City of Manningham

State of the City and Health Needs Analysis: 2020

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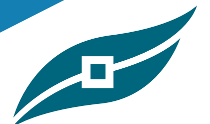

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Executive Summary

The document provides an overview of the policy and legislative context for health and wellbeing planning in Manningham; an evidence-based snapshot of key health and wellbeing, climate change, housing and economic indicators; and, an analysis of health needs to inform the development of the next municipal public health and wellbeing plan.

The health needs analysis is structured around the ten priorities outlined in the Victorian Public Health Plan 2019-2023. Four of the priorities have been designated by the Victorian Government as focus areas, namely climate change; healthy eating; active living; and, tobacco use. A range of publicly available and for-purchase datasets were used as the basis for the health needs analysis from which key results are outlined below:

1. **Tackling climate change and its impact on health**
   Manningham Council as an organisation is on track to achieve its target of a 25% reduction in CO_2 emissions (2008 baseline). However, municipal CO_2 emissions increased 3.9% from 2017/18 to 2018/19, as did residential CO_2 emissions per capita increased (from 3.01 tonnes to 3.10 tonnes). The data suggests an enhanced role for MC in supporting community emissions reduction and climate change adaption. Further investigation is required to better understand the intersection and impacts of climate change with health and wellbeing outcomes in Manningham.

2. **Reducing injury**
   Between 2015 and 2020, Manningham experienced 7,789 hospital admissions due to falls. The majority occurred in the 80 to 89 age cohort, representing 35% of the total number of admissions. This number is significantly higher than the Victorian percentage of 26%. As such, falls are a significant cause of injury in older Manningham residents, particularly among older females, with the 80 to 89 age cohort representing 21.6% of the total hospital admissions.

   From 2015/16 to 2019/20, Manningham residents were treated for 771 intentional injuries in hospital. They had either intentionally self-harmed or been involved in an assault. Those in the age category 20 to 29 years accounted for 24% of the total intentional injuries treated.

   In the five years from 2014 to 2018, 10 people died and 475 people were hospitalised due to traffic accidents in Manningham. Accident victims in Manningham are more likely to be female and older in comparison to metropolitan Melbourne, and, two-thirds of accidents occur on major roads. The data indicates the need for greater awareness of road safety, particularly among the older population, along with advocacy and partnerships with VicRoads and the State Government to reduce the injuries and deaths on Manningham's major transport corridors.

3. **Preventing all forms of violence**
   Crimes are categorised as drug offences, public order or security offences, justice procedures offenses, crimes against a person, most commonly in the form of family violence and violence against women. Significant health and wellbeing impacts from crimes may impact negatively in terms of fear of crimes, limitations to people's everyday activities, limiting social interaction and physical activity.

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Whilst Manningham continues to be one of the safest municipalities in Victoria, there has been a 37.6% increase in the number of offences since 2011 (Victoria: 22.4%). Manningham experiences the same types of crime as elsewhere across the state, with property and deception offences (72%) and crimes against the person (16.6%) most common. Crimes against the person increased in Manningham from 342 in 2011 to 522 in 2019.

Family violence causes physical and mental health impacts, social isolation from family and friends, food insecurity, displacement of housing, loss or limited employment and even death. It is estimated that it costs Australia $21.7bilion dollars a year to address family violence incidences (Vic Health 2015). Despite having a significantly lower level of reported family violence than the Victorian average, there were nonetheless 708 family violence incidents in the 12-months to March 2019 affecting people of all ages. Those affected were primarily female, and those responsible for the violence were primarily male. People aged 45+ years account for 40% of those affected (Victoria: 30%) most likely a consequence of the municipality's older age profile. Furthermore, regional and Victorian data indicates that women with disability; LGBTQIA+ people, people from culturally diverse backgrounds, and Aboriginal and Torres Strait Islander peoples are significantly more likely to experience family violence than the wider community.

In regards to LGBTQIA+ data there is a significant gap as many organisations do not have inclusive forms or may not ask clients if they identify as LGBTQIA+. It is also evident many people who experience family violence may not call the police. The violence may be emotional, spiritual, and financial. In addition, there may be stigma or fear of the police which may prevent someone seeking help. The crime and family violence data indicates an ongoing need for community policing; engagement and partnerships with stakeholders support for the local delivery of state government initiatives (e.g. the "Call it Out" campaign targeting males); and advocacy and support for services for women and their families fleeing violence. Further, initiatives should have an inclusive approach to include all people's needs and experiences and ongoing commitment to work with partners around addressing the root cause of violence against women – gender inequity.

One-quarter of older people aged 75+ years do not feel safe walking alone during the day, and only 29.3% of females feel safe walking alone at night. People with disability are only half as likely to feel safe walking alone during the day and two-thirds as likely to feel safe walking alone at night, compared to people without disability. Perceptions of safety impact upon an individual's mental health and wellbeing, and their willingness to engage in physical activity.

4. **Increasing healthy eating**

A healthy diet is a significant protective factor against many diseases. Only half of Manningham's population eat sufficient daily serves of fruit, and only one in 10 people eat sufficient daily serves of vegetables. There has been little change in consumption habits since 2011. Females tend to eat more healthily than males – with males eating proportionally less fruit and vegetables and more takeaway/snacks. Victorian data indicates that people with disability are one third more likely to purchase takeaway food or snacks at least three times per week, compared to people without disability. The proportion of Manningham residents who experience food insecurity is consistent with the Victorian average, with females twice as likely as males to experience food insecurity.

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The data indicates the need for partnerships and initiatives designed to support positive behaviour change; to influence local food environments to increase the accessibility of healthy foods; and, support for targeted programs to address food insecurity.

5. **Decreasing the risk of drug resistant infections in the community**
   Further exploration is required to determine the most appropriate role for local government within the context of the *National Anti-Microbial Resistance Strategy – 2020 and Beyond* for reducing the risk of drug resistant infections in the community.

6. **Increasing active living**
   Active living is a significant protective factor against obesity and disease, and supports mental wellbeing. Only half of the Manningham adult population meet the *Australian Physical Activity Guidelines*, and almost one in five people engage in no physical activity each week. People with disability are 40% less likely to be physically active than people without disability who, along with LGBTQIA+ and culturally diverse people, may be less inclined to join sports clubs and fitness centres unless it has a welcoming, inclusive culture. In the period 2014-2018, only one in every four young people in Inner Eastern Melbourne did the recommended amount of physical activity every day, and the proportion of young children (commencing primary school) in Manningham whose physical health and wellbeing was "on track" declined from 88.5% (2012) to 77.8% (2018). Approximately half the Manningham population is either overweight or obese.

   The data indicates the need to leverage the municipality's excellent sporting, recreation and natural assets to increase levels of physical activity across the entire population, particularly among young people, LGBTQIA+ people, people with disability, people from culturally diverse backgrounds and older people.

7. **Improving mental wellbeing**
   The subjective wellbeing of Manningham residents is consistent with the wider Victorian average. However Victorian data indicates that LGBTQIA+ people, people with disability and people with very low incomes tend to experience lower levels of subjective wellbeing.

   Similarly, self-reported life satisfaction in Manningham is consistent with the wider Victorian average. However young people aged 18 to 24 years, people with disability, people with low incomes and people from culturally diverse communities reported a lower level of life satisfaction.

   Manningham residents report a lower incidence of depression and anxiety than the Victorian average mainly due to a lower rate among males, although it is unclear if this is due to a under reporting. Manningham females have a higher rate of depression and anxiety than males, consistent with the Victorian average.

   From July 2015 to March 2020, there were a total of 3,509 mental health diagnostic presentations to Metropolitan public hospitals by Manningham residents, representing 2.81% of Manningham's total emergency department presentations for that time period. Of note is the number of Manningham females presenting to the emergency department with a psychiatric illness compared to the state figure (44.84% versus 39.55% respectively).

   Ninety-nine people in Manningham died by suicide in the ten-year period from 2010 to 2019, and up to 3,000 people *may* have attempted suicide during the same period. It should be noted that overlap exists between the Victorian Public Health and Wellbeing Plan 2019-

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2023 priorities of *reducing injury* and *preventing all forms of violence.*

The data indicates a need for advocacy and funding for more and accessible services to support mental wellbeing, as well as innovative, local programs which enable social connections and healthy lifestyle choices. There are currently insufficient services available, and significant waiting lists to access those which are available.

8. **Improving sexual and reproductive health**
Manningham's fertility rate is lower than the Victorian average and that of neighbouring Councils in the Eastern Metropolitan Region, most likely due to its older population profile. The municipality has a lower incidence of sexually transmitted infections (STI), with around 300 people infected with a STI each year - the majority being younger people. Chlamydia is most common and affects males and females equally; whereas gonorrhoea and syphilis infections are almost exclusively among males. Manningham's cervical screening participation rates are consistent with the wider Victorian average, with approximately two-thirds of women participating in the previous two years (note: since 2017, cervical screening occurs every five years) The data indicates ongoing awareness and education regarding safe sexual practices is required, particularly among young people and MSM (men who have sex with men).

9. **Reducing tobacco-related harm**
Smoking is the leading cause of preventable health burden in Australia, though it is less prevalent in Manningham compared to the state. However, Aboriginal and Torres Strait Islander peoples and LGBTQIA+ people are significantly more likely to smoke and, in 2017, 8% of 16 to 17 year-olds in secondary school reported smoking. Australian research also suggests a higher prevalence of smoking among people from Arabic, Indian, Chinese and Vietnamese cultural backgrounds. The data indicates an opportunity to partner in the delivery of state government anti-smoking and smoking cessation programs, and the need for further investigation into whether targeted programs are required for specific cohorts.

10. **Reducing harmful alcohol and drug use**
Each year in Manningham, 10 to 20 people die due to alcohol-related causes and 400-500 people are admitted to hospital for alcohol-related reasons. People of all ages are admitted, with males more likely to be admitted than females. In 2018, more than half of young people in the Inner Eastern Melbourne region reported having drunk alcohol (more than a few sips) on at least one occasion, and 11.3%-14.8% of Manningham residents exceed the recommended daily maximum of two standard alcoholic drinks. Younger people, people with mental illness and LGBTQIA+ people are more likely to consume alcohol at levels which exceed the lifetime risk guidelines.

    The data clearly indicates that harmful alcohol consumption is an issue in Manningham. Opportunities exist to explore partnership opportunities to deliver state government awareness and education programs, and to consider targeted initiatives for specific cohorts, and advocacy for accessible support services.

Rather than being a relatively affluent municipality with "not much to see" in terms of health and wellbeing challenges, it is clear that the Manningham community experiences all the challenges of other communities. Furthermore, regional and Victorian data suggests that some cohorts are likely to experience these health and wellbeing challenges more keenly: people with disability, women, young people, Aboriginal and Torres Strait Islander peoples, LGBTQIA+ people, people from

culturally diverse backgrounds and older people. In the absence of published data, stronger relationships need to be developed with Council and local service providers to better understand local experience and enable the development of partnership-based responses.

Furthermore, the COVID-19 pandemic appears to be having a significant impact on people's health and wellbeing. At the time of writing very limited data is available, however there are indications of a significant impact on mental wellbeing; increased rates of family violence; increased food insecurity; increased loneliness and isolation due to social distancing and other restrictions; and financial hardship. Uncertainty surrounding the spread of the virus; the length and severity of restrictions (i.e. lockdown); the likelihood and availability of a vaccine, and the severity and duration of the economic impact means that COVID-19 is likely to be front and centre in health and wellbeing planning for the foreseeable future. Furthermore, it is important to recognise the gendered nature of the pandemic, with the shutdown of female-dominated industries (retail, hospitality); additional schooling and caring responsibilities at home; and the high proportion of females in healthcare frontline (nursing) who are at greater risk of contracting COVID-19.

All ten priority areas are important and of relevance to Manningham, however six priorities have been escalated as a result of the analysis (in no particular order):

1. Tackling climate change and its impact on health
2. Increasing active living
3. Increasing healthy eating
4. Improving mental wellbeing
5. Preventing all forms of violence
6. Reducing injury.

However, the data underpinning the analysis is quantitative and, in some cases, it is a number of years old. Furthermore, a genuine partnership approach involving Councillors, community, businesses, government agencies and service providers will be required if the next municipal public health and wellbeing plan is to achieve positive, sustainable impacts. It is therefore recommended that consultation be undertaken on nine of the ten priorities, using the data contained in this report as a starting point for the conversation. Insights from the lived experience of community, the experience of local service providers and the perspective of government agencies working across multiple LGAs in the Eastern Metropolitan Region will provide invaluable information about what really is important to the community and assist in identifying where good work is already underway. This, in turn, will help to engender greater commitment among partners towards achieving the agreed priorities and promote enhanced alignment of effort.

In addition to engaging in extensive consultation, it is recommended that a mapping exercise be undertaken – using the available research – to better understand the relationship between the nine priorities, and their relationship to the social determinants of health. The resulting insights will enable a more nuanced understanding among decision makers of the complexity of factors which influence health and wellbeing, and will thereby assist in broadening the field of potential policy and program responses.

This report has endeavoured to utilise inclusive and respectful language and terminology to align with Manningham Council's *Inclusive Language Guide*. However, it is acknowledged that language preferences vary between individuals and with time and context. This document also recognises that some formal titles of reports and studies cited in this report are unable to be altered, despite the fact that they may feature outdated language.

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INTRODUCTION

This document serves three primary purposes:

1. To provide an overview of the policy and legislation that impacts upon municipal health and wellbeing planning.
2. To provide an updated "State of the City" report (previously published in 2013) detailing a comprehensive overview of the current state of health and wellbeing in the municipality.
3. To analyse the health needs of the municipality to inform the development of the next municipal public health and wellbeing plan (2021 to 2025).

The structure of the document reflects its primary purposes.

Section 1 provides an overview of key federal, state and local policy and legislation which impact upon health and wellbeing outcomes in Manningham. Policy and legislation relating to the inclusion of different communities is considered (e.g. Aboriginal and Torres Strait Islander peoples, people with disability, LGBTQIA+ people, culturally diverse people) as well the National Health Priorities. In addition, policy and legislation relating to each of the ten priorities identified in the Victorian Public Health and Wellbeing Plan 2019-2023 are explored.

Section 2 presents a picture of how Manningham is currently faring and its recent trajectory in relation to a wide range of health, wellbeing, environmental and economic indicators. The data included is sufficiently rich to provide a comprehensive municipal overview, however it is by no means exhaustive. As such, it is hoped that the data will serve as a springboard for further enquiry, particularly with regard to understanding the impact of intersectionality on health and wellbeing, and on exploring the relationship between comorbidity and the social determinants of health.

Section 3 includes an analysis of health needs as assessed against the nine priorities contained in the Victorian Public Health and Wellbeing Plan 2019-2023. The analysis is intended to inform a consultation process with key service providers, government agencies and the community with regard to the development of the next municipal public health and wellbeing plan.

Data was selected for inclusion in this report on the basis of availability, currency and cost.

The impact of COVID-19 is being keenly felt by the community. However, at the time of writing, little data is available on the wider health and wellbeing impacts of the virus. Media reports indicate - in addition to the health impacts of the virus itself and its global/national/local economic impact - that family violence, depression and anxiety, food insecurity, isolation and loneliness and the harmful consumption of alcohol are increasing. As at August 2020, the Victorian Coroner's Court advised there has been no significant increase in the number of people who have died by suicide since the onset of the pandemic. Furthermore, the uncertain trajectory of the infection rate; the uncertainty regarding the development of a vaccine; the need for continued restrictions on movement and social distancing; and the depth and duration of the economic downturn all indicate that COVID-19 will remain at the forefront of community health and wellbeing planning for the foreseeable future. It is therefore vital that the data and analysis included in this report be supplemented with emerging COVID-19 data as it becomes available, and that COVID-19 will be a lens through which the priorities of the next municipal public health and wellbeing plan be assessed.

The Victorian Population Health Survey is a key data source used throughout this report. However, at the time of writing the 2019 survey results had not been released and therefore the 2017 results were the most recently available.

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POLICY LANDSCAPE

Federal, State and Local

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Local government has a responsibility to plan for the health and wellbeing of the local community, in accordance with the following legislation:

1. The *Local Government Act 2020* specifies the role of Council as "provid[ing] good governance in its municipal district for the benefit and wellbeing of the municipal community".
2. The *Municipal Public Health and Wellbeing Act 2008* requires that each Council develop a municipal public health and wellbeing plan every four years to drive improved health and wellbeing outcomes in the municipality. Councils are required to report annually on the progress made.

The municipal public health and wellbeing plan is a key strategic document which sits alongside the Council Plan. Manningham's current municipal public health and wellbeing plan *(Healthy City Strategy 2017-2021)* outlines an evidence-based and partnership-based approach to support health and wellbeing in the community, particularly among vulnerable and disadvantaged cohorts. Key focus areas and priorities in the current *Healthy City Strategy 2017-2021* appear below:

Focus area	Priority
Inclusive and harmonious	An inclusive, diverse community
	Generation friendly
Healthy and well	Healthy mind
	Healthy lifestyles
	Quailty service system
Safe and resilient	A safe community
	A resilient community
Connected and viabrant	Creative community
	Sense of place
	Involved community

Figure 1. Healthy City Strategy 2017-2021, Focus Areas and Priorities

The *Healthy City Strategy* is scheduled to conclude June 2021 and attention is now shifting towards the development of a new municipal public health and wellbeing plan.

The *Victorian Public Health and Wellbeing Plan 2019-2023:* *https://www2.health.vic.gov.au/about/publications/policiesandguidelines/victorian-public-health-wellbeing-plan-2019-2023* identifies ten priorities for improving health and wellbeing across the state, of which four have been designated *focus areas* for specific action (in ***bold italics***):

1. ***Tackling climate change and its impact on health***
2. Reducing injury
3. Preventing all forms of violence
4. ***Increasing healthy eating***
5. Decreasing the risk of drug resistant infections in the community
6. ***Increasing active living***
7. Improving mental wellbeing
8. Improving sexual and reproductive health
9. ***Reducing tobacco-related harm***
10. Reducing harmful alcohol and drug use

The *Victorian Public Health and Wellbeing Plan 2019-2023* provides a useful framework for the development of Manningham's next municipal public health and wellbeing plan.
This next section outlines key policy and legislation across federal, state and local government regarding:

1. The inclusion of vulnerable, disadvantaged and priority cohorts
2. The 10 priorities in the Victorian Public Health and Wellbeing Plan 2019-2023
3. Reducing the burden of disease as per the National Health Priority Areas
4. Key local policies, engagement and research

1. Inclusion

1.1. People with Disability

Federal

The *2010-20 National Disability Strategy* was adopted by the Council of Australian Governments (COAG) on 11 February 2011 with the aim to achieve the shared vision of an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens. The Strategy covers six policy areas:

1. Inclusive and accessible communities—the physical environment including public transport; parks, buildings and housing; digital information and communications technologies; civic life including social, sporting, recreational and cultural life.
2. Rights protection, justice and legislation—statutory protections such as anti-discrimination measures, complaints mechanisms, advocacy, the electoral and justice systems.
3. Economic security—jobs, business opportunities, financial independence, adequate income support for those not able to work, and housing.
4. Personal and community support—inclusion and participation in the community, person-centred care and support provided by specialist disability services and mainstream services; informal care and support.
5. Learning and skills—early childhood education and care, schools, further education, vocational education; transitions from education to employment; and, life-long learning.
6. Health and wellbeing—health services, health promotion and the interaction between health and disability systems; wellbeing and enjoyment of life.

In 2013, the National Disability Insurance Scheme (NDIS) was established to provide funding to Australians with permanent and significant disability to ensure they can access the support they need to strengthen their skills and independence over time. The NDIS is managed by the National Disability Insurance Agency (NDIA). Eligible persons are allocated funding and a plan is developed – either by the NDIA or a registered provider – to utilise the allocated funding to access appropriate support and services. The NDIA is also responsible for supporting the establishment and regulation of a competitive market of service providers to ensure the availability of services and support which are high quality and value for money.

Key federal legislation includes:

1. *Disability Discrimination Act (DDA) 1992*
2. *National Disability Insurance Scheme Act 2013*
3. *Disability Services Act 1986*

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Complaints regarding direct or indirect discrimination prohibited under the *Disability Discrimination Act 1992* are considered by the Australian Human Rights Commission.

State

The Victorian Government's disability plan, *Absolutely everyone 2017-2020* aims to tackle the barriers and exclusion that people with disability experience on a daily basis. The plan is structured around four pillars including:

1. *Inclusive communities* (universal design and intersectionality)
2. *Health housing and wellbeing* (affordable housing, sport and recreation, vulnerable families and NDIS transition)
3. *Fairness and safety* (family violence and advocacy)
4. *Contributing lives* (inclusive education, employment and voice)

Consultation to inform the development of the Victorian Government's *Disability Plan 2021-2024* is underway at the time of writing. In February 2020, Council, in consultation with the community, prepared a submission to the State Government on the *Disability Plan 2021-2024*.

The Victorian Government funded the Metro Access program until 2019 to enable local governments to provide opportunities for inclusion of people with disability. Some local governments have retained their Metro Access Officers or created new disability positions in order to retain their Metro Access staff and capability.

Key Victorian legislation includes:

1. *Disability Act 2006*
2. *National Disability Insurance Scheme Transition Amendment Act 2019*
3. *Victorian Equal Opportunity Act 2010*
4. *Charter of Human Rights and Responsibilities Act 2006*

Complaints regarding direct or indirect discrimination on the basis of disability under the *Victorian Equal Opportunity Act* are considered by the Victorian Equal Opportunity and Human Rights Commission.

Local

Under the *Disability Act 2006*, Council is required to prepare a Disability Action Plan which currently sits within the *Healthy City Action Plan 2017 – 2021.* This is an organisation wide responsibility and responds to common barriers such as: physical access to buildings, access to information, access to community services and programs, and access to employment.

Council employs a Community Development Officer (Access and Inclusion) to design and deliver initiatives which seek to address these barriers and support the inclusion of people with disability in Manningham.

The *Access and Equity Advisory Committee* provides advice to Council on issues affecting Manningham's diverse communities, including people with disability. However, Council recently endorsed the establishment of a Disability Advisory Committee. Commencing in 2021, by way of Expression of Interest, the Committee will reflect best practice, with membership predominantly compromised of Manningham residents with lived experience of disability, and a smaller proportion of carers.

1.2. Lesbian, Gay, Bisexual, Transgender and gender diverse, Queer and questioning, Intersex and Asexual (LGBTQIA+) People

Federal

The *Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* amended the *Sex Discrimination Act* to make it unlawful to discriminate against a person on the basis of their sexual orientation, gender identity or intersex status. Complaints of discrimination are considered by the Australian Human Rights Commission.

In 2017, following completion of the Australian Marriage Law Postal survey, the *Marriage Act 1961 (Cth)* was amended so as to redefine marriage as ‘a union of two people’.

State

The *Victorian Equal Opportunity Act (2010*) prohibits discrimination in employment, sexual harassment and victimisation at work on the basis of a range of attributes including gender identity and sexual orientation.

In 2014, Victoria’s first Minister for Equality was appointed and in 2015, Victoria’s first Commissioner for Gender and Sexuality was appointed. The Minister and Commissioner are supported by the LGBTQIA+ Taskforce.

In 2016, the Victorian Premier apologised to those previously convicted under laws that criminalised homosexual acts, following decriminalisation in 1980 and the expunging in 2014 of criminal convictions related to homosexuality.

At the time of writing, the Victorian Government was undertaking public consultation to inform the development of its LGBTQIA+ Strategy.

Local

The *Diversity and Inclusion Action Plan 2020-2021* outlines Council’s approach for ensuring the inclusion of all people in Manningham, including LGBTQIA+ people.

The Diversity and Inclusion Working Group provides advice to Council on matters in relation to Manningham’s LGBTQIA+ community.

1.3. Aboriginal and Torres Strait Islander Peoples

Federal

Closing the Gap

In December 2007, COAG committed to achieving health equality (measured as life expectancy equality) for Aboriginal and Torres Strait Islander peoples. Widely known as “Closing the Gap’, the approach identified the following specific targets:

1. close the gap in life expectancy by 2031
2. halve the gap in child mortality by 2018
3. ensure 95 percent of Aboriginal and Torres Strait Islander four-years-olds are enrolled in early childhood education by 2025
4. halve the gap in reading, writing and numeracy by 2018
5. halve the gap in year 12 attainment by 2020

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6. halve the gap in employment by 2018
7. close the gap in school attendance by 2018 (this target was added in May 2014)

In addition, a range of "building blocks" were identified which influence the underlying determinants of health and wellbeing, including early childhood; schooling; health; economic participation; healthy homes; safe communities; and, governance and leadership.

In 2016, COAG agreed to refresh the Closing the Gap agenda ahead of its tenth anniversary and with four of the targets due to expire. Two of the seven targets were on track to be met by 2018.

In 2017, COAG agreed that the refresh should adopt a strengths-based approach and to ensure the centrality of Aboriginal and Torres Strait Islander peoples in the development and implementation of the strategy. In December 2018, COAG released a statement on the refresh, including the draft strengths-based framework and revised targets. The fifteen Commonwealth-led and State-led targets relate to the policy themes of families, children and youth; health; education; economic development; housing; justice; including youth justice; and, land and waters. State and Territory Governments are required to publicly report on an annual basis regarding their progress towards achieving the targets.

Specific strategies and policies designed to support the achievement of the Closing the Gap targets include:

1. *National Aboriginal and Torres Strait Islander Health Plan 2013-2023*
2. *National Aboriginal and Torres Strait Islander Education Strategy (2015)* outlines a set of principles and priorities to inform jurisdictional approaches to Aboriginal and Torres Strait Islander education.
3. *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013*
4. *National Aboriginal and Torres Strait Islander Cancer Framework 2015*
5. *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*
6. *National Aboriginal and Torres Strait Islander Peoples Drug Strategy 2014–2019*

The National Indigenous Australians Agency (NIAA) was established in 2019 and is responsible for implementing the Commonwealth Government's policies and programs to improve the lives of all Aboriginal and Torres Strait Islander peoples.

The *Indigenous Advancement Strategy* consolidates a number of existing programs and policies in three priority areas: getting children to school, adults into work and building safe communities. The NIAA is responsible for overseeing implementation of the *Indigenous Advancement Strategy*.

State

Victorian Aboriginal Affairs Framework 2018-2023

The Framework outlines the Victorian Government's plan for working with Aboriginal communities and organisations, changing structures and systems, and enabling self-determination to improve Aboriginal and Torres Strait Islander peoples' health outcomes. The Framework recognises the importance to prioritise culture; address trauma and support healing; address racism and promote cultural safety; and, to transfer power and resources to communities. The approach aims to address structural and systemic barriers, and to empower Aboriginal and Torres Strait Islander Victorians. It also aims to ensure universal and targeted services are safe, relevant and accessible so that Aboriginal and Torres Strait Islander Victorians are able to confidently access the services they need to help them thrive.

Treaty

In 2016, the Victorian Government announced its intention to establish a treaty with Aboriginal and

Torres Strait Islander Victorians. The three-phase process included:

1. Extensive consultation; appointment of a Victorian Treaty Advancement Commissioner and the establishment of a First People's Assembly of Victoria
2. Establishment of an independent Treaty Authority; development of a treaty negotiation framework and creation of a self-determination fund.
3. Treaty negotiations between the State and Aboriginal negotiating parties.

In July 2020, an Aboriginal Truth and Justice Commission was established. The First People's Assembly of Victoria is leading the Commission, and the truth and justice process is occurring in parallel with the treaty process.

Key polices relating to the health and wellbeing of Aboriginal and Torres Strait Islanders peoples in Victoria include:

1. *Korin Balit-Djak* – to improve health wellbeing and safety
2. *Balit Murrup* – to support social emotional wellbeing and mental health
3. *Koolin Balit* – a health strategy to increase life expectancy

Local

Manningham Council is situated entirely within Wurundjeri Woi wurrung homelands, the traditional custodians of the land. MC has been involved with reconciliation efforts since 1997, since which time it has developed a number of policies and Reconciliation Action Plans (RAP) to guide its efforts. In 2019 Manningham Council formed a RAP Working Group comprised of Aboriginal and/or Torres Strait Islander community members, representatives from a range of agencies and Council to guide the development and implementation of the RAP. Council has established regular Cultural Consultations with Elders and staff of the Wurundjeri Woi wurrung Cultural Heritage Aboriginal Corporation.

1.4. Culturally Diverse People

Federal

The *Racial Discrimination Act 1975 (Cth)* prohibits discrimination on the basis of race, colour, descent, national origin or ethnic origin, or immigrant status. The RDA protects people in many areas of public life including employment, education, getting or using services, renting or buying a house or unit, and accessing public places.

Multicultural Australia: United, Strong, Successful is the Federal Government's multicultural statement.

State

The *Racial and Religious Tolerance Act 2001* prohibits vilification, defined as behaviour that incites or encourages hatred, serious contempt, revulsion or severe ridicule against another person or group of people because of their race and/or religion. Complaints are considered by the Victorian Equal Opportunity and Human Rights Commission.

The *Multicultural Victoria Act 2011* outlines the principles underpinning Victoria's multiculturalism, and establishes the Victorian Multicultural Commission which is supported by Regional Advisory Councils.

The Victorian Government's multicultural policy statement *Victorian and Proud of It.* outlines a range of initiatives designed to support inclusion of people from migrant backgrounds, and to support people from migrant or refugee backgrounds in staying connected to their cultural traditions. It is underpinned by the *Victorian Values Statement* which articulates the rights and responsibilities shared by all Victorians.

Local

Manningham Council has a number of policy and program initiatives which respond to the municipality's cultural, religious and linguistic diversity, including:

1. Access and Equity Advisory Committee
2. Healthy City Strategy 2017-2021
3. Support for a range of ethno-specific and multicultural organisations (e.g. Chinese Social Services, Women's International Friendship Group, Manningham Interfaith Network) and festivals (e.g. Persian Fire Festival, Chinese New Year) through Manningham's community grants program.

1.5. Gender Equality

Federal

Key Commonwealth legislation with regard to gender equality includes:

1. The *Sex Discrimination Act 1984* protects people from unfair treatment on the basis of their sex, sexual orientation, gender identity, intersex status, marital or relationship status, pregnancy and breastfeeding. It also protects workers with family responsibilities and makes sexual harassment illegal. Complaints are considered by the Australian Human Rights Commission.
2. The *Workplace Gender Equality Act 2012* aims to:
    a. promote and improve gender equality (including equal remuneration for all genders) in employment and in the workplace
    b. support employers to remove barriers to the full and equal participation of women in the workforce
    c. promote, amongst employers, the elimination of discrimination on the basis of gender in relation to employment matters (including in relation to family and caring responsibilities)
    d. foster workplace consultation between employers and employees on issues concerning gender equality in employment and in the workplace
    e. improve the productivity and competitiveness of Australian business through the advancement of gender equality in employment and in the workplace.

The Workplace Gender Equality Agency oversees implementation of the *Workplace Gender Equality Act 2012.*

State

Safe and Strong is the Victorian Government's gender equality strategy. The strategy identifies four areas for action:

1. Leadership, empowerment and cultural change
2. Safety and freedom from gender-based violence
3. Economic security
4. Health and wellbeing

The Victorian Government's gender equality efforts are led by the Minister for Women, with support from the Ministerial Council on Women's Equality.

The *Gender Equality Act 2020* requires public sector organisations to undertake Gender Impact Assessments and to develop Gender Equality Action Plans every four years (commencing March 2021)

to improve gender equality in the work place, and to report publicly on progress every two years. The legislation also established the Public Sector Gender Equality Commissioner.

Local

Manningham Council has a number of policy and program initiatives in relation to gender equality

1. Access and Equity Advisory Committee
2. Gender Equity Working Group
3. Participation in the Gender Equality Local Government Implementation Project
4. Women's Health East – Our Watch training
5. Establishment of an internal Diversity and Inclusion Working Group and Action Plan
6. Inclusive Sporting Clubs project in partnership with Access Health and Community which is building the capability of participating clubs to be more gender inclusive.

1.6. Older People

Federal

The Commonwealth Government does not have a formal ageing policy per se, however it is responsible for aged care and services. An assessment is required to access Commonwealth-funded services for people aged 65 and over. There are two levels of assessment:

1. Regional Assessment Services (RAS) conduct Home Support Assessments to assess people's eligibility for entry level home help services through the Commonwealth Home Support Programme (CHSP).
2. Aged Care Assessment Services (ACAS) conduct comprehensive assessments to assess people for eligibility to access higher level services, including Commonwealth-funded residential aged care, residential respite care, Transition Care Programme (TCP), Short Term Restorative Care Program, Home Care Packages, as well as the CHSP.

Both levels of assessment are managed in Victoria by the Department of Health and Human Services on behalf of the Commonwealth Government.

The *Aged Care Act 1997* provides the overarching framework for the provision and regulation of federal government-funded aged care. In 2018, the *Aged Care Quality and Safety Commission Act* established a new Commission to assess and monitor the quality of care and services.

In October 2018, the Royal Commission into Aged Care Quality and Safety was established to examine the quality of aged care services in Australia; to consider how services should best be delivered for people with disability and with dementia; and, to explore how best to establish and support a high quality, person-centred, sustainable service system. In October 2019, the Royal Commission tabled its interim report entitled *Neglect* in Parliament. It is scheduled to table its final report in Parliament in February 2021.

State

In Victoria, ageing policy is the responsibility of the Minister for Disability, Ageing and Carers. The Commissioner for Senior Victorians advocates to government on the needs of older Victorians.

The Victorian Government fulfils a range of roles in relation to ageing including:

1. Delivery of the supported independent living program to enable older people to live independently for longer.
2. Regulation of Supported Residential Service (SRS) providers which deliver short- and longer-term accommodation and support services to people who need help with everyday activities.

