Have your say on a
national obesity strategy

Consultation report

Disclaimer

This author of this report is The Social Deck Pty Ltd.

The analysis presented in this report reflects data from two surveys (long-form and short), open community forums, a national webinar and targeted discussions with community members. It is a summary of input only and focuses primarily on what community members and community organisations said is important.

An extensive amount of data and comments have been collated and analysed to inform this summary. Data has been presented in a series of comprehensive background reports. The National Obesity Strategy Working Group will review and consider this consultation report alongside the background reports, and other information and evidence about what works to prevent overweight and obesity in society.

The National Obesity Strategy Working Group accepts no responsibility for the accuracy or completeness of any material contained in this report. Additionally, the National Obesity Strategy Working Group disclaims all liability to any person in respect of anything, and the consequences of anything, done or omitted to be done by any such person in reliance, whether wholly or partially, upon any information contained in this report.

Any views and recommendations of third parties contained in this report do not necessarily reflect the views of the National Obesity Strategy Working Group, or indicate a commitment to a particular course of action.

All direct quotes in this report are excerpts from the survey and what people said during the consultation process. It is, however, important to note that The Social Deck was not able to verify the accuracy of the comments. Nor should the analysis be read as representative of all Australians, because participants and respondents were self-selected.

Similarly, the case studies in this report are examples provided by participants to demonstrate what has been working in their community. They are not based on a review of best practice.

Links to evidence

The strategies proposed in the consultation paper were strongly informed by evidence. Individuals' responses to the public consultation do not necessarily consider the evidence of the effectiveness of different strategies, but rather capture what individuals and organisations think is important in preventing overweight and obesity. Some organisations and individuals provided evidence to support their views. Evidence supporting specific strategies will be further considered by the National Obesity Strategy Working Group.

Acknowledgments

The Social Deck extends its thanks to all those who participated in the consultations, in particular to community members and organisations who took the time to attend discussions.

We also acknowledge the significant effort and time of organisations who contributed and supported people to participate.

We acknowledge the traditional custodians of Country throughout Australia and recognise their continuing connection to land, waters and culture.

Contents

Appendices B, C and D are available to download as separate files:

Executive summary

Overweight and obesity is a significant issue in Australia, affecting many people and all parts of society.

The Queensland Department of Health, supported by a working group, is leading the development of a national obesity strategy for Australia on behalf of the former Council of Australian Governments (COAG) Health Council.

A national strategy is proposed to be a 10-year framework for action to reduce overweight and obesity. It will identify opportunities to create benefits for many people and sectors and will look to:

- have a focus on prevention, whilst supporting people already overweight and obese to avoid further weight gain and/or to lose weight
- scale up or leverage current efforts
- be innovative and bold
- facilitate working together
- fill gaps
- influence the broader social, commercial and cultural determinants of health that can create systemic barriers.

The consultation process

To inform development of the strategy, we (The Social Deck, on behalf of government) undertook a national consultation process from 4 November to 15 December 2019, as well as some additional targeted consultations completed in February 2020.

The consultation adds to the information gathered from two evidence reviews (Population-level strategies to support healthy weight and Addressing the social and commercial determinants of healthy weight), a practice review and the outcomes of the Senate Select Committee Inquiry into the Obesity Epidemic (2018), and a National Obesity Summit held in 2019.

This evidence and previous activity informed the proposed framework and specific strategies being considered for a national obesity strategy, which were outlined in a detailed consultation paper.

The consultations were open for anyone to participate, however targeted discussions helped to ensure community members and priority populations would be included. Feedback and comments were received from approximately 2000 participants, including community members, individuals working in the health, education, research, industry and other sectors, and stakeholder organisations who represent a range of interests. People were consulted through face-to-face discussions, open community forums, a national webinar and two online surveys (a long-form survey to provide detailed feedback, and a shorter survey for community members). Some organisations also provided written submissions.

The Working Group, comprising Commonwealth and state and territory health departments, will consider information gathered through this consultation process and progress the development of a draft national obesity strategy for consideration by Health Ministers.

The issue and what to do about it

For community members who took part in the consultations, the large majority saw the issue of overweight and obesity as a problem—particularly for society and communities.

The consultations confirmed the public expect to see overweight and obesity addressed at a population-level, across Australian society and communities. There was broad acknowledgment that this requires making the healthier option also the easier, more affordable, appealing and accessible option.

Participants acknowledged the current levels of overweight and obesity in Australia, and agreed that 'action is needed now':

- **More than 14 million people in Australia are overweight or obese, including 2 in every 3 adults, and 1 in every 4 children.**
- **By 2030, 18 million Australians or more than three quarters of the projected Australian population will be overweight or obese.**

Many participants cautioned a focus solely on individual-level change, suggesting population-level change would not be achieved until many of the system and environmental factors that contribute to overweight and obesity in society were addressed. Community members, and organisations supporting them, identified significant barriers to living a healthier life, things that make it harder to consume healthier food and drinks, and to be active throughout the day.

As a result, across most participant groups, there was prominent support for strategies that result in:

- reducing exposure to and promotion of unhealthy foods and drinks
- making the cost of healthier foods cheaper and more affordable, as well as limiting availability of unhealthy options
- creating environments and settings (e.g. workplaces, schools and communities) that support people to consume healthier foods and to move more throughout the day.

There was also strong support for obesity prevention to start early in a person's life, so a focus on families and children was considered important. Participants agreed that determinants—social, commercial, cultural and environmental—that make some populations more susceptible to overweight and obesity need to be specifically addressed by the strategy.

Support for a comprehensive national strategy

Responses showed very strong support for a national obesity strategy for Australia. There was also strong support for the role of government in tackling obesity, with sustained resourcing being crucial for action and implementation over the long-term.

Most people want the strategy to be comprehensive and supported its broad focus across priority areas.

In community discussions, people said support was needed across the system, in communities and for individuals. They welcomed the broader focus on policies and regulations relating to the food system. Some people noted that behaviour change campaigns and programs were already in place, but issues like exposure to unhealthy foods, cost of buying healthier foods and access make it very hard for some individuals to achieve changes in behaviour, even when the intent is there.

Some participants suggested the focus could be even broader—supporting healthy lifestyles and promoting health and wellbeing for all. Given the social and environmental determinants that impact health, and the links between obesity and mental health, they suggested broader health factors could have been considered in the consultation paper.

Key themes

The following four themes were areas commonly raised by participants in verbal and written feedback:

1. A FOCUS ON POPULATION-LEVEL INTERVENTIONS

Participants wanted population-level interventions and system changes to be prioritised in the strategy.

This is consistent with the two evidence reviews, and demonstrates that the expectation of stakeholders and the community is for a population-wide approach that incorporates actions and interventions for systems change and for whole communities, as well as individuals.

2. INTENTION NEEDS TO LEAD TO ACTION AND SUSTAINED, LONG TERM RESOURCING

Participants acknowledged the issue is urgent. Many participants reported being frustrated by a perceived lack of progress in implementing effective and sustained action to prevent overweight and obesity, given its impact on Australian society.

They wanted to see whole-of-government, sustained action and a commitment at all levels to ensure a strategy will be funded, implemented, reported on and evaluated. They acknowledged change won't be immediate and cautioned that we may see increases in obesity rates, before decreases. Participants suggested that the cost of overweight and obesity on Australian society and the economy needs to be acknowledged to ensure ongoing support for a preventive strategy.

Participants wanted to see a better logic in the proposed strategy, so that governments and stakeholders can understand how action will be prioritised. They also wanted to ensure the intent of each strategy and sub-strategy will be made very clear.

3. ADDITIONAL EFFORTS ARE NEEDED FOR PRIORITY POPULATION GROUPS

Almost all participants agreed specific efforts and measures are needed to address overweight and obesity amongst priority population groups. Priority population groups are those who experience additional social disadvantage or environmental factors that may increase their risk of obesity. Participants supported a strong equity focus that would support priority population groups.

Priority population groups identified in the consultation paper included lower socioeconomic households, people living in regional, rural and remote areas, Aboriginal and Torres Strait Islander people and people with disability. Participants also identified other groups which are described below, and suggested having specific strategies for people already living with obesity.

Aboriginal and Torres Strait Islander people and communities: The focus on reducing and preventing overweight and obesity in Aboriginal and Torres Strait Islander communities needs to be a holistic, community-led approach, both in rural and remote and urban settings. A specific strategy or implementation plan was proposed by some participants to ensure funding and strategies are appropriately targeted for Aboriginal and Torres Strait Islander people and communities, and to address cultural safety.

Regional, rural and remote: People living in regional, rural and remote areas face geographic, social and sometimes environmental (e.g. climatic) barriers to living healthy lifestyles. Participants agreed these communities are disproportionately impacted by obesity and that targeted strategies to address identified barriers are required.

Lower socioeconomic households: Affordability and access to healthy options was the primary concern for people who are on low incomes, or under financial stress. Participants agreed that low cost, community-led programs, developed in partnership with community members, are needed. In addition, improved accessibility to prevention and appropriate weight-management services would assist people who are currently finding it difficult to access and afford these.

People with disability: People with disability identified similar barriers to others, such as cost and access to fresh and healthier food and drinks. However, specific barriers commonly related to accessibility needs in participating in physical activity and having less access into the community to buy fresh groceries and healthier foods. Statistically, people with disability are more likely to be unemployed and rely on income support to live, so cost can also be a significant factor. Some people noted there can be limitations in food preparation and choice for people with disability, and that neurological and sensory disabilities can also greatly affect what people eat and drink.

Children and young people: A focus on children and young people was supported, and participants noted that the most helpful actions or strategies for this population group was to limit exposure to the promotion of unhealthy food and drinks and the availability of these options in children's settings. Some people identified that while there's a strong focus on younger children aged 0–7 years in the strategies, there may be gaps in strategies for older children who are at an age when peer influences, pressure and disordered eating may become a greater issue.

4.   STIGMA AND UNINTENTIONAL CONSEQUENCES NEED TO BE AVOIDED AND REDUCED

Participants raised concerns that some language used may result in stigma or hinder minimising stigma about overweight and obesity. People noted that a focus on weight and strategies targeting individual behaviour change risks further stigmatising those already living with obesity, and some suggested the strategy focus on holistic health and wellbeing rather than weight.

Priority population groups may also be more vulnerable to stigma. Many participants requested that strategies be designed with the input of these populations, including people who have experienced or have obesity, to avoid unintended impacts on them.

The food and beverage industry highlighted possible consequences of some of the specific strategies listed, such as impacts on revenue and the economy. They suggested allowing time to design actions to ensure implementation of strategies avoided any unintended consequences.

Part 1: Consultation methodology

Public consultation to inform a national obesity strategy was undertaken from 4 November 2019 to 14 February 2020.

1.1 How did we consult?

People and organisations had the opportunity to contribute to the consultation through:

- **a long-form survey**
- **a short survey**
- **a community forum**
- **community discussions**
- **a targeted focus group with young people**
- **targeted discussions with seniors**
- **targeted discussions with people with disability.**

In addition, 35 organisations provided stand-alone submissions.

The comprehensive consultation paper and a summary consultation paper was used as the basis for questions. In addition, an Easy Read discussion questionnaire was made available. The consultation paper outlined the proposed scope, vision, priorities, strategies, enablers, and implementation and reporting for a national obesity strategy. This included 81 individual sub-strategies.

During the consultation people were asked about:

- what a national obesity strategy should focus on and achieve
- their views on and support for specific strategies and to identify anything missing
- what might be needed to ensure a national obesity strategy is implemented and measured.

1.2 Who was involved?

In total, there were more than 2000 participants across the range of consultation activity. The consultation process was open to all community members and organisations.

Participants were self-selected and were not a representative sample of the Australian population or specific population groups, demographics or locations. However, specific consultation activities helped to reach priority population groups including in regional and rural areas.

A range of stakeholder organisations participated in the process as listed at Appendix B and Appendix C.

For the purposes of this report, individuals and organisations who contributed are identified as 'participants'. All comments and quotes from individuals and community members have been de-identified, however comments from organisations provided in the long-form survey or written submissions are attributed.

1.2.1 Face-to-face engagement

In total, 620 people were engaged face-to-face throughout Australia

We engaged with **620** people in:

39 community discussions, mini-workshops and pop-ups
✕ including representatives from these locations

7 Community forums

1 National webinar
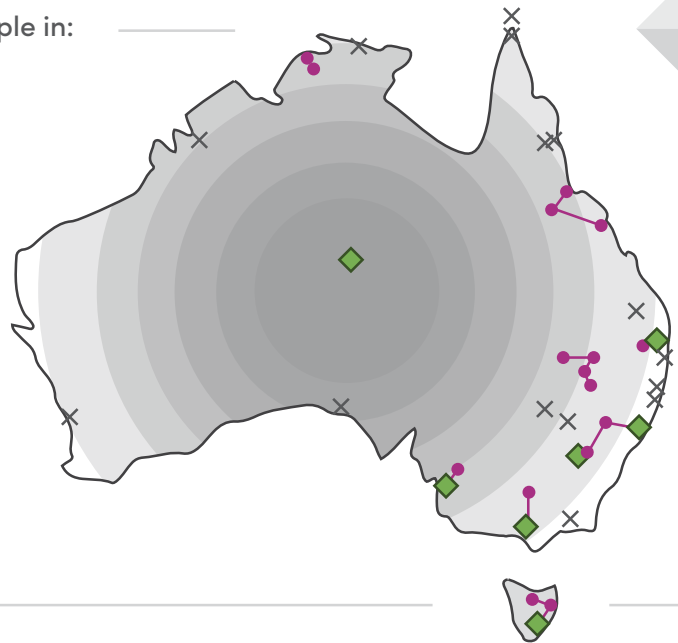
Who was engaged?

Community discussions (269)

Category	Value
Indigenous organisation	66
Interested community members	51
Healthcare	33
Community organisation	29
CALD/migrant	24
Preventative health	15
Government (State/Cmnwlth)	13
NGO/Peak body	10
Senior and disability organisation	10
Local government	9
Academia or research	9
Fitness/sport/wellness	6
Business	1
Education	1
Other	8
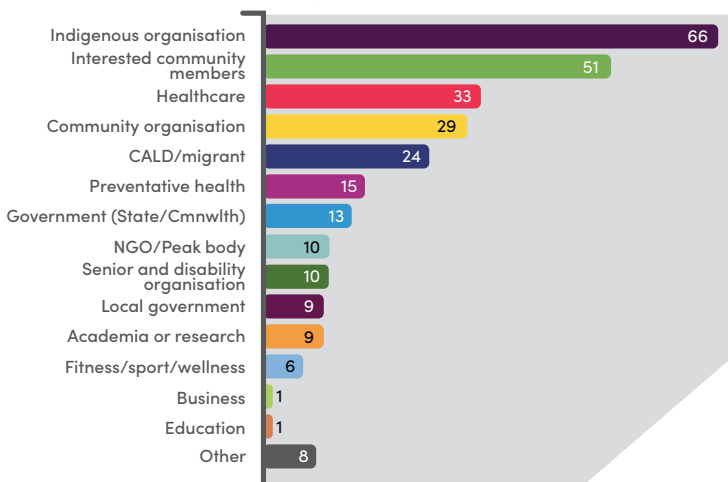
Community forums inc. webinar (335)

Category	Value
Government (State/Cmnwlth)	49
Preventative health	42
Academia or research	36
Healthcare	35
NGO/Peak body	34
Interested community member	29
Community organisation	17
Food/beverage industry	14
Education	13
Fitness/sport/wellness	10
Indigenous organisation	10
Local government	8
Pharmaceutical industry	8
Business	7
CALD/migrant organisation	4
Other	19

Figure 1: Infographic showing participation in face-to-face engagements for a national obesity strategy.

