au/alcohol-your-health/alcohol-and-mental-health/.
34. Lingamanaicker K, Geelhoed E, Fatovich DM, Investigators obotAHiED. Direct cost of alcohol-related presentations to Royal Perth Hospital emergency department. Emergency Medicine Australasia. 2019;31(6):1045-52.
35. Australian Institute of Health and Welfare. Burden of tobacco use in Australia: Australian Burden of Diseases Study 2015. Canberra: Australian Institute of Health and Welfare; 2019. Contract No.: BOD 20.
36. Australian Bureau of Statistics. National Aboriginal and Torres Strait Islander Health Survey: Smoking. Canberra: Australian Bureau of Statistics; 2019.
37. Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2018. Canberra; 2021. Contract No.: Cat. no. BOD 29.
38. Department of Health WA. Western Australian Burden of Disease Study 2015: Contribution of risk factors to burden in Aboriginal Western Australians. Perth; 2020.
39. Sims M, Mindell JS, Jarvis MJ, Feyerabend C, Wardle H, Gilmore A. Did smokefree legislation in England reduce exposure to secondhand smoke among nonsmoking adults? Cotinine analysis from the Health Survey for England. Environ Health Perspect. 2012;120(3):425-30.

The Development of our Plan

Our Plan has been developed by the EMHS Health Promotion team in consultation with key service providers who participated in a stakeholder workshop.

Multiple desktop reviews of the evidence were undertaken throughout the development of our Plan to inform the final priorities. A rapid and brief independent review of the risk factor strategies was conducted by several public health and population health experts to guide the development of this document.

We would like to acknowledge these Western Australian experts for their time, advice, and contribution:

Lorena Chapman
Make Smoking History Policy and Research Coordinator, Cancer Council Western Australia

Krista Coward
Manager Health Promotion, North Metropolitan Health Service

Samantha Menezes
General Manager Injury Prevention, Injury Matters

Adj. Prof. Trevor Shilton

Noni Walker
Community Partnerships Director, Australian Council on Smoking and Health

Kristy Law
Public Health Dietitian, EMHS

Dr Claire Pulker
Principal Public Health Nutritionist, EMHS

Compiled: June 2022

This document can be made available in alternative formats on request.

East Metropolitan Health Service
Kirkman House, 10 Murray Street, PERTH WA 6000
PO Box X2213 PERTH WA 6847

eastmetropolitan.health.wa.gov.au