3. Funding and support for public sector residential aged care services (PSRACS). PSRACS provide access to services for older people with more complex care needs, as well as specialist mental health residential services for older people.
4. Funding of wellbeing and participation initiatives designed to support age-friendly communities, and health, wellbeing and security for older Victorians.

Local

Manningham Council has a range of policies, programs and engagement mechanisms in place to support healthy ageing, including:

1. Manningham Positive Ageing Alliance
2. Dementia Friendly Inclusive Manningham Action Plan 2017-2019
3. Positive Ageing Action Plan 2019-2021

In 2017, Manningham Council signed the Age-Friendly Victorian Declaration, endorsing the importance of partnership between government, community and business sectors to work together to achieve age-friendly communities.

Historically, Manningham Council has delivered a range of government-funded services to support independent living among older people and people with disability (e.g. Home and Community Care), however this is currently undergoing a process of realignment as some clients have transitioned to the NDIS.

2. National Health Priority Areas

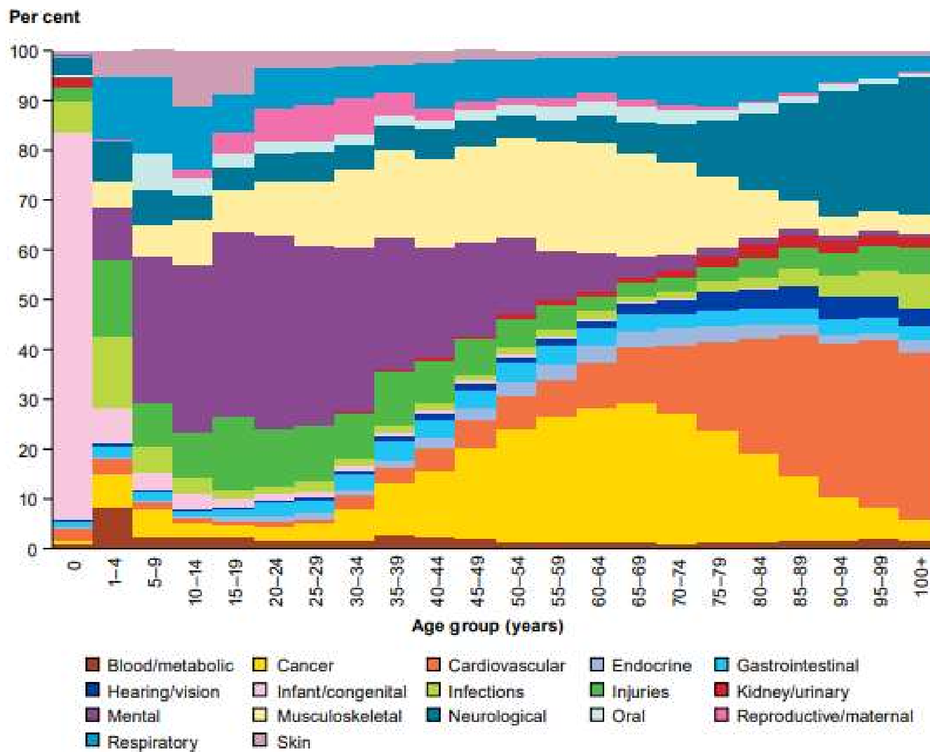
The National Health Priority Areas (NHPA) consist of nine diseases and conditions that make the most significant contribution to the burden of illness and injury in Australia. Four NHPAs were initially agreed in 1996 and a further five priorities were added by 2012:

1. Cancer control (1996)
2. Cardiovascular health (1996)
3. Injury prevention and control (1996)
4. Mental health (1996)
5. Diabetes mellitus (1997)
6. Asthma (1999)
7. Arthritis and musculoskeletal conditions (2002)
8. Obesity (2008)
9. Dementia (2012)

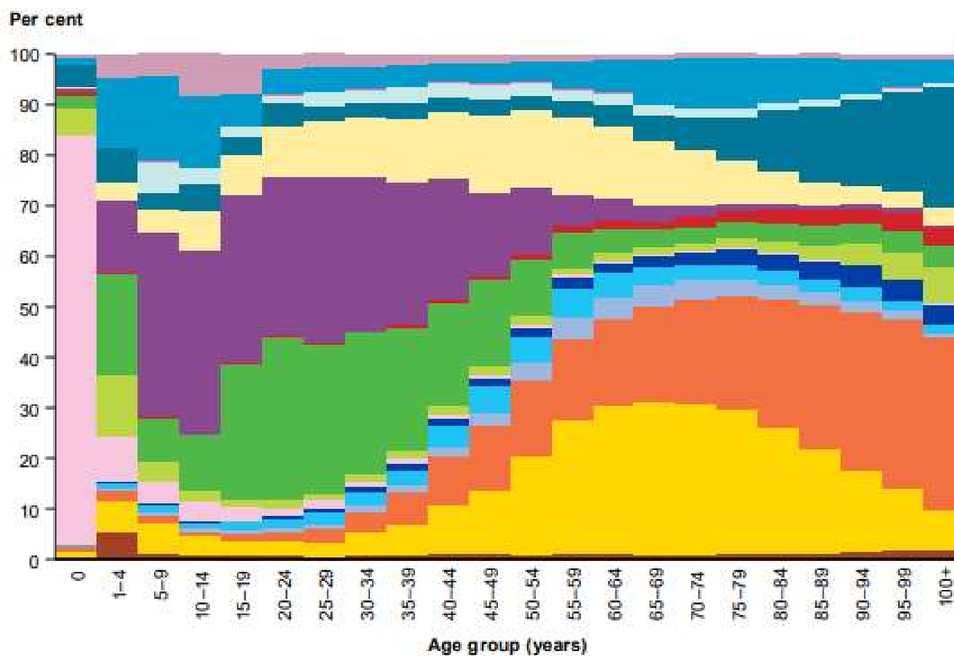
The *Australian Burden of Disease Study 2015* found that 65% of the disease burden in Australia was due to cancer, cardiovascular diseases, musculoskeletal conditions, mental and substance abuse disorders, and injuries. Furthermore, 38% of the disease burden was preventable and due to modifiable risk factors.

Figure 2 below illustrates the relative proportion (per cent) of total burden (Disability Adjusted Life Years, or DALY) for males and females by major disease group and age group.

Females



Males



Source: Australian Burden of Disease Study 2015, p20

Figure 2. Relative proportion total burden (DALY) for males and females by major disease group and age group.

3. Victorian Public Health and Wellbeing Plan 2019-2023 - Priorities

3.1. Tackling climate change and its impact on health

Federal

Commonwealth policy primarily focuses on emission reduction whilst ensuring energy security, and adaptation. Most relevant is the *National Climate Resilience and Adaptation Strategy* https://www.environment.gov.au/climate-change/adaptation/strategy which identifies the health and wellbeing impacts of climate change as heatwaves, droughts and an increased risk of food and water borne diseases, and their potential disruptive effect on health services, food, water and sanitation systems. Climate change is identified as likely to impact the affordability and availability of agricultural products which are essential to a healthy diet; and potentially altering the prevalence of bacteria, parasites and viruses. Key areas of strategic focus include to:

1. consider the risks of climate change across health services from a national to a local level
2. address climate risks in workplaces and, in particular, consider heat-related illnesses in the design and organisation of work
3. support adaptation in other sectors that provide services which improve our health, wellbeing and food security such as agriculture, water resources, emergency services and infrastructure.

State

This priority has been designated a *focus area* in the Victorian Public Health and Wellbeing Plan 2019-2023.

Victoria's *Climate Change Framework:* https://www.climatechange.vic.gov.au/__data/assets/pdf_file/0021/55254/DELWPClimateChange_Framework.pdf outlines the overall architecture of the state's approach to climate change and the goal of achieving net zero emissions by 2050.

The *Climate Change Act 2017* https://www.climatechange.vic.gov.au/__data/assets/pdf_file/0022/55282/CC-Act-2017_Fact-Sheet_Overview_v2.pdf provides the legislative basis for action, including:

1. A long-term emissions reduction target of net zero by 2050.
2. The requirement for five-yearly interim targets, to keep Victoria on track to meet this long-term target.
3. The introduction of a new set of policy objectives and an updated set of guiding principles to embed climate change in government decision making.
4. A requirement for the government to develop a Climate Change Strategy every five years, which will set out how Victoria will meet its targets and adapt to the impacts of climate change.
5. A requirement that Adaptation Action Plans (AAPs) be prepared for key systems (e.g. primary health care) that are either vulnerable to the impacts of climate change or essential (from 2021)
6. The establishment of a pledging model to reduce emissions from government's own operations and from across the economy (from 2020)
7. The establishment of a system of periodic reporting to provide transparency, accountability and ensure the community remains informed.

In preparation for the AAPs, the Department of Health and Human Services is running the *Pilot Health and Human Services Climate Change Adaptation Action Plan 2019–21.* https://www.dhhs.vic.gov.au/sites/default/files/documents/201912/Pilot%20health%20and%20human%20services%20climate%20change%20adaptation%20action%20plan%202019-21-20191209.pdf

The Plan indicates that increased exposure to more frequent and intense extreme weather events will increase the vulnerability of our health and human service system to a range of risks, including:

1. More frequent surges in client demand
2. Disruption of workforce attendance at their workplace (e.g. health centres, hospitals)
3. Psycho-social impacts on staff
4. Damage to built assets from, for example, floods, storms, and bushfires
5. Disruption or failure of service infrastructure such as telecommunications, transport, electricity, and water supplies
6. Disruption of supply chains.

It includes 21 actions across the following domains:

1. Governance and regulation
2. Communication and engagement
3. Knowledge building
4. Asset readiness

Action #7 is to survey councils to assess the extent to which actions to address the health impacts of climate change have been included in their municipal public health and wellbeing plans in accordance with their requirements under the *Climate Change Act 2017*.

Local

Manningham Council reports on progress made with regard to energy consumption, waste, water and biodiversity through its annual Environment Report: https://www.manningham.vic.gov.au/environment-and-sustainability

In January 2020, Manningham Council declared a climate emergency in recognition of the threat that climate change represents to the municipality and the importance of a sustained, effective response. A Climate Emergency Response Plan is to be included in the next Environment Report.

The Manningham *Council Plan 2017-2021*, under the theme of Resilient Environment, includes the goal to *reduce our environmental impact and adapt to climate change*.

The *Healthy City Strategy 2017-2021* identifies climate change as both a chronic stressor and an acute shock (e.g. bushfire, flood), and defines *disaster resilience* as an action area under the priority of a *Resilient Community*.

3.2. Reducing injury

Federal

Injury is a leading cause of preventable death and permanent disability in Australia, and is the primary source of death among people aged 1 to 45 years, putting significant pressure on our health care system. The leading causes of disability burden (measured as Disability Adjusted Life Years (DALY)) for each age cohort and overall are illustrated in Figure 3 overleaf.

Rank	Overall	0-14 years	15-24 years	25-64 years	65+ years
1	Suicide and self-inflicted injuries	Other unintentional injuries	Suicide and self-inflicted injuries	Suicide and self-inflicted injuries	Falls
2	Falls	Road transport injury	Road transport injury	Poisoning	Suicide and self-inflicted injuries
3	Poisoning	Falls	Other unintentional injuries	Road transport injury	Road transport injury
4	Road transport injury	Drowning	Poisoning	Falls	Other unintentional injuries
5	Other unintentional injuries	Homicide and violence	Falls	Other unintentional injuries	All other external causes of injury
6	Homicide and violence	Other land transport injuries	Homicide and violence	Homicide and violence	Poisoning
7	Other land transport injuries	Suicide and self-inflicted injuries	Other land transport injuries	Other land transport injuries	Other land transport injuries
8	Drowning	Fire, burns and scalds	Drowning	Drowning	Drowning
9	All other external causes of injury	Poisoning	Fire, burns and scalds	All other external causes of injury	Fire, burns and scalds
10	Fire, burns and scalds	All other external causes of injury	All other external causes of injury	Fire, burns and scalds	Homicide and violence

Source: *AIHW 2015 Burden of Disease Study, as contained in the (draft) National Injury Prevention Strategy 2020-2030 (p.5)*

Figure 3. Leading causes of burden of injury based on Disability Adjusted Life Years (DALY), 2015

The draft *National Injury Prevention Strategy 2020-2030* **https://www.health.gov.au/initiatives-and-programs/national-injury-prevention-strategy-2020-2030-0** has a dual focus on preventing injury among priority populations (Aboriginal and Torres Strait Islander peoples, rural and remote communities, and low socio-economic status cohorts) and across different age cohorts (0-14 years,15-24 years,25-64 years,65+ years). The draft Strategy includes 30 objectives each with supporting actions designed to reduce injuries relating to intentional self-harm; falls; poisoning; road and land transport; homicide and violence; and, drowning.

The draft Strategy identifies alcohol, extreme weather events and better planning for the built environment as cross-cutting themes which impact on all age cohorts and priority populations.

State

The Victorian Injury Prevention Program:
http://www.farmerhealth.org.au/sites/default/files/Alex_Natora_Rob_Grenfell_presentation_-_VIPS_to_NCFH_conference_12-10-2010_.pdf encompasses a range of policy, research and activities including:

1. Victorian Injury Surveillance Unit at Monash University which analyses, interprets and disseminates injury data on deaths, hospital admissions and emergency department presentations.
2. Kidsafe Victoria, an independent for-purpose organisation, dedicated to the prevention of unintentional death, injury and associated disability to children.
3. Resources to prevent child poisoning, distributed to parents through local Maternal and Child health services.
4. Injury prevention is embedded in the Achievement Program https://www.achievementprogram.health.vic.gov.au/ in order to create safe learning spaces in early childhood and school settings.
5. The Victorian Road Safety Alliance and its key program, the Victorian Road Safety Partnership.

Local

The *Healthy City Strategy 2017-2021:* https://www.manningham.vic.gov.au/healthy-city-strategy identifies falls (particularly among older residents), road safety and suicide (particularly among gender diverse people) as safety issues in the community.

3.3. Preventing all forms of violence

Federal

The *National Plan to Reduce Violence Against Women and their Children 2010-2022:* https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022 implemented through the *Fourth Action Plan 2019-2022* focuses on five national priorities to reduce family, domestic and sexual violence, namely:

1. Primary prevention for the whole community to change attitudes, behaviours and accepted standards that excuse, justify or encourage violence against women and their children.
2. Aboriginal and Torres Strait Islander women and children, who continue to experience disproportionately high rates of family violence.
3. Respect, listen and respond to the diverse lived experience and knowledge of women and their children affected by violence.
4. Respond to sexual violence and sexual harassment through primary prevention, including gender equality, consent and healthy sexual relationships particularly for young people.
5. Improve support and service system responses to ensure women and their children have help when they need it and reducing the stigma associated with seeking support.

State

Family violence is a key priority of the current Victorian Government, beginning with the establishment of a Royal Commission into Family Violence in 2015 which delivered its final recommendations in March 2016. Key Victorian policies relating to family violence now include:

1. *Ending Family Violence – Victoria's Plan for Change:* https://www.vic.gov.au/ending-family-violence-victorias-10-year-plan-change is a 10-year plan outlining how the government will implement all 277 recommendations from Victoria's Royal Commission into Family Violence.
2. *Free from Violence:* https://www.vic.gov.au/sites/default/files/2019-05/Free-From-Violence-First-Action-Plan2018-2021.pdf is a primary prevention strategy designed to change social norms, structures and practices that enable and support violence against women and children.
3. *Safe and Strong: A Victorian Gender Equality Strategy:* https://www.vic.gov.au/safe-and-strong-victorian-gender-equality aims to progressively build the attitudinal and behavioural change required to reduce violence against women and deliver gender equality. It utilises a range of levers including legislative change, governance structures, employment practices, budget, policy, procurement, funding decisions and advocacy to the Commonwealth Government. The strategy focuses on six key settings for early action including education and training; work and economic security; health, safety and wellbeing; leadership and representation; sport and recreation; and, media, arts and culture.

Family Safety Victoria has been established to implement key recommendations from the Royal Commission.

The *Gender Equality Act 2020:* https://www.vlga.org.au/advocacy/womens-policy/gender-equality-act-2020-fact-sheet provides the legislative basis for implementing key aspects of the Government's gender equality strategy *(Safe and Strong)* , in particular the requirement to develop Gender Equality Action Plans (GEAP) every four years, and to publicly report on progress every two years.

Local

Manningham's *Council Plan 2017-2021:* https://www.manningham.vic.gov.au/council-plan, under the *Healthy Community* theme, includes the action area of "a community that is active in the prevention of family violence"*,* through strengthened community confidence to report family violence and link to support services.

Manningham's *Healthy City Strategy 2017-2021* identifies the prevention of violence as an action area, through committing and acting to end violence and its impacts, with a focus on women and children who are victims, people with disability, and LGBTQIA+ people. The targets are a 5% increase in reporting incidents of family violence, reflecting confidence in the system and intolerance of family violence by 2025 (2016 baseline), and an increase in the proportion of bystanders who are prepared to safely intervene in a family violence situation.

Women's Health East has led the development of a regional strategy on the prevention of violence against women, *Together for Equality and Respect*. Manningham is a key partner on the initiative.

The *Gender Equality Act 2020* commences on 31 March 2021, at which point Manningham Council will be required to commencing developing a Gender Equality Action Plan, to be finalised by October 2021.

Gender inequity is a key driver of family violence. To enable a safe, respectful and inclusive community it is vital to address gender inequity and work with stakeholders to unpack gender stereotypes and include work with diverse settings/backgrounds and experiences.

3.4. Increasing healthy eating

Federal

Commonwealth nutrition and healthy eating policy is articulated through a number of guidelines and strategies:

1. *Australian Dietary Guidelines:* https://www.eatforhealth.gov.au/guidelines/australian-dietary-guidelines-1-5 provide advice about the amount and kinds of foods needed to encourage and maintain health and wellbeing.
2. *Australian Guide to Healthy Eating* is a visual guide to the recommended daily consumption of the five food groups.
3. *Infant Feeding Guidelines:* https://www.eatforhealth.gov.au/sites/default/files/files/the_guidelines/n56_infant_feeding_guidelines.pdf which assist health workers to provide consistent advice about breastfeeding and infant feeding.
4. *Australian National Breastfeeding Strategy 2019 and beyond:* https://consultations.health.gov.au/population-health-and-sport-division/breastfeeding/ outlines priorities for protecting, promoting, supporting and monitoring breastfeeding throughout Australia.
5. *Nutrient Reference Values for Australia and New Zealand* provides recommendations for nutritional intake based on currently available scientific knowledge.

State

This priority has been designated a *focus area* in the Victorian Public Health and Wellbeing Plan 2019-2023.

The promotion of healthy eating is one of five strategic imperatives identified action in the VicHealth *Action Agenda for Health Promotion 2013 – 2023* https://www.vichealth.vic.gov.au/media-and-resources/publications/action-agenda-for-health-promotion to guide action for the ten years to 2023. VicHealth's *Healthy Eating Strategy 2019-2023* focuses on sports settings, fruit and vegetable consumption and food cultures.

The Victorian Government's *Achievement Program* supports workplaces, schools and early childhood services to create healthy places for working, learning and living. Healthy eating is a priority in the program.

Local

Manningham's *Healthy City Strategy 2017-2021* identifies healthy eating as an action area by making it easier to make healthy food and drink choices. The target is a 5% reduction in the prevalence of overweight and obesity among adults by 2025 (2011 baseline), with the measure being the proportion of adults, adolescents and children who consume sufficient fruit and vegetables.

The *Food Security Plan 2016-2021:* https://www.manningham.vic.gov.au/search/site/%22food%20security%20plan%22 identifies priorities for supporting food security among Manningham's most vulnerable communities. It documents existing Council actions in relation to:

1. Food education
2. Building the local food system
3. Community food and access
4. Partnership and engagement
5. Promotion, marketing and advocacy

3.5. Decreasing the risk of drug resistant infections in the community

Federal

Australia's Antimicrobial Resistance Strategy - 2020 and Beyond was endorsed by COAG on 13 March 2020, and builds on Australia's First National AMR Strategy 2015-2019. The First National AMR Strategy enabled the establishment of a One Health antimicrobial resistance online hub to serve as a central repository for trusted information and resources, as well as the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System.

The 2020 Strategy enlarges the focus to include food, the environment and other classes of antimicrobials such as antifungals and antivirals. Its 20-year vision aims protect the health of humans, animals and the environment through minimising the development and spread of AMR whilst continuing to have effective antimicrobials available. The 2020 Strategy aligns with the World Health Organisation's *Global Action Plan on AMR* and focuses on seven objectives:

1. Clear governance for antimicrobial resistance initiatives
2. Prevention and control of infections and the spread of resistance
3. Greater engagement in the combat against resistance
4. Appropriate usage and stewardship practices
5. Integrated surveillance and response to resistance and usage
6. A strong collaborative research agenda across all sectors
7. Strengthen global collaboration and partnerships.

The 2020 Strategy focuses on aged care, agriculture and forestry, animal owners, general practice, pharmacy, veterinary practice and the wider public.

State

The Victorian Government contributed to the development of the 2020 Strategy and is responsible for

the design and delivery of key initiatives to achieve the Strategy's objectives. For example, Safer Care Victoria's support for antimicrobial stewardship (AMS) programs designed to help reduce inappropriate antimicrobial usage and deliver better patient outcomes.

Local

Local municipal policy in relation to AMR does not currently exist.

3.6. Increasing active living

Federal

Commonwealth policy is expressed through the *Australian Movement Guidelines Sport 2030:* https://www.sportaus.gov.au/__data/assets/pdf_file/0005/677894/Sport_2030_-_National_Sport_Plan_-_2018.pdf and programs targeting key cohorts *(e.g. Girls Make Your Move).*

The *Australian Movement Guidelines* provide advice on movement and sedentary behaviour for early years, children and young people, adults and older people and families. The guidelines are periodically reviewed and updated based upon global best practice, with a particular focus on the relationship between physical activity, sedentary behaviour and health outcome indicators including the risk of chronic disease and obesity.

Sport 2030 outlines the Commonwealth Government's vision for Australia *"to be the world's most active and healthy sporting nation, known for its integrity and sporting success".* One of its aims is to reduce inactivity amongst Australians by 15% by 2030 through the following ways:

1. Drive movement for life through sport and physical activity participation for all Australians.
2. Ensure all Australian children have the skills, confidence and motivation to be active for life and safe in the water.
3. Reduce barriers to sport and physical activity participation, including swimming and actively promote incentives for participation.
4. Coordinated investment in sport and recreation facilities to achieve sustainable outcomes for communities, with a focus on universal design to ensure sport is accessible to all Australians.

State

This priority has been designated a *focus area* in the Victorian Public Health and Wellbeing Plan 2019-2023.

At a Victorian level, the policy focus is on improving neighbourhood and precinct planning to create accessible and adaptable spaces for active living; supporting sport and recreation in the community; and, increasing active transport.

The Victorian Government's *Achievement Program* supports workplaces, schools and early childhood services to create healthy places for working, learning and living. Active living is a priority of the program.

1. *Plan Melbourne 2017-2050:* https://www.planning.vic.gov.au/policy-and-strategy/planning-for-melbourne/plan-melbourne is a long-term plan for ensuring the city grows more sustainable, productive and liveable. Outcome 3 of the Plan focuses on the development of an integrated transport system that connects people to jobs and services and goods to market. Key directions under this outcome include improving local travel options (walking, cycling, public transport) to support 20-minute neighbourhoods and supporting cycling for commuting.
2. *Active Victoria – A strategic framework for sport and recreation in Victoria 2017-2021:* https://sport.vic.gov.au/__data/assets/pdf_file/0018/55602/download.pdf focuses on meeting demand through investment in sports and recreation infrastructure, along with support for broader and more inclusive participation in sport, and active recreation.

3. *Victorian Cycling Strategy 2018-2028:* https://gtaconsultants.worldsecuresystems.com/images/insights/GTA%20Insights_Victorian%20Cycling%20Strategy.pdf supports planning and investment to get more people cycling to work, school, public transport and shops. It focuses on investing in a safer, lower-stress, better-connected cycling network and on making cycling a more inclusive experience.

In 2014, the Victorian Government established an *Inquiry into Women and Girls in Sport and Active Recreation* to understand why females had a lower participation rate and what options are available to increase participation rates. In response to the Inquiry's findings, the Government established the Office for Women in Sport and Recreation and the *Change our Game* initiative which is focused on strengthening leadership, culture, showcasing achievement and funding to increase participation.

Local

The Manningham *Council Plan 2017-2021*, includes a number of goals and action areas relating to active living:

1. A healthy, resilient and safe community - delivery of local initiatives to support healthy lifestyles through life-long learning, volunteering, *recreation* and safe choices
2. Well connected, safe and accessible travel – public transport and active options, well planned and maintained roads, pathways and transport infrastructure, improved sustainable transport options to reduce congestion, and pursuit of the 20-minute neighbourhood as envisioned in Plan Melbourne.

The *Healthy City Strategy 2017-2021* identifies active living as an action area to make it easier to engage in recreation and be physically active. It includes the target of a 20% increase in sufficient physical activity prevalence among adolescents by 2025 (2014 baseline).

Manningham's *Active for Life Recreation Strategy 2010-2025* (reviewed 2019): https://www.manningham.vic.gov.au/sites/default/files/active_for_life_recreation_strategy_2010-2025_2019_review.pdf provides the foundation for investment and program development for sport and recreation in the municipality. Key elements of the strategy include:

1. The provision of flexible, multi-use and durable spaces for recreation
2. Inclusion and capacity building
3. Collaboration and partnerships

Manningham's *Bicycle Strategy 2013:* https://www.manningham.vic.gov.au/file/4016 outlines the approach to cycling infrastructure, bicycle facilities, community education and cycling promotion programs.

Walk Manningham Plan 2011-2020: https://www.manningham.vic.gov.au/file/7266 is designed to get more people walking to more places, more often. The *Open Space Strategy 2014-2024:* Part 1 https://www.manningham.vic.gov.au/file/4546 and Part 2: https://www.manningham.vic.gov.au/sites/default/files/uploads/OSSPart%202%20Final%20for%20Web.pdf sets out priorities and guidelines for the protection, development and use of all public open space in Manningham to support a healthy community and environment. The Strategy includes details on 313 open spaces in Manningham.

3.7. Improving mental wellbeing

Federal

The Commonwealth has an almost 30-year history in mental health and the prevention of suicide.

Australia's *National Mental Health Strategy:* https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-i-midrev2-toc~mental-pubs-i-midrev2-2~mental-pubs-i-midrev2-2-nat commenced in 1992 and mental health is designated a *National Health Priority Area*.

In 2013, the first National *Aboriginal and Torres Strait Islander suicide prevention strategy:* https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pub-atsi-suicide-prevention-strategy was launched.

In 2015, as part of its response to the National Mental Health Commission Review of mental health programs, the Commonwealth Government announced the new *National Suicide Prevention Strategy* which involved:

1. A systems-based regional approach to suicide prevention led by Primary Health Networks (PHNs) in partnership with Local Hospital Networks, states and territories, and other local organisations with funding available through a flexible funding pool;
2. National leadership and support activity, including whole of population activity and crisis support services;
3. Refocussed efforts to prevent suicide in Aboriginal and Torres Strait Islander communities, taking into account the recommendations of the Aboriginal and Torres Strait Islander Suicide Prevention Strategy; and
4. Joint commitment by the Australian Government and states and territories, including in the context of the Fifth National Mental Health Plan, to prevent suicide and ensure that people who have self-harmed or attempted suicide are given effective follow-up support.

The *Fifth National Mental Health and Suicide Prevention Plan (2017-2022):* https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan was endorsed by COAG on 4 August 2017 and established a national approach for collaborative government effort across eight priority areas:

1. Achieving integrated regional planning and service delivery.
2. Effective suicide prevention.
3. Coordinated treatment and supports for people with severe and complex mental illness.
4. Improving Aboriginal and Torres Strait Islander peoples' mental health and suicide prevention.
5. Improving the physical health of people living with mental illness and reducing early mortality.
6. Reducing stigma and discrimination.
7. Making safety and quality central to mental health service delivery.
8. Ensuring that the enablers of effective system performance and system improvement are in place.

Commonwealth investment focuses on population level activity such as anti-stigma and awareness campaigns, crisis support services and activities that support regional approaches commissioned by Primary Health Networks (PHN). At the time of writing, a *National Mental Health Workforce Strategy* is under development.

State

In 2015, the State Government launched *Victoria's 10-Year Mental Health Plan:* https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-plan to guide

investment and deliver better mental health outcomes for Victorians. The Plan includes four focus areas and fifteen outcomes in support of its overall goal of ensuring that all Victorians experience their best possible health, including mental health as outlined below in Table 1.

Focus areas	Outcomes
Victorians have good mental health and wellbeing	1. **Mental health and wellbeing** – the prevalence of mental illness is reduced, and Victorian individuals, families and communities are resilient.
	2. **Equality in emotional and social wellbeing** – the gap in social and emotional wellbeing is reduced for at-risk groups, particularly for people from culturally and linguistically diverse backgrounds, refugees and asylum seekers, children in out-of-home care, and people who are same-sex attracted, trans, gender diverse or intersex.
	3. **Close the gap** – the health gap between Aboriginal Victorians and the general population attributable to suicide, mental illness and psychological distress is reduced, and resilience-building activities, health promotion, treatment and support are culturally safe and responsive.
	4. **Reduce the suicide rate** – the occurrence of suicide deaths, suicidal ideation and suicidal attempt is reduced, and the gap between the suicide rates for particular vulnerable groups and the general population is reduced.
Victorians promote mental health for all ages and stages of life	5. **Early in life** – infants, children, young people and their families are supported to develop the life skills and abilities to manage their own mental health.
	6. **Best mental health at all ages** – older Victorians are supported to build the protective factors for good mental health, address modifiable risks and access age-appropriate treatment and services that meet their mental health and physical health needs.
	7. **Families and carers** – the role and needs of family, kinship community, and carers of people with mental illness are respected, recognised, valued and supported.
Victorians with mental illness live fulfilling lives of their choosing, with or without symptoms of mental illness	8. **Respect** – people living with mental illness, their families and carers get the same respect, advantages and opportunities as others, live free from stigma or discrimination, and have their rights upheld.
	9. **Inclusion and participation** – people with mental illness and their carers and families maintain good physical health, stable housing, finances, employment and educational opportunities.
	10. **Self-management** – people experiencing psychological distress or mental illness, and their families or carers, have the skills and support to manage and maintain their best mental health.
	11. **Safe** – people with mental illness have less contact with the criminal justice system, including as either perpetrators or victims of abuse or violence.
The service system is accessible, flexible and responsive to people of all ages, their families and carers and the workforce is supported	12. **Choice** – people with mental illness have genuine choice about the treatment options, rehabilitation and support available and provided to them.
	13. **Recovery** – people receiving treatment and other services are supported to define and realise personal wellbeing through recovery-oriented, trauma-informed, family-inclusive services that build optimism and hope.
	14. **Universal access to public services** – people with mental illness and their

to deliver this	families and carers have access to high-quality, integrated services according to their needs and preferences
	15. **Access to specialist mental health services** – people with mental illness, their carers and families have access to the public treatment and support services they need and choose, appropriate to their age and other circumstances, where and when they need them most.

Source: Victoria's 10-Year Mental Health Plan, p.2

Table 1. Victoria's 10-Year Mental Health Plan Priorities

In 2019, a *Royal Commission into Victoria's Mental Health System* was established to explore how the state's mental health system can most effectively prevent mental illness and deliver treatment, care and support to people living with mental illness, their families and carers. The Commission delivered an interim report in November 2019 and is scheduled to provide recommendations to the Victorian Government by October 2020. Interim recommendations include:

1. A new approach to mental health investment (a tax or levy), to ensure a substantial increase in funding for mental health – now and into the future.
2. The creation of a Victorian Collaborative Centre for Mental Health and Wellbeing to bring together different skills and expertise to drive better mental health outcomes for all Victorians.
3. An additional 170 youth and adult acute mental health beds to help address critical pressures in areas of need.
4. Expansion of the Hospital Outreach Post-suicidal Engagement (HOPE) program into all area mental health services and linked to sub-regional health services as well as a new assertive outreach and follow up care service for children and young people, to increase the availability of support and outreach for Victorians at risk of suicide.
5. The creation of an Aboriginal Social and Emotional Wellbeing Centre and expansion of Aboriginal and Torres Strait Islander social and emotional wellbeing teams across the state.
6. Establishing Victoria's first residential mental health service, as an alternative to an acute admission, designed and delivered by people with lived experience of mental illness.
7. Expanding and supporting consumer and family-carer lived experience workforces.
8. Addressing workforce shortages and preparing for reform including through the provision of more training and recruitment pathways to boost the number of graduate nurses and allied health professionals in public mental health services.
9. Establishing a Mental Health Implementation Office to start work on the delivery of these recommendations.

The Victorian Government has already committed to implementing all of the Commission's recommendations and has established Mental Health Reform Victoria to lead their implementation.

The Victorian Government's *Achievement Program* supports workplaces, schools and early childhood services to create healthy places for working, learning and living. Mental health and wellbeing is a priority in the program.

<u>Local</u>

At the local level, Manningham's *Healthy City Strategy 2017-2021* identifies youth mental wellbeing as a priority and includes the target of a 5% increase in resilience of adolescents by 2025 (2014 baseline).

In 2018, limited accessibility of youth mental health services in Manningham resulted in the Council decision to fund Headspace to establish a presence in the municipality 1 day/week. This service was discontinued during the COVID-19 pandemic as staff were not permitted to go from site to site. However, Headspace continued to offer phone and telehealth appointments to Manningham clients.