Community discussion and a forum was held in all jurisdictions, except for Western Australia (WA)[1].

Community discussions

In total, 285 individuals were consulted through face-to-face community discussions (see Figure 1). These included:

- meetings and in-depth discussions
- regional road shows
- small discussion groups

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1   The Western Australian Department of Health chose not to have a community forum during this round of consultation as there had been extensive recent consultation in WA in relation to overweight and obesity, including the Sustainable Health Review (2018-19), Preventive Health Summit (2018), extensive community consultation on development of the WA Healthy Weight Action Plan that included an Obesity Collaborative Summit (2018-19), and a WA Parliamentary Inquiry into the Role of Diet in Type 2 Diabetes (2018), which had informed the consultation paper for a national obesity strategy.

- mini workshops
- pop-up stalls at three regional libraries and the National Aboriginal Community Controlled Health Organisations (NACCHO) conference.

Appendix B contains the full list of community discussions.

Open community forums

A total of 335 individuals participated in seven community forums and a national interactive webinar, which were open to anyone to attend.

Forums were held in:

Jurisdiction	Location	Total attendees
ACT	Canberra	27
NSW	Paramatta	33
NT	Alice Springs	26
QLD	Ipswich	38
SA	Adelaide	43
VIC	Melbourne	45
TAS	Hobart	38
	Total	250

On 10 December 2019, 85 participants–mostly from the health sector and government–attended an interactive webinar. The webinar was a 2-hour, online version of the community forum.

1.2.2 Public surveys

During the consultation period, the Australian community could complete one of two online surveys.

Short survey

A total of 1,038 respondents completed the short survey.

The shorter survey was aimed at community members and individuals. These results have been used as the primary basis of this report, along with discussions with community members and organisations who support priority populations.

The short survey included questions about the purpose of a national obesity strategy, current barriers to healthy eating and being more active. It encouraged respondents to rate and provide comments on strategies being considered under the four priority areas, as well as what will help to enable the strategy.

Long-form survey

A total of 342 individuals and organisations completed the long-form survey. As shown in Figure 3, 171 were organisations and 171 were individuals. Of the organisations who completed the survey, over half were from a health or medical organisation. A list of organisations who completed the survey is at Appendix C.

The long-form survey was more detailed than the short survey. Individuals and organisations could comment on each individual sub-strategy, the scope and purpose of a national obesity strategy, and how it will be implemented. Respondents also had the opportunity to identify gaps.

SHORT SURVEY

1038 responses

Interest

I am an interested member of the community	52.3%
I am a health professional	34.5%
I am employed by federal, state or local government	15.5%
I work in a health promotion organisation	10.7%
I work in the health/fitness/ sport/wellness industry	9.6%
I am a teacher/educator	8.9%
I am an academic or researcher	8.1%
I am a business owner	3%
I work for a business that sells or markets food/drink or produce	0.9%
I work for an organisation that represents businesses that sell or market food/drink or produce	0.2%
Prefer not to say	1.3%
Other	9.4%

(multiple answers permitted)

Geographical location

A capital city **(54.2%)**

A regional town or city **(36.6%)**

A remote town or area **(8.2%)**

Prefer not to say **(1%)**

Figure 2: Number of respondents to short survey broken down by interest and geographical location

LONG SURVEY

342 reponses by individuals and organisations

Type of organisation

171 responses

57.3%
Health or medical organisations

23.4% Research or education organisation

18.1% Government

11.1% Representing population groups

8.2% Food or beverage industry

(multiple answers permitted)
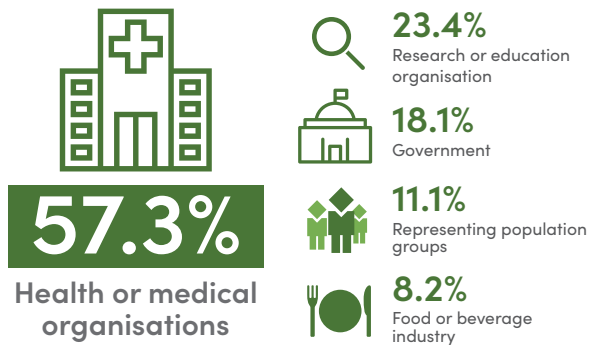
Interest of individual

171 responses

62.6%
Health professionals

33.3% Interested community member

30.4% Government employee

18.1% Academic or research

(multiple answers permitted)

Figure 3: Number of respondents to short survey broken down by interest

1.2.3 Additional targeted engagement

During January and February 2020, additional targeted consultations were undertaken with three priority population groups.

People with disability: a series of six interviews with people with disability and service providers in Tasmania.

Young people: Consumer Health Forum of Australia engaged with seven young consumers aged between 21 and 26 from the Youth Health Forum network through a two-hour focus group.

Seniors: interviews with two seniors and a targeted meeting with Chairperson of Maggie Beer Foundation.

1.2.4 Submissions

Given previous related activity, a formal public submission process was not part of this round of consultation.

However, during the process, 35 organisations provided stand-alone submissions, which have been reviewed and considered in this report. A number of these organisations represent priority population groups. Some organisations who completed the long-form survey also provided additional supporting information.

A list of organisations who made submissions, or provided supporting documentation, is at Appendix C.

1.3 How did we analyse results?

In interpreting the findings in this report, it is important to recognise that the sample consists of participants and respondents who are interested in a national obesity strategy.

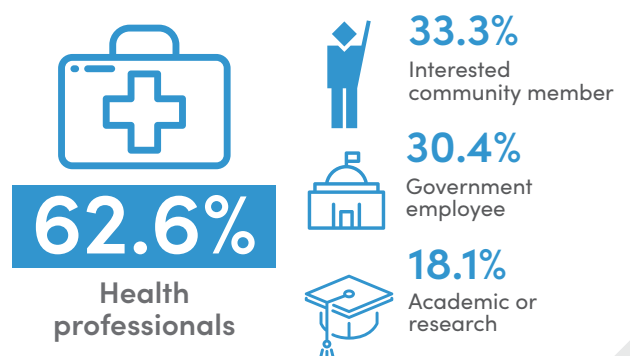The methodology for data collection, analysis and reporting followed a data-driven, thematic analysis approach. The approach enabled an in-depth understanding of key themes and subthemes along with the most common issues and suggestions, and the different needs of the priority groups outlined in the proposed strategy. While common themes and issues are outlined in this report, there were also a number of specific issues of particular interest to groups raised, and these are highlighted in quotes and stories.

Part 2:

Key areas of feedback

The large majority of consultation participants agreed that Australia needs a strategy to tackle overweight and obesity. They supported a comprehensive strategy that focused on setting policy, regulation and population-wide interventions.

The majority of respondents considered all of the strategies put forward (in the long-form and short surveys) to be at least moderately important/helpful. The community expects a national strategy to be multi-faceted and to include a broad range of measures. However, the level of support varied across strategies, and many respondents provided suggestions for how to alter or improve proposed strategies.

The following section covers what participants considered to be strengths of the proposed strategy and areas that were commonly supported.

2.1 Key areas supported in the proposed strategy

2.1.1   Focus on prevention

2.1.2   Equity is key

2.1.3   A systems approach

2.1.4   Whole-of-government, collective and cohesive action

2.1.1 Focus on prevention

Participants supported a focus on prevention. In particular, they noted the high burden of overweight and obesity in Australia and that prevention will have a high return on investment. Given the focus on prevention, some participants suggested the title or name of the strategy specifically include the word 'prevention'.

Participants commonly noted that a Government-led national prevention strategy for obesity is needed because policies aimed at environmental and structural changes will be the most effective at supporting all Australians, regardless of their weight status. They said a focus on prevention should be used to prioritise actions and ensure the best use of resources to achieve population-level change. They also commented that a national prevention strategy would provide more foundation and support for community-based preventative action.

Many organisations noted there is currently only a relatively small amount of funding dedicated to prevention of obesity. They said more is needed to reduce the burden of chronic disease on future generations.

90% of respondents to the long-form survey agreed **'the strategy should focus on primary and secondary preventive actions that promote and support healthy eating, regular physical activity and a healthy weight for all'**.

2.1.2 Equity is key

Many participants suggested prioritising equity, particularly ensuring that delivery of any strategies does not further exacerbate inequities for priority populations. When asked to think about what a national obesity strategy should achieve, equity was commonly identified (see Figure 4).

Figure 4. Word clouds are generated by Mentimeter in response to the question: 'What 3 words come to mind when you think about what you want a new national obesity strategy to achieve?' (examples from Hobart and Alice Springs forums)

Participants suggested an equity lens needs to be applied over many, or all, of the sub-strategies to better address the socio-economic determinants impacting choice, and guard against unintended consequences.

Some organisations also commented that considering equitable approaches within the strategies is particularly important for people who have experienced overweight and obesity.

Read more about priority populations here.

2.1.3 A systems approach

A systems approach is needed to effect real population-level impact instead of placing the responsibility solely on individuals, which many participants suggest doesn't, and hasn't, worked. Systems thinking is needed to recognise the interconnectedness of health, political, food, economics and transport systems.

> *'There is a strong evidence base for interventions that modify systems and structures to facilitate healthy eating and higher levels of physical activity"*
>
> **– George Institute comment in long-form survey**

Many participants suggested the main focus of the strategy should be on **addressing systems first** so that environmental factors and barriers can be reduced, before expecting to change individual behaviours. Many strongly suggested making priority 4, which addresses the food system, the first priority.

Community members highlighted that current 'systems' greatly affect choices, for themselves and their families. They identified major barriers to changing their behaviours, most commonly:

- excessive exposure to unhealthy options
- the higher cost of buying healthier food and drinks
- a lack of appropriate infrastructure for regular physical activity
- the high cost of physical activity
- a lack of transport (public and private).

In the short survey, almost all (95% of) respondents agreed that '**many different factors, including social, environmental and financial factors, contributed to overweight and obesity**'. In addition, 87% agreed the most significant barrier to consuming healthier food and drinks was that '**there were too many unhealthy and processed food and drinks available**' (see Figure 5).

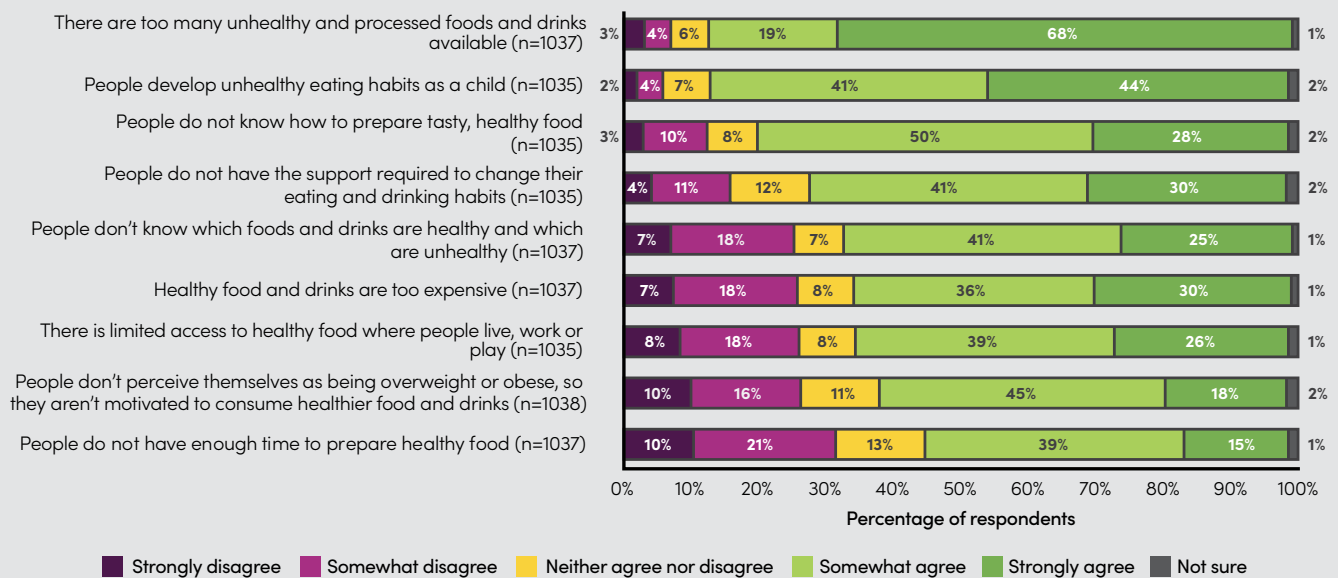**Perceived barriers to consuming healthier food and drinks**

Figure 5. Perceived barriers to consuming healthier food and drinks – short survey.

In response, community members rated strategies that focused on systems issues very highly in the short survey.

> The strategy to **'ensure our food system favours the production of healthy and sustainable products'** received the greatest level of support with 88% of respondents rating this as very or extremely helpful.

Organisations and individuals in the long-form survey also gave high ratings to strategies that support changes in the food system and overcome systemic barriers to people being physically active.

> **89%** of organisations and 93% of individuals rated **'ensuring economic policies that make production of healthy food and drinks more attractive…'** as very or extremely important.

> **92%** of organisations rated **'develop and maintain infrastructure that grows participation…'** as very or extremely important.

2.1.4 Whole-of-government, collective and cohesive action

There was strong support for a coordinated, collaborative approach across government to tackle overweight and obesity. A number of participants noted frustrations with fragmented or unsustained efforts and programs in this area in the past.