3.8. Improving sexual and reproductive health

Federal

Commonwealth policy relating to sexual and reproductive health includes:

1. National Women's Health Policy 2010 (NWHP): https://www1.health.gov.au/internet/main/publishing.nsf/Content/national-womens-health-policy
2. National Framework for Maternity Services (NFMS) 2017
3. National Plan to Reduce Violence against Women and their children 2010-2022: https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022
4. The Third National Hepatitis B Strategy 2018-2022
5. The Fourth National Sexually Transmissible Infections Strategy 2018-2022: https://www1.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-1//$File/STI-Fourth-Nat-Strategy-2018-22.pdf
6. The Fifth National Hepatitis C Virus (HCV) Strategy 2018-2022
7. The Fifth National Aboriginal and Torres Strait Islander Blood Borne Viruses and STI Strategy 2018-2022
8. The National HIV Strategy 2015-2020
9. National Blood-borne Virus and STI Surveillance and Monitoring Report 2016
10. National Pregnancy, Baby and Birth Helpline

State

The Victorian Government's *Women's Sexual and Reproductive Health Key Priorities 2017-2020* https://www2.health.vic.gov.au/about/publications/policiesandguidelines/womens-sexual-health-key-priorities identifies four priority action areas:

1. Improved knowledge and capacity to manage fertility
2. Improved access to reproductive choice
3. Improved access to reproductive health services for women with endometriosis, polycystic ovarian syndrome or undergoing menopause
4. Confidence to access culturally safe sexual health services for testing, treatment and support

In addition, specific population groups are identified including adolescents, young and older women; Aboriginal and Torres Strait Islander peoples, people from culturally diverse backgrounds, people living in regional and rural Victoria, people with disability; women in same sex relationships; and gender diverse people.

Women's Health Victoria's 1800 My Options is a free and confidential web and telephone service which provides evidence-based information about contraception, pregnancy options and sexual health, as well as pathways to appropriate and trusted health care services.

Local

Manningham's *Healthy City Strategy 2017-2021* identifies safe sexual health as an action area under the Healthy Lifestyles priority. Furthermore, Manningham Council delivers Maternal and Child Health services for parents and children.

3.9. Reducing tobacco-related harm

Federal

Commonwealth policy in relation to tobacco is articulated through the *National Drug Strategy 2017-2026:* https://www.health.gov.au/resources/publications/national-drug-strategy-2017-2026, in conjunction with the following sub-strategies:

1. *National Tobacco Strategy 2012-2018:* https://www.health.gov.au/sites/default/files/national-tobacco-strategy-2012-2018_1.pdf
2. *National Aboriginal and Torres Strait Islander People Drug Strategy 2014-2019:* https://campaigns.health.gov.au/drughelp/resources/publications/report/national-aboriginal-torres-strait-islander-peoples-drug

The *National Drug Strategy 2017-2026*:

1. Focus on the three pillars of harm minimisation: demand reduction, supply reduction and harm reduction.
2. Identifies priority populations including: Aboriginal and Torres Strait Islander peoples, people with mental health conditions, young people, older people, people in contact with the criminal justice system, LGBTQIA+ people and people from culturally diverse backgrounds.
3. Identifies priority actions including enhanced access to treatment, data sharing, new responses to prevent uptake and delay first use; restriction and regulation of availability, enhanced national coordination, reduced adverse consequences, and increased participatory processes.

The National Tobacco Strategy 2012-2018 builds upon previous strategies in place since 1999, and includes a range of priority areas and actions:

1. Protect public health policy, including tobacco control policies, from tobacco industry interference.
2. Strengthen mass media campaigns to: motivate smokers to quit and recent quitters to remain quit; discourage uptake of smoking; and, reshape social norms about smoking.
3. Continue to reduce the affordability of tobacco products.
4. Bolster and build on existing programs and partnerships to reduce smoking rates among Aboriginal and Torres Strait Islander peoples.
5. Strengthen efforts to reduce smoking among populations with a high prevalence of smoking
6. Eliminate remaining advertising, promotion and sponsorship of tobacco products.
7. Consider further regulation of the contents, product disclosure and supply of tobacco products and alternative nicotine delivery systems.
8. Reduce exceptions to smoke-free workplaces, public places and other settings.
9. Provide greater access to a range of evidence-based cessation services to support smokers to quit.

The *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019* outlines a more targeted and contextualised approach to addressing challenges within Aboriginal and Torres Strait Islander communities.

Key national reforms over the past thirty years include:

1. National ban on tobacco advertising (1992, 2012)
2. Plain packaging for tobacco products (2012)

State

This priority has been designated a *focus area* in the Victorian Public Health and Wellbeing Plan.

In Victoria, the *Tobacco Act 1987:* https://www2.health.vic.gov.au/public-health/tobacco-reform/tobacco-reform-legislation-and-regulations introduced a levy on the wholesale sale of tobacco products. VicHealth was established to distribute the funds raised by the new levy and Quit Victoria was one of the

initiatives funded. Today, Victoria's tobacco policy is expressed through:

1. Continued support for Quit Victoria and its smoking cessation programs
2. Regulations to limit the sale and use of tobacco products, including:
    - Bans on smoking in places where people may be exposed to second hand smoke e.g. building entrances, learning environments, outdoor dining and drinking areas
    - Restrictions on selling tobacco products to anyone under 18 years of age
    - Regulation of e-cigarettes and shisha tobacco

The Victorian Government's *Achievement Program* supports workplaces, schools and early childhood services to create healthy places for working, learning and living. Tobacco control is a program priority.

Local

Smoking is acknowledged as a health risk in the *Healthy City Strategy 2017-2021.*

3.10. Reducing harmful alcohol and drug use

Federal

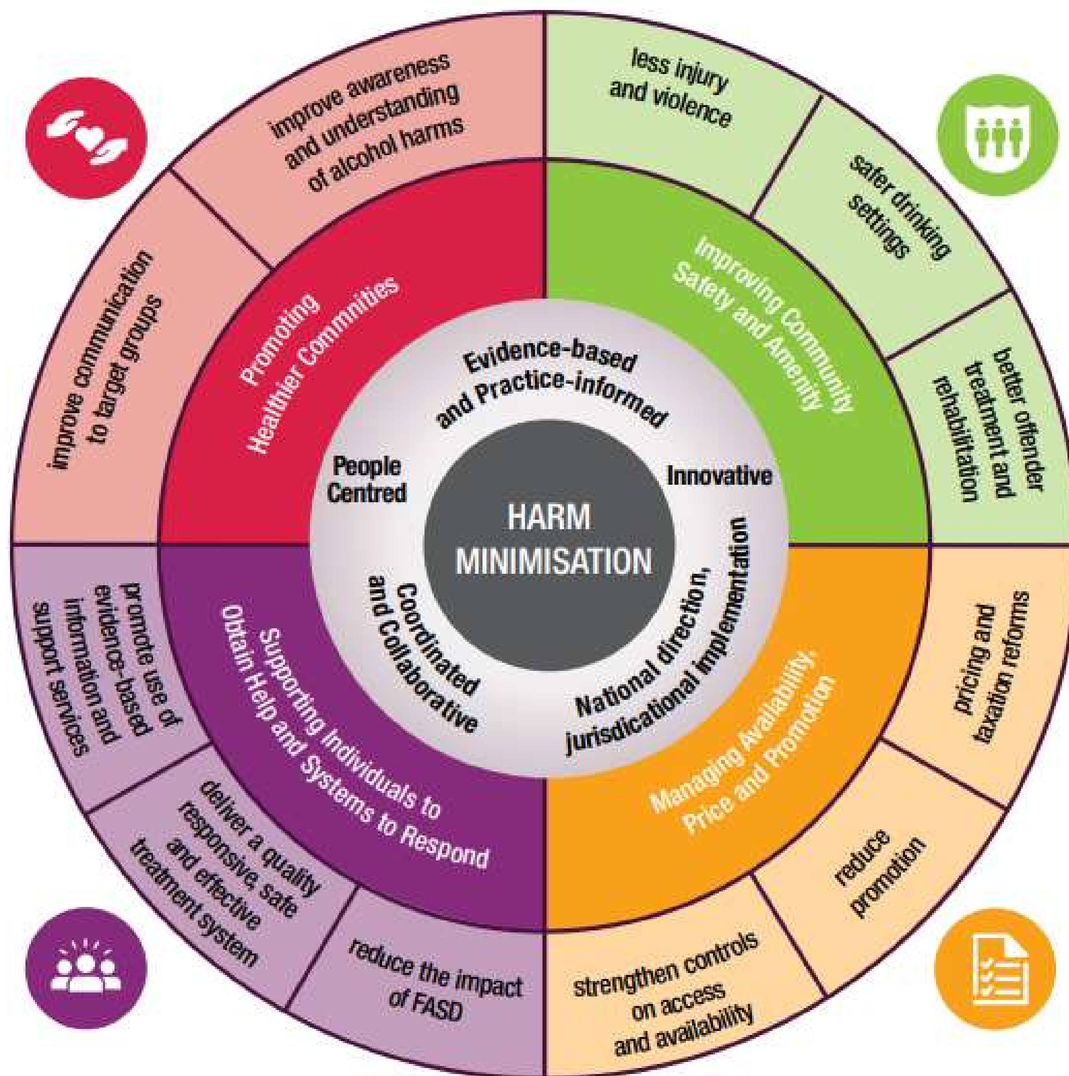
Commonwealth policy is articulated through the *National Drug Strategy 2017-2026*, in conjunction with the following sub-strategies:

1. *National Alcohol Strategy 2019-2028:* https://www.health.gov.au/resources/publications/national-alcohol-strategy-2019-2028
2. *National Foetal Alcohol Spectrum Disorder (FASD) Strategic Action Plan 2018-2028:* https://www.health.gov.au/resources/publications/national-fetal-alcohol-spectrum-disorder-fasd-strategic-action-plan-2018-2028
3. *National Ice Action Strategy 2015:* https://www.health.gov.au/resources/publications/national-ice-action-strategy-2015
4. *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019:* https://campaigns.health.gov.au/drughelp/resources/publications/report/national-aboriginal-torres-strait-islander-peoples-drug
5. *National Alcohol and other Drug Workforce Development Strategy 2015-2018:* https://www.health.gov.au/resources/publications/national-alcohol-and-other-drug-workforce-development-strategy-2015-2018

The National Alcohol Strategy 2019-2028: https://www.vichealth.vic.gov.au/media-and-resources/publications/vichealth-alcohol-strategy also adopts a harm minimisation approach to minimise alcohol-related harms among individuals, families and communities by targeting a 10% reduction in harmful alcohol consumption. It is structured around four priority areas of focus:

1. Improving community safety and amenity
2. Managing availability, price and promotion
3. Supporting individuals to obtain help and systems to respond
4. Promoting healthier communities

Figure 4 overleaf outlines the objectives for each area of focus.



Source: National Alcohol Strategy 2019-2028 p.18
Figure 4. National Alcohol Strategy 2019-2028

SafeScript is a new system which provides doctors, nurses and pharmacists with a history of high-risk medications supplied to patients in their care, in order to assist with the early identification, treatment and support of patients who are developing signs of dependence.

State

In Victoria, the *VicHealth Alcohol Strategy 2019-2023* focuses on:

1. Changing risky drinking cultures, by building on the *Alcohol Cultures Framework* to shift the focus from individual behaviour to the shared activities and practices of a group or social world.
2. Enabling environments to support low-risk drinking by working with councils to reduce the affordability, promotion and availability of alcohol products.

In addition, the Victorian Government supports a range of initiatives including:

1. Provision of specialist drug and alcohol treatment services, including residential rehabilitation, residential withdrawal and post-treatment youth supported accommodation.
2. Ice Action Plan focuses on the provision of treatment for ice users, family support, the protection of frontline worker and closing down of manufacturers.
3. Drug Rehabilitation Plan to increase residential rehabilitation beds, trial a medically supervised injecting room and provide additional workforce training.

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The Victorian Government's *Achievement Program* supports workplaces, schools and early childhood services to create healthy places for working, learning and living. Harmful alcohol and drug use is a priority in the program.

Local

Manningham's *Healthy City Strategy 2017-2021* identifies reducing harm from drugs, alcohol and gambling as a priority under the *Safe and Resilient* focus area, and identifies the target of a 10% decrease in excess alcohol consumption by adults by 2025 (2014 baseline).

Manningham Council is an active member of the Eastern Metropolitan Region Action on Alcohol Flagship Group (AAFG). The AAFG's priorities as articulated in its Strategic Plan 2017-2021 include the development of leaders who champion change; facilitating preventative planning frameworks; and, legislation and creating an informed and mobilised community.

4. Local Research, Engagement and Projects

Other key documents to inform the development of the new municipal health and wellbeing plan are outlined below.

Generation 2030
Launched in 2011, Generation 2030 involved an extensive community engagement which culminated in the development of a community plan, a community vision for Manningham and action plans to support delivery.

Thousands of Voices
In 2016, community consultation was undertaken to identify priorities for the development of the Council Plan 2017 – 2021 and Healthy City Strategy 2017 – 2021. Priorities were clustered around the five themes of the environment, places and spaces, community, council leadership and the economy.

Manningham Liveability Study
In 2018, Manningham Council and the Department of Health and Human Services (DHHS) engaged RMIT University to undertake a liveability study of Manningham involving a spatial analysis of 16 liveability indicators for 280 neighbourhoods across the municipality. The indicators included:

1. Socio-Economic Index for Areas (SEIFA)
2. Access to Alcohol
3. Access to Food
4. Access to Public Open Space
5. Access to Services of Daily Living
6. Access to Services for Older People
7. Access to General Practitioners
8. Early Childhood
9. Education
10. Employment
11. Family Violence
12. Gambling
13. Housing Affordability
14. Social Infrastructure
15. Transport
16. Walkability

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The results indicate that socio-economic disadvantage is less visible in the eastern suburbs of municipality, however the community is also less well serviced by public transport, health and community services and walkable neighbourhoods. Conversely, neighbourhoods closer to central Melbourne have better access to some services, but also have low public transport use and limited walkable access to public open space. In addition, the study revealed the existence of neighbourhoods experiencing housing affordability stress which are in areas with high expenditure on electronic gaming and above average developmental vulnerability in children.

Imagine Manningham 2040

In 2019, an extensive community engagement initiative was undertaken across the municipality to understand the community hopes, desires and aspirations for the Manningham of 2040. The engagement was undertaken to inform the development of the Liveable City Strategy, the Doncaster Hill Framework and the new Community Vision. Whilst these documents are yet to be finalised, key themes emerging from the engagement include:

1. Getting the basics right – safety, infrastructure, vibrant precincts
2. Keeping it green – protecting and enhancing natural assets
3. Build connections – to each other, public transport and services

Smart Cities

The Smart Cities Project is piloting the use of smart technology at Jackson Court to deliver enhanced economic, social and environmental outcomes. The project is engaging traders and the community to explore and make sense of the data from a range of sensors installed across the precinct and to identify potential enhancements through infrastructure, vegetation, the design of spaces, and behavioural change.

KEY DATA

Every picture tells a story

MANNINGHAM

5. A few words about the data

This section includes selected data regarding demographics, health, wellbeing, housing, climate change and the economy. The data provides a picture of both the current situation and the trajectory since the last State of the City Report was produced in 2013.

Comparative data is also presented from Victoria, metropolitan Melbourne, Eastern Metropolitan Region (EMR) and other local governments. Comparative data has been selected on the basis of availability and/or what makes the most sense.

Each data source has its own update schedule. For example, the most recent VicHealth Indicators Survey was undertaken in 2015, whereas LGA water consumption data is available up to 30 June 2020. Despite temporal limitations, trend analysis can still provide important insights into how Manningham is tracking and changing.

In many cases data is available at LGA level, however in some cases the lowest level of geographic granularity is the EMR or Victoria. Where appropriate, EMR and Victorian data has been included as the primary source of insight into the situation in Manningham (rather than for comparative purposes). In some cases, data is available at sub-LGA level however time and resource considerations have meant that the lowest level of analysis contained in this report is at LGA level.

The questions contained in some surveys have changed over time, making it impossible to undertake longitudinal analysis. In such cases, longitudinal analysis has been limited to those years in which the same questions were asked in the survey.

The quantitative data included in this report represents only a fraction of the data which is available. Use it as a springboard for thinking and exploration, and seek out additional data to help triangulate and dig deeper into specific areas of interest. Additional data may include published quantitative and qualitative data, along with insights from service providers and businesses operating in Manningham, and the lived experience of community members.

Often, the availability of data for a particular issue reflects its status as a policy priority. The higher the priority, the greater the likelihood that data will be available and that resources are dedicated to capturing more granular, detailed data. Conversely, the opposite is true. Where this is the case, Council should not be dissuaded from exploring the topic through the lived experience of the local community, the experience of service providers, and from (international) experience in similar contexts. Local insights can provide the basis for securing resources to research a topic more formally, and to advocate to get it onto the policy radar of decision makers.

Understanding the Charts

The Victorian Population Health Survey and the VicHealth Indicators Survey are two key surveys used throughout this report.

In a survey, data is collected from a representative sample of the population of interest. The size of the sample compared to the population of interest determines how certain one can be drawing conclusions about the population based upon the survey results.

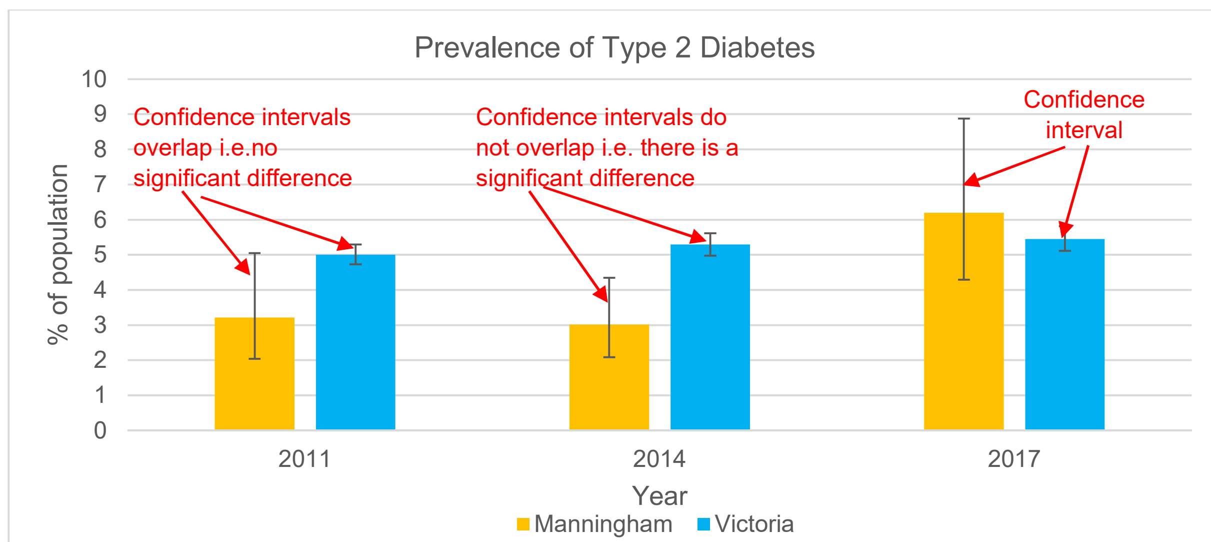
The concept of *confidence level* and *confidence interval* have been developed to address this issue.

1. The confidence interval is the range of values that is likely to include the population value with a certain degree of confidence.
2. The confidence level is the degree of confidence that a population value lies within the confidence interval. It is usually 95% or 99%.

Unless stated otherwise, a 95% confidence level is used throughout this report.

Example

The chart below illustrates the prevalence of Type 2 Diabetes in Manningham and Victoria in the years 2011, 2014 and 2017. The confidence intervals are highlighted.



In 2011 for Manningham (the left-most yellow column) we can say that there is 95% certainty *(confidence interval)* that between 2% and 5% *(confidence level)* of the population had Type 2 Diabetes.

In 2011 for Victoria (the left-most blue column) we can say that there is 95% certainty that between 4.7% and 5.3% of the population had Type 2 Diabetes.

Furthermore, in 2011 we say there is *no significant difference* between Victoria and Manningham because the confidence intervals overlap.

However, in 2014 there *is a significant difference* between Victoria (5.0% to 5.6%) and Manningham (2.1% to 4.4%) because there is no overlap of the confidence intervals, i.e. in 2014 Manningham had a significantly lower incidence of Type 2 Diabetes compared to Victoria.

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6. Population Demographics

Understanding the age profile and the forecast growth of Manningham's population is key to planning for, resourcing and delivering an appropriate mix of services which meet the needs of the community. Population insights also enable Council to advocate for policy change and resources to both State and Commonwealth governments.

6.1. Population Forecast

As at 2020, Manningham's Estimated Resident Population (ERP) was forecast at 131,757, an increase of 15,006 persons or 12.9% since 2011. Victoria's ERP grew by 19.1% during the same period.

Manningham's population is forecast to grow at a similar rate for the next 15 years, as illustrated below in Table 2.

Year	ERP	% change (from 2020)
2020	131,757	0.0%
2025	138,440	5.1%
2030	144,016	9.3%
2035	148,432	12.7%

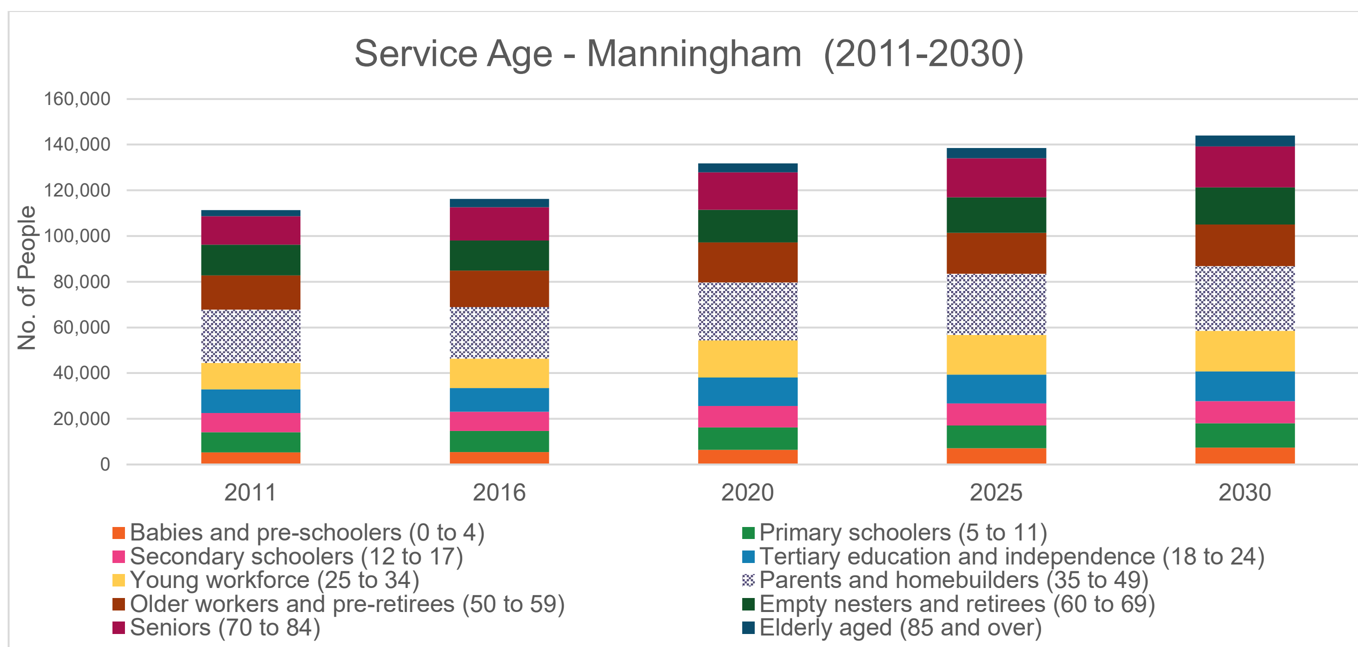
Source: Forecast i.d.

Table 2. Estimated Resident Population, 2020 to 2035

6.2. Service Age

The concept of "service age" is used to assist with service planning. It indicates the level of demand for services that target people at different stages in life and how that demand is changing.

Figure 4 overleaf illustrates how the service age of the Manningham population has changed since 2011 until today, and how it is forecast to change over the next ten years to 2030. The number of people is forecast to increase across all service age categories over the next 10 years, indicating a growing demand for services.



Source: Profile i.d. and Forecast i.d

Figure 5. Service age, 2011 to 2030

Table 3 below illustrates the distribution of the population across different service ages in 2020 and 2030. The number of people is forecast to increase across all service age categories; however, some categories are forecast to experience greater increases – with important implications for service planning. These include babies and preschoolers, young workforce, parents and homebuilders, and people aged 60+ years.

Service Age	2020 (Persons)	2030 (Persons)	Change (Persons)	% of Population (2030)
Babies and preschoolers (0 to 4)	6,475	7,481	+1,006	5.2%
Primary schoolers (5 to 11)	9,798	10,573	+775	7.3%
Secondary schoolers (12 to 17)	9,427	9,680	+253	6.7%
Tertiary education and independence (18 to 24)	12,332	12,973	+641	9.0%
Young workforce (25 to 34)	16,356	17,811	+1,455	12.4%
Parents and homebuilders (35 to 49)	25,281	28,263	+2,982	19.6%
Older workers and pre-retirees (50 to 59)	17,500	18,291	+791	12.7%
Empty nesters and retirees (60 to 69)	14,322	16,158	+1,836	11.2%
Seniors (70 to 84)	16,383	17,969	+1,586	12.5%
Elderly aged (85 and over)	3,882	4,816	+934	3.3%
Total	**131,756**	**144,015**	**+12,259**	**100.0%**

Source: Forecast i.d.

Table 3. Service Age, Change in Persons 2020 to 2030

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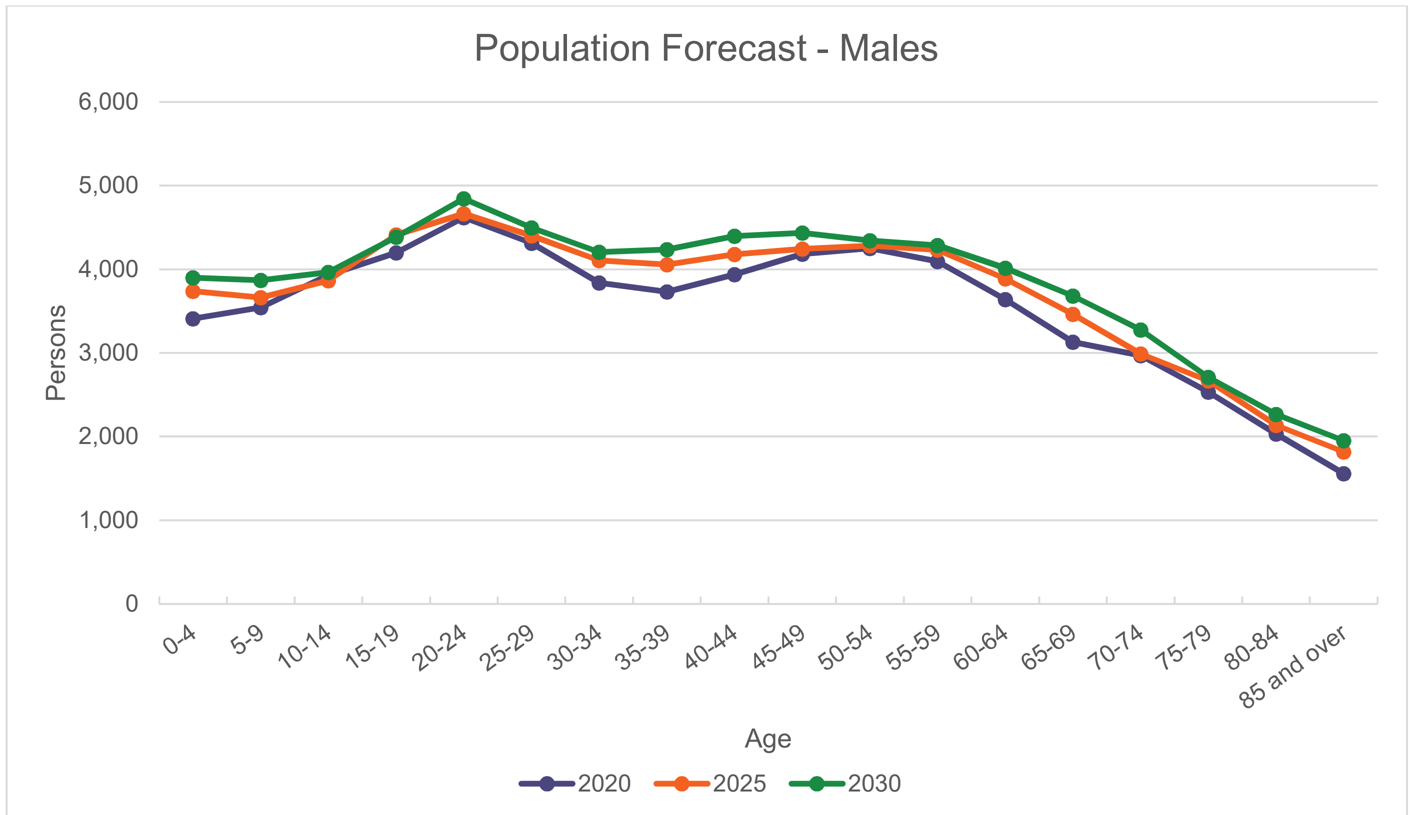
The unique nature of Manningham's population profile indicates the need for:

1. Appropriate, affordable housing and local employment opportunities to provide opportunities for young people to remain in Manningham and attract young people from other municipalities.
2. Affordable housing and quality family, education and health services for families and mid-career workers.
3. Services and programs which support healthy ageing, ageing in place and staying connected.

Manningham's population is forecast to retain a similar age and gender profile over time, as illustrated in Figures 6 and 7 below.



Source: Forecast i.d

Figure 6. Male population forecast by age

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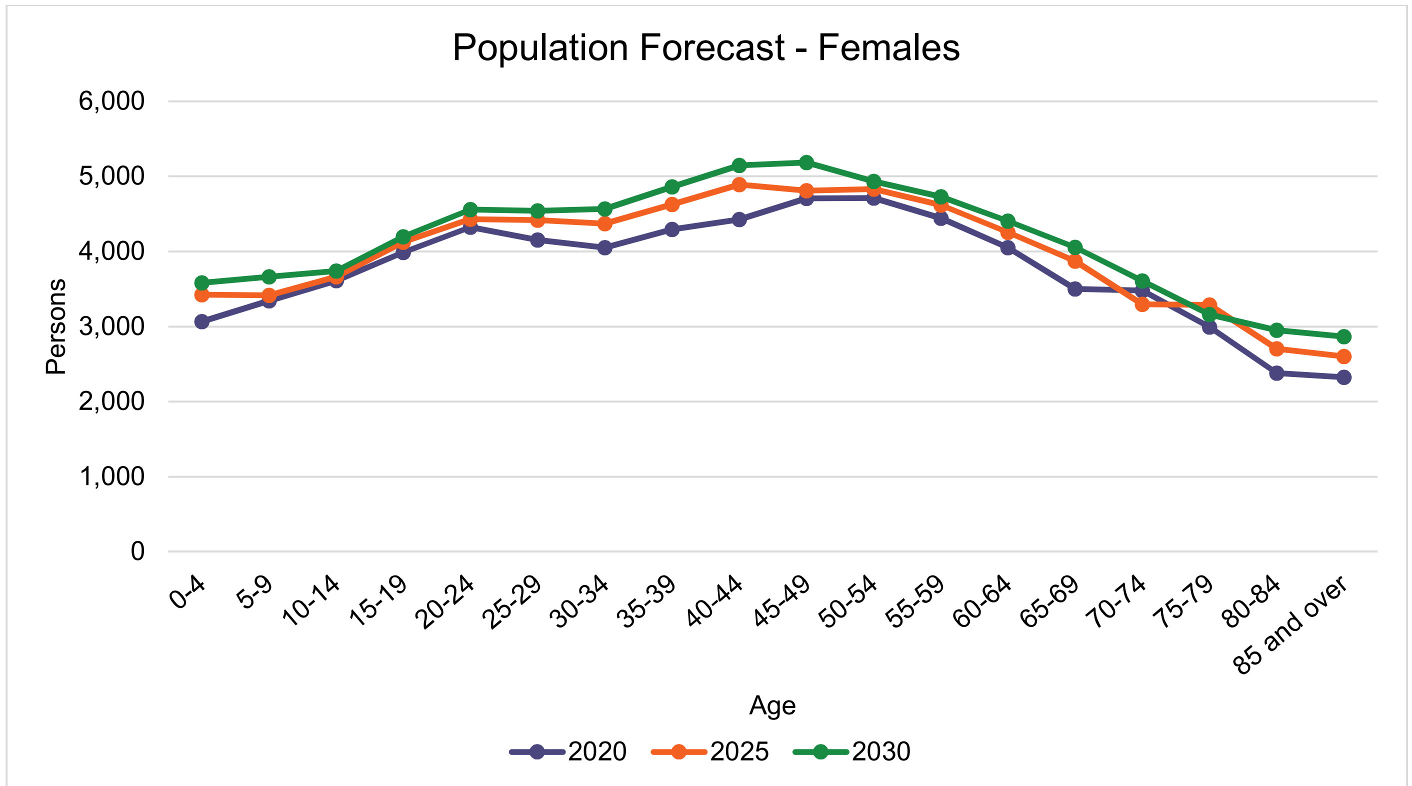


Source: Forecast i.d

Figure 7. Female population forecast by age

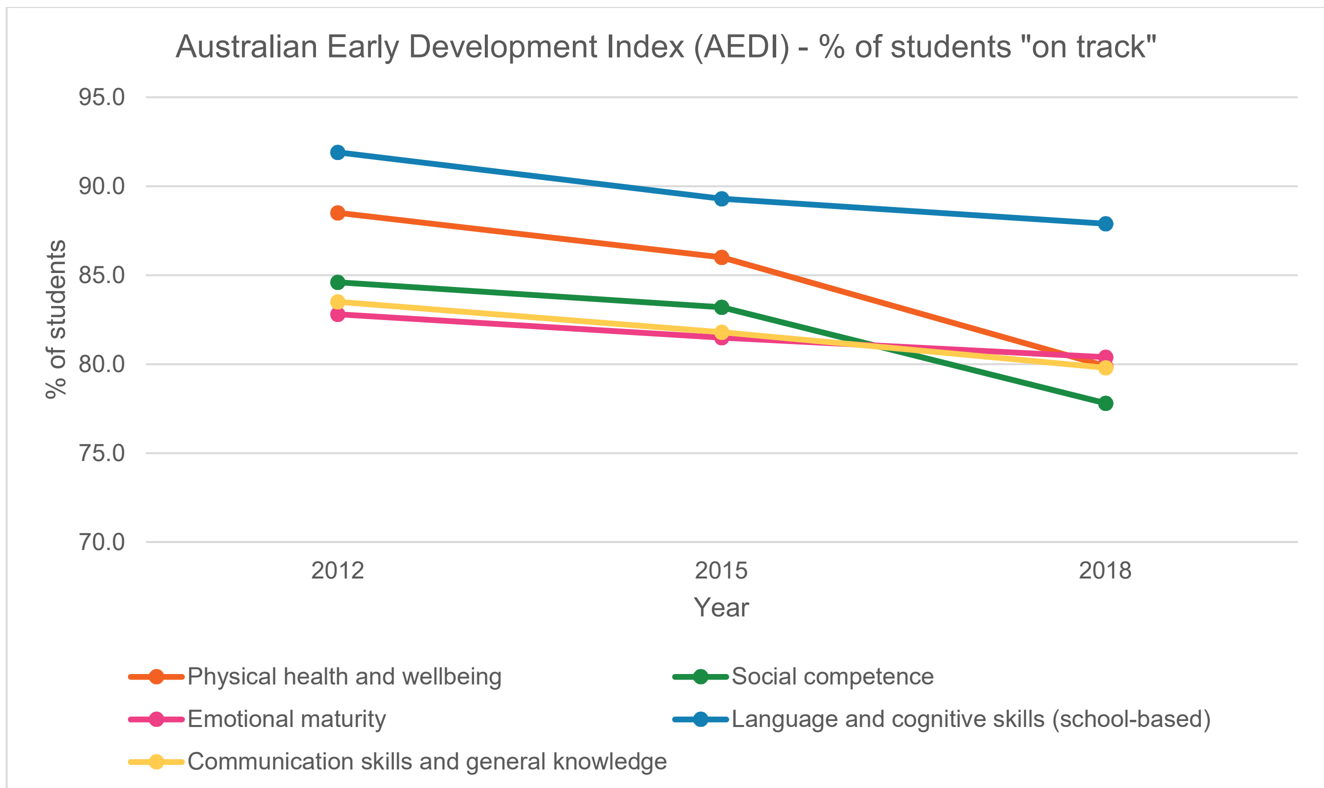
6.2.1. 0-11 years (babies, pre-school and primary school)

In 2018, more than 95% of children starting school in Manningham had attended pre-school programs, consistent with the Victorian average (Source: Australian Early Development Census).

The Australian Early Development Index (AEDI) utilizes data from the AEDC to track student development across the five key domains of:

1. physical health and wellbeing
2. social competence
3. emotional maturity
4. language and cognitive skills (school based)
5. communication skills and general knowledge

In Manningham, the proportion of children whose development is "on track" has declined across all domains since 2012 with corresponding increases in the proportion of children deemed "at risk" or "developmentally vulnerable". (Figure 8)



Source: Australian Early Development Index

Figure 8. Australian Early Development Index - students (per cent) "on track"

In 2018, the percentage of students "on track" was lowest for the social competence (77.8%), communication skills and general knowledge (79.8%) and physical health and wellbeing domain (79.9%). Physical health and wellbeing and social competence have shown the greatest decline since 2012.

With regard to developmental vulnerability:

1. 19% were vulnerable on at least 1 domain (Victoria – 19.9%), up from 14% in 2012.
2. 9.6% were vulnerable across 2 or more domains (Victoria – 10.1%), up from 6% in 2012.

6.2.2. Secondary school leavers (15 – 18 years)

A survey of Manningham's 2018 school leavers (*On Track*, Department of Education and Training) found:

1. More than 8 out of 10 (85.7%) planned to engage in further education or training (Bachelor Degree, Certificate/Diploma, or Apprentice/Trainee), compared to 75.2% for Victoria.
2. For those not continuing in further education or training (14.3%, compared to 24.8% for Victoria):
   a. 11.7% were employed, although two-thirds of these were engaged in part-time employment.
   b. 2.6% were looking for work

The post-school preferences of Manningham school leavers have remained relatively stable since 2012, indicating that many young people are opting to continue investing in education and training in order to enhance their future employment prospects. Notable is the five per cent of young people who have moved away from vocational training and towards apprenticeships and employment since 2012.

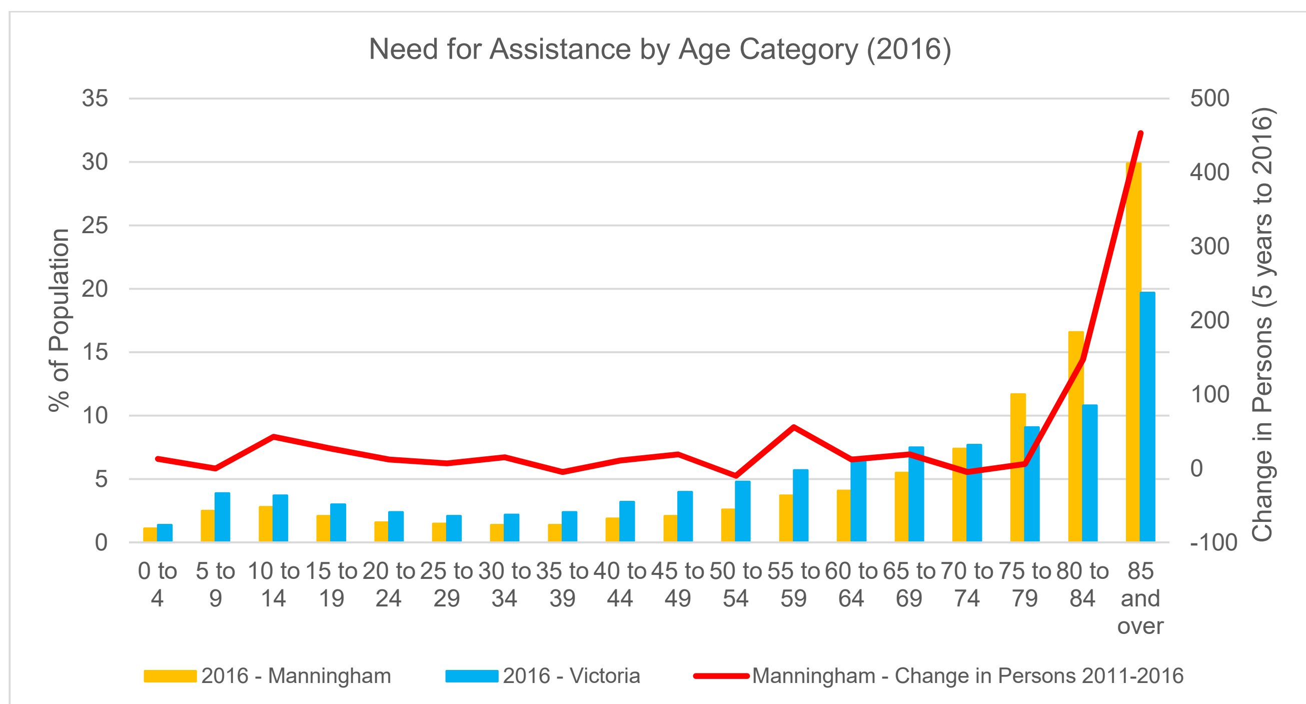
6.3. Need for Assistance

Need for assistance is captured in the Census and used as a proxy indicator for disability. However, it is important to note that it understates the prevalence of disability in the community for a number of reasons:

1. Some people do not disclose disability on the census due to the stigma still attached to having a disability, particularly in some cultural settings.
2. Some people have a disability but do not need 'help' in their daily lives, but rather use personal management, adaptive aids and technology, such as people who are deaf, blind, have mild autism or a mental illness. These cohorts would potentially not tick the question to indicate they require support in the census.
3. Some people have a disability but do not identify as having one (older adults who experience disability as a result of ageing, for example).

In 2016, 5,843 Manningham residents (5.0%) required assistance in their day-to-day lives due to disability, consistent with the wider Victorian average (5.1%). This represented an increase from 5,023 in 2011 (+18%) and 3,936 in 2006 (+48%), primarily among the oldest age groups which is consistent with Manningham's ageing population. (Figure 9)

Almost 7% of Aboriginal and Torres Strait Islander Victorians report they need assistance with core activities. For people under 65 years of age, 50 per 10,000 had used disability support services, 2.9 times the rate of non-Aboriginal people. *(Various sources, as cited in the EMPHN Needs Assessment Report, 2018)*



Source: Profile i.d.

Figure 9. Need for assistance by age

People needing assistance in Manningham are more likely to be older, with the increase since 2011 primarily among people aged 80+ years.

7.3% of people with a need for assistance in 2016 participated in the labour force - up from 6.2% in 2011, however this remains lower than the Victorian average (2016 – 9.2%, 2011 – 7.6 %).

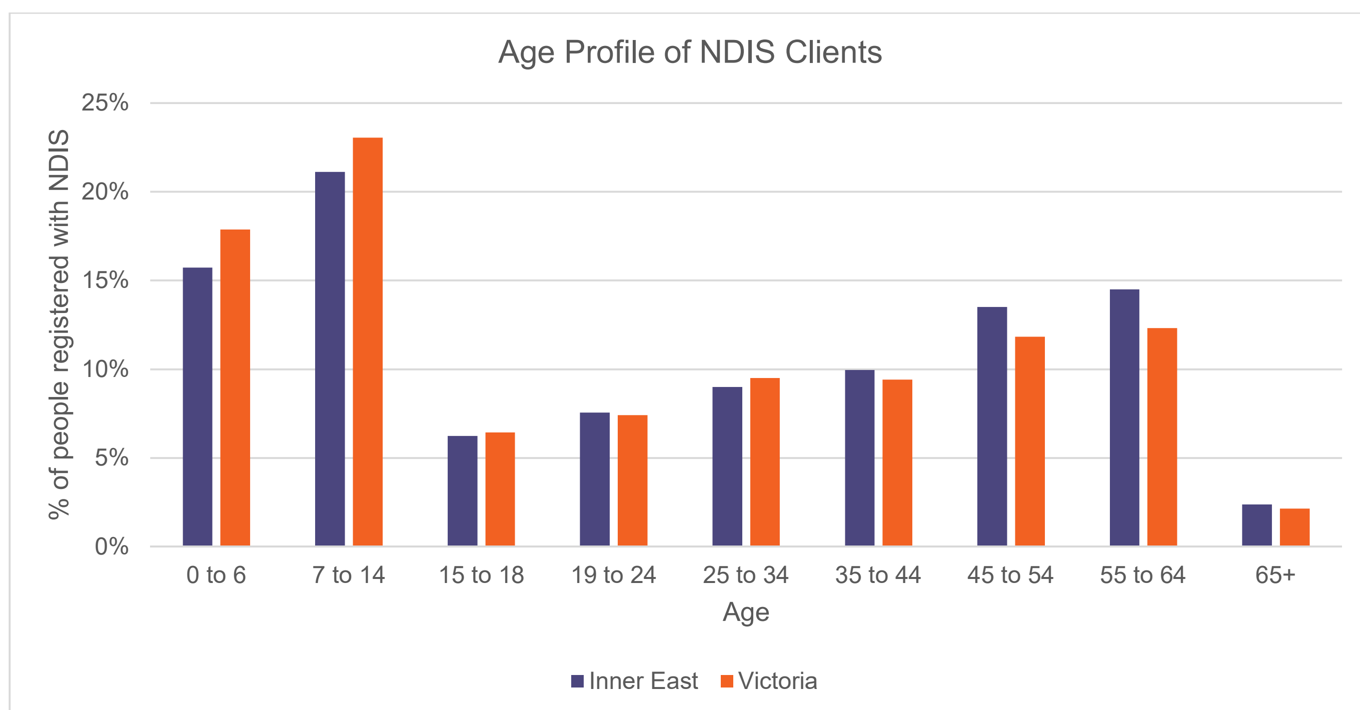
Females account for almost 6 out of every 10 (59%) people with need for assistance in Manningham compared to Victoria at 54.7%.

In terms of household type in 2016:

1. 66% live as couples with or without children (Victoria - 58.6%)
2. 17.1% live in lone person households (15.2% in 2011).
3. 13.9% are one parent families (Victoria – 17.9%)

As at 31 December 2019, 7,103 people had registered with the NDIS in the Inner Eastern Melbourne Service Region (Manningham, Boroondara, Whitehorse and Monash), of whom 1,310 live in Manningham i.e. only 1.0% of the Manningham population had registered to receive assistance through the NDIS.

In the Inner East, young people (0-14 years) represent a smaller proportion of NDIS clients and older people (35+ years) a larger proportion of NDIS clients compared to Victoria. (Figure 10)



Source: National Disability Insurance Agency
Figure 10. Age profile of NDIS participants

Disaggregated by gender, NDIS participants nationally include 37% who identify as *female*, 61% as *male*, and 1% as *other*.

The type of disability experienced by NDIS participants in the Inner East Service Region broadly reflects the wider Victorian profile, as illustrated in Figure 11 below. Of particular note are:

1. the greater proportion of NDIS participants in the Inner East with cerebral palsy, multiple sclerosis, hearing impairment, and other neurological conditions;
2. the greater proportion of NDIS participants in the Inner East with autism, which present a range of access and support challenges, including complex behaviours and sensory requirements.

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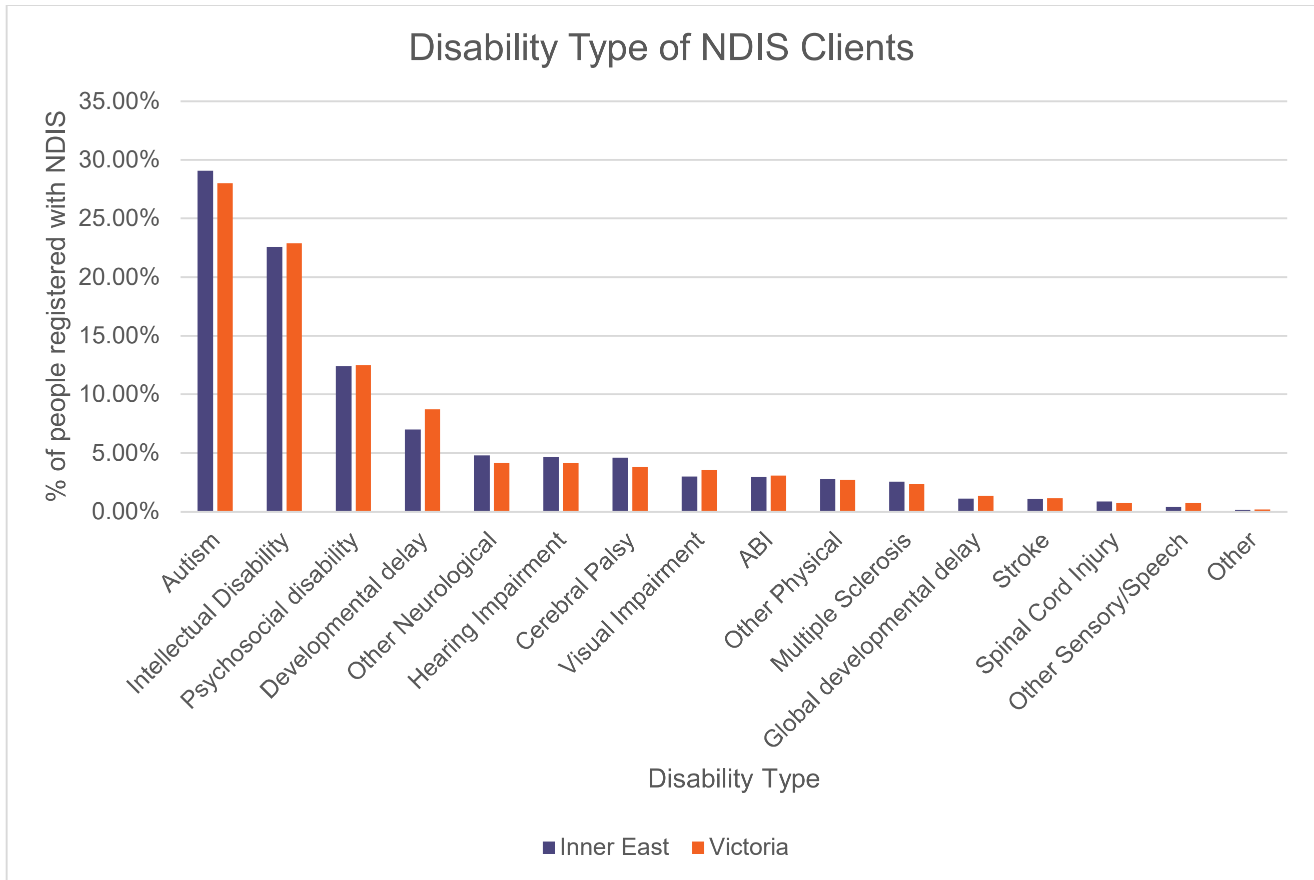

Source: *Source: National Disability Insurance Agency*

Figure 11. Disability type of NDIS participants

6.4. Culturally Diverse People

An understanding of the changing cultural diversity in Manningham enables Council to respond appropriately to the culturally diverse needs of communities; to build and advocate for enhanced cultural capability within Council and service providers, and to support targeted inclusion efforts to build cross-cultural understanding and social cohesion.

In 2016, almost 4 in every 10 Manningham residents (39.8%, 46,362 people) were born overseas, representing an increase of 5,713 people from 2011 (36.5%, 40,669 people). During the same period, Manningham's Estimated Resident Population increased by 5,820 persons, indicating that 98% of the net population growth was due to people born overseas.

In 2016, Manningham residents born overseas originated from 98 countries, with the top 10 countries accounting for 71% of people born overseas. People born in China and Hong Kong constitute 12% of the Manningham population, whilst people from Malaysia, Italy, U.K and Greece all together constitute 11.1% of the Manningham population. Manningham has a higher proportion of residents born in China, Malaysia, Italy, Hong Kong, Greece and South Africa than does the EMR or Victoria, as illustrated below in Figure 12.

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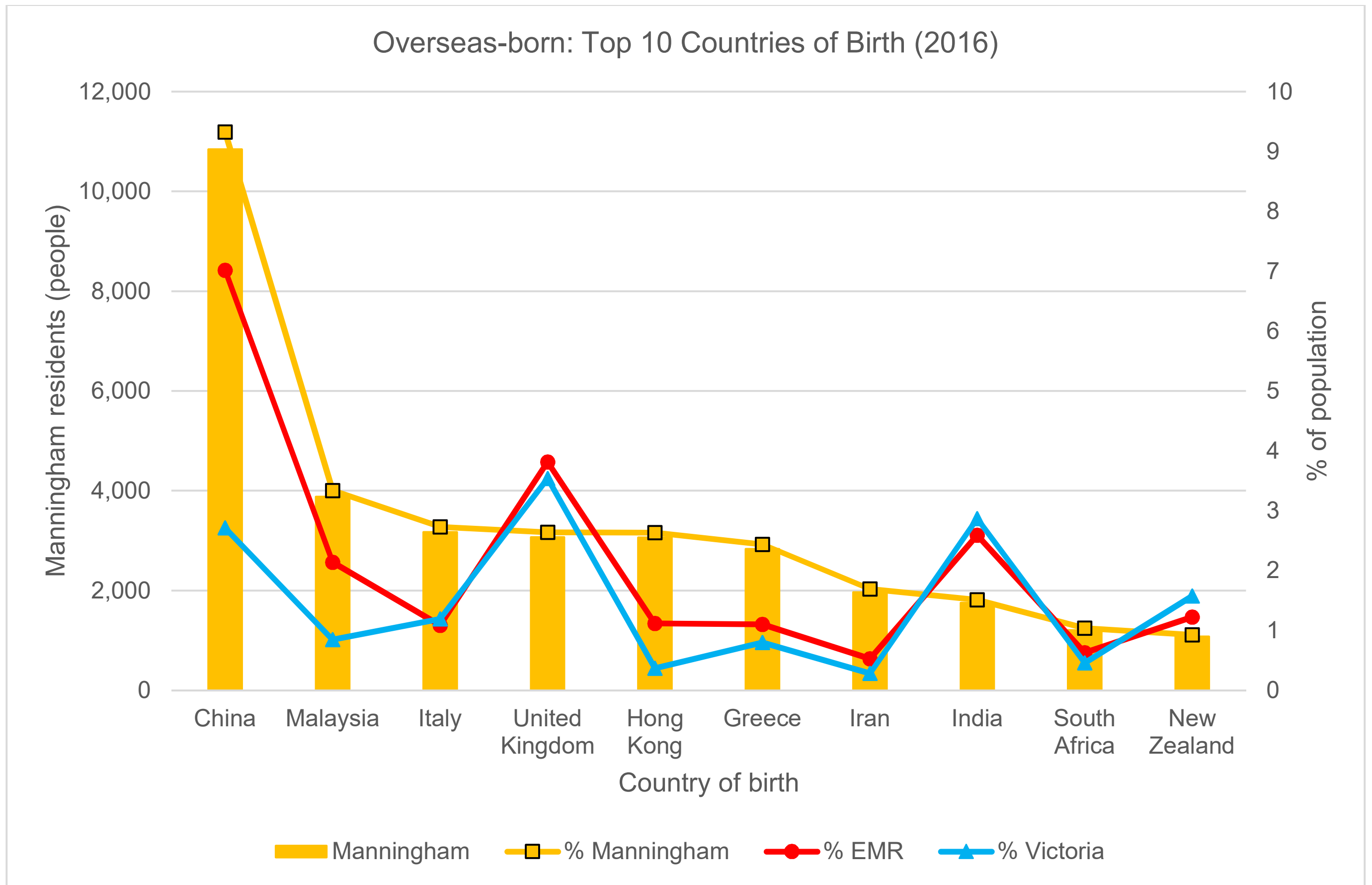

Source: Profile i.d.

Figure 12. Top 10 countries of birth for overseas-born residents

6.5. Aboriginal and Torres Strait Islander Peoples

Manningham's Aboriginal and Torres Strait Islander community is diverse, with varied cultures, heritages and histories. Based on the 2016 Census data, Manningham hosts a population of 209 people who identify as Aboriginal and/or Torres Strait Islander, representing 0.2% of the resident population. Census data does not take into consideration those who may reside outside Manningham but have continuing cultural or community connections to the municipality. The *Local Government Act 2020* refers directly to Traditional Owners of land in the municipal district of the Council as members of the municipal community.

An understanding of local Aboriginal and Torres Strait Islander communities enables Council to provide and advocate for culturally-appropriate services which serve the needs of these communities and which progress Council's commitment to reconciliation.

In 2016, 209 Manningham residents identified as Aboriginal and/or Torres Strait Islander, an increase of 48% (62 people) from 2011. The increase was across a range of 5-year age categories. Figure 13 illustrates the age profile of Manningham's Aboriginal and Torres Strait Islander community in 2016, of whom half were less than 25 years.

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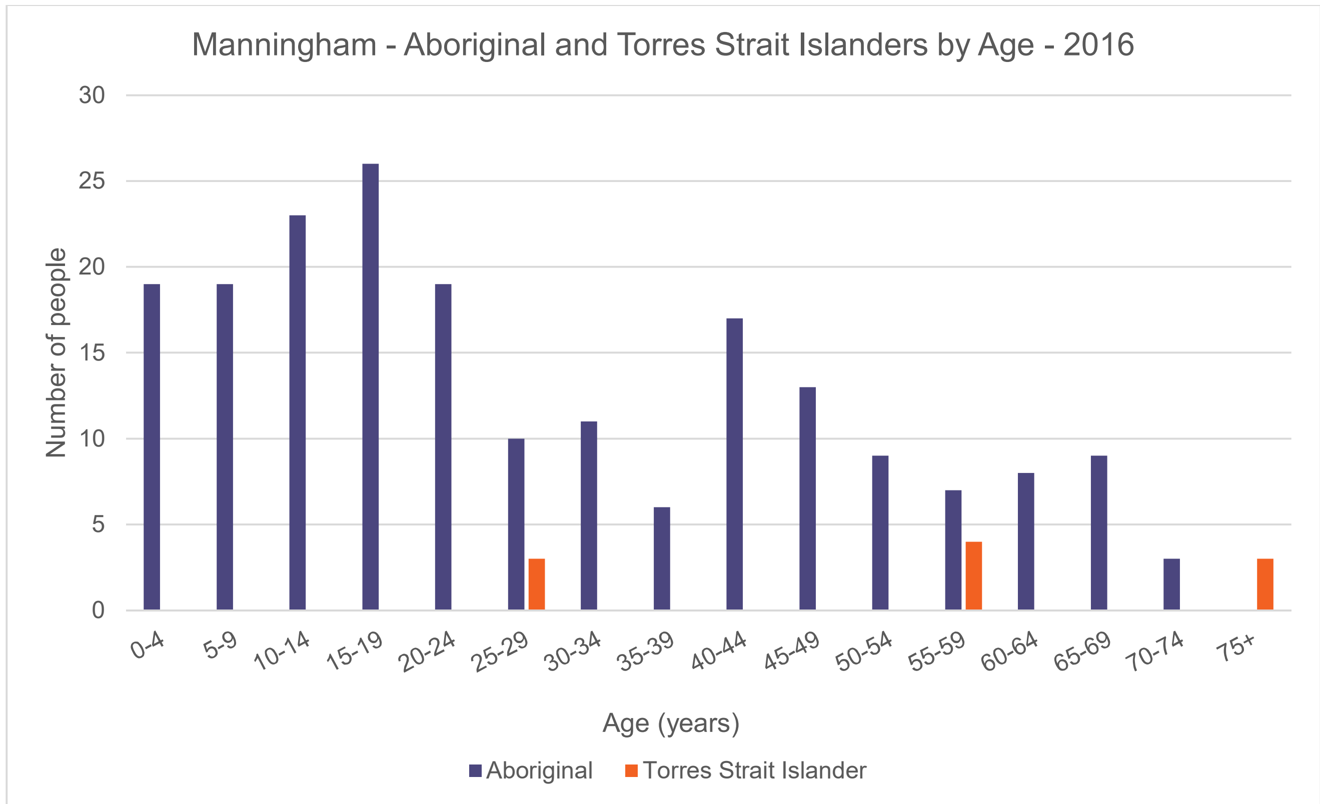

Source: Australian Bureau of Statistics, Census 2016

Figure 13. Aboriginal and Torres Strait Islander People by age

6.6. LGBTQIA+ People

Data regarding LGBTQIA+ communities in Manningham is currently limited. However, some data is available at the Eastern Metropolitan Region and at state level which provides important insights into the current and emerging needs of LGBTQIA+ communities. Such data is included throughout this report, where available.

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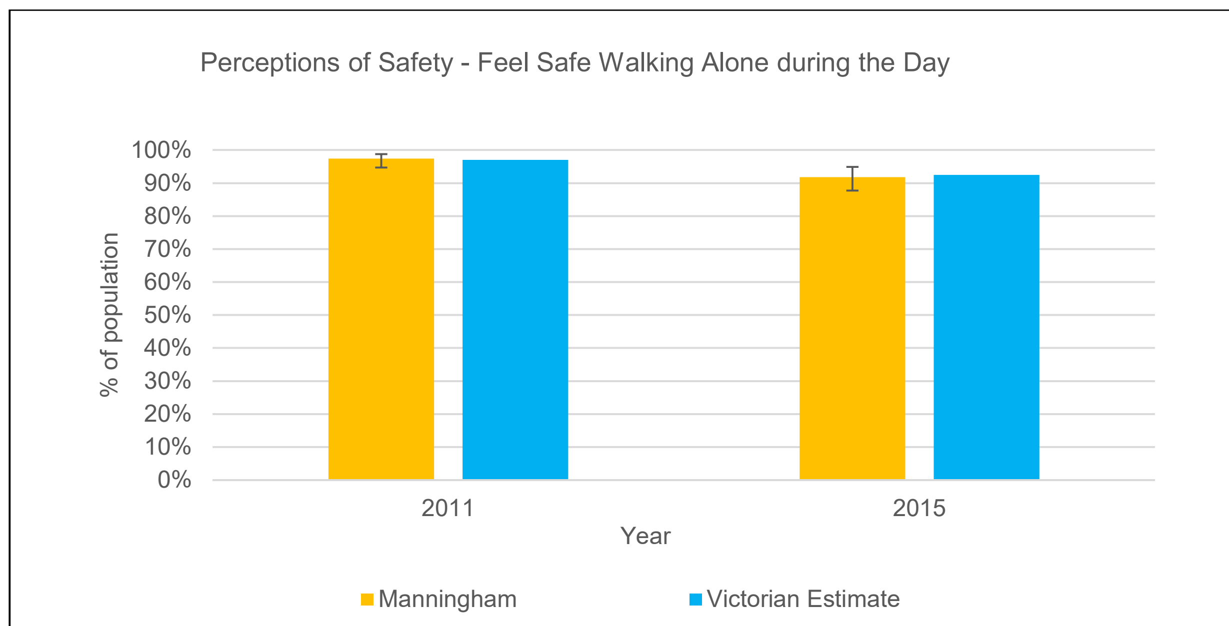
7. Community Safety

Community safety encompasses a range of factors including perceptions of safety, crime rates, family violence incidents, transport accidents and avoidable injuries. Community safety can be influenced by a range of factors including economic disadvantage, employment opportunities, alcohol and other drugs, and attitudes towards women.

7.1. Perceptions of Safety

The vast majority of Manningham residents feel safe walking alone during the day (2015 - 91.8%) in line with the Victorian estimate. However, fewer people in both Manningham and Victoria felt safe in 2015 than was the case in 2011, as illustrated below in Figure 14.



Source: VicHealth Indicators Survey, 2011 & 2015

Figure 14. Perceptions of safety walking alone during the day

In 2015, 55.3% of Manningham residents reported feeling safe walking alone after dark, down from 68.7% in 2011 as illustrated overleaf in Figure 15.

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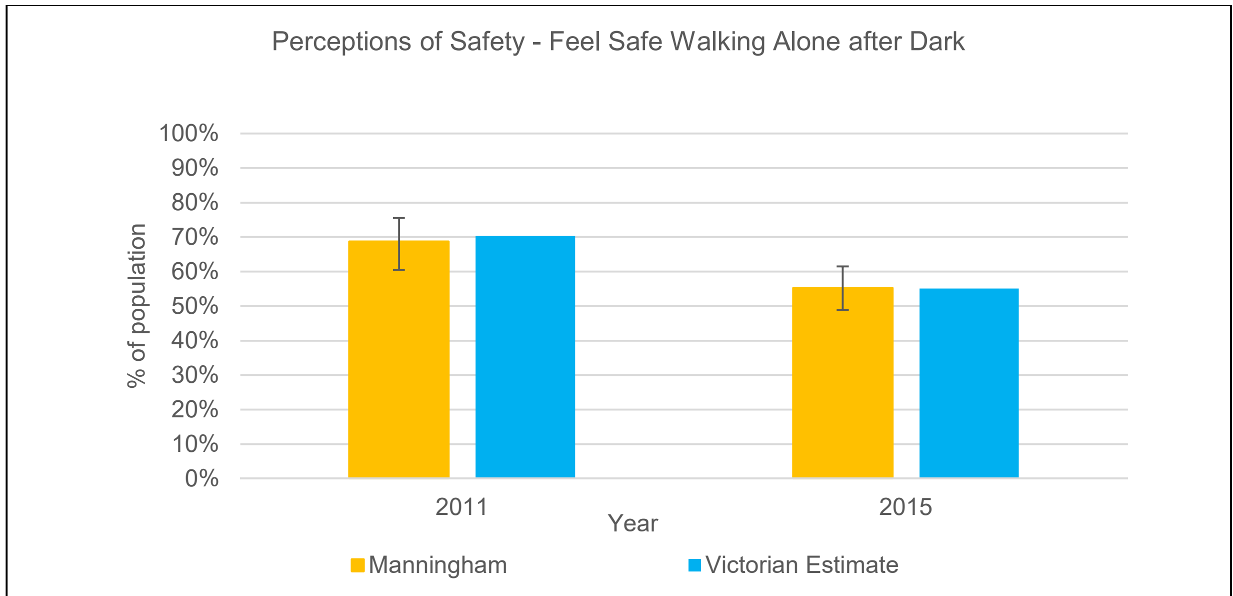


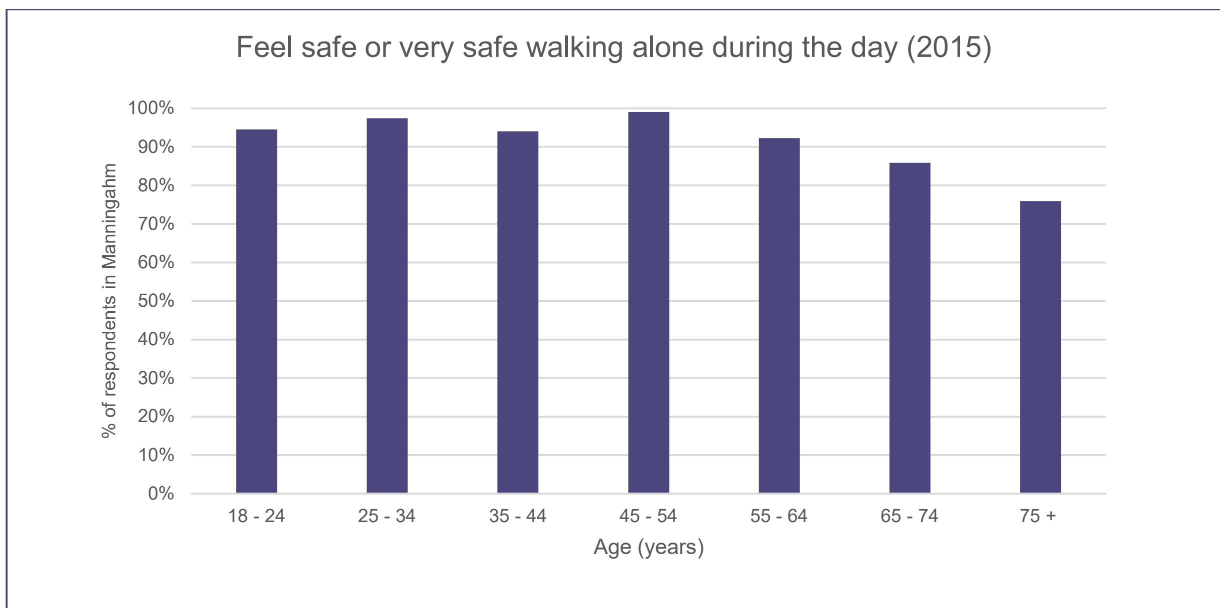
Source: VicHealth Indicators Survey, 2011 & 2015

Figure 15. Perceptions of safety walking alone after dark

Perceptions of safety differ significantly based on gender. In 2015, 86.8% of women felt safe walking alone during the day, whilst only 29.7% felt safe walking alone after dark. For men, the figures were 97.3% and 83.1% respectively.