Community members and organisations highlighted concerns that programs 'start and stop' and that this prevents sustaining the impact they can have on preventing overweight and obesity.

Participants wanted to ensure the strategy has bipartisan support so there can be a commitment to action for many years into the future.

In the short survey, there was majority (89%) agreement that government intervention was needed to make it easier for people to be physically active and consume healthier food and drinks. Many respondents shared a desire for strong, bold government leadership.

In the long-form survey:

> **95%** agreed **'the strategy should encourage government leadership for collaborative, whole-of-society action'.**

> **96%** agreed it **'should identify actions for Commonwealth and State and Territory governments'.**

Participants noted that many of the proposed strategies have been considered over years and decades. Some said that without strong leadership from government to implement the policy changes needed, there is likely to be little impact on current overweight and obesity trends in Australia. They suggested government will need to prioritise action on relevant policies and regulation, and ensure all sectors—not just the health sector—are engaged in developing and implementing the strategy. This included: collaboration across transport, planning and infrastructure; and strategies to improve cross-sector collaboration, particularly between employment, transport, social services and health.

Many participants raised concerns with the role of industry in policy development for overweight and obesity prevention. A small number suggested involvement in the implementation phase is appropriate.

Participants also noted that governments need to model the changes required, for example through:

- setting stronger policies on what can be sold in government facilities and institutions
- establishing workplace practices that promote the consumption of healthier food and drinks, and more physical activity throughout the day
- setting standards for government-funded programs to ensure they provide healthier food and drinks in settings, and during programs and events.

Local government was commonly identified as being best placed to enable change in communities, and so many suggested they should be a focus of the collective action. This was especially important to people in regional and remote areas. Participants suggested the strategy needed:

- strong local government involvement in its development and implementation
- more focus on local government-led initiatives
- specific actions and objectives for local government.

2.2 Strategies of focus

This section summarises the strategies that participants commonly supported or commented on in the surveys, community forums and discussions. Supporting stories are included as well as case studies which participants shared as examples of what's worked in their community.

2.2.1 Supporting better access to affordable, healthier food and drinks

Community members focused strongly on strategies that would help to make healthier food and drinks more accessible and affordable in their communities.

Three out of four of the top-rated strategies in the short survey related to making healthier foods more accessible.

88% rated strategies to **'ensure our food system favours the production of healthy and sustainable products'** as very or extremely helpful.

87% rated strategies to **'develop ways to make good quality, culturally appropriate, healthy food and drinks more available and affordable in communities that are currently worse off'** as extremely or very helpful.

86% rated strategies to **'increase the availability of healthier, more sustainable food and drinks in the places we live and work'** as very or extremely helpful.

Community participants suggested ways of making fresh, healthier foods more available such as:

- investing in community-led approaches to improve the supply of healthier foods in communities and workplaces
- assisting local producers with sustainable farming practices
- local investment in community gardens and fresh-food markets
- subsidising or improving transport of fresh foods into regional, rural and remote areas.

CASE STUDY: Port Melbourne City Farm

Melbourne, Victoria

In Melbourne, one participant highlighted an example of an 'urban farm' in Port Melbourne, which is helping to provide and promote fresh food options in the workplace and to vulnerable people.

Employees nominated two car spaces in an industrial parking lot to convert into an urban farm. The farm is a collaboration between Cirrus Fine Coffee, Biofilta and Australian Ecosystems. It uses coffee compost and food waste that would otherwise go to landfill to grow herbs and vegetables. In the first eight months of the project the farm has generated 360 kilograms of produce, 90% of which has been donated to OzHarvest. Coffee husks are also repurposed into bricks to fuel an on-site wood fire pizza oven on Fridays.

Read more

The availability and access to affordable, healthier and fresh foods was a big issue for some priority populations, particularly those living in regional, rural and remote areas and Aboriginal and Torres Strait Islander communities. **Read more (3.1).**

2.2.2 The price of food and drinks

Community members consistently said they thought healthier foods cost more than unhealthy, processed or packaged foods and that this made it difficult for them to choose the 'healthier' option. They suggested changes in price so the cost of healthier food and drinks is cheaper than, or more equal to, that of unhealthy options. Many said this would be the best way to support them to choose and afford the healthier options for themselves or their families. They supported strategies to:

- subsidise fresh, healthier foods
- use price to make unhealthy options less attractive, as long as this did not adversely impact people or make food purchasing more inequitable.

'It's not our choice'

One Aboriginal parent in a northern suburb of Adelaide, South Australia explained that when feeding five children in their care, the cost of five apples is more than twice that of a large packet of chips. They said *'It's not really our choice. We have money for food that's cheaper. Then they (the children) get used to that food early on because it's available. It's hard to change to healthy food later once kids know what they're used to, even though we know what the better choice is.'*

81% of community respondents strongly supported a strategy to **'look at ways of changing the price of food and drinks to shift consumer purchases towards healthier options'**, rating this as very or extremely helpful in the short survey.

Targeted engagement with young people also showed that the cost of food was a particular concern for them. Young people said they believed the cost of fresh food is increasing. They had concerns that price was being manipulated by the major supermarkets, particularly noting that when there is 'hype' or 'trend' around particular fresh foods, supermarkets increase the price of that food, and that is limiting choice.

Stakeholder views and differences

Stakeholders, including the majority of organisations who responded to the long-form survey, also noted that addressing price was an important population-level approach.

> **85%** of organisations rated **'consider emerging evidence and policy approaches that use price to reduce consumption of sugar-sweetened beverages and high sugar snacks'** as very or extremely important in the long-form survey.

However, some were concerned about the impacts of strategies that might increase the price of food (such as sugar taxes). In particular, they feared the cost of food might increase overall, and disproportionately impact people on low incomes and who are financially insecure. The Arnhem Land Progress Aboriginal Corporation highlighted this concern, noting *'Increasing the price of unhealthy foods could increase food insecurity in the remote setting. Strategies to restrict price promotions (4.7.4) and placement of unhealthy items may be more effective for all populations.'*

Participants said any adverse impacts on people and their ability to buy foods needs to be carefully managed. Some suggested a tax on unhealthy foods should fund subsidies of healthy options so the price of these foods would reduce.

Many representatives of the food and beverage industry raised concerns with most strategies relating to price, suggesting that there was 'questionable' or inadequate evidence to demonstrate it would have an impact on obesity rates or reducing calorie consumption. For example, in relation to beverages, Coca-Cola suggest that *'SSB (sugar-sweetened beverages) taxation is regressive policy and places an unfair burden on lower SES households.'*

Dairy Australia recommended *'rather than focusing solely on SSBs and high sugar snacks, consider emerging evidence and policy approaches that reduce consumption of all discretionary foods.'*

However, other stakeholders submitted there was strong evidence that a tax on sugar, in conjunction with other strategies, would influence preferences and consumption levels in the community. The University of Queensland (School of Public Health, Faculty of Medicine) stated *'there is already a strong, robust, clear body of evidence supporting the use of pricing strategies to reduce consumption of sugar-sweetened beverages and high sugar snacks.'*

Using price to reduce consumption of alcohol beverages

There were mixed views about using price to reduce alcohol consumption and whether this should be included in the strategy. The food and beverage industry stakeholders and interested individuals who completed the long-form survey were the most likely to disagree with the inclusion of alcohol.

> However, **39%** of individual respondents and **57%** of organisations in the long-form survey still rated the strategy **'consider using price to reduce consumption of alcoholic beverages....'** as extremely important.

A range of organisations cited evidence and reviews in support of using price to reduce alcohol consumption. For example, the Cancer Council cited *'recent research from Deakin University highlighting a price increase on alcohol through a uniform volumetric tax was the most cost-effective obesity prevention intervention.'*

However, some participants, especially those from the food and beverage industry, questioned the value and appropriateness of including alcohol within a national obesity strategy. Of those that rated this strategy (4.7.3) of no, low or slight importance in the long-form survey, common reasons were:

- they were unsure if altering price on alcohol would work to reduce obesity, given alcohol is addictive
- lower socioeconomic households may be more highly impacted by this strategy
- alcohol is already heavily taxed
- alcohol consumption is a separate issue to obesity
- there is a National Alcohol Strategy so this should be out of scope.

2.2.3 Reducing advertising and exposure to unhealthy food and drinks

Parents consistently told us that exposure to marketing and advertising of 'junk food' or unhealthy options, particularly targeted at their children, had a big impact on their ability to make better food and drink choices for their family.

'Supermarkets look different in Australia'

A parent in a Hispanic playgroup in Adelaide mentioned that supermarkets look different in Australia and there's less local, fresh options. They also said *'they market junk food in an attractive way with kids favourite characters on the packets... cost is a factor, but the marketing is also a significant factor'.* They described the impact this has on avoiding "junk food" as it is the first thing their children see. They suggested plain packaging for junk food and that these types of products are not placed where children can easily see them.

The majority of respondents to the surveys supported reducing advertising and exposure of unhealthy food and drinks, especially to children.

> **78%** of respondents to the short survey agreed strategies to **'reduce exposure to marketing and promotion of unhealthy food and drinks'** were extremely or very helpful.
>
> **80%** of organisations and **76%** of individuals in the long-form survey thought it was extremely important to **'restrict unhealthy food and drink advertising during peak television viewing times for children'**. Respondents from a culturally and linguistically diverse background rated this as the most important sub-strategy overall (78% rating it as extremely important).

In community discussions, parents and health professionals described a range of limiting factors that impacted parents' ability to have the level of control and influence they needed or wanted over what their children ate and drank. Some of these included:

- advertising targeted at children during peak television viewing
- placement of products in stores and supermarkets
- use of merchandise and characters aimed at children alongside very unhealthy or high-sugar products
- exposure to unhealthy foods in different settings (schools, parties etc)

- cultural and language barriers in understanding what's 'good' food and what's not
- the aggressive marketing of infant and toddler milks, which was also raised as an issue in relation to normalising breastfeeding.

'There are no rewards or discounts for fresh foods'

In Moree (rural NSW), a mother of three highlighted the difficulty in making healthy food decisions for her family. She supported the free fruit initiative for kids in supermarkets, which she finds helpful to entertain the children and avoid the temptation of unhealthy snacks. But she also believed that supermarkets could take further steps to incentivise healthy foods and fresh fruit and vegetables, saying *'there are no rewards or discounts for fresh foods, only packaged.'* She also explained the easy access and availability of unhealthy fast foods in her regional town promoted norms of unhealthy eating, **'there aren't healthy, tasty takeaway options like there are in the city'**.

The price of healthier food was highlighted as a particular issue for lower socioeconomic households and people with large families. **Read more (3.2).**

Stakeholder views and differences

Participants from the health and education sectors particularly favoured stronger approaches to advertising and promotion restrictions for unhealthy foods. They suggested approaches should be similar to the approach taken with tobacco. They emphasised the importance of government regulation in this area, citing evidence that existing voluntary initiatives have not reduced children's exposure to marketing.

In contrast, some organisations and individuals in the long-form survey suggested individuals were responsible for making the right choices and a strategy should avoid government regulation that limits choice. For example, the Australian Food and Grocery Council (AFGC) stated that they did not support restricting promotions of food and drinks in the *'absence of evidence-based research demonstrating a health outcome in relation to weight status and would require careful design and monitoring of its effectiveness.'* The AFGC suggested a self-regulatory approach to the marketing of food to children with an independent auditing and complaints-handling process.

Other industry representatives raised concerns about strategies to restrict advertising. For example, it was suggested proposed advertising restrictions may disadvantage outdoor advertising.

> 'Most advertising content restrictions unfairly disadvantage outdoor advertising while leaving market disrupters like digital advertising largely unregulated... The restrictions proposed will have a negative impact on the outdoor advertising industry specifically and is likely to simply redirect advertising spend to other, less regulated channels such as online.'
>
> **– Outdoor Media Association, comment in long-form survey**

2.2.4 Settings where people live, work and spend time

Community members and many organisations suggested focussing efforts on settings where people live, work and spend time each day. They noted people's food choices and behaviours towards eating and being physically active were most influenced in their day-to-day settings.

87% of short survey respondents rated strategies to **'increase the availability of healthier, more sustainable food and drinks in the places we live and work'** as very or extremely helpful.

Participants suggested the following strategies to promote physical activity and improve the availability of healthy food and drinks in settings:

- A focus on whole-of-school approaches, including canteens and tuckshops and health and food literacy education.
- Assist schools and workplaces with advice on fundraising opportunities that avoid unhealthy food and drinks, and promote physical activity.
- Lead the way with guidelines and mandates to ensure government and publicly-funded settings avoid unhealthy options, and share advice and guidance with other workplaces.
- Work across and within community to make sure people's regular settings promote health, and are accessible and inclusive.

Many comments highlighted a lack of healthier food choices available to those living in supported accommodation or care settings and some settings have very limited options to be active. This was seen as particularly affecting people with disability and older Australians.

Read more (3.1.4).

Schools

Whole-of-school approaches to promoting healthy behaviours were identified in community forums as most important for supporting children and families.

More than 50% of short survey respondents said **'healthy policies and practices in schools and promotion of healthy behaviours in education curriculum'** would be extremely helpful to prevent overweight and obesity.

CASE STUDY: Healthy food at school

Willmot, NSW

In community discussions with The Hive team in Mount Druitt, we heard that Willmot Public School is leading change in their community. The suburb of Willmot has a low socioeconomic population with a significant number of people receiving government support. Although this area is in the outer suburbs of Sydney, food security is an issue. There is only one small shop in the area that provides limited options and many people have poor access to personal transport.

The school-based initiative is built on strong leadership by the Willmot Public School principal and a cohort of motivated parents who form PATCH: Parent Action Team Community Helpers. They have shaped the school as a community resource alongside their strong focus on student health. This is built on the understanding that for students to truly thrive, their home lives also need to be healthy. They have built trust and strong relationships with the community, understanding that small changes should be made slowly to ensure community support, and that the needs of families must be taken into account.

When the previously privately-run canteen came up for renewal of tender, PATCH had the idea to 'get in there and do it themselves' by providing healthy, nutritious food and a breakfast club every day. The idea is for the school kitchen to become a hub of healthy activity, including preparing and cooking healthy meals for students and composting waste for the school garden. PATCH is also working on an initiative to prepare healthy ready-to-eat meals for children to take home, including a healthy recipe card—providing a healthy 'takeaway option' for families.

Workplaces

Workplaces were seen as critical to influencing adult behaviours. Participants noted issues such as workplaces that were not physical activity-friendly and that often promoted unhealthy snacking, with vending machines full of poor options and catering for those who needed a 'sugar fix'.