Victorians with disability are only *half as likely* to feel safe walking alone during the day compared to Victorians without disability. *(VicHealth Indicators Survey 2015 Supplementary Report: Disability)*

People aged less than 65 years are more likely to feel safe walking alone during the day (92% - 99%). Older people are less likely to feel safe, with 1 in 4 people aged 75+ years not feeling safe walking alone during the day as illustrated below in Figure 16.



Source: VicHealth Indicators Survey, 2015

Figure 16. Feel safe walking alone during the day by age

After dark, around half of people aged 35-44 years and 55+ years feel safe walking alone, whilst around 70% of those aged 25-34 and 45-54 feel safe as illustrated below in Figure 17.

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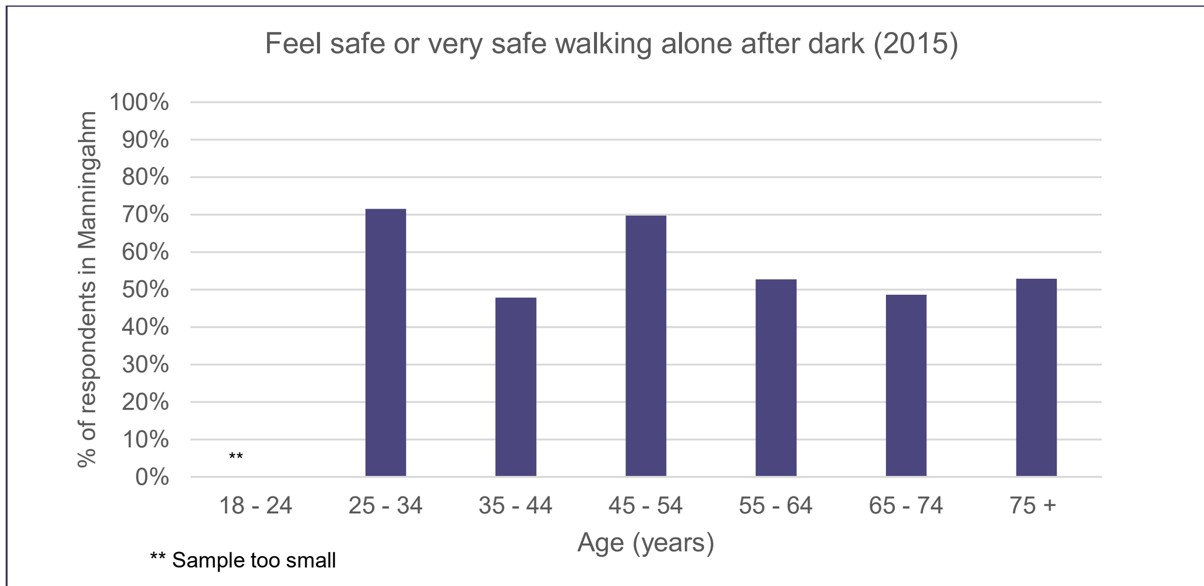
Victorians with a disability are *one-third less likely* to feel safe walking alone after dark, compared to Victorians without a disability. *(VicHealth Indicators Survey 2015 Supplementary Report: Disability)*



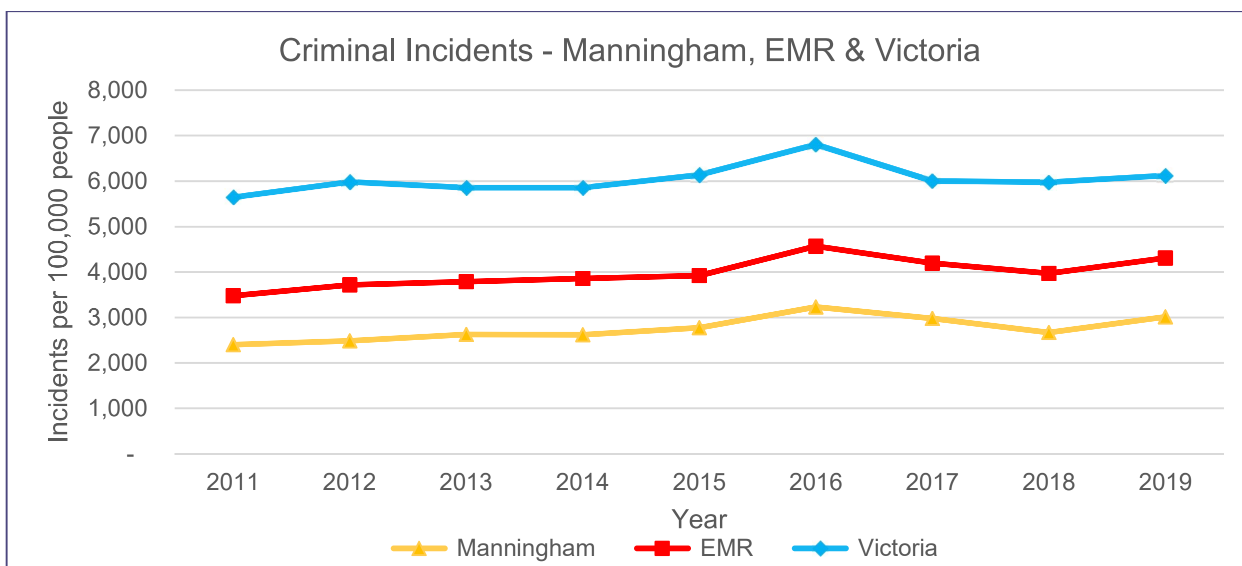
Source: VicHealth Indicators Survey, 2015

Figure 17. Feel safe walking along after dark by age

In 2015, there was no significant difference in perceptions of safety between people LGBTQIA+ people and the wider community. *(VicHealth Indicators Survey 2015 Supplementary report: Sexuality)*

7.2. Crime Rates

Manningham continues to be one of the safest municipalities in Victoria. Since 2011, crime rates within the municipality have fluctuated in line with wider trends across Victoria and the EMR (Figure 18).



Source: Victorian Crime Statistics Agency

Figure 18. Rate of criminal incidents by year

Manningham experiences the same types of crimes as the wider State, albeit at a lower rate. *Property and deception offences* are most common, representing more than 72.0% of all offences in Manningham in 2019, followed by *crimes against the person* (13.6%). (Table 4)

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Offence Division	Year								
	2011	2012	2013	2014	2015	2016	2017	2018	2019
Crimes against the person	342	377	394	399	467	570	495	485	522
Property and deception offences	2,196	2,272	2,413	2,364	2,459	2,953	2,686	2,392	2,758
Drug offences	91	80	120	136	129	93	122	130	117
Public order and security offences	79	105	98	87	107	107	100	92	120
Justice procedures offences	84	84	86	141	188	236	295	243	307
Other offences	12	5	1	3	5	3	1	4	6
Total	**2,804**	**2,923**	**3,112**	**3,130**	**3,355**	**3,962**	**3,699**	**3,346**	**3,830**

Source: Victorian Crime Statistics Agency

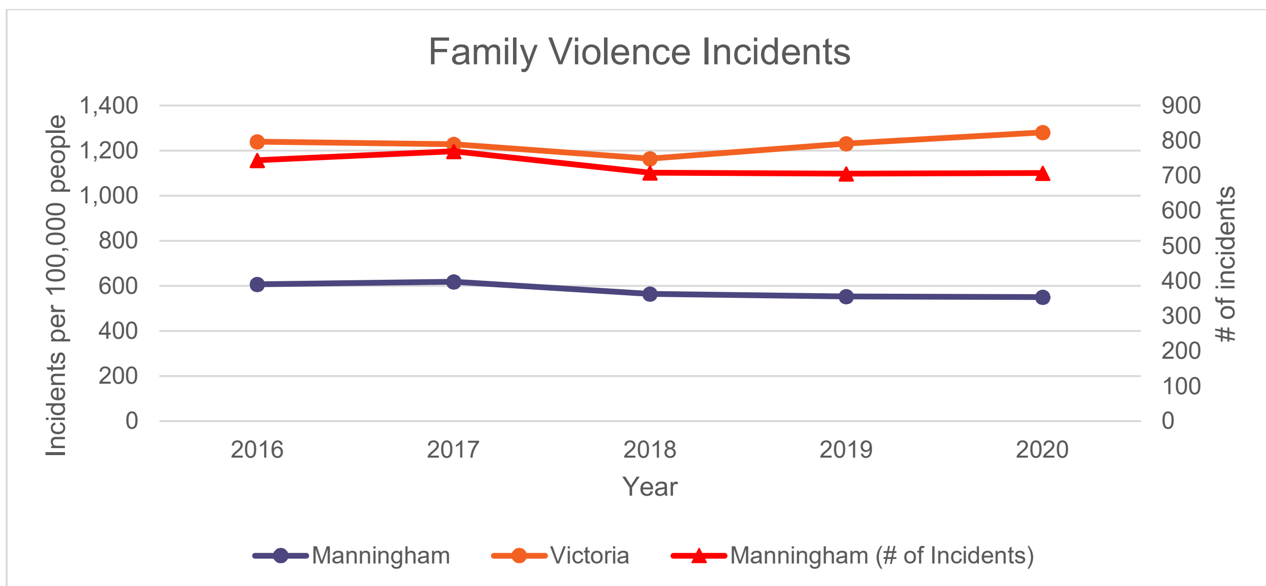
Table 4. Offence division by year

Of particular note is the increase in the number of *justice procedure offences* and *crimes against the person* since 2011. In 2019, almost half (46.5%) of *justice procedure offences* were due to *breaches of family violence orders* and almost one-third (31.9%) due to *breaches in bail conditions*. In 2019, 61.7% of *crimes against the person* were due to *assault and related offences*, and 12.6% due to *stalking, harassment and threatening behaviour*.

Further information is available at https://www.crimestatistics.vic.gov.au/

7.3. Family Violence Incidents

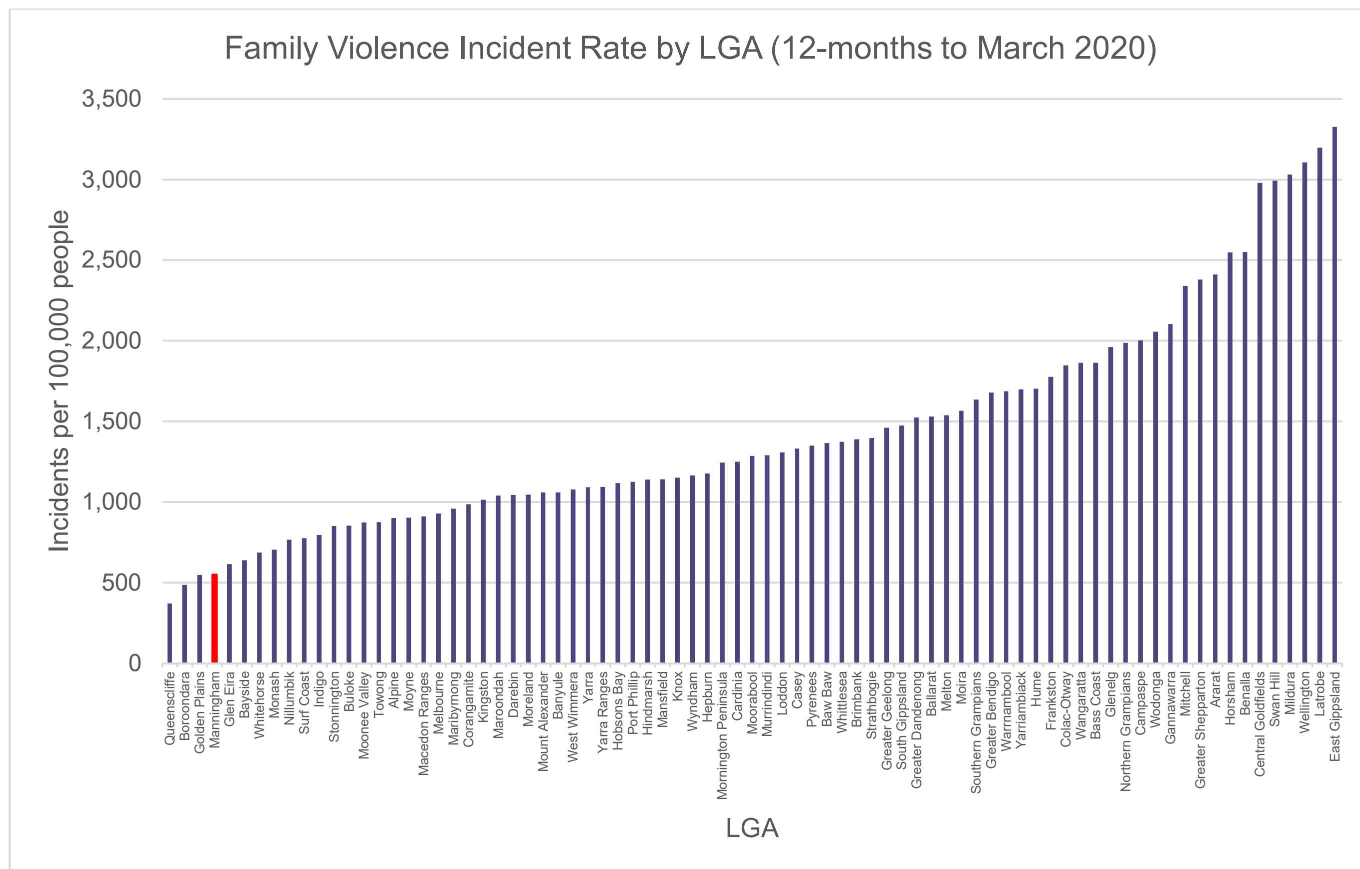
Manningham experiences less than half of reported family violence incidents compared to the Victorian average and changes in the municipality since 2016 broadly correlate with those across the state, as illustrated in Figure 19 below.



Source: Victorian Crime Statistics Agency

Figure 19. Family violence incidents by year

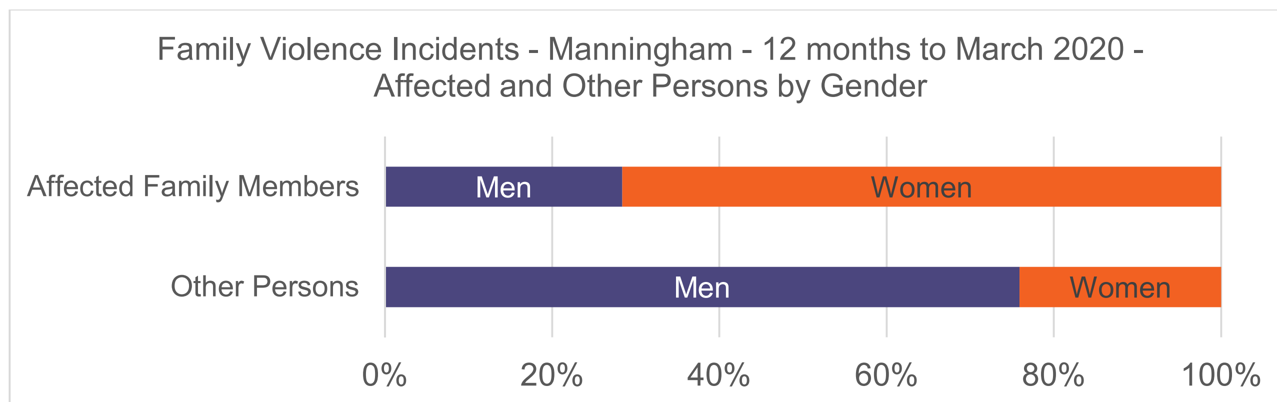
In the 12-months to March 2020, Manningham had one of the lowest rates of family violence compared to other Victorian LGAs as illustrated below in Figure 20.



Source: Crime Statistics Agency

Figure 20. Family violence incident rate by LGA (12-months to March 2020)

In the 12 months to March 2020, women accounted for 72% of people affected by family incidents in Manningham, whilst men accounted for more than 76% of “Other Persons” (i.e. the person responsible for the reported family incident) as illustrated below in Figure 21. This is consistent with the wider Victorian experience.



Source: Victorian Crime Statistics Agency

Figure 21. Manningham, family violence incidents by gender

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Family incidents affect people of all ages. In Manningham in 2020:

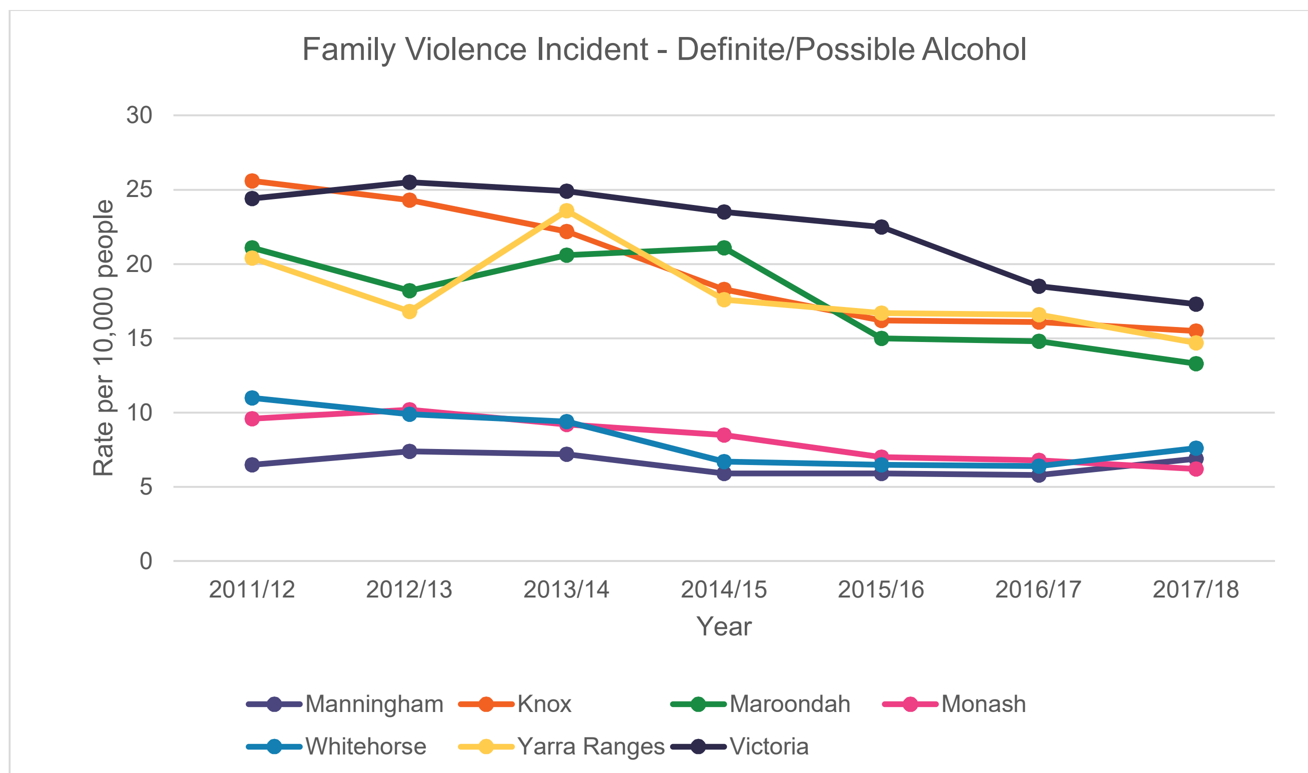
- 7.4% were aged 0 to 17 years
- 9.9% were aged 18 to 24 years
- 18.4% were aged 25 to 34 years
- 23.9% were aged 35 to 44 years
- 20.3% were aged 45 to 54 years
- 20.1% were aged 55+ years

The age distribution of affected people has remained relatively unchanged since 2016.

The incidence of possible or definite alcohol involvement in family violence incidents is low in Manningham compared to the Victorian average. However, the Victorian average trended down significantly from 2013/14 – 2017/18, whereas Manningham's rate remained relatively static and increased slightly in 2017/18 as illustrated below in Figure 22.

LGBTQIA+ Victorians are *more than twice as* likely to have experienced family violence (13.4%) compared to the broader population (5.1%). *(Discussion Paper for the Victorian LGBTIQ Strategy)*

Within the EMR, Manningham, Whitehorse and Monash exhibit similarly low levels of alcohol involvement in family incidents. However, Manningham and Whitehorse increased slightly and Monash decreased slightly in the 12 months to June 2018.



Source: AODStats by Turning Point and Monash University

Figure 22. Family violence incidents involving alcohol by LGA

Further information is available at https://www.crimestatistics.vic.gov.au/family-violence-data-portal

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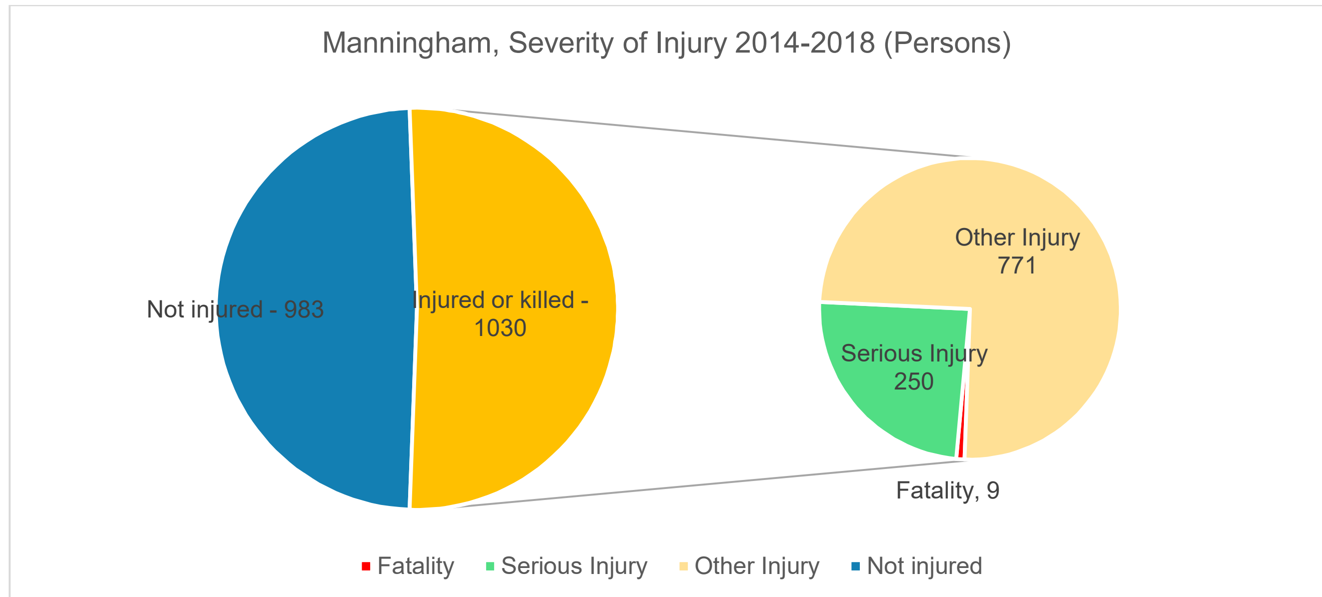
7.4. Transport Accidents

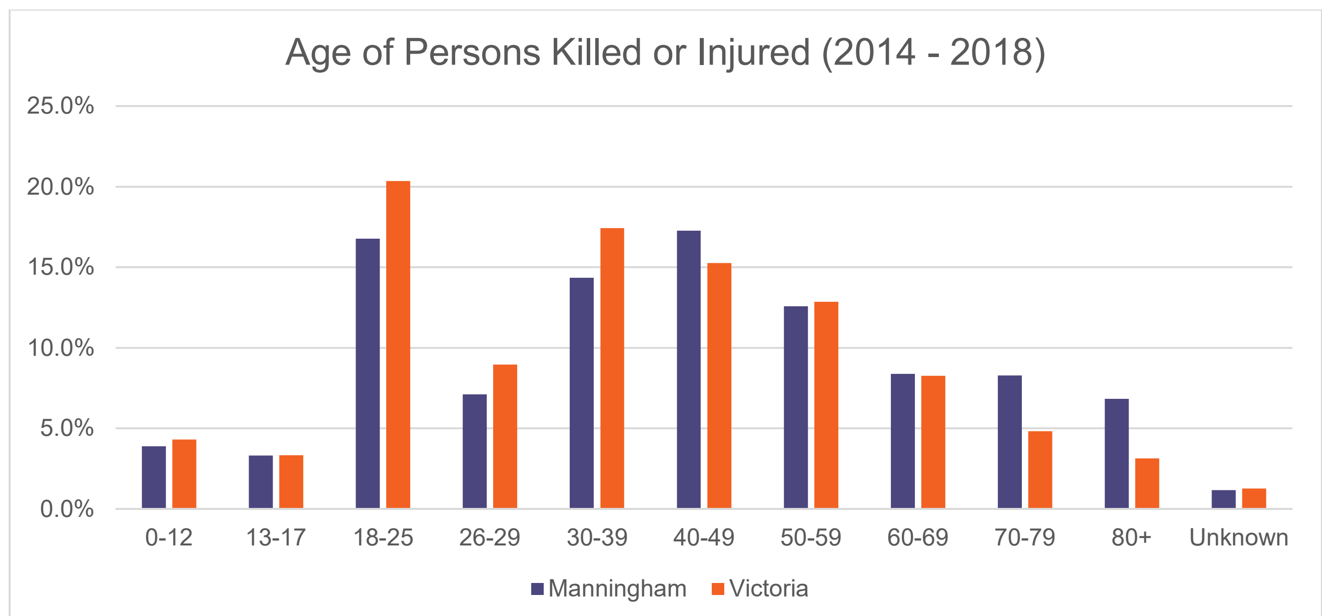
In the period 2014-2018, 820 accidents occurred on Manningham's roads which involved 2,013 people. More than half (50.7%) were injured in some way, with 250 seriously injured. Nine people died. (Figure 23).



Source: VicRoads

Figure 23. Severity of transport accident injury (2014-2018)

The age distribution of persons killed or injured generally correlates with Victorian state figures for the same period. However, of note is the lesser proportion in Manningham of people aged 18-39, and the greater proportion of people aged 70+ who were killed or injured as illustrated in Figure 24 below.



Source: VicRoads

Figure 24. Age of persons killed or injured due to transport accidents (2014-2018)

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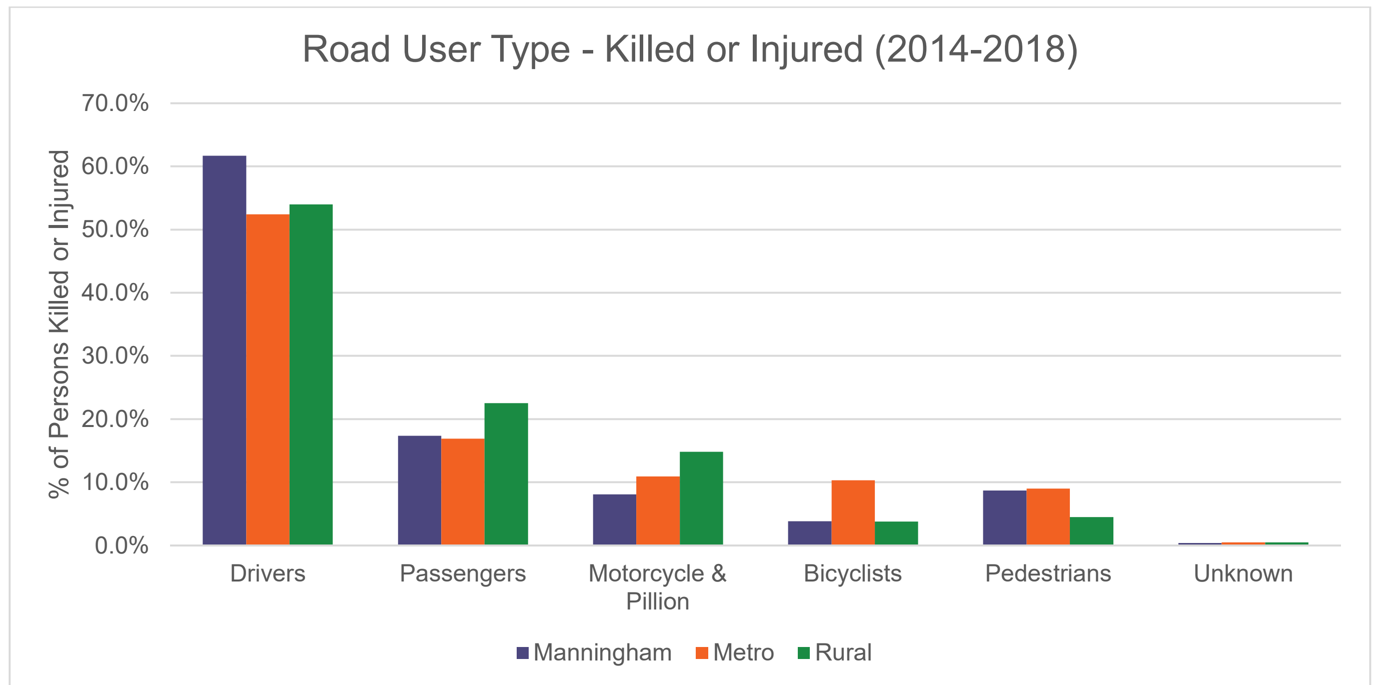
In Manningham, people killed or injured in an accident are more likely to be a driver and less likely to be a motorcyclist or bicyclist than is the case for metropolitan and rural averages, as illustrated in Figure 25 below.



Source: VicRoads

Figure 25. Persons killed or injured by road user type (2014-2018)

Further information is available at:

https://www.vicroads.vic.gov.au/safety-and-road-rules/safety-statistics/crash-statistics

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8. Housing

The ability to access secure, affordable, appropriate housing is a human right that affords people dignity and is essential for people to achieve their full potential.

8.1. Household Type

In 2020, it is forecast that there are 47,821 households in Manningham, with the dominant housing type being *Couple Families with Dependents* (18,241 or 39.1%).

From 2020 to 2030, the number of households is forecast to increase by 5,673 or 11.9%. *Lone person households* and *one parent families* are forecast to increase to 20.4% and 9.5% respectively, whilst *Couple families with dependents* are forecast to reduce to 36.8%. (Table 5)

Household Type	2020		2025		2030		Change 2020 - 2030
	Households	%	Households	%	Households	%	
Couple families with dependents	18,241	39.1	19,021	37.3	19,665	36.8	1,424
Couples without dependents	13,522	28.3	14,367	28.2	15,037	28.1	1,515
Group households	1,019	2.0	1,096	2.1	1,163	2.2	144
Lone person households	9,248	18.6	10,215	20.0	10,937	20.4	1,689
One parent family	4,347	8.9	4,757	9.3	5,097	9.5	750
Other families	1,444	3.0	1,527	3.0	1,595	3.0	151
Total	**47,821**	**100.0**	**53,008**		**53,494**	**100.0**	**5,673**

Source: Forecast i.d.

Table 5. Household type (2020 to 2030)

8.2. Household Income

Under the Planning and Environment Act, affordable housing is defined as housing (including social housing) that is appropriate to the needs of very low, low, and moderate income households. The thresholds for very low, low and moderate income are defined for different household types by the Minister for Planning from time to time and published in the Victorian Government Gazette. Table 5 below indicates the distribution of household incomes in Manningham.

Household Income	Number	Percentage
Very low income	10,760	24%
Low income	8,560	19%
Moderate income	8,420	19%
Higher income	16,870	38%

Source: SGS Manningham Affordable Housing Needs Analysis

Table 6. Household income

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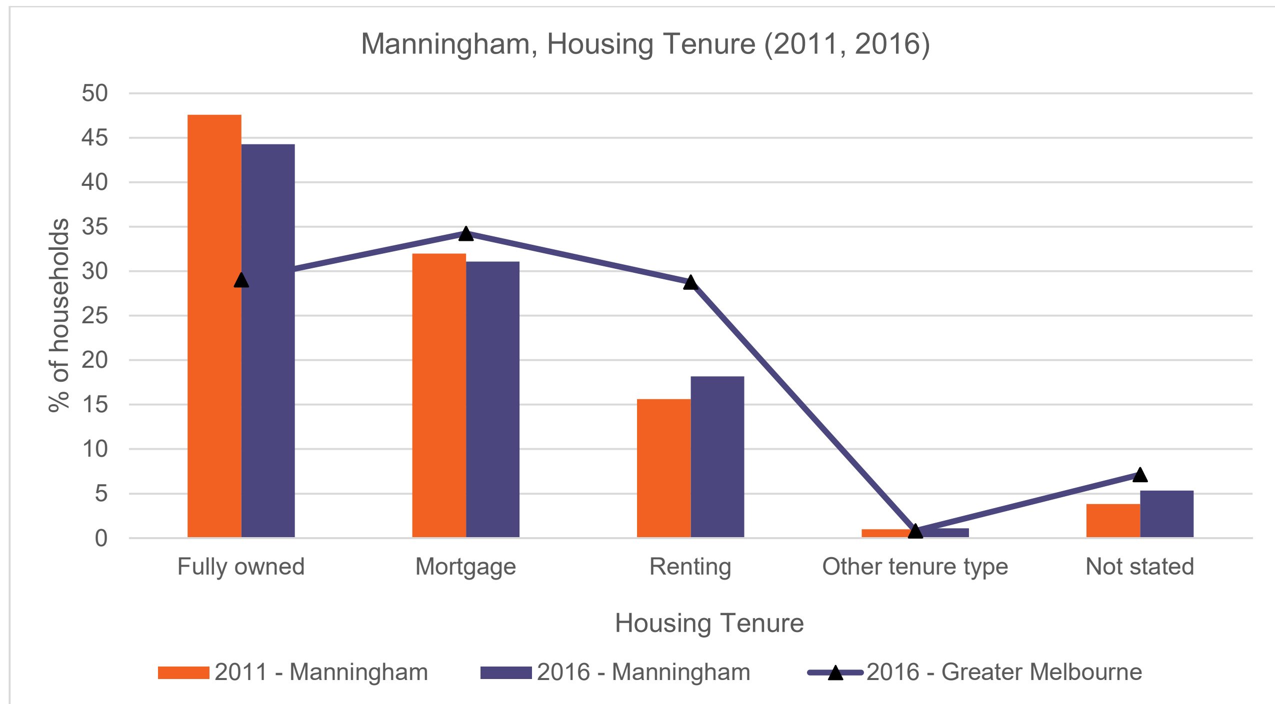
8.3. Housing Tenure

In Manningham, a greater proportion of houses are fully owned compared to Greater Melbourne (44.3% and 29.0% respectively in 2016), and a lessor proportion is renting. However, in the period for 2011 to 2016, the proportion of households renting in Manningham increased whilst fully owned houses decreased as illustrated below in Figure 26.



Source: Profile i.d.

Figure 26. Housing tenure

8.4. Affordable Housing and Homelessness

Housing stress occurs where households are required to spend more than 30% of income on mortgage or rental payments.

It is estimated 3,390 households were in rental stress, homeless or social housing in 2016, consisting of:

- 1,520 households in moderate rental stress
- 1,370 households in severe rental stress
- 290 households in social housing
- 220 people experiencing homelessness

Source: SGS Affordable Housing Study, 2019

This total could grow to between 4,120 and 4,530 households by 2036 – an increase of between 21 and 34 per cent. The range depends on population growth and income growth relative to rising rents.

There are 2,283 households on the priority access register waiting to move into or transfer to social housing properties in the Inner Eastern Melbourne Region. There are currently 290 social housing dwellings in Manningham, of which approximately two-thirds are public housing and the remainder are owned and operated by Registered Housing Agencies (community housing).

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People experiencing homelessness (220) represent 0.5% of all households in the municipality. Almost half were living in supported accommodation and one-quarter were living in 'severely' crowded dwellings.

It is estimated there is a 60% shortfall in Specialist Disability Accommodation (SDA) for people with extreme functional impairment or very high support needs across the nation. *(Summer Foundation SDA Market Insights Report, 2018)*

Manningham Inclusive Community Housing (MICH) is a local organisation which supports people with disability and their families to secure appropriate residential accommodation. MICH report having 42 people in need of accommodation on their waiting list.

Structural inequalities and trauma contribute to LGBTQIA+ people being at least *twice* as likely to ever have experienced homelessness. *(VicHealth Indicators Survey 2015 Supplementary report: Sexuality)*

9. Climate Change

9.1. Energy ($C0_2$ emissions)

9.1.1. Municipality

In 2018/19, 1,185,800 tonnes of CO_2 were emitted in Manningham - an increase of 45,000 tonnes or 3.9% from the previous year. (Table 7)

Source	Sector	2017/18		2018/19		Change
		CO_2 tonnes	%	CO_2 tonnes	%	CO_2 tonnes
Electricity	Residential	239,200	21.0%	244,000	20.6%	4,800
	Commercial	225,000	19.7%	216,300	18.2%	-8,700
	Industrial	36,700	3.2%	35,300	3.0%	-1,400
Gas	Residential	137,300	12.0%	147,300	12.4%	10,000
	Commercial	40,900	3.6%	80,100	6.8%	39,200
	Industrial	6,700	0.6%	8,800	0.7%	2,100
Transport	On road	419,800	36.8%	420,500	35.5%	700
Waste	Landfill	22,400	2.0%	19,600	1.7%	-2,800
	Water	12,800	1.1%	13,900	1.2%	1,100
Total		**1,140,800**	**100.0%**	**1,185,800**	**100.0%**	**45,000**

Source: Snapshot (snapshotclimate.com.au)

Table 7. CO_2 Emissions

In 2018/19, transportation (petroleum, diesel) accounted for 35.5% of emissions, whilst residential consumption (gas, electricity) accounted for 33.0% of emissions.

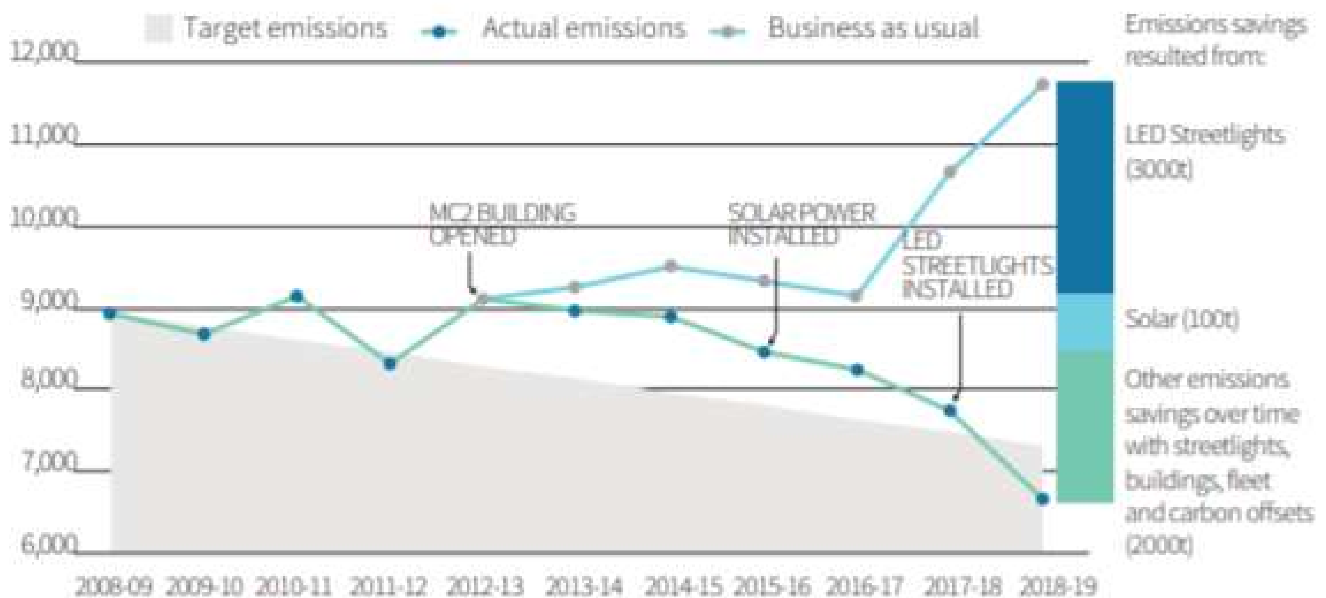
Commercial emissions accounted for 25.0% and further investigation is required to understand the drivers behind the almost doubling of gas consumption from 2017/18 to 2018/19.

Electricity emissions were twice that of gas emissions (41.8% and 19.9% respectively). However, the decreases have been in electricity emissions (commercial and industrial).

Annual CO_2 residential emissions per capita increased from 3.01 tonnes to 3.10 tonnes between 2017/18 and 2018/19, two-thirds of which was due to increased gas consumption.

9.1.2. Council

Council has reduced its emissions by 25% (2008/09 baseline) through the installation of solar power generation capacity; energy efficient street lighting; and, hybrid vehicles as illustrated below in Figure 27.



Source: Manningham Environment Report 2018/19

Figure 27. Manningham City Council, emission reductions by year

9.2. Waste

Since 2014/15, landfill has reduced year-on-year. In 2018/19, 55% of waste (24,310 tonnes) was diverted from landfill, with the lowest level of waste sent to landfill since 2001/02 (19,648 tonnes).

In addition, green waste as a proportion of all waste increased significantly in 2016/17. Since then it has remained at a relatively high level though is trending down in line with landfill.

The data suggests a significant shift in the awareness and behaviour of Manningham residents with regard to waste with these positive changes occurring despite population growth, as illustrated below in Figure 28.

Source: Manningham Environment Report 2018/19

Figure 28. Waste tonnage by year

9.3. Water

In 2019/20, residential water consumption accounted for 89% of all water consumption in Manningham.

Total annual water consumption increased by 9.0% from 2014/15 (8.84 Gigalitres) to 2018/19 (9.64 Gigalitres), before decreasing by 3.7% in 2019/20 (9.28 Gigalitres).

In 2019/20, the daily potable water usage per person was 174 litres per person per day – the lowest level since 2011/12 when Melbourne was in the midst of drought. In 2018/19, water usage spiked to 184 litres per person per day, before reducing in 2019/20 as illustrated below in Figure 29.

Manningham's 2019/20 average daily consumption per person is above Yarra Valley Water's target of 155 litres per person per day.

In 2019/20, 462 residential properties and one business had access to reticulated recycled water. Recycled water constituted 0.4% of annual consumption across the municipality.

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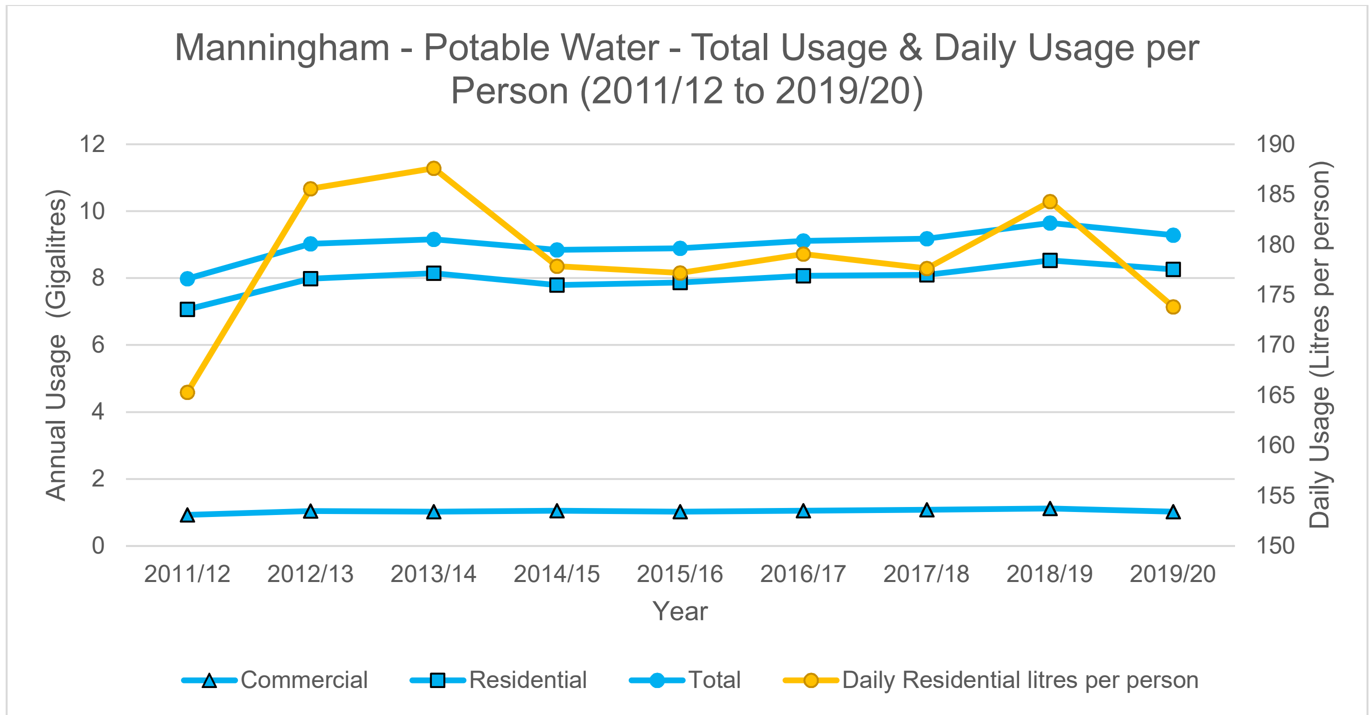

Source Yarra Valley Water, Profile i.d and Forecast i.d

Figure 29. Potable water usage by year

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10. Healthy Eating, Active Living and other Behaviours

Active living and healthy eating are the most accessible and impactful ways people can support their own health and wellbeing. A lack of exercise and/or poor eating can contribute to obesity, certain types of disease, poorer mental health outcomes and lower quality of life, among other things.

10.1. Healthy Eating

Consumption of the recommended daily serves of fruit and vegetables is a lead indicator for healthy development in children and the prevention of obesity and certain diseases.

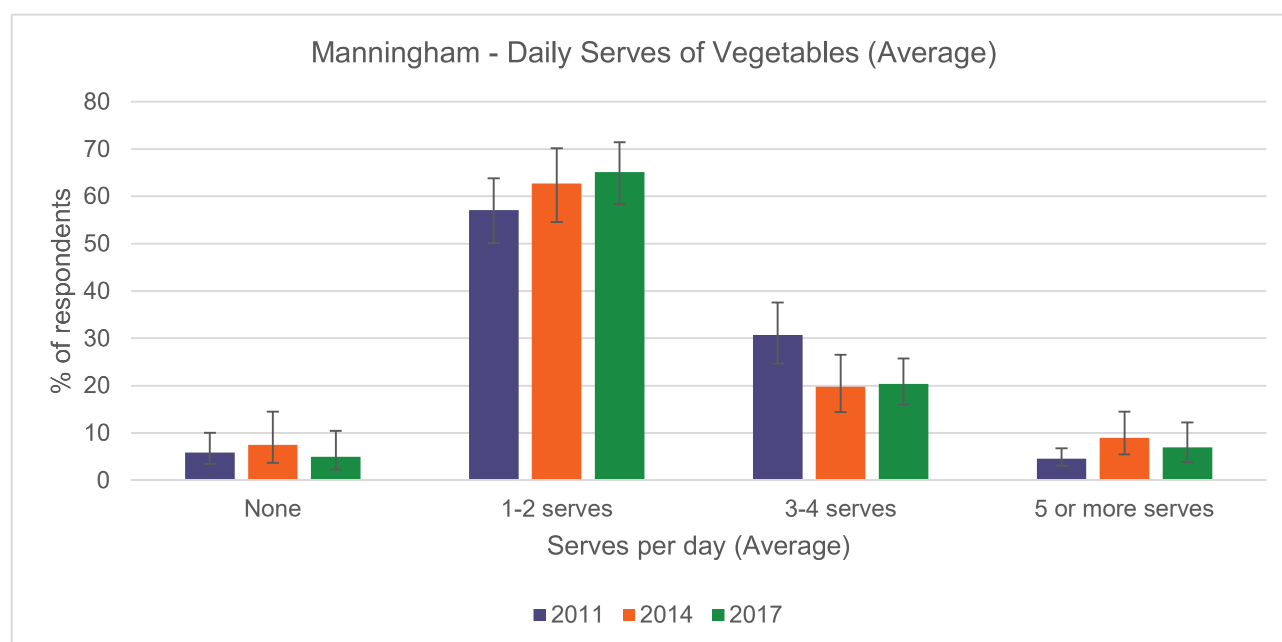
10.1.1. Vegetable Consumption

The Australian Dietary Guidelines recommend that 5 to 6 daily serves of vegetables and legumes be consumed, depending upon gender and age. In 2017, approximately 1 in 10 people (2.9% - 11.1%) in Manningham ate the recommended daily serves of vegetables - a figure which has not changed significantly since 2011. Disaggregated by gender, those eating the recommended daily serves include:

- 1.8%-4.3% of men (Victoria: 1.9%- 2.6%)
- 4.5%-19.2% of women (Victoria: 7.8%-9.1%)

Therefore, women are at least *2-5 times more likely* to eat the recommended daily serve of vegetables than men in Manningham. These figures broadly reflect Victorian averages.

Nonetheless, too many men and women in Manningham continue to eat insufficient daily serves of vegetables with the majority (2017: 58.4% - 71.2%) eating only 1-2 serves per day – a figure which has not changed significantly since 2011 as illustrated below in Figure 30.



Source: Victoria Population Health Survey 2011, 2014 & 2017

Figure 30. Average daily serves of vegetables

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A greater proportion of women ate 3+ daily serves of vegetables on average than men, whereas a greater proportion of men ate 1-2 daily serves of vegetables on average than women. In 2017:

1. 48.1%-65.9% of women ate 1-2 serves per day, and 24.6%-54.1% ate 3+ serves per day.
2. 63.3%-81.2% of men ate 1-2 serves per day, and 10.6%-29.0% at 3+ serves per day.

Further information can be found at:

1. Victorian Population Health Survey (https://vhiss.reporting.dhhs.vic.gov.au/)
2. VicHealth Indicators Survey (https://www.vichealth.vic.gov.au/programs-and-projects/vichealth-indicators-survey)

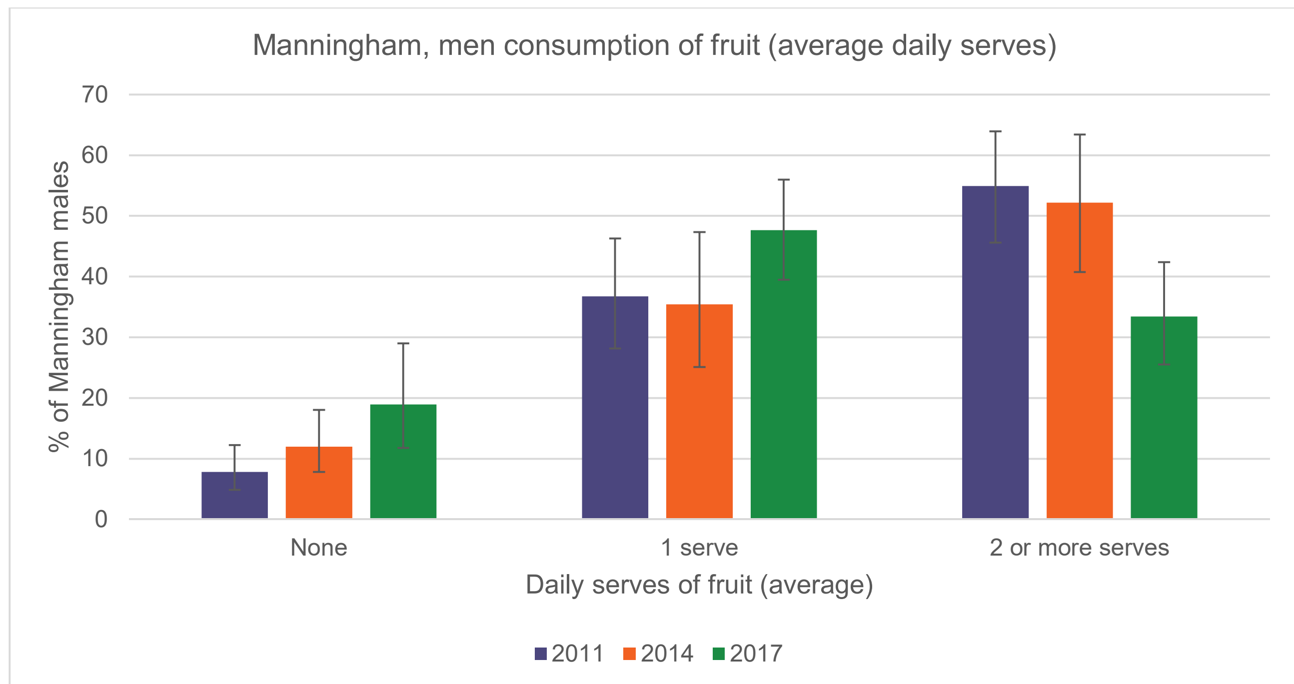
10.1.2. Fruit Consumption

The Australian Dietary Guidelines recommend that two serves of fruit be consumed daily.

In 2017, 4-5 out of every 10 people (38.6%- 51.8%) in Manningham ate the recommended daily serve of fruit – a figure which has not changed significantly since 2011. Disaggregated by gender, women tended to eat more fruit on average, with 46.6%-65.3% eating the recommended daily serves (Victoria: 45.6%-48.1%). Among Manningham men, 25.5%-42.4% ate the recommended daily serves (Victoria: 38.0%-40.6%).

Of note is the reduction in the proportion of men eating two or more serves of fruit per day from 2011 and 2017 (Figure 31). There has been no significant change among women during the same period (Figure 32).

At least 4 out of 5 Manningham residents eat *at least* one serve of fruit daily.



Source: Victoria Population Health Survey 2011, 2014 & 2017

Figure 31. Men fruit consumption

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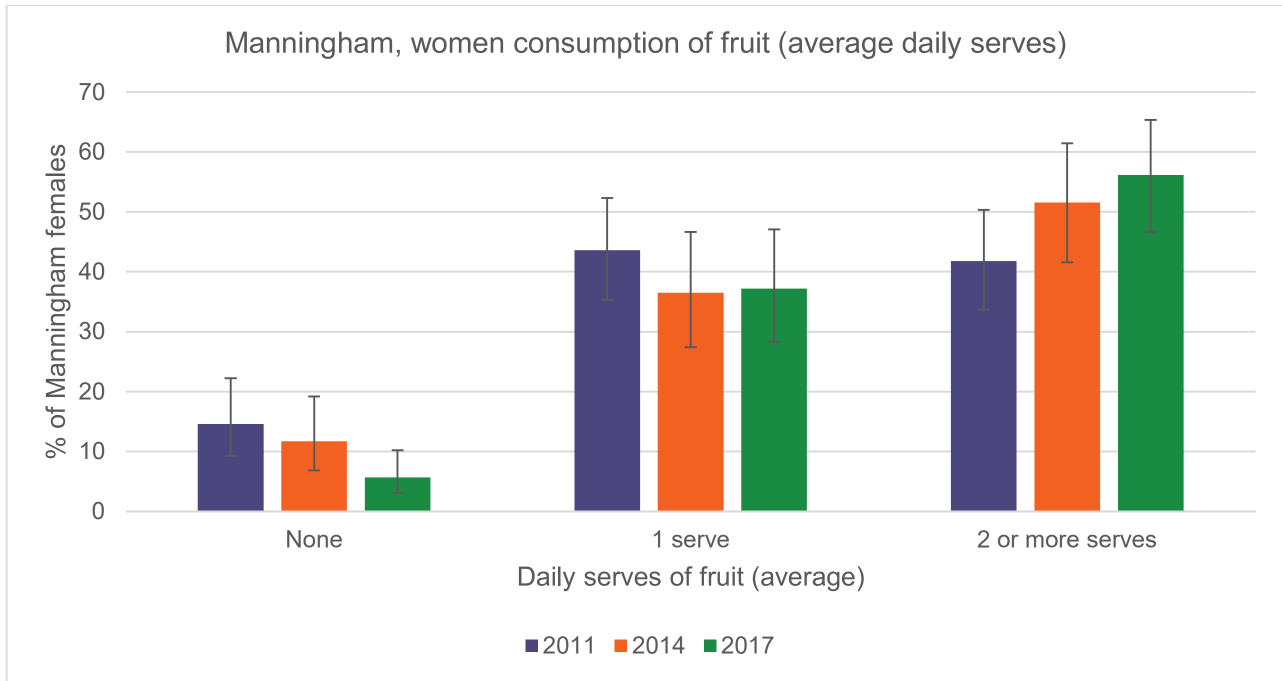


Source: Victoria Population Health Survey 2011, 2014 & 2017

Figure 32. Women fruit consumption

10.1.3. Takeaway Foods

In 2015, 7.0% - 15.7% of people in Manningham ate take away meals or snacks at least 3 times per week, consistent with the Victorian average of 14.4%. Coincidentally, 14.4% of Manningham men ate take away meals or snacks at least 3 times per week. The sample size was too small to gain any insight into consumption by women and across different age groups. *(VicHealth Indicators Survey 2015 – Manningham LGA Profile).*

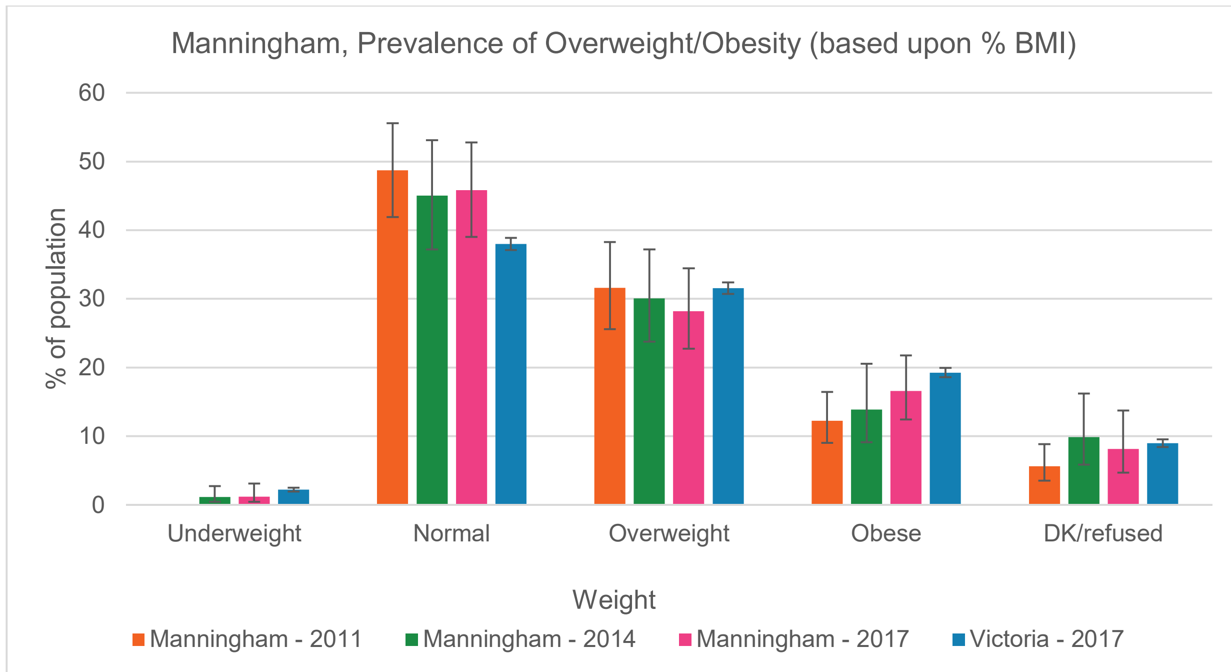
People with disability were one third more likely to eat takeaway food regularly than people without disability. *(VicHealth Indicators Survey 2015 supplementary report - disability)*

10.1.4. Water Consumption

In 2015, people in Manningham consumed on average 4.7 – 5.5 cups of water per day, consistent with the Victorian average of 5.4 cups per day.

In 2015, 1.3% - 6.6% of people in Manningham consumed no water per day, consistent with the Victorian average of 3.1%.

10.1.5. Prevalence of Obesity/Overweight



Source: Victorian Population Health Survey (2011,2014 & 2017)

Figure 33. Prevalence of obesity and overweight

Disaggregated by gender, the prevalence of overweight and obese men and women in Manningham broadly aligns with the wider Victorian community.

In 2017, more Manningham men were overweight than women (men: 27.4%-46.0%, women: 15.1%-28.6%), whereas a similar proportion of both genders were obese (men: 11.2% - 25.6%, women: 10.8%-22.4%).

62% of Aboriginal and Torres Strait Islander peoples aged over 2 years living in the Eastern Melbourne region are overweight or obese. *(EMPHN Needs Assessment Report, 2018)*

10.1.6. Food Insecurity

The proportion of Manningham residents who experience food insecurity (1.7% - 6.5%) is consistent with the wider Victorian average (5.8% - 6.7%) as illustrated below in Figure 34. However, women in Manningham are more likely to experience food insecurity (2.6% - 10.9%) than men. Furthermore, the COVID-19 pandemic is likely to increase the incidence of food insecurity due to financial hardship resulting from unemployment and underemployment (particularly among women) as well as women fleeing family violence situations.

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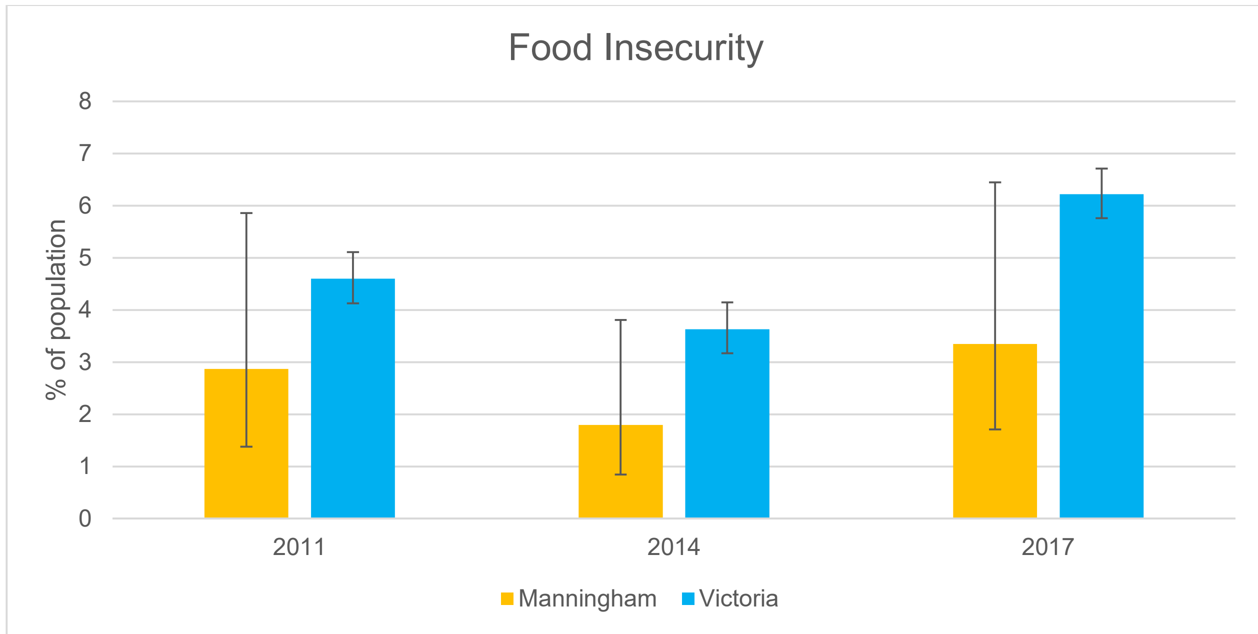


Source: Victorian Population Health Survey (2011, 2014 & 2017)

Figure 34. Food insecurity

10.2. Physical Activity

The *Australian Physical Activity Guidelines* detail the recommended levels of physical activity to support health and wellbeing for different age groups.

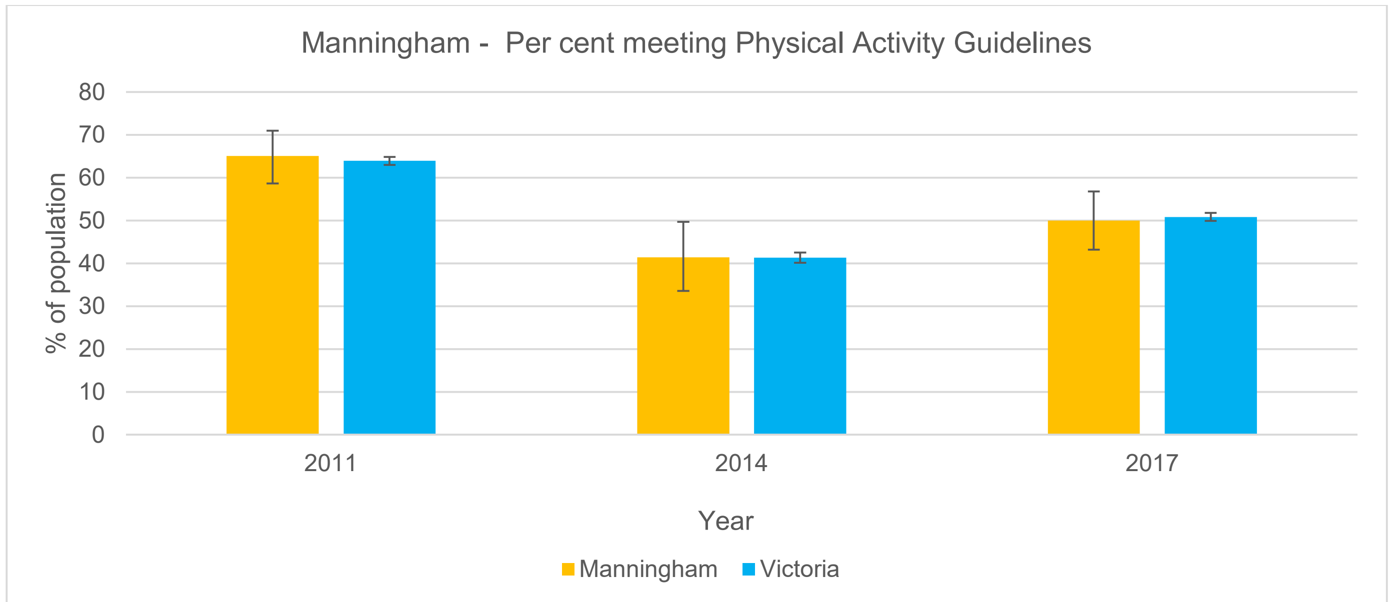
The Guidelines recommend the following for 18 to 64 year olds:

1. Doing any physical activity is better than doing none. If you currently do no physical activity, start by doing some, and gradually build up to the recommended amount.
2. Be active on most, preferably all, days every week.
3. Accumulate 150 to 300 minutes (2 ½ to 5 hours) of moderate intensity physical activity or 75 to 150 minutes (1 ¼ to 2 ½ hours) of vigorous intensity physical activity, or an equivalent combination of both moderate and vigorous activities, each week.
4. Do muscle strengthening activities on at least 2 days each week

The Guidelines also make recommendations regarding sedentary behaviour.