Participants suggested a range of strategies involving workplaces, such as: programs and incentives to improve workplace eating culture; offering free or cheap access to gyms or giving staff paid, 'active' breaks for physical and mental health; putting in place bike racks, e-bike fleets and charging stations, showers, etc.

There was also a strong focus on supporting school and workplace settings to encourage more physical activity that included both:

- better active transport infrastructure and facilities, alongside more programs to encourage active transport
- policy changes such as more flexible work hours, more downtime for physical play at schools, and mandated movement in both schools and workplaces.

Sporting grounds and other facilities

The strategy to **'encourage greater availability of healthy food and drinks and limit unhealthy food and drinks at sporting, recreation and community venues, facilities, clubs and events'** was strongly supported across the consultation activity. It was the most highly rated sub-strategy amongst organisations for supporting children and families.

Many community participants also mentioned this was critical to reducing exposure of unhealthy food and drinks to children and to creating healthier communities overall. Similarly, many participants generally supported strategies to ensure local sponsorships for events promoted health and avoided unhealthy options, as long as there are not unintended consequences.

For example, a number of participants were concerned strategies that target local sporting organisations might unintentionally lead to less physical activity options in the community. Some participants suggested governments need to provide supports and incentives to ensure healthier options can be implemented, and to avoid adverse financial impacts on local groups.

'Selling processed foods is easy money'

In the Melbourne community discussion, a representative of *Parents Voice*, an online network of parents interested in improving the food and activity environments of Australian children, said the number of parents contacting them with concerns about the food options offered in sports and recreation facilities has increased. The group shared this is a wider system issue in that local sports clubs, often run by volunteers, need 'easy money' to support their club and one way to do this is to sell processed foods, which are cheaper and have a long shelf life. They noted that alternative healthy options often take more time and money to prepare, which may not be viable for a local volunteer organisation. To improve the system and encourage local clubs to change what they offer, the group noted that support is needed for local clubs. They said sporting codes need to lead the way, such as removing sponsorship from large corporations who are promoting unhealthy food and drink options.

2.2.5 Invest in infrastructure and urban design that promotes healthy lifestyles

Across consultation activity, participants gave strong support to investing in infrastructure and urban planning that would promote healthy lifestyles. Common areas participants suggested to focus on were:

- better walking and cycling infrastructure with provision of shade
- making planning decisions that promote production of fresh, healthy food in urban settings
- access to water stations in urban, regional and remote settings.

> **88%** of short survey respondents rated the strategy to **'make walking, riding, public transport and participation in sport and recreation a more convenient and affordable option for people'** as very or extremely helpful.

Participants noted that making physical activity a more convenient and affordable option would only be achieved with investment in infrastructure. Some said once infrastructure and urban planning is done right, programs to motivate people will work better. Community members identified that key barriers to regular physical activity including cost and safety need to be reduced through better infrastructure and design. This included ensuring places and facilities are inclusive and accessible.

Ensuring infrastructure and spaces are accessible and inclusive was particularly important for people with disability, and those over the age of 65. Many participants identified that older people and people with disability were more affected by poor urban design and inaccessible infrastructure, which prevents them from being active. **Read more (3.3).**

In addition to infrastructure, strategies to promote access to open, green spaces and natural environments were also supported, especially by participants from regional, rural or remote areas.

> **85%** rated **'invest in and promote green spaces and natural environments'** as very or extremely helpful in the short survey.
>
> **73%** of individuals also rated **'conserve and develop open spaces, green networks, recreation trails and ecologically diverse natural environments that enable active interaction with nature'** as extremely important in the long-form survey.

2.2.6 Information, guidance and skill-building

Education and skills for families and children

In relation to supporting children and families, participants noted the importance of delivering more education, information, guidance and practical skills and training. This included practical education for parents and children, and people who support families to be healthy. Many Aboriginal and Torres Strait Islander participants highlighted (in the survey and community discussions) the importance of giving families and children more education about healthy food options.

Participants had suggestions about the way information was delivered and shared. Most commonly, people noted delivery of information, guidance and skill-building needs to be done in settings where people already interact safely, such as schools, workplaces, pre-natal classes etc. There was less focus on campaigns and general information websites to provide this information. Many participants suggested familiar sources such as peers or local organisations people already engage with about healthy lifestyles should give practical advice and build skills at regular times. Some people also noted a lack of trust in what was seen on television, online and in other media, given the amount of misinformation that can be shared through the popular media on food and nutrition.

Many community members and organisations suggested there should be a focus on 'screen time'. While guidance and advice on screen time is mentioned within existing strategies (1.1.4, 1.2.1 and 1.2.3), a number of participants suggested more specific strategies in this area, particularly as screen time and sedentary behaviour is likely to get worse into the future as digital technologies and gaming increases.

CASE STUDY: Accessing food and getting advice in a community setting

Starting Point Neighbourhood House, Ravenswood, Tasmania

The Starting Point Neighbourhood House in the Launceston suburb of Ravenswood is a thriving, community-focused space that packs more into its walls than seems possible. The house supports their community's social, mental, and financial health, with a range of programs and staff for these areas. When it comes to physical health, people access help with both nutrition and fitness.

This is a great example of using a trusted community location to help people with what they need and to share important information and advice about living a healthy lifestyle.

Every day, bread, bakery goods, and fresh produce are donated, and together with produce from community gardens the house gives away more than 600 crates of food every year. Parents come in with their kids to grab what they need, and while the little ones participate in an Active and Alive fitness session, mum and dad can head into the food forest to see what will be harvested next. Teenagers on their way home from school can discover a vegetable they've never heard of—like kale, eggplant, or Jerusalem artichoke—learn what it is and how to cook it, then on their way out they can borrow a basketball and pick up a game on the free courts next door. Adults in transition can enroll in 14-week Healthy Shed classes, where they learn life skills around relationships, exercise, and cooking, and they can put their healthy habits into action by joining the walking group. Seniors can make a day of participating in an Eating with Friends community luncheon, having a go at an Active Armchair or a Bounce into Life fitball workout, and then take home a Freezer Filler meal. Meals and meal kits have led to particularly beneficial outcomes, with community members losing weight and lowering their cholesterol due to the nutritious and portion-controlled servings.

Promoting breastfeeding

There was very strong support across the health sector for promoting breastfeeding. In general, the strategy to **'provide support for mothers to breastfeed and continue to breastfeed by implementing the National Breastfeeding Strategy'** received strong support.

Many participants in community forums and discussions highlighted the importance of breastfeeding for all, in particular for strategies to support priority population groups who may experience poorer maternal health, and face additional barriers to breastfeeding.

Social marketing tailored to communities

While campaigns generally received broad support, the analysis of comments showed participants strongly suggested a focus on campaigns and social marketing that was community-driven. They also wanted to ensure any media or education campaigns are complemented by community programs and local capacity building to address more specific local population and community needs.

Aboriginal and Torres Strait Islander organisations and participants from the health sector noted that health promotion and all communication with Aboriginal and Torres Strait Islander communities should be tailored for each local area and culturally appropriate, with consistent and sustained messages about healthy eating and being active.

Many community members and organisations suggested if there are campaigns, they should be positive.

> *'Real food needs to be repositioned as fun, delicious, colourful, abundant, and the real 'treat' for healthy growing bodies, with the objective to encourage and achieve higher consumption rates of fruit and vegetables.'*
>
> – *Root Cause* long-form survey submission.

Guidance and labelling at time of purchase

Many participants noted the importance of consumers having accurate information at the time of purchase. Community members generally agreed that labelling is important because it gives them information as they are purchasing or considering different foods.

More than 50% of respondents to the short survey rated strategies to **'provide easy to understand information to help people choose healthier options at the time of purchasing food or drinks'** as extremely helpful.

But many people were also confused by current guidance, particularly labelling on food and drinks. In the targeted consultations with young people, participants noted that 'there is so much conflicting information about what is healthy and what is not, and this makes it hard for consumers to make healthy choices.'

In discussions, some participants mentioned the Health Star Rating system and said it was an important system for providing guidance at the time of purchase. Some participants reflected on current work underway to revise the system and said improving it was very important to ensure there is trust in it and that it more accurately reflects the degree to which a product is healthy.

Individual respondents rated **'continue to strengthen the uptake of the Health Star Rating system towards universal implementation and continue to consider options for the ongoing enhancement of the system'** as relatively less important in the long-form survey than other strategies (overall 35% rated it as moderately important or lower).

However, analysis of responses shows some lower ratings are the result of concerns with the current rating systems and the wording of the sub-strategy. Some individuals said these issues need to be addressed before the Health Star Rating is expanded.

Specific barriers were identified for people from culturally and linguistically diverse backgrounds when it comes to accessing information and guidance, including that there is a lack of information provided in language. **Read more (3.4.2).**

2.2.7 Support for primary care and strengthened referral pathways

Community participants focused strongly on the need to have supports and referrals, and to ensure current gaps in services are addressed. In particular, people in regional, rural and remote areas were finding it harder to access expert support and advice such as dietitians and allied health professionals. In discussions, people said unless there is support close by, they were unlikely to seek the advice and guidance they needed to lose weight. Some suggested more emphasis on tele and online services would help. Some also recommended more support for education and weight management interventions, including a focus on training GPs and their practices to prevent and manage overweight and obesity health risks and improve access to advice and treatment in regional, rural and remote areas.

A number of participants from the health sector said primary healthcare, especially GPs, play an important role in overweight and obesity prevention. Some mentioned primary care was critical to helping people access help before their health deteriorates further. Community members also shared stories about how these supports and referrals have assisted them.

'Maintaining a healthy weight is a journey'

One participant from country Victoria told us about how she had recently lost 58kg and the importance of having help through Medicare to keep the weight off. After struggling with being overweight most of her life, she said she's often been able to lose a lot of weight but it's been hard to sustain the weight loss in the long-term.

"Because I have had trouble sustaining weight loss in the past, my GP referred me to a dietitian. I get six visits for free under Medicare. She is helping me to design a balanced diet that will work for me. One thing I always try to remember is that maintaining a healthy weight is a journey and if I have a 'fall', I should fall forward, not get discouraged, and keep on going."

Some participants identified that there is no Medicare item for GP consults specifically for overweight and obesity issues and this limits their access to support. They reported GPs often don't have enough time to examine patients' issues surrounding overweight and obesity or direct them to the most appropriate services or programs.

Other feedback indicated people on lower incomes were finding it harder to access services for early intervention as there is generally a cost associated with it through a GP referral. If free programs exist, many people, including GP's, were often not aware of them. Some suggested a community hub model could encourage collaboration between services across health and social sectors, so that social service support, access to dietitians and other allied health are more available to them at that point of service.

Respondents from the health sector emphasised that effective early intervention through health services and GPs required clearer referral pathways and appropriate options to direct patients to. Suggestions included:

- stronger pathways to qualified health promotion, exercise physiologists and nutrition professionals
- broadening types of referrals commonly used by health practitioners to include other support such as mental health and naturopathy
- embedded physical activity counselling in primary healthcare

- enabling 'social prescribing', such as referring to social/community supports, to equip patients to take healthy practical steps
- the need to review clinical guidelines to ensure consistent, appropriate advice is provided and communicated sensitively.

To make referral pathways clearer, some participants suggested a better registry of available (and evidence-based) programs and services. The register could be localised and include a range of health and wellbeing options. Some suggested that the Primary Health Network (PHN) Health Pathways system could be broadened to provide this register.

Annual Aboriginal and Torres Strait Islander health checks by GPs was also suggested as a strong referral point.

Appropriate referral pathways and training for health professionals were particularly important for Aboriginal and Torres Strait Islander communities. **Read more (3.4.2).**

2.2.8 Sustainability and environment

While some organisations and individuals gave lower ratings to strategies focusing on environmental sustainability, the analysis of the comments shows this was often due to a lack of understanding or clarity about how these strategies fit within the context of obesity prevention.

In many community discussions and forums, the environment and climate change was raised as an important factor for supporting healthier food production. Participants regularly noted that the climate will impact what we can and should grow or farm in the future, and they suggested we will need to adapt our food choices accordingly. Some people were concerned that more packaged and processed foods would continue to emerge over fresh options, as the climate becomes more difficult to manage.

> *'It is well established that climate change will exacerbate existing inequities that cause issues like overweight and obesity, so stronger Federal Government action to support climate change mitigation and adaptation is necessary.'*
>
> **– City of Greater Bendigo—comment from long-form survey**

In the focus group with young people, they were particularly concerned about the importance of environmental sustainability and the impacts of climate change on food and their ability to be more physically active throughout the day. They recognised the significant impact of their food choices on the environment and so were keen to see a strong focus on sustainability throughout the strategy. Participants also believed that sustainability is a factor impacting the choices young people make about what products to buy and what foods to eat.

In relation to the strategy to **'consider options for incorporating the cost of obesity and greenhouse gas emissions into the price of food and drinks'**, comments suggested some respondents were concerned about taxing the wrong people and that there may be impacts on local farmers. Strategies focused on trade policy and sustainable development also had slightly less support than others, with participants noting concerns these could make the scope of the strategy too broad and distract from its main objectives.

A few industry respondents suggested the sustainable development principle broadens the scope of the strategy too far and it should be removed.

Part 3:

Issues affecting priority populations

Targeted community discussions helped to draw out the additional environmental factors and barriers to healthy weight for specific population groups, and which strategies might be most important to them.

The consultation paper identified priority populations who are disproportionately affected by obesity as:

- Aboriginal and Torres Strait Islander people
- people living in regional, rural and remote areas
- people with disability
- people from lower socio-economic backgrounds or experiencing disadvantage.

These groups were all included in the targeted community discussions. Also included were:

- people and organisations from culturally and linguistically diverse backgrounds
- young people
- seniors.

The issues and suggestions raised by diverse participants were often common to one another, and similar to other participants. This section highlights key themes raised by participants in these priority population groups. They include:

Availability and access to healthier food and drinks	**Cost of healthy food and participating in physical activity**
Physical activity for all ages and abilities	**Community, culture and history**

The table at Appendix A includes additional considerations relevant to specific population groups.

3.1 Availability and access to healthier food and drinks

Availability and access to healthier food and drinks was an issue raised by many people, but this was highlighted as one of the most critical issues for priority populations—mainly people:

- living in regional, rural and remote areas
- from Aboriginal and Torres Strait Islander communities
- living with disability.

There was very strong support by all participants for the strategy to '**encourage good quality, culturally appropriate, healthy food availability and affordability in stores, workplaces and institutions in rural and remote communities'**. Some suggested the wording of this strategy needs to be strengthened to 'ensure' availability and affordability rather than 'encourage'.