In 2017, approximately half the Manningham population met the guidelines for physical activity. This was an increase from 2014. The Guidelines were revised in 2014 which may explain the significant difference between 2011 and 2014 survey results.

During the period 2011 to 2017, changes in Manningham's performance aligned closely with those in the broader Victorian community as illustrated overleaf in Figure 5.4.



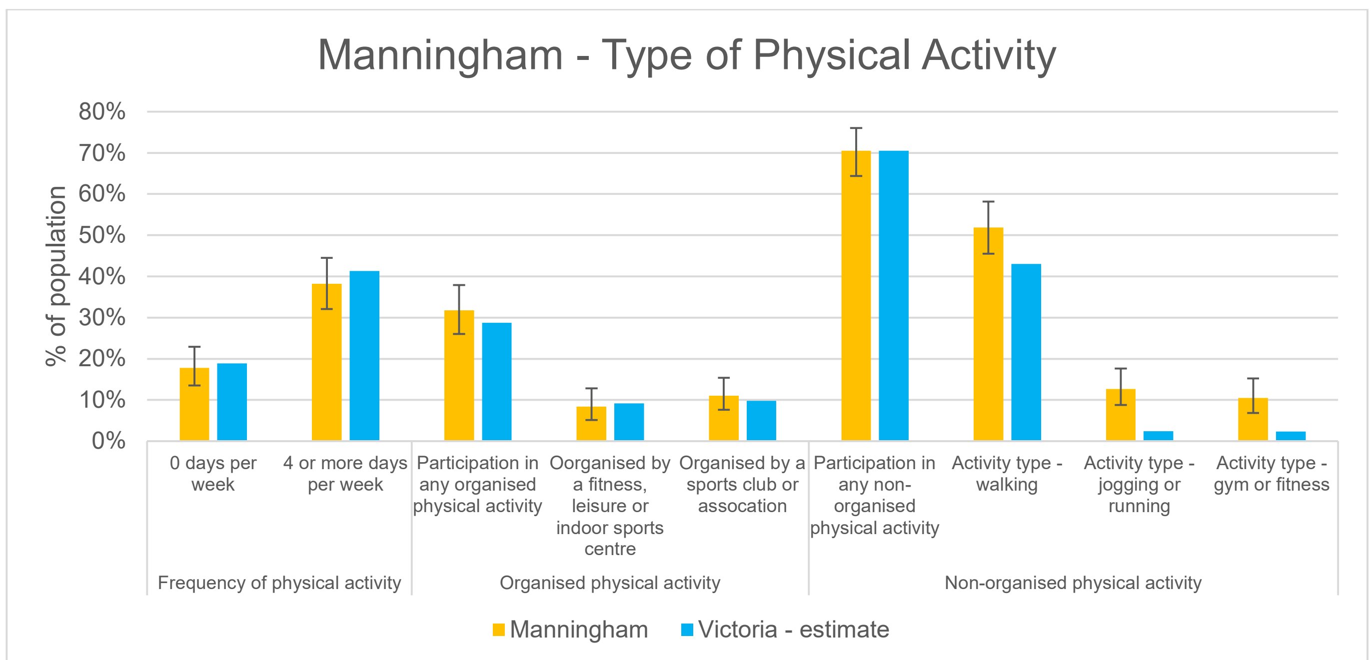
Source: Victoria Population Health Survey 2011, 2014 & 2017

Figure 35. Meeting physical activity guidelines

In 2017, there was no significant difference between the proportion of men and women who met physical activity guidelines (men: 42.9%-62.8%; women: 38.4%-56.8%).

In 2015, Victorians with disability were 40% less likely to be physically active than people without disability. The gap widens with age: 18 to 34 year olds are 20% less likely; 35 to 64 year olds are 30% less likely; 65+ year olds are nearly 50% less likely. *(Vichealth Indicators Survey 2015 supplementary report – disability)*

In terms of the type of physical activity undertaken, the preferences of Manningham residents align broadly with the wider Victorian experience. However, of note are the higher rates of walking, jogging or running, and gym or fitness compared to the Victorian average, as illustrated below in Figure 36.



Source: VicHealth Indicators Survey 2015

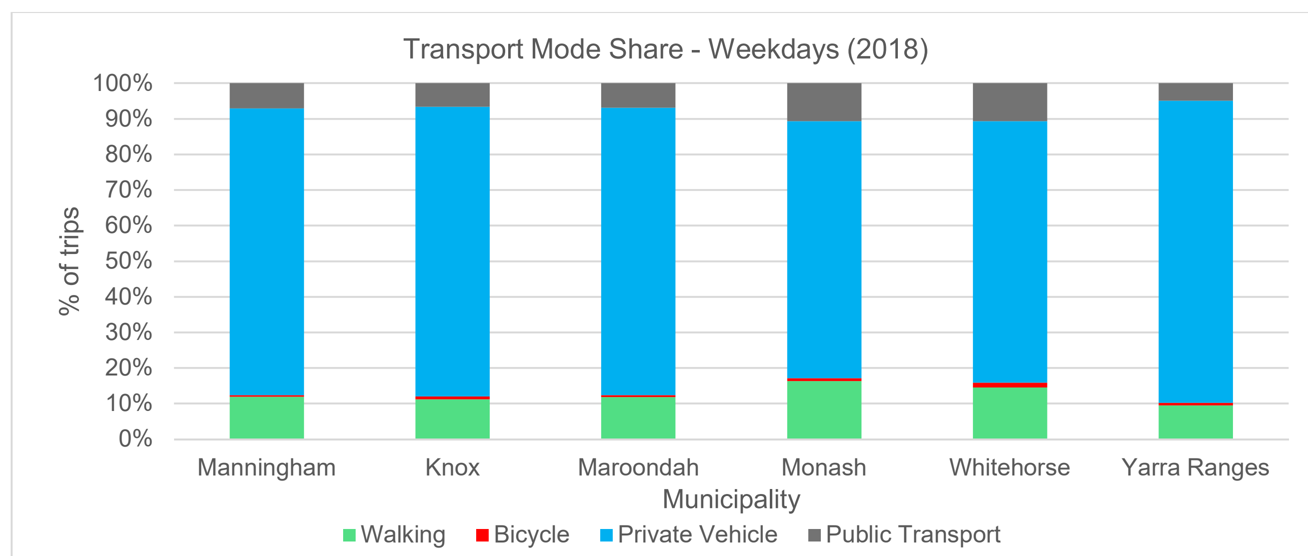
Figure 36. Type of physical activity

44% of LGBTQIA+ Victorians report feeling the need to hide their sexuality or gender identity in public which may impact participation rates in sporting clubs which do not understand LGBITQA+ inclusivity. *(Victorian Discussion Paper for the LGBTIQ Strategy).*

10.3. Active and Public Transport

10.3.1. Weekdays

In 2018, almost 1 in 5 weekday trips (19.4%) by Manningham residents involved public or active transport. This figure increased from 16.8% in 2010 and 18.5% in 2016 primarily due to more walking trips. Private vehicle use accounted for 80.6% of all weekday trips in Manningham, which was broadly consistent with other municipalities in the EMR as illustrated below in Figure 37.



Source: Victorian Integrated Survey of Travel and Activity 2018

Figure 37. Transport mode share - weekdays (2018)

Over the period 2010 to 2018, the weighted average distance and time of trips for each weekday transport mode in Manningham remained fairly static, with walking trips generally being around 1km and 15 minutes duration, and bicycle trips around 5km and 30 minutes duration. Public transport trips are around 16km and take around an hour, most likely commuting to the city as illustrated below in Table 7.

TRANSPORT MODE	YEAR	WEIGHTED AVERAGE DISTANCE (KM)	WEIGHTED AVERAGE TIME (MINUTES)
Walking	2010	0.9	13
	2016	1.2	18
	2018	1.1	16
Bicycle	2010	8.9	30
	2016	4.2	33
	2018	5.1	31
Public Transport	2010	15.7	55
	2016	16.9	61
	2018	16.1	59
Private Vehicle	2010	8.4	19
	2016	9.4	21
	2018	9.0	21

Source: Victorian Integrated Survey of Travel and Activity 2010, 2016 and 2018

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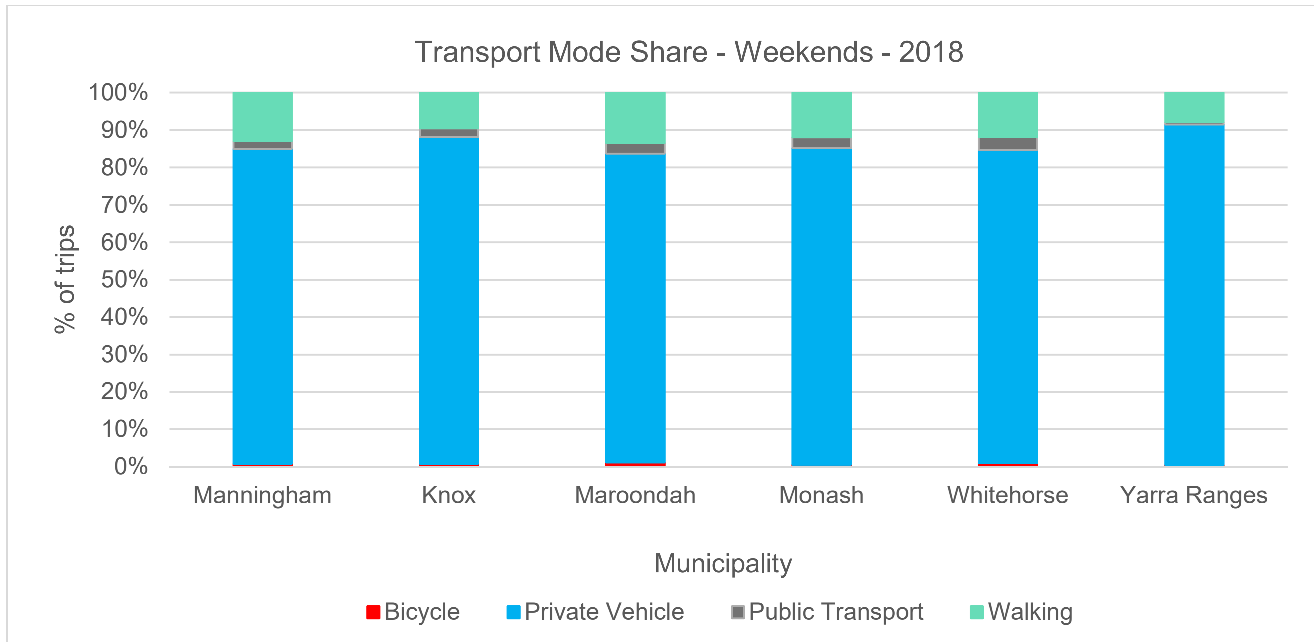
Table 8. Average weighted distance and time of weekday trips by transport mode

10.3.2. Weekends

In 2018, 15.7% of weekend trips by Manningham residents involved active or public transport. This figure increased from 12.8% in 2010 and 14.3% in 2016 primarily due to more walking trips. Private vehicle use accounted for 84.2% of all weekend trips in Manningham, which was broadly consistent with other municipalities in the EMR as illustrated below in Figure 38.



Source: Victorian Integrated Survey of Travel and Activity 2018
Figure 38. Transport mode share - weekends (2018)

Over the period 2010-2018, the weighted average distance and time of weekend trips for active and public transport modes in Manningham has varied considerably. Walking trips appear to be increasing in distance and duration (2010: 0.9km, 12 minutes; 2018: 1.4km, 19 minutes). Public transport trips are roughly equal in both distance and duration to weekday trips, suggesting people continue to use it to visit the city as illustrated below in Table 8.

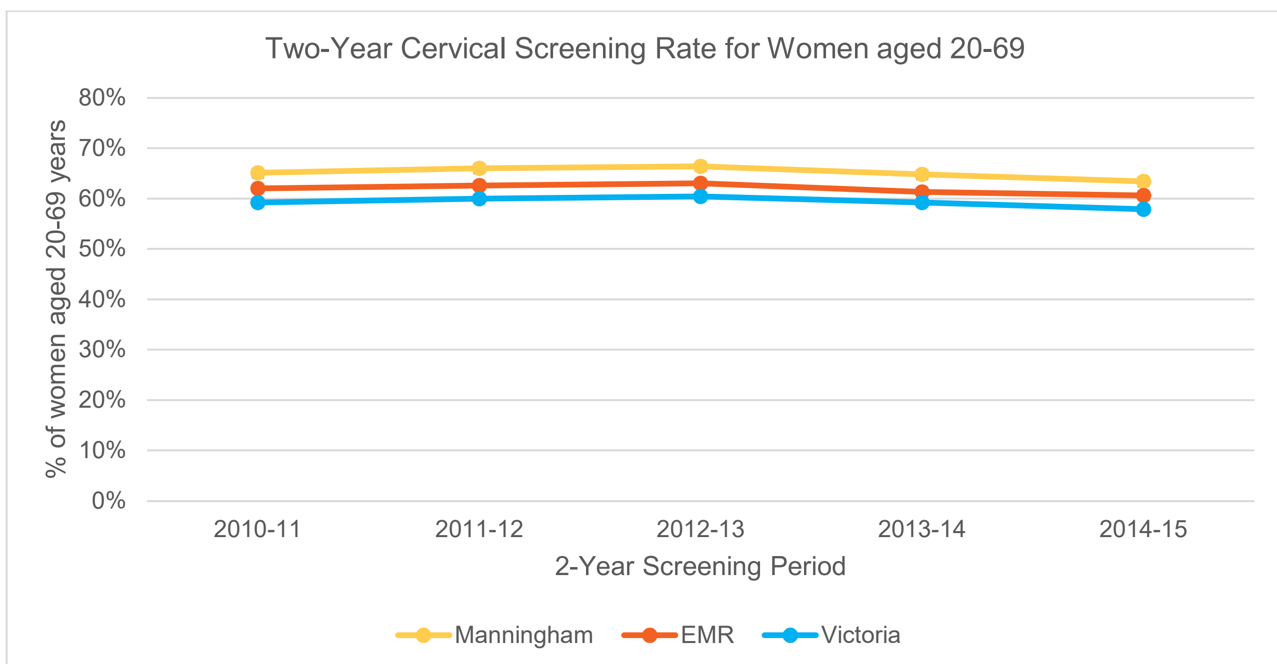
Transport Mode	Year	Weighted Average Distance (km)	Weighted Average Time (minutes)
Walking	2010	0.9	12
	2016	1.4	18
	2018	1.4	19
Bicycle	2010	1.1	6
	2016	7.6	60
	2018	4.5	25
Public transport	2010	12.5	44
	2016	15.4	68
	2018	15.2	64
Private vehicle	2010	11.8	19
	2016	11.6	22
	2018	10.8	21

Source: *Victorian Integrated Survey of Travel and Activity 2010, 2016 and 2018*
Table 9. Average weighted distance and time of weekend trips by transport mode

10.4. Cervical screening

Cervical screening enables the early identification of abnormalities of the cervix which may lead to cervical cancer. The majority of cervical cancers are caused by Human Papilloma Virus (HPV) which is a common virus spread through sexual contact. LGA cervical screening rates are available up to 2015, after which screening rates in the public domain are available at State level.

In the period 2010 – 2015, approximately two-thirds of women aged 20-69 years in Manningham participated in the program, slightly higher than the EMR and Victorian average as illustrated below in Figure 39.



Source: Victoria Cervical Cytology Registry
Figure 39. Two-year cervical screening rate for women aged 20-69 years

Victorian data on participation in cervical screening programs by age indicates that younger women are much less likely to participate, perhaps due to the nature of the testing procedure or because they may have already been vaccinated against HPV (Figure 40).

In 2017, 80.2% of girls turning 15 and 75.9% of boys turning 15 were fully vaccinated against HPV under the National Immunisation Program *(National Immunisation Strategy for Australia 2019-2024)*

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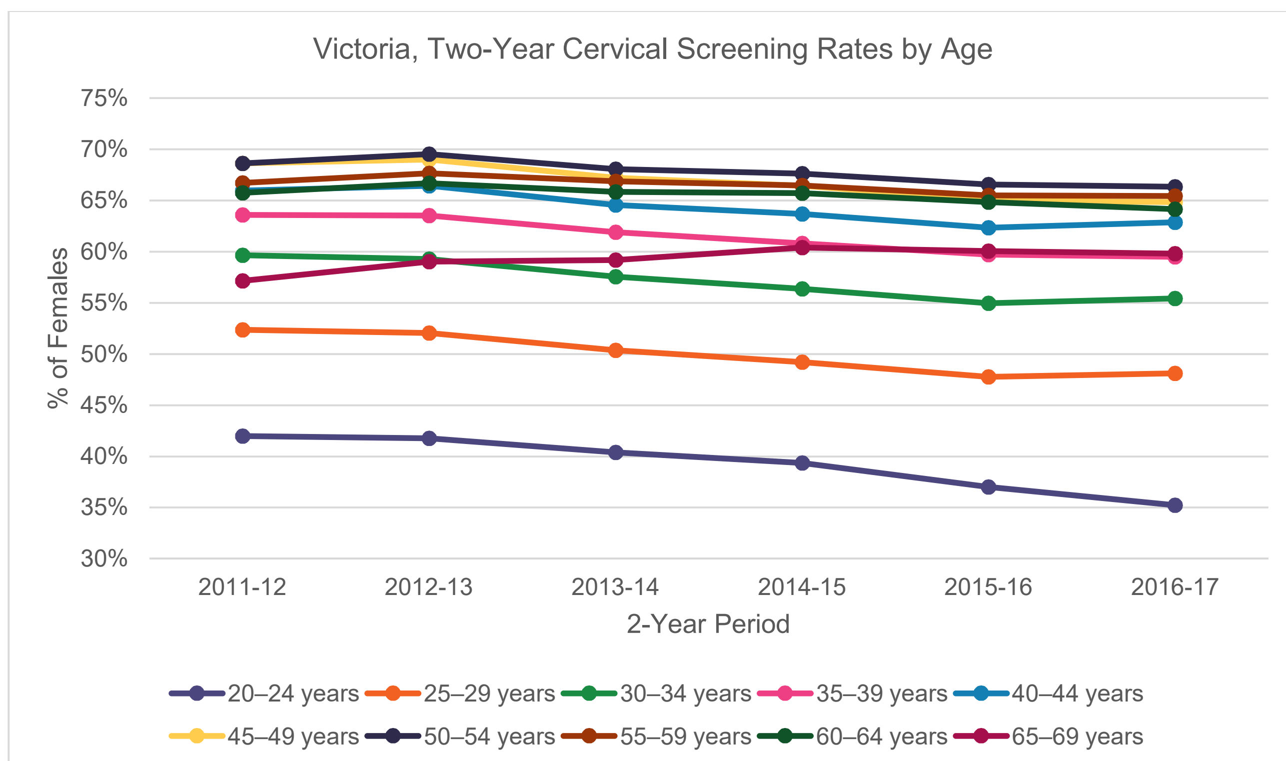


Source: Australian Institute of Health and Welfare

Figure 40. Two-year cervical screening rate by age

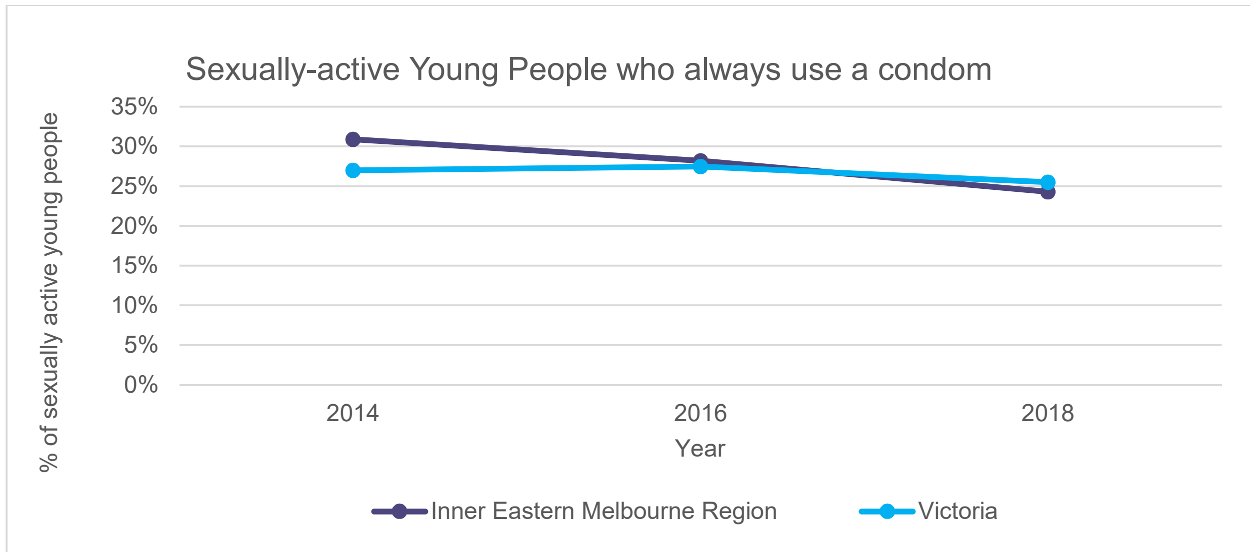
Further information is available at:

1. Victorian Cervical Cytology Registry – Annual Reports (https://www.vcs.org.au/population-health/statistical-reports/annual-statistical-reports/)
2. Australian Institute of Health and Welfare (www.aihw.gov.au)

10.5. Sexual practices of young people

The majority of young people (93%) learn about sex and sexual health from school-based sexuality education programs, whilst family members are also a significant source of information (Department of Education and Training, from *Writing themselves in again*, 2005).

Only one-quarter of sexually active young people report always using a condom as illustrated below in Figure 41. The low level of condom usage correlates with the higher rate of sexually transmitted infections among young people.



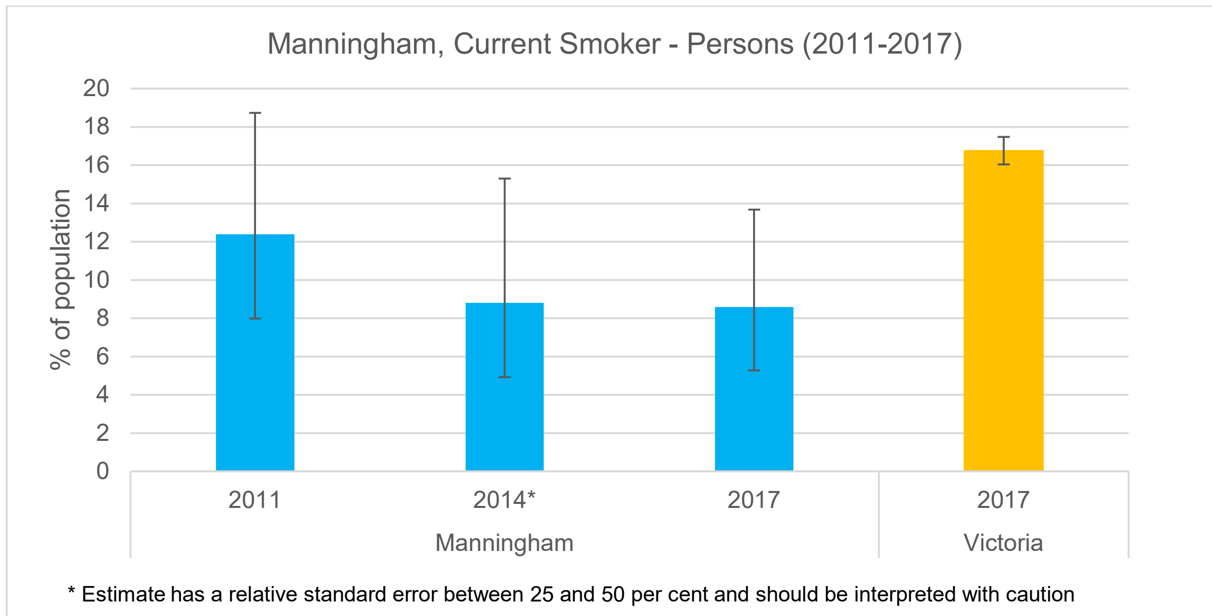
Source: Victorian Student Health and Wellbeing Survey

Figure 41. Proportion of sexually-active young people who always use a condom

10.6. Tobacco

In 2017, fewer people in Manningham smoked (5.3%-13.7%) compared to the wider Victorian average reported of 16.0%-17.5% (daily and occasional smokers) as illustrated below in Figure 42.

The Cancer Council's *Victorian Smoking and Health Survey 2018* found that one in ten Victorian adults report being daily smokers.



Source: Victorian Population Health Survey (2011, 2014 & 2017)

Figure 42. Prevalence of smoking

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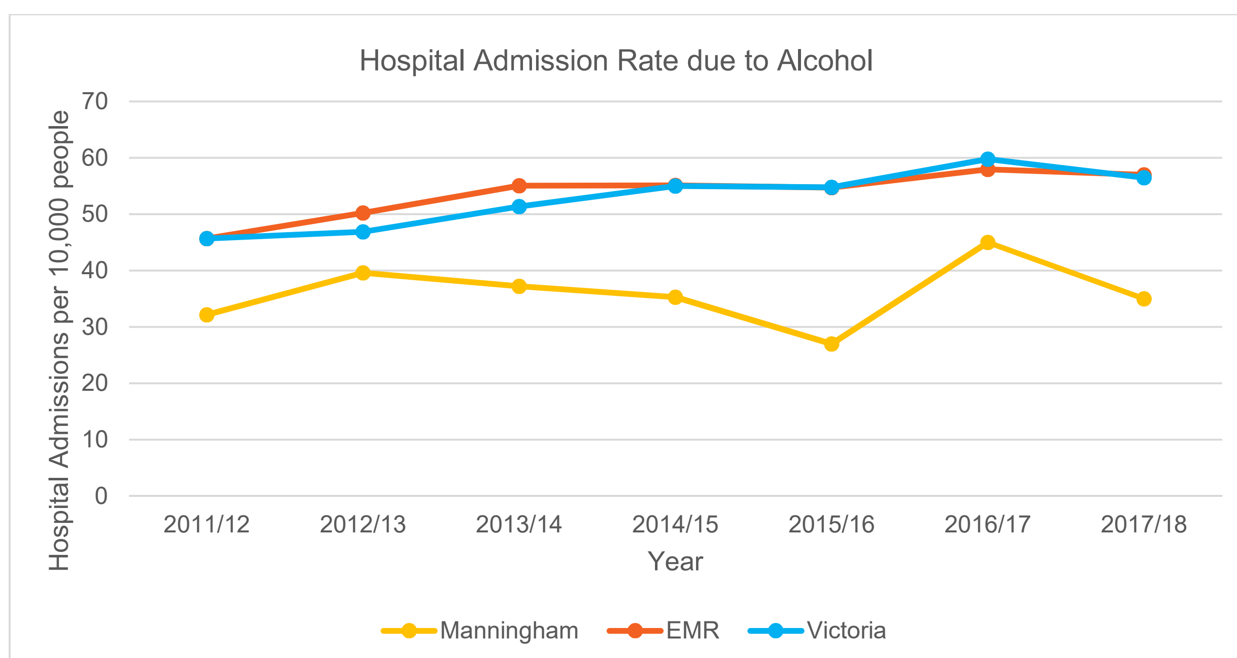
Cohorts with a higher incidence of smoking include:

1. Males in Manningham have a higher incidence of smoking than females (male: 5.3%-18.3%; female: 3.5%-13.8%). Across the state, males smoke at twice the incidence of females. *(Victorian Population Health Survey).*
2. LGBTQIA+ Victorians are more likely to smoke (17.8%) than the broader community. *(Victorian Discussion Paper on the LGBTIQ Strategy)*
3. 33% of Aboriginal and Torres Strait Islander people aged 15 years and over in Eastern Melbourne smoke, as do 31% of pregnant Aboriginal and Torres Strait Islander people. *(EMPHN Needs Assessment, 2018)*
4. A number of research studies have found a high incidence of smoking among first-generation Australian Chinese males.

10.7. Alcohol and other drugs

10.7.1. Alcohol

In the period 2011/12 to 2017/18, Manningham had a consistently lower rate of hospital admissions due to alcohol than the EMR and Victoria, as illustrated in Figure 43.



Source: AODStats by Turning Point and Monash University

Figure 43. Hospital admission rate due to alcohol

Significant differences exist between males and females, with males having consistently higher hospital admission rates than females since 2012/13. Of note is the inter-year variability – particularly for males, with the admission rate doubling in 12 months from 2015/16 to 2016/17 (Figure 44).

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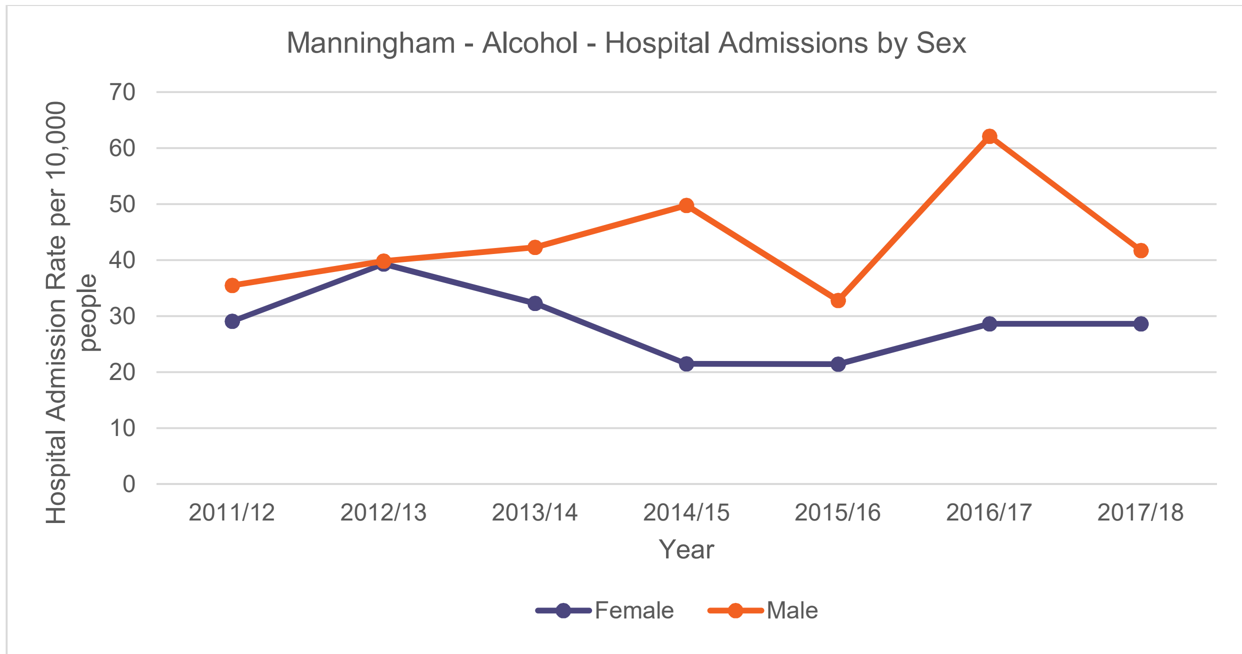
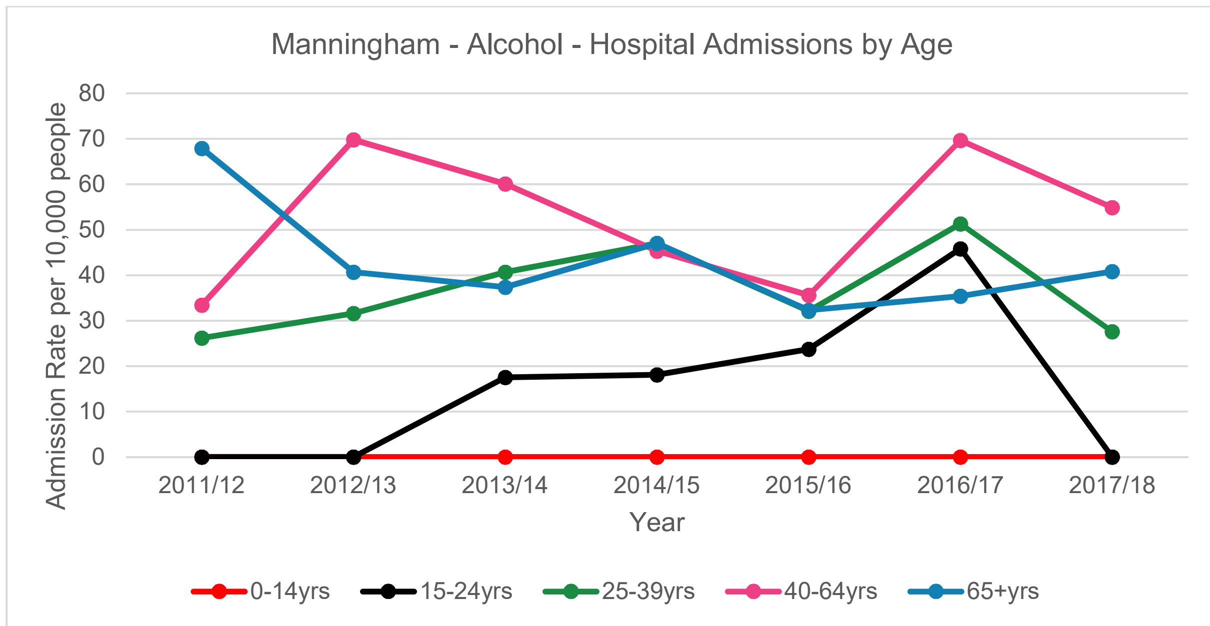


Source: AODStats by Turning Point and Monash University

Figure 44. Hospital admissions due to alcohol by sex

When disaggregated by age, people aged 40-64 years generally have a high rate of admission compared to other age groups, followed by those aged 25-39 years. Of particular note is the increase in the rate of hospital admissions for 15-24 years old in the period 2012/13 – 2016/17, which tapered off in 2017/18. Also, of note is the high degree of variability from year to year within each age category as illustrated below in Figure 45.