3.1.1 Keeping food local

In some areas in northern Australia roads can be cut for significant periods of time because of weather events. However, they were not the only times when food availability was an issue.

In general, participants agreed convenient, packaged, processed foods were likely to be more available and more affordable in regional, rural and remote communities and towns.

The same population group is often the closest to fresh produce being farmed and produced. However, many reported they were missing out as produce is taken and shipped into capital and large regional cities, where the populations are higher. Participants said there were few programs and incentives available to keep fresh or other produce from farms local and suggested this be included in the strategy.

> *'People living in rural areas in Australia may be priced out of purchasing healthy foods. The costs of transport, handling and storage are too often passed onto consumers living in remote communities, making fresh fruit and vegetables disproportionately expensive.'*
> – *Choice* submission

3.1.2 Access to, and storing, fresh produce

According to participants, many of Australia's remote Aboriginal and Torres Strait Islander communities were not adequately serviced with fresh, healthy food. Storing food in remote stores and housing was a major issue. These environmental factors would need to be addressed alongside strategies that support and encourage changes in eating and drinking behaviour.

CASE STUDY: Healthy Stores 2020

Northern Territory/Queensland

The 'Healthy Stores 2020' research project tested a strategy in remote stores to reduce sugar. This project is a National Health and Medical Research Council (NHMRC) funded partnership between several universities (with Monash University as lead) and the Arnhem Land Progress Aboriginal Corporation (ALPA), which operates 24 stores in very remote Australia.

The project aimed to advance knowledge on how changing the retail environment can improve population-level diet in remote communities. The strategy targeted products that contribute the most sugar (sugar-sweetened beverages, table sugar, sweet biscuits, and confectionery) and reduced merchandising of these products (e.g. no price promotions, no placement in high traffic areas, reduced shelf space; plus in some stores no refrigerated sugary soft drinks >600ml). This was tested in a community-level randomised control trial meaning one group of communities tested this strategy and the other communities conducted business as usual (control group).

According to the Queensland Aboriginal and Islander Health Council (QAIHC) submission, this strategy caused a significant decrease in sales of sugary drinks and sugar overall while the stores did not lose revenue. Representatives from Community Enterprise Queensland (retail stores in Aboriginal and Torres Strait Islander communities in North Queensland) attended a workshop about the Healthy Stores 2020 initiative and are convinced this can work in their stores as well.

NHMRC Grant #APP1138629

The contents of the published material are solely the responsibility of the Healthy Stores 2020 research collaborative and do not reflect the views of NHMRC.

Read more.

3.1.3 Supply and demand increasing poor choices

Some participants reported that food stores servicing disadvantaged areas don't carry as much fresh and healthy food, such as fruit and vegetables, as is available in other areas. This was mentioned to be the case even in low socioeconomic 'urban fringe' areas of Sydney.

Participants noted food stores changed their stocks based on what was purchased. This can have an impact in areas where poorer food habits already exist and there are generational behaviours or preferences towards eating cheaper, packaged foods. Some thought the strategy should have ways to make sure major food stores focus on providing and promoting healthier options everywhere.

3.1.4 Opportunity to make healthier choices in care and food relief

People said that facilities and settings which care for people should be made to provide healthier, fresh and nutritious food for all people in care. The settings identified as a focus were: supported accommodation; hospitals; aged care settings; and jails.

A number of organisations identified people with disability in group homes or nursing home facilities were not able to choose healthy options or have control over what is available to them. Participants suggested Supported Independent Living (SIL) arrangements that encourage active lifestyles, and the development of suitable meal plans for people with disability, could be a focus in the strategy.

A number of participants suggested additional training for disability support workers about nutrition and ways to prepare healthier foods. Some also suggested there should be a strategy to provide greater support for people with disability to get groceries and to make their own food choices. This could include guidance and education for people to use online ordering systems, while ensuring grocery delivery is safe and appropriate.

Some participants noted a lack of well-paid and well-trained cooks and chefs in aged care who specialise in foods that are good for elderly people. Some participants suggested needing strategies to improve guidelines in aged care settings, and to train cooks and staff in these long-term care facilities.

Some participants commented that many charity food programs in disadvantaged areas also didn't provide as healthy food as they should, and guidelines may be needed to ensure healthy foods are prioritised.

3.1.5 Unsafe drinking water leading to unhealthy (but safer) options

People identified that the availability of fresh, safe drinking water was a growing and significant issue in rural and remote areas, especially during drought. Some participants in rural areas noted access to clean, drinkable, tasty water was an issue for them. They thought more efforts could be made to improve access to good quality drinking water as part of the strategy.

Some people, especially children, were drinking unhealthy, high-sugar drinks as an alternative to water because the local water supply was not good quality. They were also buying soft drink rather than water as the price of bottled water was sometimes higher at some supermarkets and shops than other drinks, which were also well promoted.

3.2 Cost of healthy food and participating in physical activity

The cost of food was particularly prominent in discussions with people from priority population groups. Many participants highlighted that individuals and communities experiencing social disadvantage often struggled to afford fresh, healthy food as well as having the means to participate in sporting activities or attending gyms, for example.

People noted inequity is amplified when some of the cheapest foods were often the most unhealthy—particularly carbohydrate-rich processed and packaged food that people could buy in bulk.

Social, health and environmental determinants made food cost a very significant issue for Aboriginal and Torres Strait Islander people, including in urban areas. Lower employment and work options, having larger families and higher risks of chronic disease were identified as having a greater impact in these communities.

3.2.1 Higher costs in remote settings

Non-processed and packaged food—especially fresh fruit and vegetables—is considered to be relatively more expensive in regional, rural and remote areas. Participants highlighted that fresh fruit and vegetables may not be available regularly, or at all, in very remote communities.

Aboriginal and Torres Strait Islander health services and remote outreach dietitians, who support families in rural and remote areas, were particularly concerned about the higher cost of fresh options in stores in these communities. They said the high cost of fresh food removes the ability for most families to choose those healthier options.

'A meal for less than the price of one lettuce'

A participant at the NACCHO conference in Darwin related how they had visited a store in a remote community and were shocked to see that fresh food was so much more expensive. They had observed that a small, fresh lettuce cost $9 whereas a pack of frozen pies was just $4. It was not surprising, they said, that families opted to buy the pies which could provide a meal for a whole family for less than the price of one lettuce.

Participants suggested having dedicated strategies to ensure all people living in regional, rural and remote areas can access fresh food at an affordable price. This included subsidies to reduce the cost of fresh, healthier food, and for transport of food to rural and remote communities.

In addition, regional, rural and remote health workers noted that many people in remote communities may be unable to afford physical activity and other health programs, when it is not free. But the cost of putting on free programs, when factoring in external costs, getting people there and providing food or other support, is also very high and sometimes not adequately funded.

3.2.2 Other priorities outrank healthy eating and physical activity

Some participants who worked with disadvantaged communities noted that eating healthy and being active was low on the list of priorities for families and individuals who may be experiencing severe financial insecurity, abuse, increased stress, addiction, poor mental health and/or trauma. It was important to them that any interventions took these factors into account.

3.2.3 Low incomes mean less choice

Many participants noted that raising incomes would be critical to reducing obesity rates and changing trends for the future. A number of participants, particularly those supporting people from priority population groups made this point. For example, Central Australian Aboriginal Congress recommended:

'The strategy should include action to reduce poverty and inequality as a key way to prevent the prevalence of obesity. For example an increase in the Newstart and similar citizenship entitlements by $75 per week for all participants, and an additional loading on such payments for those in remote or very remote areas to address significantly higher costs of healthy food in those places.'
– CAAC written submission

In a northern suburb of Adelaide, a number of Aboriginal families reported that the cost of providing fruit and vegetables for their families often exceeded their income support.

For newly arrived migrants and refugees, increased barriers to employment could mean that people were on relatively low incomes. Fast or packaged foods were cheaper and more convenient to buy for their families. When they realised this, it became the much easier—or sometimes only—option when they didn't have the income to support buying and consuming fresh, healthy food and drinks on a regular basis.

People with disability also raised cost as a significant barrier, particularly where they were on the disability support pension or other income support. This also included higher costs to participate in programs and physical activities due to additional accessibility requirements.

In the targeted consultation with young people, it was noted that when living on Centrelink payments, it is simply not possible to cover the costs of a gym membership or sports club fees. These participants felt that raising welfare payments would give people the ability to make healthy food choices and engage in sport and physical activity.

While school initiatives that promote healthy food were highly supported, some participants cautioned that the way programs are delivered needs to be carefully considered to avoid impacts on families who have limited income. For example, a participant in NSW mentioned an initiative where children are required to bring fresh fruit or vegetables and water in for the first snack break of the day. They said that while this might work for the majority, it could exclude some children and parents experiencing disadvantage who didn't buy or couldn't afford fresh fruit and vegetables. It's possible families may not be aware of supports available to them to access this food, or they do not want to ask. Participants commented that any initiatives under the strategy need to avoid creating barriers to participation by those experiencing disadvantage.

3.3 Physical activity for all ages and abilities

Priority populations identified that physical activity was very important. Participants highlighted the need for strategies to ensure it is available to all people, of any age, ability and in any location.

Common barriers across a number of the priority population groups to doing more physical activity related to accessibility, cost, safety and prejudice.

One participant with disability commented:

> *'I don't feel safe to go out on my own. When I've tried community activities I felt excluded. When I've tried gym, pool I didn't feel supported and generally stopped because I didn't feel safe. With very high medical costs, medication, therapy, specialists (mental health), I don't have money to spend on physical activities.'*
> **– short survey respondent**

3.3.1 Accessibility hinders participation

People with activity-limiting disability or health issues face additional barriers that impact on overweight and obesity, including being able to do more physical activity.

Participants said it was important to have:

- inclusive environments
- accessible facilities
- programs for people of all abilities to take part in.

Access to transport was also an issue. Those who experience disadvantage and those who live in regional, rural and remote areas reported less access to transport—both private and public. This affected their ability to engage in community activities, sports and facilities even when they might be available in their region.

3.3.2 Physical activity and community

People highlighted the positive effects sport and other physical activities had on Aboriginal and Torres Strait Islander community health and wellbeing. This included the physical health effects, as well as building and maintaining social connections. A number of participants from Aboriginal and Torres Strait Islander communities, in both urban and remote settings, said local sport and physical activity can build connections and trust among community members, and reduce isolation.

Sport was also mentioned to be 'social capital' in regional communities. Some noted there were increased barriers, such as higher costs and further distances to travel for organised sport in regional towns. Rural and remote community participants suggested government subsidies to play sports, attend fitness centres and purchase home fitness equipment would assist people to be more active. However, the stronger focus from this group was on a 'whole of community approach' with local education and leadership, and all services working together to promote health and physical activity.

3.3.3 Leaving sport between youth and adulthood

While sport was commonly an integral part of community activities for children, participants suggested more could be done to support children to keep playing sports through the later teenage years and early 20s transition period. This was when people often stopped playing sport for a variety of reasons.

A specific recommendation from young people, was to 'develop targeted programs to support young people to continue participating in sport and exercise through high school and university, including providing non-competitive options'.

People also mentioned a need for more strategies to support adults, particularly in regional, rural and remote areas, to connect with physical activity, and to attend gyms and active programs. A number of Aboriginal families attending the Aquagym program in a northern suburb of Adelaide, South Australia suggested access to free, culturally sensitive and regular programs was critical for adults to keep active. One participant said that without these programs, she would likely remain at home and have poorer physical and mental health. She said walking around suburban streets was sometimes not a pleasant experience, and could be unsafe and regularly too hot or cold.

It was also noted that having physical activity programs where both adults (parents) and their children can attend together can reduce barriers to parents being able to participate.

3.3.4 Access to community spaces and infrastructure

Access to community facilities and spaces was also important to people in the community. Community centres were identified as places where people could connect and be supported to be healthier.

People reinforced the need to ensure facilities were free or very low cost and that they were consistently well-maintained and safe, or people would not use them. This was very important in regional towns where outside infrastructure was more limited and where there was an average lower income level and/or higher proportion of people experiencing disadvantage. Many older community participants also identified that being able to exercise in a safe, air-conditioned facility helped them to be more active.

In the focus group with young people, they spoke about the importance of incidental exercise to support living a healthy lifestyle, but noted broader structural considerations impacted their ability and willingness to incorporate this into their lives. For example, feeling safe using public transport and having lighting on walking or cycling paths would be important to enable this.

CASE STUDY: Free community-led programs provide a safe place and support to be active

Adelaide, South Australia

In Adelaide, a number of local organisations work together to provide a free program for Aboriginal and Torres Strait Islander participants that combines gym activities, quit smoking support, water aerobics, and offers healthy meals. The program is about getting people together, in a safe and fun environment, to be active and to learn new skills.

Participants praised the program. They said it's made fitness accessible for them, and encouraged and motivated them to be active. It also provides an outlet for social interaction for some. They said it offers a safe environment to come together, share knowledge and encourage and learn from each other about being healthy. Local schools also support the initiative allowing children to attend with their parents so it's an activity they can do and learn together.

"It's great to be active in the program, but it's also great for my mental health and keeps me feeling well... I can come here knowing it's safe and I can talk about anything... It's also made me join other groups so now I'm out of the house a few times every week. Once you start, it's easier".

"Gym memberships are expensive and can be a big barrier but by having the free program every Friday, we're motivated to take part".

Most importantly it's free! Participants said free programs are important as they take away the barriers of having to find money to participate.

3.4 Community, culture and history

Aboriginal and Torres Strait Islander organisations and some community members highlighted the importance of having strong recognition of community and culture in the strategy, including in its principles and approach, as well as to have practical strategies to promote culture.

Participants identified that cultural recognition and awareness, as well as cultural safety, needs to be embedded in all health programs, promotions and services.

> '*Aboriginal and Torres Strait Islander peoples experience a disproportionate burden of illness and social disadvantage when compared with non-Indigenous Australians. Also, Aboriginal and Torres Strait Islander peoples experience much higher levels of racism and discrimination. To overcome these issues, cultural safety must be embraced at all levels of health care planning and delivery (programs, services, policies and strategies) in order to provide the best possible health care for Aboriginal and Torres Strait Islander peoples.'*
> **– *QAIHC* written submission**

Central Australian Aboriginal Congress suggested recognition in the strategy that, for Aboriginal and Torres Strait Islander people, *'programs to reduce obesity should incorporate positive attitudes to Aboriginal culture and ways of being, and be resourced to be trauma-informed and healing-focused'.* They also recommended including actions to encourage and support Aboriginal and Torres Strait Islander people to have access to and live on their Traditional Country as an evidence-based approach to reducing obesity and chronic disease risk.

Participants suggested the strategy should acknowledge that the experiences of dispossession, marginalisation, intergenerational trauma, and systemic racism interact with the social determinants of health and can make healthy lifestyle changes difficult to achieve.

A few of the respondents who identified as being Aboriginal and Torres Strait Islander raised that racism was a key barrier to physical activity. This was also mentioned in relation to accessing some services when they needed help with concerns about weight or were seeking advice for their family.

3.4.2 Community-led and culturally-appropriate responses

Community leaders, family and peer networks were commonly mentioned to be the key to spreading knowledge and ensuring better engagement of Aboriginal and Torres Strait Islander people on their health.

Participants suggested it is more culturally appropriate that Aboriginal and Torres Strait Islander health professionals and practitioners lead and deliver health promotion and education in communities, rather than outsiders. They said Aboriginal and Torres Strait Islander people often want direct support from someone they trust and are comfortable with. Many Aboriginal and Torres Strait Islander organisations and health professionals suggested investing in local capacity building and training so roles are supported by *local* Aboriginal and Torres Strait Islander people. Some participants also mentioned it was important more Aboriginal and Torres Strait Islander people are trained as dietitians and health workers, and that additional funding and the creation of new jobs are needed to support this.

CASE STUDY: Let's Talk Tucker

Regional NSW

In NSW, community participants said a good example of a program using local health workers is 'Let's Talk Tucker' in NSW. This aims to support Aboriginal and Torres Strait Islander health education officers to deliver preventative nutrition information to communities. They noted the key success factors of the program were that it was being delivered by trusted people in culturally appropriate ways and that this was key to engagement and change in Aboriginal and Torres Strait Islander communities.

Similarly, participants raised the importance of training health professionals and community leaders from culturally and linguistically diverse backgrounds to better understand the factors that can cause obesity, and to be able to deliver information about prevention in their communities, including in language. This included investing to ensure weight management or health promotion programs are led by appropriate culturally and linguistically diverse organisations, so they are culturally appropriate.

For both Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities, people noted it was important to bring services to where people are already—whether in homes or common meeting places, as people do not want to engage on these issues in places where they are not comfortable.

CASE STUDY: Aboriginal and Torres Strait Islander led health promotion

Deadly Choices

The Deadly Choices program is a health promotion initiative of the Institute for Urban Indigenous Health (IUIH) that is now delivered through Aboriginal Community Controlled Health Organisations (ACCHOs) throughout Australia. It was identified numerous times during community discussions and submissions as an example of a successful community-led prevention program enabling Aboriginal and Torres Strait Islander young people to make healthy choices about tobacco use, diet and exercise and getting an annual Health Check.

Participants in the consultations highlighted key factors that make Deadly Choices effective:

- Use of culturally aware, appropriate and positive community engagement for preventative health and health promotion.
- Community-driven and supported, leveraging existing connections and partnerships within communities.
- Use of role models and incentives from within communities to motivate young people to participate.
- The focus on holistic health, rather than targeting obesity or disease risks specifically.

Part 4:

A focus on community

4.1 Community-driven and led

Almost all participants supported a government-led strategy. However, they wanted government to work in genuine partnership with local councils, community leaders and the community itself. Many participants suggested a stronger focus on community-led approaches within the strategy, including clear actions to support community responses.

4.1.1 Place-based programs and local facilities

A number of participants suggested there was a need to understand the factors and barriers at the local level, in order to implement community initiatives in local areas and settings. Having access to local 'hubs' and place-based programs led by community were highlighted as being particularly important for supporting people to eat heathier and to be active. Some suggested actions led by local government or community that are tailored to local needs will be more effective.

Some organisations also highlighted the importance of seed funding initiatives at the local level and allowing communities to set the targets and outcomes specific to their environments.

CASE STUDY: Activity for and by community

Tai Chi community group, Charters Towers (regional Queensland)

In regional Australia, activities led by the community have a much greater likelihood of success—just like the Tai Chi group in Charters Towers. At eight years in, this bi-weekly activity group is one of the longest running in town. While it was originally set up thanks to grant funding, it is now kept free, accessible, and trusted due to passionate support from the community. This includes the supply of an air-conditioned, safe, and welcoming space from a local health service. The classes have been particularly welcomed as an asset to cardiac-rehab patients, but have been recognised as benefitting physical and mental health for all participants.

4.1.2 Community leadership and co-designing with Aboriginal and Torres Strait Islander people

Community-driven and led approaches were particularly important for Aboriginal and Torres Strait Islander communities. Participants noted the importance of ensuring strategies for Aboriginal and Torres Strait Islander people have local community involvement in all aspects of design, development and delivery. Participants said change must be culturally appropriate and driven by community leaders to be supported. This includes involving local Elders and respected community members who understand the local social determinants of health and the cultural environment.

Aboriginal and Torres Strait Islander organisations were supportive of co-designing with Aboriginal and Torres Strait Islander people to develop culturally appropriate and safe initiatives/programs and resources. Queensland Aboriginal and Islander Health Council (QAIHC) suggested mandating partnership and engagement of Aboriginal Community Controlled Health Organisations (ACCHOs) and their representative bodies to lead co-design and delivery of preventive health initiatives/programs for Aboriginal and Torres Strait Islander people. They also referenced the importance of supporting and empowering Aboriginal and Torres Strait Islander people to deliver and lead these initiatives. They noted that the proposed strategy does not fully acknowledge and uphold Aboriginal and Torres Strait Islander peoples' right to self-determination. Specifically, QAIHC suggested that, *'more needs to be done to recognise the distinct cultures and forms of social organisations, governance and decision-making practice of Aboriginal and Torres Strait Islander people in the Strategy. Actions and process for transferring responsibility and decision-making power to Aboriginal and Torres Strait Islander communities, so that they can make decisions on matters that affect them, are not sufficiently incorporated in the proposal'.*

Separate and sustained funding for prevention and health promotion is also important in Aboriginal and Torres Strait Islander communities. A number of participants noted short-term programs were detrimental to long-term behaviour change. Some Aboriginal and Torres Strait Islander organisations said support for change should be allowed to run at a longer timeframe, to allow for the early stages of community ownership and involvement.

4.1.3 Local decision making

In regional, rural and remote communities, participants raised issues with having a lack of control or say over decisions made about the types of food sold or food suppliers approved in their community. For example, in Ballarat (Victoria), a number of organisations raised concerns about approvals of fast-food or takeaway establishments, which they believe are determined under state laws.

4.1.4 Suggestions to enable community-driven approaches

Participants across consultation activity suggested that community-driven and locally-led approaches would require:

- seed funding for community-driven actions and strategies, and to encourage partnerships
- commitment to long-term and adequate funding to design, develop and implement community-driven and place-based programs
- consultation with communities to identify their particular needs and priorities
- ensuring diversity of culture and community when co-designing strategies
- strategies supporting the trial of co-developed regional, rural and remote interventions or programs
- changes to laws and policies so that regional communities have more say over what's available in their communities
- investment in training and building local capacity
- opportunities for communities to set targets and measurements that consider local contexts and priority populations.

4.2 Partnerships in community

Some suggested more focus on partnerships, particularly at the local level and with a focus on education, training and the distribution of food.

In regards to partnerships, it was suggested the working group consider strategies that include:

- support and encouragement for schools to link with local food producers so they can provide healthier, cost-effective food to the school directly and be involved in food literacy curriculum
- health clinics and health professionals partnering with schools to have in-school supports for nutrition and dietitian information, which parents can access
- partnerships between health and education sectors to embed core units of competency in nutrition and physical literacy in national vocational training packages. This includes for other areas of community care, such as mental health counselling, early childhood, fitness disability and cookery, so messages are not only coming from health professionals
- support cross-collaboration between established groups (e.g. Scouts, sporting clubs) and nutrition and health organisations to reach children and parents with information and guidance
- community hubs supporting the distribution of locally produced, fresh foods, and redistribution of food to people in need that would otherwise go to waste.

4.3 Trials and innovation at a community level

Some stakeholders suggested there be more emphasis on supporting regional and specific population research, trials and interventions. They suggested system-level intervention in a community or place-based setting will be more effective.

Some noted that any trials would need to be given sufficient time to be established and set up in the right way, to avoid damage or stigma, and will need a longer timeframe to show results. Measures in trials should be staged to focus initially on participation, uptake, awareness and understanding, but with a clear link to longer-term outcomes where the program or intervention is sustained.

Some participants also suggested learning from other trials and funding programs that have been effective in place-based settings and in targeting specific population groups.

Part 5:

Developing the strategy

5.1 Considerations: scope and language

5.1.1 A holistic approach

Participants supported a comprehensive strategy and many commented that the strategy could include an even more holistic approach to the prevention of overweight and obesity.

Many participants suggested better recognising the link between general health, wellbeing and healthy lifestyles and weight. This was particularly common in regional areas and in forums with a higher proportion of health workers. It was also a key theme raised by young people in targeted consultations.

Participants said a more holistic health focus may avoid contributing to stigma about weight and encourage organisations implementing actions to focus on helping people improve a broader range of health outcomes beyond overweight and obesity. It may also allow the strategy to influence factors in schools and workplaces, which would be considered as contributing to healthy lifestyles, not just weight.

Some participants noted they were concerned that important social and environmental determinants may not be considered if the focus is solely on weight. Many participants also supported that the strategy interact with social policies (e.g. leveraging welfare policies, and labour/employment policies) that encourage healthier lifestyles.

5.1.2 Potential gaps in the consultation paper

Mental health

Mental health was a specific area many participants, including priority populations, suggested should be better incorporated in the strategy.

Mental health was discussed both as a contributing factor to overweight and obesity and as an issue that can be heavily impacted by obesity-related illness. Participants said it was important to recognise that poor health, particularly mental health affects people's ability to engage in healthy eating, drinking and physical activity.

> *'The proposed National Obesity Strategy has not included mental health, and social and emotional wellbeing, as a key component of obesity prevention. Evidence shows that people living with mental illness face considerable health challenges including risk of cardiovascular disease, diabetes and obesity.'*
> *– Queensland Aboriginal and Islander Health Council* written submission

Some suggested mental health should underpin the approach across all strategies. Others thought there could be specific mention of mental health within strategies, particularly healthy lifestyle management programs, or the addition of new strategies that acknowledge the links between mental health and obesity. Some participants said support for mental health expertise to be part of the prevention and treatment of overweight and obesity should be included through the strategy.

> *'The mental health of obesity is so underrated. It is a debilitating health issue to live with and so hard to overcome.'*
> *– Short survey respondent*

Inclusion of tertiary prevention

There was division on whether to include tertiary prevention in a national obesity strategy. In the long-form survey, 51% of organisations and 49% of individuals agreed that the strategy should not focus on tertiary prevention. A number of organisations emphasised the importance of focusing on investment in prevention (primary and secondary) as the core of the strategy.

However, of the 244 respondents who commented on the scope of the national obesity strategy, 51 raised strong concerns that tertiary prevention and access to healthcare was missing. Common reasons to include tertiary prevention were:

- It will be difficult to reduce current rates of obesity without a focus on treatment.
- Treatment is an effective form of prevention for obesity.

The majority of respondents in the surveys who were very overweight thought treatment should be included. Participants raised health equity as a reason to include tertiary prevention, noting that:

- people living with obesity deserve the same access to management and treatment as other conditions that are not left untreated, such as mental health or cancer
- being in rural and remote areas added extra challenges and extra cost for programs to meet the needs of the population
- tertiary interventions may be particularly important to include in strategies for young adults.

Diabetes Queensland noted the exclusion of tertiary interventions would make it *'difficult to tackle obesity as a community-wide issue when those most acutely affected are not included in the consideration.'*

There was also some support for bariatric surgery to be included as a tertiary prevention, as it *'remains the most efficacious weight loss intervention in individuals and would reduce the per capita cost of healthcare'* (Johnson & Johnson Medical long-form survey comment).

Other suggestions

While the proposed list of strategies was seen to provide good coverage of the actions needed to prevent overweight and obesity, other specific areas participants suggested could be included were:

- stress management
- oral health
- sleep and sleep hygiene
- holistic strategies to address addictive behaviours
- additional focus on workplace, labour and employment policies.

Some participants also suggested acknowledging and addressing eating disorders in the strategy. Some thought the strategy should also include a focus on underweight if the vision is a 'healthy weight for all Australians'.

5.1.3 Avoiding, reducing and preventing stigma

The issue of stigma was a concern for many participants. It was suggested that language of the strategy and its actions need to avoid causing or contributing to stigma.

Many participants suggested that the term 'obesity' be removed from the title, however a smaller number suggested that it should remain to make the purpose of the strategy clear. Some also suggested there should be specific strategies included to help reduce weight stigma in the community.

Feedback from the Women's Council of Health Matters in the ACT was that language in the strategy should be bolder and more inspiring by taking the emphasis off weight and BMI measurement and instead promoting a positive body image. Some participants suggested that focusing only on ideal weight can intimidate people and may result in them not making the effort to become healthier.

> *'When it comes to describing an 'ideal weight' there's an obsession with outdated, healthy weight/height charts, which means that overweight people were not motivated or encouraged to be as healthy as they could be when all the focus was on their weight... you don't necessarily have to be thin in order to be healthy.'*
> **– Canberra discussion group participant.**

Impacts of stigma on particular population groups

Stigma was raised frequently in relation to its impact on particular population groups, including children, women and those from different cultural backgrounds.

Some participants were concerned about the appropriateness of weight management programs targeting **children**. They commented that weight management programs may make children feel stigmatised and ashamed. Some suggested there should be more focus on broader 'health and

nutrition' for children, rather than weight. In addition, concerns were raised about the impacts of stigma on children's general wellbeing and that strategies should specifically reduce and address this.

> *'Weight-based teasing and stigma mediates the relationship between childhood weight and mental ill-health. Given the increasing attention that childhood bullying has received in recent years, we strongly recommend that policies recognise human diversity and support each child's individual pattern of growth and development to improve their short and long-term health and wellbeing. Removing the focus on body weight and supporting body diversity is important and leads to positive health behaviours.'*
> **– HAES Australia Inc comment in long-form survey.**

Some people we spoke to from **culturally and linguistically diverse backgrounds** noted there may be a range of reasons why people from some cultures are a higher weight. This can include genetic factors and changes in lifestyle. They noted that sometimes there was a drastic change in the type of foods available and consumed when new migrants came to Australia. Participants suggested the need for education in the community to reduce stigma, in consideration of other cultures and ethnicities.

Women were also mentioned as being particularly impacted by or vulnerable to stigma. This included during vulnerable lifespan stages, especially during pregnancy. Some suggested programs during and post-pregnancy need to be focused on holistic health, not weight, for the benefit of the mother and child. There was also concern about the use of some language related to breastfeeding. They said it could also cause shame or stigmatise parents who are unable to breastfeed.

5.2 A strategic framework

5.2.1 Describing the strategy and its vision

While participants broadly supported the vision set out in the consultation paper, some said it could be more aspirational. Others suggested removing reference to weight to ensure this is truly a holistic strategy.

Current proposed vision:

'A community and environment that encourages and enables healthy weight for all Australians.'

To address concerns with the inclusion of 'weight' in the vision, some alternative suggestions were:

- A community and environment that enables all Australians to be healthy and well.
- A community and environment that encourages and enables healthy living for all Australians.
- A community and environment that encourages and enables health for all Australians.

In contrast, some participants were strongly of the view that the strategy and language should remain focused on overweight and obesity and that this should be specifically mentioned in the vision, so it is clear what the strategy is about. Some noted this would align with the World Health Organisation language of tackling the problem of overweight and obesity. Some suggested this would add to a sense of urgency. However, some of these participants also indicated that local initiatives should have separate names without reference to obesity.

5.2.2 Social and environmental factors before individual behaviour

Many participants said structural changes and population-level interventions to address the environmental factors impacting healthy behaviours would be significantly more effective than actions targeting individual behaviours.

A large number of participants wanted to see the focus on system and environmental factors to come first in the strategy. Many organisations and some individuals said Priority 4: building a healthier and more resilient food system should be the first priority. This would bring the priorities more in line with the principles and would acknowledge that unless the issues in the system are addressed, strategies that focus on individuals are unlikely to have significant impact.

Community members we spoke to agreed, and identified that guidance and information was unlikely to be effective while the cost of food and marketing of unhealthy food and drinks remained at its current state. Many said people typically already knew what they should be doing, and that further information was unlikely to change behaviours while environmental determinants that made healthier foods less affordable and available remained the same.

People who are living with obesity also cautioned putting the onus of the problem on individuals.

'As someone who struggles with this issue I find it is like being an alcoholic and being forced to live in a bar. I am surrounded by foods, ads, promotions (e.g. magazine covers, displays, TV shows) and bombarded by foods specifically designed to be attractive and addictive – and then I am blamed for not being strong enough to resist it all and find the very limited ways of eating more healthily... authorities such as yourself seem to put all the focus back on the individual. As long as you continue to do that you will be completely ineffective. Look more into why people can't do what they know they should do for better health.'
– Short survey respondent

Stakeholder comments in the surveys for Priority 2: mobilising people and communities pointed out that strategies in community which aim to address environmental factors and social determinants should be implemented prior to increasing people's knowledge and seeking to alter social norms.

5.2.3 Considerations for principles

All of the principles suggested in the consultation paper received strong support. However, in order to avoid the perception that individuals are the 'target' for the strategy, some participants suggested changes to the term 'people-first'. Participants broadly agreed the strategy should put improving health outcomes for people at the centre, however a 'people-first' approach was sometimes interpreted as putting the onus on people or individual behaviour, over systematic or environmental issues.

'While CHF believes a consumer-centred perspective is very important, this should not be misconstrued as suggesting that the strategy should have a focus on individual behaviours and individual responsibility as this is not supported by the evidence. CHF supports the 'people-first' principle but suggests it should clarify that the person-centred approach is about ensuring that the strategy actions are relevant and do not adversely impact on individuals and communities.'
– *Consumer Health Forum of Australia* long-form survey comment

Potentially missing principles

Some organisations suggested some new or updated principles, which could be included in the strategy:

- Cultural safety (suggested by multiple Aboriginal and Torres Strait Islander organisations).
- Community-led and co-design (suggested by multiple organisations, including most Aboriginal and Torres Strait Islander organisations).
- The Central Australian Aboriginal Congress 'welcomed' the inclusion and general commitment to 'empowerment and self- determination' in the proposed principles but felt it should be strengthened to include specific reference to the 'rights of Indigenous peoples as established under international agreements to which Australia is a signatory, including the United Nations Declaration on the Rights of Indigenous Peoples".
- A number of organisations strongly supported the principle of sustainable development, but suggested strengthening it. The University of Queensland (School of Public Health, Faculty of Medicine) recommend that *'there is a greater focus on ecological and environmental sustainability given the important relationship between health, food systems and environmental sustainability.'*
- 'Bold' should be included as a guiding principle, recognising the need for a strong policy response to the problem of obesity, which was largely yet to be tackled sufficiently (one respondent in long-form survey and multiple mentions in the Mentimeter questions about what a strategy should achieve).
- Education about obesity and preventing weight stigma could be included as a guiding principle (multiple survey responses).

5.2.4 Linking strategies with logic

Participants made numerous comments about the structure of the proposed national obesity strategy, suggesting that the strategy should have a more clearly defined logic.

Participants noted:

- The current structure does not prioritise the systems-level and environmental changes first.
- The framework needs a better logic to group and link strategies, and to show how strategies relate.
- The current structure is confusing and participants were concerned it would be difficult to implement, measure and report on.
- Clearer mapping and linkages between priorities and sub-strategies would help to prioritise what is needed to be done first.
- Behaviour change models could be used to better show the relationship between different strategies, including those that are systems-focused and those that aim to impact individual behaviour.
- Linking priorities to implementation and measurement will ensure consistent and meaningful evaluation.

It was important to some participants to include systems thinking as a priority. This would recognise the interconnectedness of health, political and food systems, economics, and transport systems.

5.2.5 Stronger language and links to evidence

Hundreds of references were made throughout the consultations about the need to strengthen the language of the strategies and sub-strategies to make sure their intent is clear to everyone.

Common concerns were around using unclear language such as 'look at ways', which many participants thought was not strong enough for a national strategy approach. Some participants suggested strengthening specific sub-strategies to regulate or mandate.

People noted that vague language was likely to lead to inaction by government, as it would create confusion in the sector and industries. Some raised concerns about the 'watering down' of evidence-based strategies, suggesting it will be unclear what change each strategy should achieve when implemented. Others suggested that the strategy include space for innovative approaches that can, with rigorous evaluation, contribute to the evidence base.

Some participants suggested linking the evidence more clearly to the specific strategies to make the intended outcome of that strategy clearer. Medtronic Australasia Pty Ltd suggested multiple times *'the evidence in support of each of these strategies needs to be disclosed and the targeted outcome from their implementation needs to be set to evaluate performance. Resources should be prioritised for strategies with strongest evidence and largest targeted outcome.'*

Participants noted that many of the strategies being proposed were already being done, to some level, and that there should be stronger references to 'scaling up' activities and actions. For example:

- 'all Councils required to have…'
- 'all supermarkets make this change by…'
- 'triple the investment in…'

Several food and beverage industry groups supported the use of language and strategies that provided opportunities for them to work with government and others to develop the specific actions or recommendations.

5.2.6 Demonstrating links with other national policies

Participants wanted to make sure that a national obesity strategy strongly links with, and incorporates reference to, other national, state and territory policies that it will need to align with and leverage. They most commonly referred to the new 'preventive health strategy' (under development). Strategies participants highlighted as requiring linkages were:

- National Preventive Health Strategy
- Closing the Gap
- National Mental Health and Suicide Prevention Plan/National Mental Health Strategy
- National Food Waste Strategy
- National Breastfeeding Strategy
- National Physical Activity Strategy
- National Diabetes Strategy
- National Strategic Framework for Chronic Conditions
- Sport 2030.

In addition, participants suggested some specific national policies they thought would complement an obesity strategy and may be needed to lever or implement the specific strategies. They included:

- national nutrition policy
- national schools canteen or food policy
- national walking and cycling strategy
- updates to the Australian Dietary Guidelines.

Part 6:

Enabling implementation and achieving outcomes

Enabling and sustaining long-term commitment to delivery of the strategies was a key focus for many participants. Most often, community members and organisations wanted to ensure there will be sustained funding and investment in the strategies.

In the short survey, a list of six key areas were presented as the proposed enablers. These were things suggested to aid effective national action and implementation of the strategies proposed. Figure 6 shows that all of these enablers were considered to be very or extremely important by the majority of respondents.

Perceived importance of proposed enablers for making sure the actions in a national obesity strategy are successful

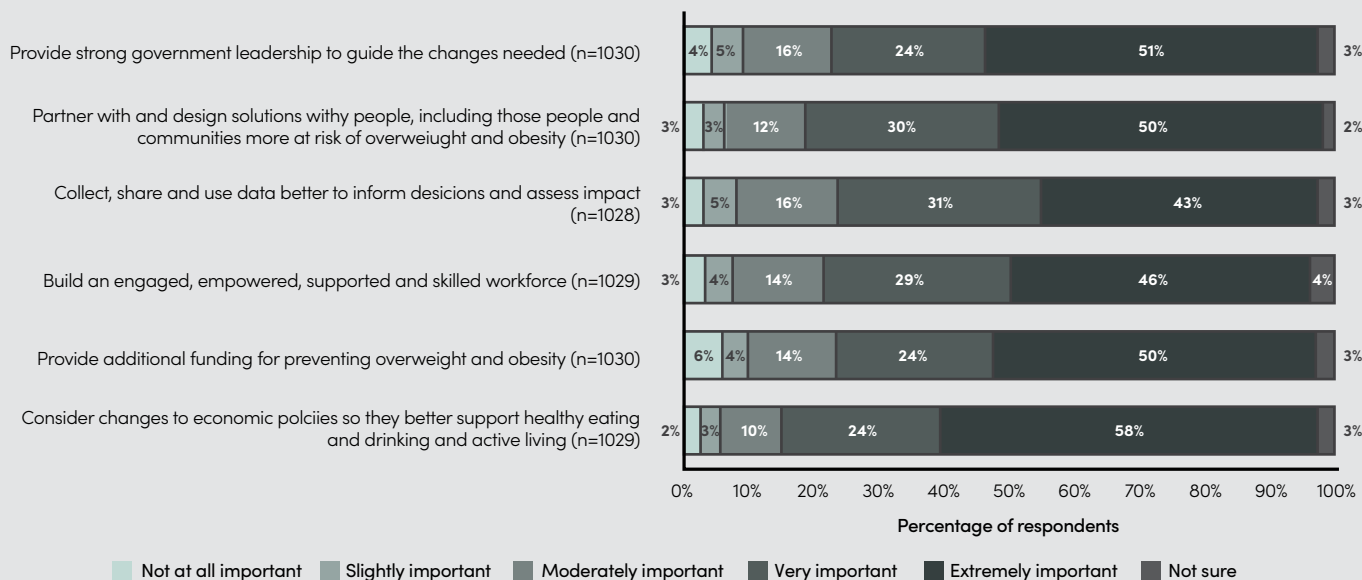| Enabler	Not at all important	Slightly important	Moderately important	Very important	Extremely important	Not sure
Provide strong government leadership to guide the changes needed (n=1030)	4%	5%	16%	24%	51%	3%
Partner with and design solutions withy people, including those people and communities more at risk of overweiught and obesity (n=1030)	3%	3%	12%	30%	50%	2%
Collect, share and use data better to inform desicions and assess impact (n=1028)	3%	5%	16%	31%	43%	3%
Build an engaged, empowered, supported and skilled workforce (n=1029)	3%	4%	14%	29%	46%	4%
Provide additional funding for preventing overweight and obesity (n=1030)	6%	4%	14%	24%	50%	3%
Consider changes to economic polciies so they better support healthy eating and drinking and active living (n=1029)	2%	3%	10%	24%	58%	3%

Percentage of respondents

Figure 6: Perceived importance of proposed enablers for making sure the actions in a NOS are successful – short survey

In community forums, participants commonly suggested that each of the enablers requires partnerships between government and 'local' implementers such as the local health services and workforce, local governments, schools, other community services and community leaders.

The enabler which had the most support in the long-form survey was to provide additional funds for effective delivery of actions (PE4.1.1). This was closely followed by support for a commitment to sustained funding to support data collection. Many participants raised concerns that the strategy would 'sit on the shelf' without a stronger commitment to the resourcing required.

In regards to building the workforce, participants supported focusing on the workforce outside of the health sector. Many suggested improved health literacy is required across all sectors. Within the health sector, participants noted 'local' capacity needs to be the focus so there are workers available to visit programs, schools and local communities.

Participants also suggested it is vital the wider health workforce is trained in cultural awareness, including the impacts of trauma and marginalisation, and can provide culturally appropriate advice and services. Some also raised the importance of including mental health awareness and training alongside health literacy that will assist in preventing overweight and obesity.

There were some comments suggesting the enablers may need to be better linked to implementation and measurement, and to other strategies. This would better demonstrate how the strategies under each enabler will be ensured in the delivery of a national obesity strategy.

Participants commonly noted a number of key areas they wanted to ensure were considered in relation to the four enabler areas. These are summarised as:

Lead the way
- Very strong support for government leadership; for strategy to guide all government.
- Calls for stronger reference to government setting and using regulation/ stronger policies.
- Need for bipartisan, long-term commitment and coordination across levels of government and govt depts/sectors.
- Priority population groups want community leadership, including resourcing at community level for delivery.
- Need for transparency.

Better use of data
- Support for collaborative research and regular surveys with focus on health behaviours rather than weight.
- Invest in social media, storytelling, case studies etc for informal research and gaining qualitative insights.
- Changes in guidelines and review of evidence for guidelines etc.
- Widen research partnerships and ensure research free from industry influence.

Build the workforce
- Build local community capacity/ community-based workforce critical.
- Focus on training and literacy in different workforces/sectors.
- Focus on GPs and allied health.
- Look at unemployment rates – skilled professionals unemployed so investment in more jobs is key.
- Suggestions for better use of volunteer workforce and skilled retirees/volunteers in program delivery.
- Specialists in schools and workplaces.

> **Invest for delivery**
> - Concerns implementation will not receive adequate budget –commitment to longer term funds.
> - Support recurrent obesity prevention funding, linked to cost of obesity to society.
> - Investing more strongly in 'local and community' food production.
> - Investment in wellbeing / healthy lifestyles (inc emotional).
> - Some support taxes to fund and providing subsidies for healthy food production and purchase.

6.1 Implementation

Participants asked for more clarity about how a strategy would be finalised, agreed and implemented with clear information about how and when strategies will be actioned. Some suggested a timeline or road map accompany the strategy to demonstrate how, when and by who the (many) strategies will be implemented.

6.1.1 Timeframe

There was broad agreement with having a 10 year timeframe for the strategy.

A few participants suggested a longer timeframe (up to 20 years) given the system-level changes required. Some industry representatives noted more time would be needed to design and implement a number of the strategies suggested.

6.1.2 Oversight of the strategy

Most participants suggested implementation is led by the Commonwealth Government (because a nationally-led approach is needed), then centrally coordinated at a state level and implemented at a local level.

Some suggested a national partnership agreement under COAG would be required to ensure the sustained commitment to implementation and support across all levels of government.

In community forums and discussions there were strong calls for the highest level of oversight and commitment to strategies as possible. Some suggested, as it is a cross-sectoral strategy and given the urgency of the problem, the strategy needs to be led by the Prime Minister and Premier's departments rather than through Health departments. They suggested this would improve accountability as each agency and department 'implements' and then is required to report back.

Some participants, including from the government sector, suggested the use of a multidisciplinary team with a governing body to manage and implement the strategy.

6.1.3 Governance

The majority supported the suggested governance arrangements but thought more committees may be needed and these should have a wider representation of people and stakeholders to advise on development, implementation and evaluation of strategies.

It was suggested that a reference group comprised of people with experience of higher body weight from a range of socio-economic backgrounds be included, to use their expertise to frame health promotion activities, strategy implementation and evaluation.

A range of participants noted that committees guiding implementation should also include mental health expertise, expert and peak body involvement, community organisations, academic experts in health environments, weight management health care professionals, and allied health professionals. Some suggested partnerships with relevant Australian professional bodies.

A few industry representatives suggested a 'Retailers, Manufacturers and Suppliers Committee' be established. However, many health and other organisations, including from research and academia, suggested it is critical that government *'not include parties with a vested, commercial interest in the setting of obesity policy, consistent with the recommendations of the World Health Organisation.'* (University of Queensland (School of Public Health, Faculty of Medicine).

6.1.4 Implementation plans

There was broad agreement with having an implementation plan, including plans for states and territories that link to other state policies and strategies. Participants commonly supported a rolling two-year implementation plan, with clear responsibility for action. Some participants suggested co-designing these implementation plans with consumers.

Local plans in each local government area were also suggested by some participants. Others suggested having local 'community' plans would improve community buy-in and ensure locally-led approaches in the delivery of strategies. However, some noted that funding local initiatives would still need to come through a national agreement.

Participants also suggested that implementation in regional, rural and remote areas will require particular support and focus. A dedicated plan or strategy for this may be required.

6.2 Reporting

Some participants suggested long-term and measurable outcomes be set from the beginning to make reporting meaningful. Participants across community forums and discussions noted the consultation paper had a lack of specific measurable strategies. Some suggested this would make monitoring, evaluating and reporting on actions difficult and wanted to ensure specific actions and measures are included in implementation plans.

Challenges were identified with reporting on the longer-term initiatives and so some also supported reporting against implementation plans that have shorter-term goals, and more measurable objectives.

A number of participants raised specific concerns that poor reporting in the past had contributed to a lack of investment in prevention, and to avoid this, regular, real-time reporting is required.

Many people suggested reporting of progress and change over time be done online, so it would be regularly updated and shared openly and transparently. Some mentioned Parliamentary reporting of progress and outcomes.

It was important to some that communities be able to feed in to the monitoring of the strategy through their local initiatives and to contribute to national indicators and progress. Some suggested a simple dashboard (similar to the one showing where taxes are being spent) would be a useful tool as part of monitoring and evaluation.

6.3 Measures

In regards to 'what should be measured' participants commonly suggested a broad focus that goes beyond measuring BMI and weight. Hundreds of individual suggestions were provided for specific areas to measure.

The most common areas for measurement suggested were:
- food, including consumption levels, availability/access, the actions of the food industry and adherence to regulation and guidelines
- health-related data, including obesity rates as well as broader health indicators in areas such as breastfeeding, mental health and life expectancy
- awareness levels and attitudes.

Other common areas included:
- social and equity indicators
- infrastructure improvements
- participation in physical activity
- progress towards making policy and regulatory changes at each level of government.

Some suggested Aboriginal and Torres Strait Islander programs may need more qualitative evaluation and measurement. Relevant organisations suggested feedback is needed from Elders and the community about how a program is really working in the community.

A number of participants suggested government also show clearly what the cost of obesity is and will be on society, as well as the economic savings resulting from implementation of the strategy.

6.3.1 Setting targets

Setting targets was supported by participants. Many suggested they are important for ensuring accountability and to be able to track progress towards achieving the strategy's outcomes.

A number of organisations suggested setting shorter- and longer-term targets. Some suggested an initial target to slow or halt the increasing rates of overweight and obesity and to impact current trends in specific populations groups. A long-term target should be set for the reduction in the prevalence of overweight and obesity.

Others also noted aligning with global targets, and setting targets at all levels: national, state, urban, regional, rural and remote. Some participants suggested providing the opportunity for communities to develop self-determined targets that contribute to state/territory and national indicators. As with the measures, there were a large number of targets suggested for inclusion in the strategy.

Appendix A

Key issues impacting specific population groups

The following table provides a brief summary of issues that are impacting specific groups, and suggestions raised by participants for things that might help to overcome these issues or barriers. Some of the suggestions are already covered within the strategies in the consultation paper, however others may require further consideration.

The key points have been derived mostly from community discussions and targeted engagements with people in community.

Aboriginal and Torres Strait Islander people	
Key topics of discussion	Ideas from priority population groups
• Cultural and social determinants impact Aboriginal and Torres Strait Islander communities • There are multi-layered barriers for Aboriginal and Torres Strait Islander people in regional and remote communities including significantly less access to healthy, fresh food and drink options • Limited access to fresh, safe drinking water in some communities • Cost of fresh and healthier foods for larger families • Lower employment rates and higher welfare dependency make cost a barrier for purchasing healthier options and accessing physical activity • Limited safe places and infrastructure for physical activity in some communities • Requirement for community ownership of and leadership in programs • Sustained funding for community facilities and programs • Social interactions that don't support healthy living • Loss of traditional food knowledge and skills	• Aboriginal and Torres Strait Islander-specific strategy and programs • Support for community-led, sustained initiatives and investment in local approaches • Subsidies to bring down cost of healthier food and drinks, particularly in regional and remote areas • Provide resources in community to help promote and produce more traditional foods • Sustained sport and fitness programs that are culturally safe and appropriate, regular and ongoing and in facilities that can be easily accessed • Holistic programs that concentrate on supporting new parents for the first 1000 days of a child's life • Better access to safe drinking water in communities • Leverage and build on existing activities, many of which are run by Aboriginal and Torres Strait Islander Community Controlled health services and through sporting codes

Regional, rural and remote areas	
Key topics of discussion	Ideas from priority population groups
- Food availability - Storing and housing fresh food - Transport of fresh food - Climate/environmental barriers physical activity and impacts on local food production, e.g. reduced local farming - Poor drinking water - Safe and appropriate places or facilities for physical activity - Reduced investment in programs that use facilities or programs that 'come and go' - Less access to specialist and allied health professionals and support	- Specific interventions and delivery mechanisms to support regional, rural and remote communities - Partnerships with communities to ensure community-led solutions (including with local stores) - Invest in production of more healthy packaged foods that last longer for remote communities - Transport subsidies - Funding community garden programs in regional and remote communities, including concentrating on traditional and native food - Focus on production of locally grown food and incentives for keeping produce local - Better access to safe drinking water in communities - Partnerships in community between settings (e.g. schools and workplaces) and food producers and stores - Infrastructure, paths and safer facilities for physical activity - Prioritise building workforce/capacity in regional and remote first

Lower socioeconomic / people experiencing disadvantage	
Key topics of discussion	Ideas from priority population groups
- Affordability and cost of healthier, fresh foods - Concerns about exclusion / stigma in some programs (including at school) - Less access to transport - Supply and demand in local stores leading to poorer options in community - Lower literacy to understand guidance and labelling - Food distributed by charities can be highly processed and packaged - Trauma, abuse and poor mental health is more prominent - Addiction	- Creating more awareness and incentives in communities of using food relief services that will deliver fresh food to communities - Ensuring food distributed by government funded services meets a higher standard - Subsidies – for fresh, healthy foods and transport - Healthy breakfast programs in schools and sending healthy, convenient food home from school to those in need, or fresh produce from school gardens - Vouchers for sport and fresh food options at markets/ stores - Facilities and sustained funding for programs in lower socioeconomic communities

Lower socioeconomic / people experiencing disadvantage cont…	
	• Peer- and community-led programs and campaigns • Build skills, practical use of fresh food and strategies to overcome potential literacy barriers • Incentivise local shops and supermarkets in lower socioeconomic communities to ensure healthy food is more accessible • Reduce junk food exposure and advertising • Medicare or other types of rebates / vouchers for gym membership and personal training • Link programs with social and welfare supports • Increase welfare support

People from culturally and linguistically diverse backgrounds including new migrants	
Key topics of discussion	Ideas from priority population groups
• Language barriers in understanding guidance/advice • Influence of supermarkets and placement of junk food • Unhealthy, fast-food options the cheapest • Rapid changes in diet among new migrants / refugees with exposure to more processed foods • Social expectations influencing choices • Over-indulgence as a sign of wealth; overweight not always perceived as negative • Food is used as a social connector • Cultural norms which impact physical activity, particularly for women • People who have experienced trauma may not be focused on healthier food choices as a priority	• Guidance and information to be translated and delivered through cultural/ethnic organisations • Focus on engaging with ethnic groups • Plain packaging of junk food with simpler labelling • Engage through workplaces and services – train ethnic community leaders to lead change in a culturally safe way • Conversation and storytelling about healthy food options • Programs for traditional cooking and sharing of foods and healthy recipes • Practical education programs to improve knowledge and skills including about 'western' groceries – e.g. buying and cooking foods • Support new migrants and refugees in first 12 months to integrate healthy food and drink into new lifestyles • Build programs into settlement services

People with disability

Key topics of discussion	Ideas from priority population groups
• Availability and choice of food in supported accommodation/ living and health care settings • Cost–statistically higher unemployment impacts incomes and ability to choose healthier options or participate in physical activities • Lack of support or accessible facilities for people with disability to be active • Lack of integration of health services with the NDIS - supports that may be needed for nutrition, weight loss interventions or active living may not be covered in NDIS plans as they're seen as a health issue. • Food sensitivities for people with neurological and psychosocial disabilities, and which may need specific supports • Effects of television advertising on people with intellectual disability, and their ability to think critically about what is said or marketed to them • Families with multiple children or parents and children with disability can be highly impacted by lack of choice and knowledge	• More training in nutrition and healthy food preparation for disability support workers who help people to make food choices and/ or prepare meals for people with disability they support • Policies, guidelines and mandates for what food and drinks are served in supported accommodation and care settings • Specific programs for supporting people with disability to get groceries and make their own food choices • Support for carers of children with disability to purchase food and drinks that will assist improved health for their child/ren • Education programs, including developing skills, in group home settings • Integrate strategies with NDIS supports, and/ or a health and wellness plan be developed alongside NDIS plans • Support for specialised dietitians and/ or therapists for children with disability to establish healthy eating habits early on, taking into account food sensitivities • Accessible infrastructure throughout community • Improve accessibility and inclusive practice at sports and other facilities in community • Increase welfare support

Young people

Key topics of discussion	Ideas from priority population groups
• Higher cost of fresh foods compared to other options • Unclear labelling and information about what is 'healthy' and what is not • Convenience and time poor – poorer food options often open later • Impacts of climate change of food production and being able to access natural environments and community for physical activity	• Meaningful incentives for young people to continue participating in sports or physical activity • Make product labelling clearer and ensure consistent messaging in health promotion • Consultation with young people, from different ages and cultural backgrounds • Invest in low or no cost programs to provide cooking skills and education to young people, with a focus on schools and low-income groups

Young people cont...

• Safety in active travel options, such as using public transport and walking or cycling • Concerns about focus on weight and body sizes • The intersection between physical health and mental health, noting that the impacts occur both ways • Changes in food purchasing, such as online restaurant ordering, impacting quantities and foods that are available to consume	• Improve referral pathways for young mental health consumers and specific actions to support the mental health and self-esteem of young people • Focus on/consider mental health of young people in all programs and interventions • Ensure information and programs are tailored to the needs of children and young people, in partnership with them (in accordance with the United Nations Convention on the Rights of the Child) • More clearly articulate strategies and links between environmental sustainability and impacts on fresh food production and health

Older people

Key topics of discussion	Ideas from priority population groups
• Changes in taste and smell which impact diet, and older people can be less motivated to eat • Older people often need different types of meal plans • Less choice of food and physical activity options in aged care settings • There are specific heathy eating guidelines for older people. Many people, including care professionals are not aware of these • Mobility impacts ability to be physically active • Mental health and illness impacting health and lifestyle • Isolation from community • Lack of income which makes buying heathier foods harder • Less ability to cook and prepare healthier foods in the home	• Practical education and easy to follow guidelines that are tailored for the older population • Better resourcing for aged care settings to provide healthier options • Training for cooks and staff in aged care settings to provide tasty, nutritious food • Continue investment in Meals on Wheels and similar programs that provide (generally) healthy food and also check up on people's wellbeing • Free, accessible spaces to walk in – parks and safe walking paths • Group activities tailored for older people such as Aquagyms and Tai Chi groups, that are low cost • Strategies that encourage movement throughout the day rather than pressure to participate, for example encouraging older people to continue gardening

People who are living with obesity	
Key topics of discussion	Ideas from priority population groups
• Perceive there's a lack of involvement of people who are overweight and obese in policy design and strategy development • Mental health issues, which can be a result of being overweight, and may impact access to support • Stigma • Fear of shame or experiencing prejudice, particularly if engaging in physical activity. • Additional barriers to physical activity and access • Facilities not accessible • Inadequate equipment resources in health facilities and OH&S support to ensure bariatric people are handled safely • Access to treatment options • Healthy food and drinks can be too expensive	• Involve people with obesity in strategy development and implementation • Better understand issues and barriers being faced by people with obesity, co-design programs with their input • Training for health professionals to reduce stigma and improve referrals to appropriate services • Improved strategies and education programs to deal with stigma in community • Positive strategies that show diverse bodies and shapes in marketing • Weight management programs that are accessible and low cost • Programs during pregnancy to manage weight gain and reduce risk factors • Counselling and similar supports • Inclusion of treatment for obesity in the strategy • Make facilities and infrastructure more accessible to all

Appendices B, C and D are available to download as separate files:

Appendix B: Community discussions

Appendix C: List of organisations who made formal contributions and submissions

Appendix D: Supporting charts