AODStats by Turning Point and Monash University

Figure 45. Hospital admissions due to alcohol by age

In 2015, more LGBTQIA+ Victorians drank at levels that put them at risk of short-term harm (5+ drinks in a single session) compared to the broader community:

- 53% of gay men compared to 41% of heterosexual men
- 35% of LGB women compared to 20% of heterosexual women

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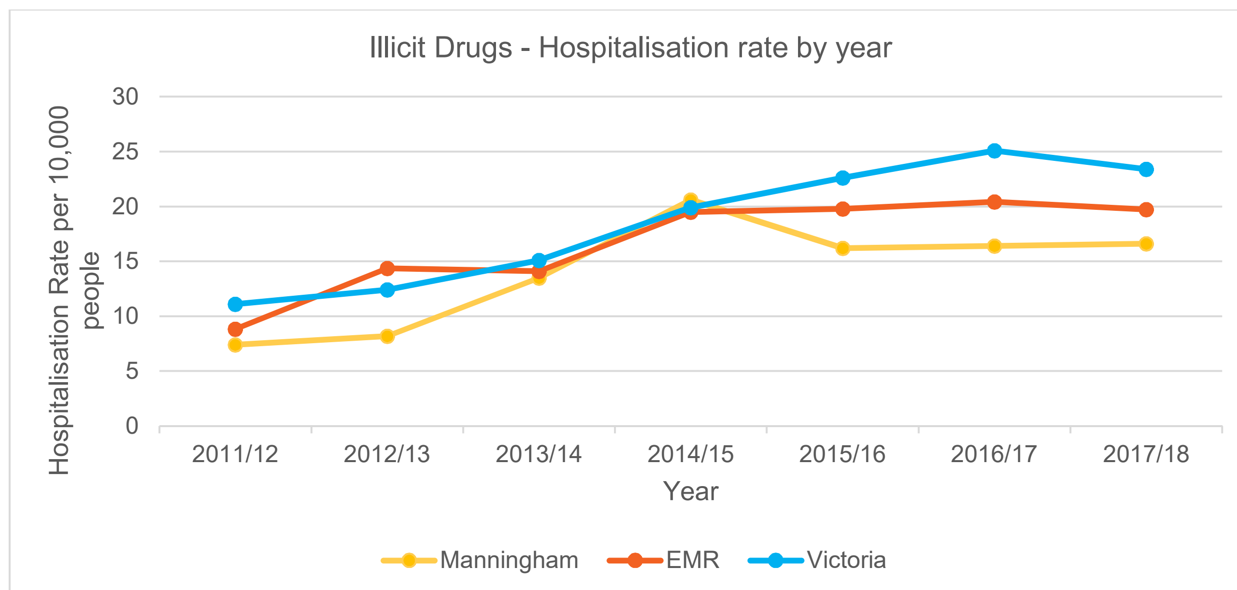
However, there was no difference in the proportion of LGBTQIA+ and other Victorians who reported drinking at levels that put them at very high risk of short-term harm (11 or more drinks in one session). *(VicHealth Indicators Survey 2015 Supplementary report: sexuality)*

In 2018, 51.5% of young people (Year 8 and Year 11) in the Inner Eastern Melbourne region (Victoria: 51.8%) report having drunk alcohol (more than a few sips) on at least one occasion. *(Victorian Student Health and Wellbeing Survey).*

The VicHealth Indicators Survey explored alcohol *culture* i.e. the formal rules, social norms, attitudes and beliefs around what is and is not socially acceptable for a group of people before, during and after drinking – by asking respondents whether they agree with the statement "getting drunk every now and again is okay". In 2015, 44% to 61% of LGBTQIA+ Victorians agreed with the statement, compared with 30% to 33% for heterosexual Victorians.

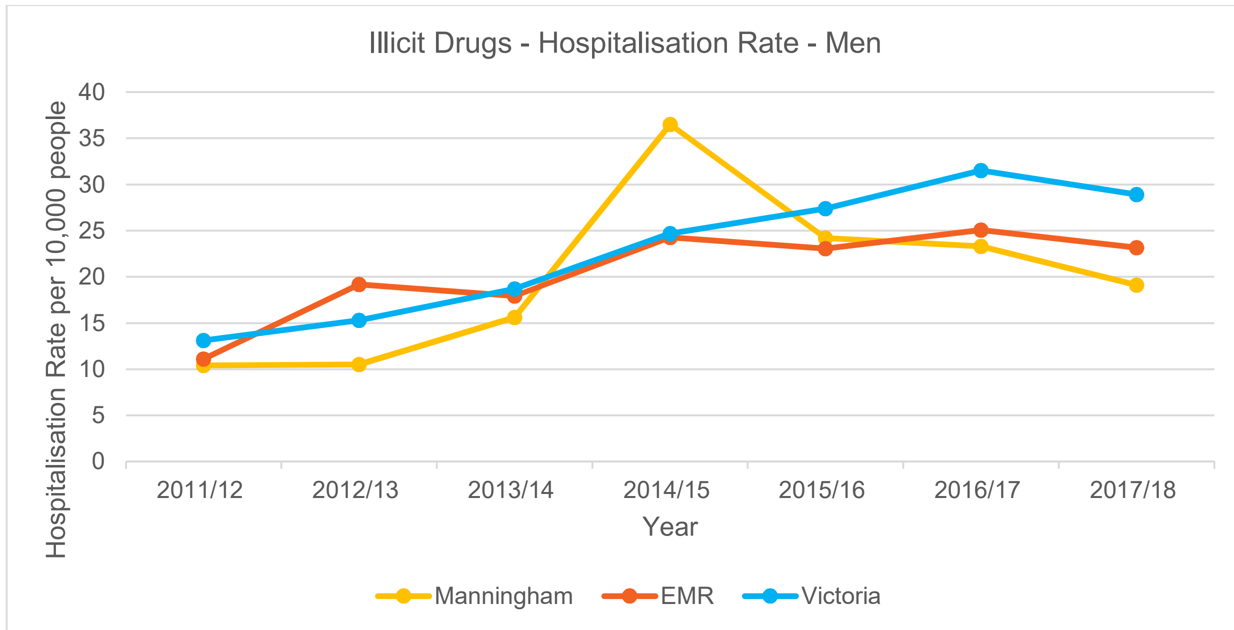
10.7.2. Other Drugs

Manningham's hospitalisation rates due to illicit drugs peaked in 2014/15 at a level slightly higher than the EMR and Victorian averages. In the three years from 2015/16 – 2017/18, hospitalisation rates stabilized, with Manningham's rate significantly less than those of the EMR and Victoria (Figure 46).

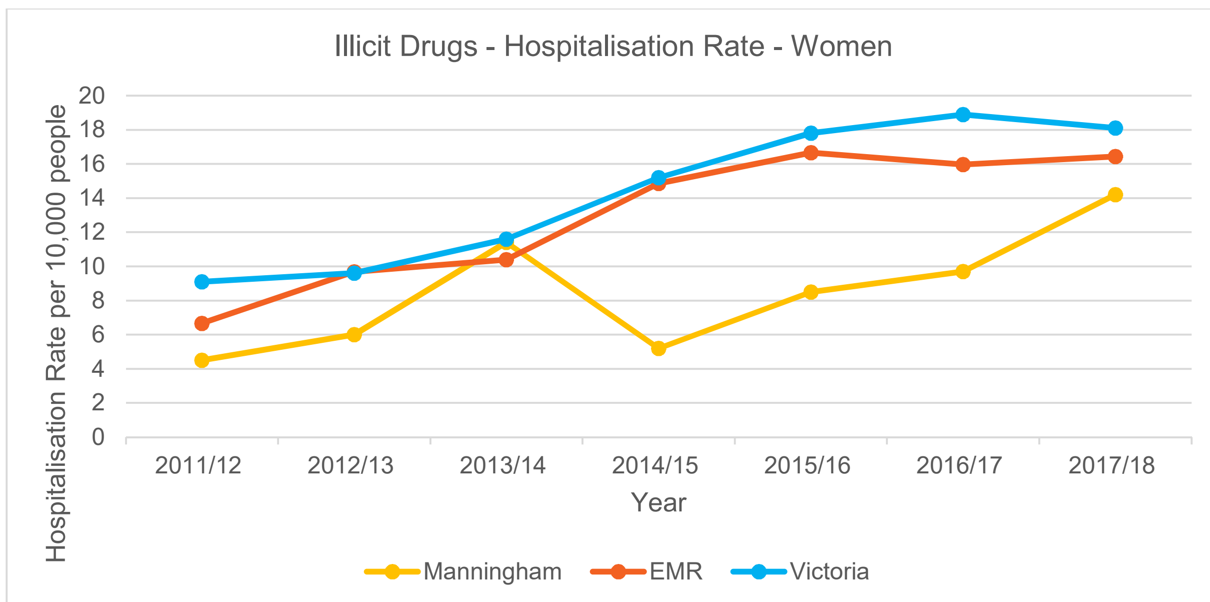


Source: AODStats by Turning Point and Monash University
Figure 46. Illicit Drug hospitalisation rate by year

Disaggregated by gender, the Manningham peak in 2014/15 was largely due to men admissions, with women showing a corresponding reduction during the same year. Since then, the admission rate for men has trended downward, whilst the admission rate for women has trended up significantly (Figures 47 and 48).



Source: AODStats by Turning Point and Monash University
Figure 47. Illicit drug hospitalisation rate for men by year



Source: AODStats by Turning Point and Monash University
Figure 48. Illicit drug hospitalisation rate for women by year

In 2017/18 in Manningham, young people (15-24 years) were hospitalised due to illicit drugs at the highest rate of all age groups (35.3 per 10,000 people). In 2018, 12.1% of young people in Inner Eastern Melbourne reported having used marijuana or other illegal drugs at least once which was higher than the Victorian average of 10.3% (Figures 49 and 50).

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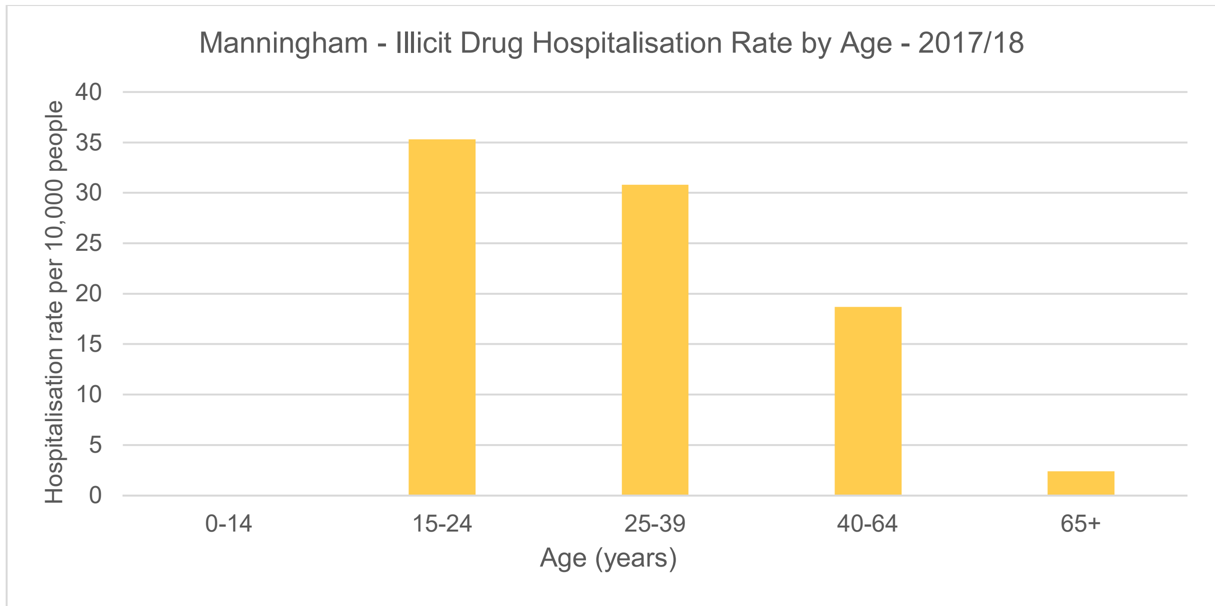
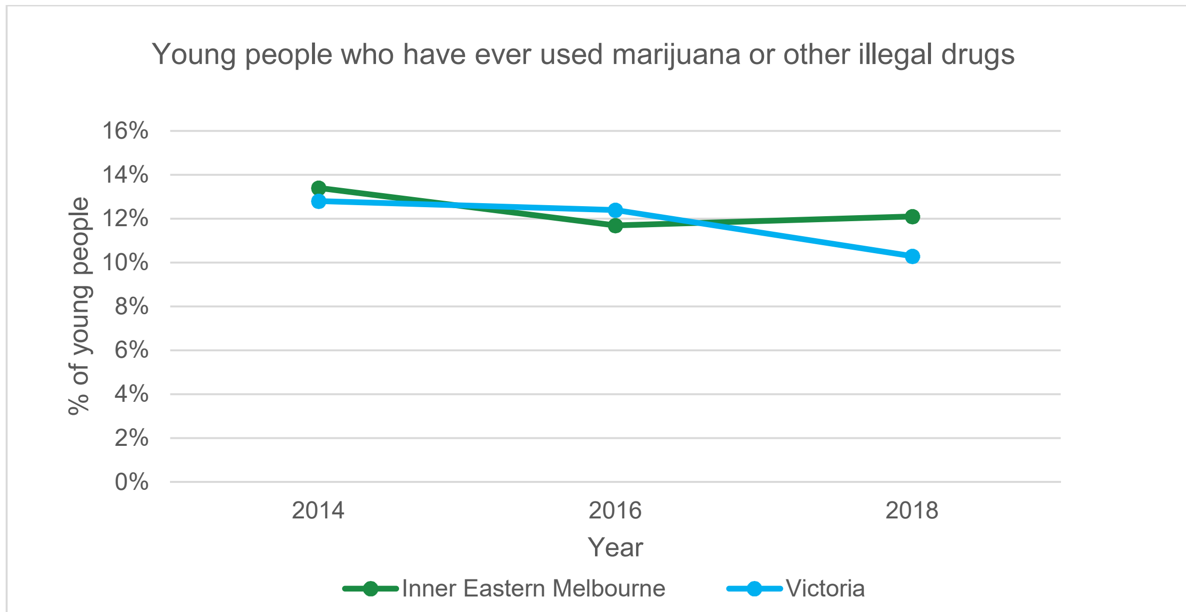


Source: AODStats by Turning Point and Monash University

Figure 49. Illicit drug hospitalisation rate by age (2017/18)



Source: Victorian Student Health and Wellbeing Survey

Figure 50. Young people who have ever used marijuana or other illegal drugs

In 2017/18, Manningham's rate of hospital admissions due to opioids was 4.9 per 10,000 which was less than the EMR and Victoria (7.3 and 6.4 respectively), however Manningham experienced a spike in such admissions in 2013/14. (Figure 51)

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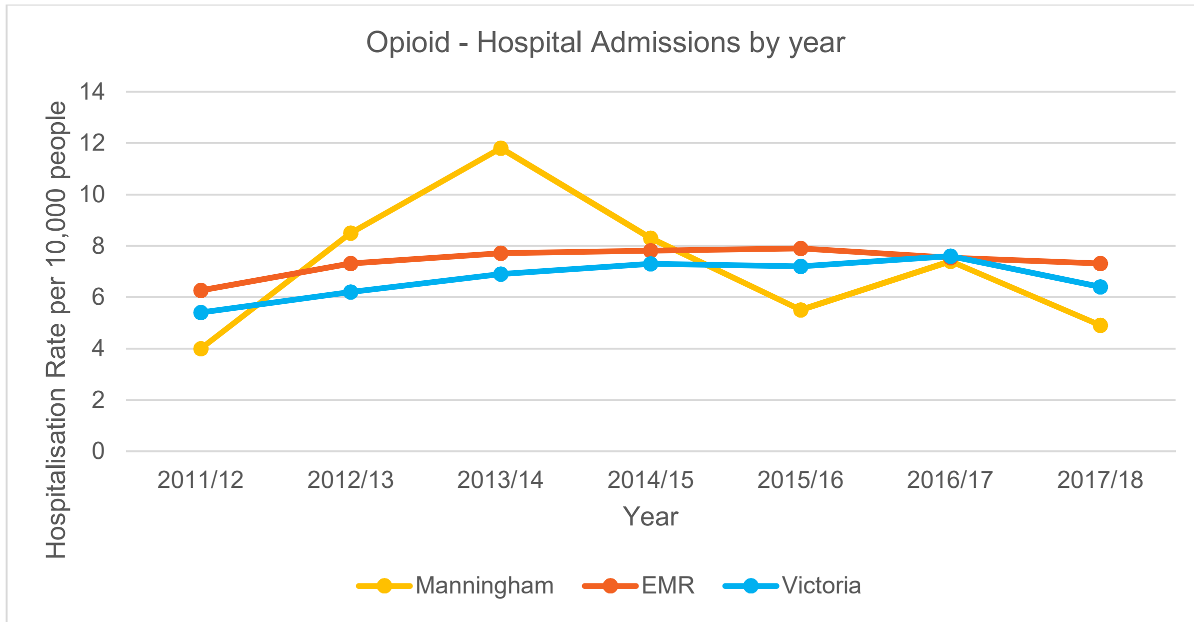
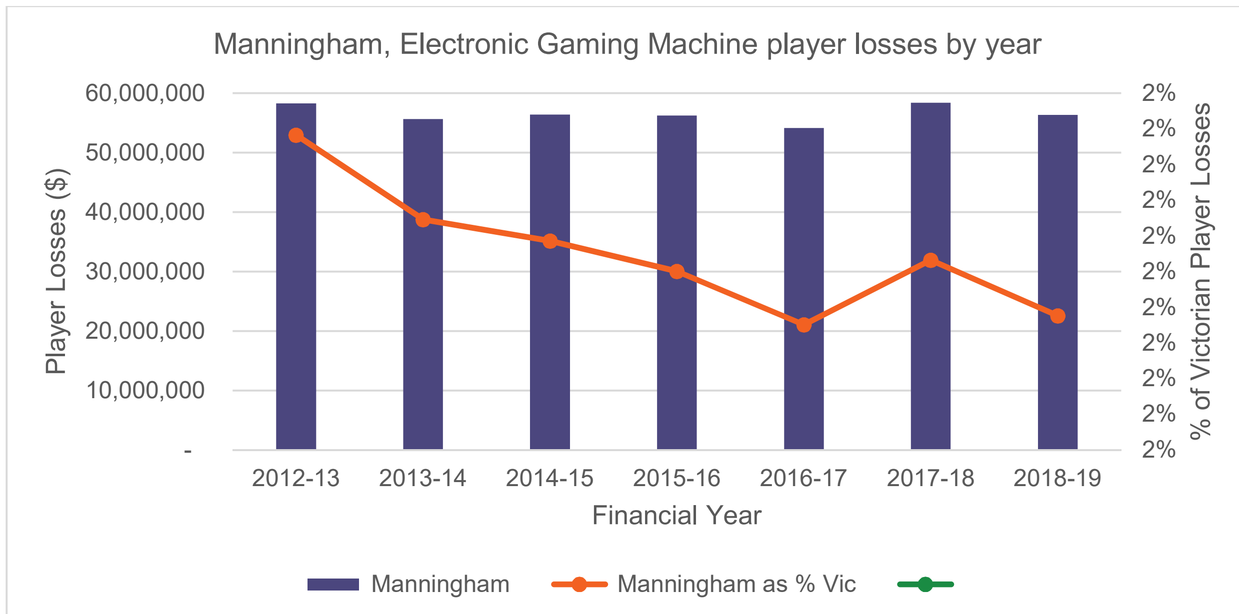
In 2017/18, virtually all admissions were among people aged 40-64 years (9.7 per 10,000 people).



Source: AODStats by Turning Point and Monash University
Figure 51. Opioid hospital admissions by year

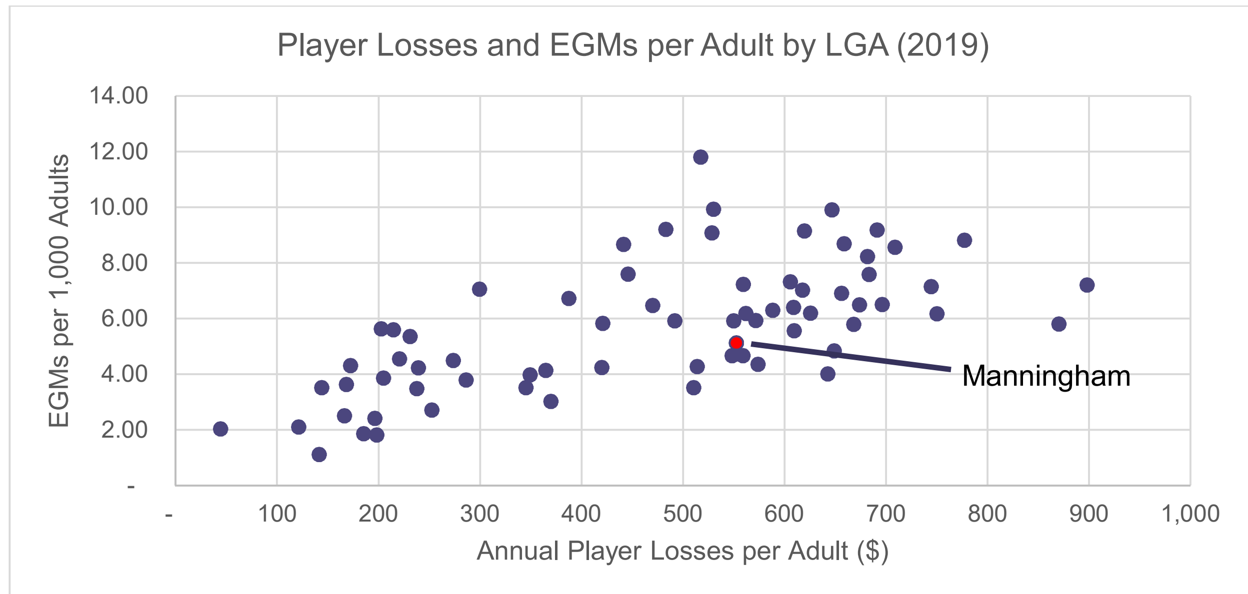
10.8. Gambling

Manningham currently has 522 Electronic Gaming Machines (EGMs) operating across seven venues. Player losses in Manningham in the period 2012 -2019 were $54-58 million annually, or 2.1%-2.3% of player losses across Victoria. (Figure 52). Over the same period, Manningham's population as a proportion of Victoria declined from 2.1% to 1.9%.



Source: Victorian Commission for Gambling and Liquor Regulation
Figure 52. Electronic Gaming Machine player losses by year

Figure 53 below plots the relationship between EGM density and annual player losses per adult for Victorian LGAs in 2019.



Source: Victorian Commission for Gambling and Liquor Regulation

Figure 53. Player Losses and EGMs per Adult by LGA (2019)

No data is currently available in relation to online gambling among Manningham residents. Further information is available at https://www.vcglr.vic.gov.au/

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11. Physical Health

11.1. Disease

Disease burden is a measure of the impact of living with illness and injury and dying prematurely. In 2015, 65% of the disease burden in Australia was due to five disease groups: cancer, cardiovascular diseases, musculoskeletal conditions, mental and substance abuse disorders, and injuries. The disease burden in Australia, expressed as Disability-Adjusted Life Years, was estimated at 4.8 million years lost due to premature death or living with illness.

Chronic diseases are long lasting conditions which can have significant social and economic consequence which impact upon quality of life. Key chronic diseases include arthritis, asthma, back pain, cancer, chronic obstructive pulmonary disease, diabetes and mental health conditions.

11.1.1. Chronic Conditions

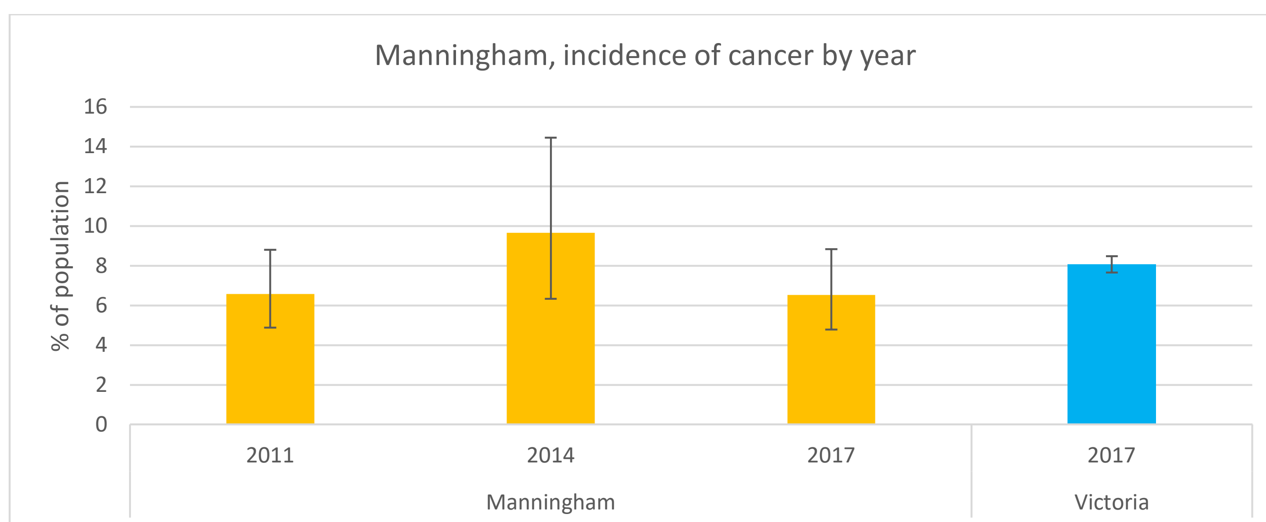
In Victoria, one in four adults (25.1%) live with two or more chronic diseases. *(Victorian Population Health Survey 2017)*

Among LGBTQIA+ Victorian adults, more than one in three (36.1%) live with two or more chronic diseases. *(Victorian Discussion Paper on the LGBTIQ Strategy)*

Among Aboriginal and Torres Strait Islander peoples living within the Eastern Melbourne Primary Health Network (PHN) catchment, 46% have two or more chronic conditions. (EMPHN Assessment Needs Report, 2018)

11.1.2. Cancer

The prevalence of cancer in Manningham is consistent with the wider Victorian experience. In 2017, 4.8%-8.8% of the Manningham population had cancer, compared to 7.7%-8.5% across Victoria. In 2017, there was no significant difference with regard to cancer between males and females in Manningham. (Figure 54



Source: Victorian Population Health Survey 2011, 2014 & 2017

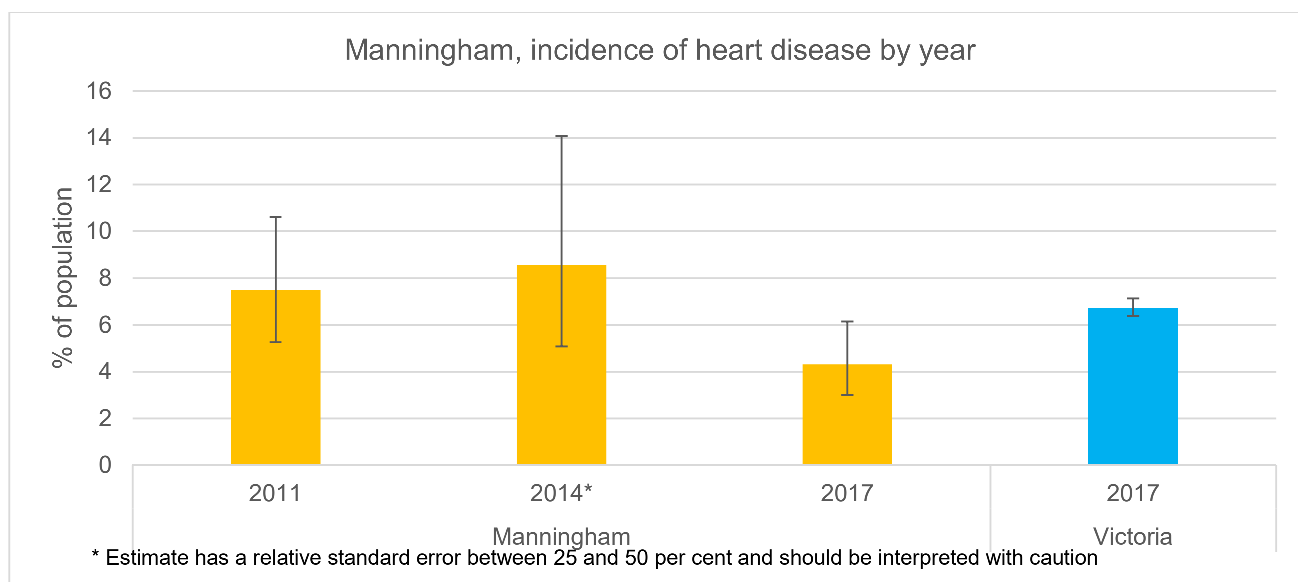
Figure 54. Incidence of cancer by year

However, Aboriginal and Torres Strait Islander Victorians have a higher incidence of some screen-detectable cancers and many preventable cancers, and they are often diagnosed at a more advanced stage and with more complex comorbidities.

In the period 2008 to 2012, the age-standardised incidence of cancer for Aboriginal and Torres Strait Islander Victorians was almost 25% higher than for non-Aboriginal Victorians (504 per 100,000 and 405 per 100,000, respectively). (Australian Institute of Health and Welfare, as cited by EMPHN Needs Assessment Report, 2018).

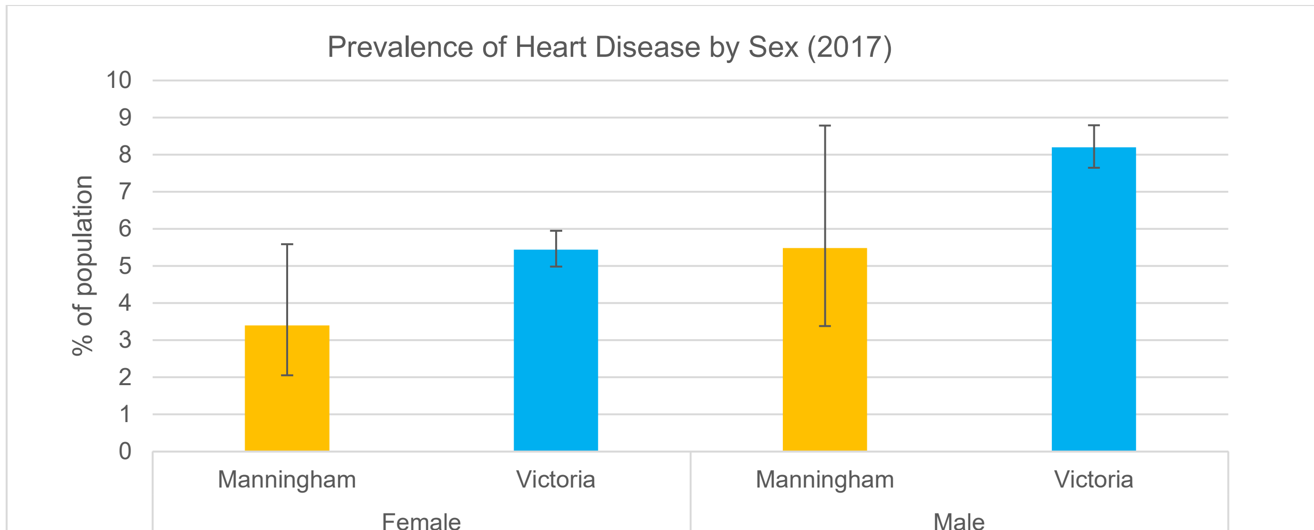
11.1.3. Heart Disease

In 2017, the incidence of heart disease in Manningham is slightly lower than the Victorian average (3.0%-6.2% and 6.4%-7.1% respectively) as illustrated below in Figure 55. However, 10% of Aboriginal and Torres Strait Islander Victorians have a heart or circulatory condition and in the period 2013-2015 the rate of hospitalisation for such conditions was 1.3 times that of non-Aboriginal Victorians.



Source: Victorian Population Health Survey 2011, 2014 & 2017
Figure 55. Incidence of heart disease by year

In 2017, Victorian males were more likely than females to experience heart disease. This experience appeared to also be the case in Manningham (see figure 56 overleaf).

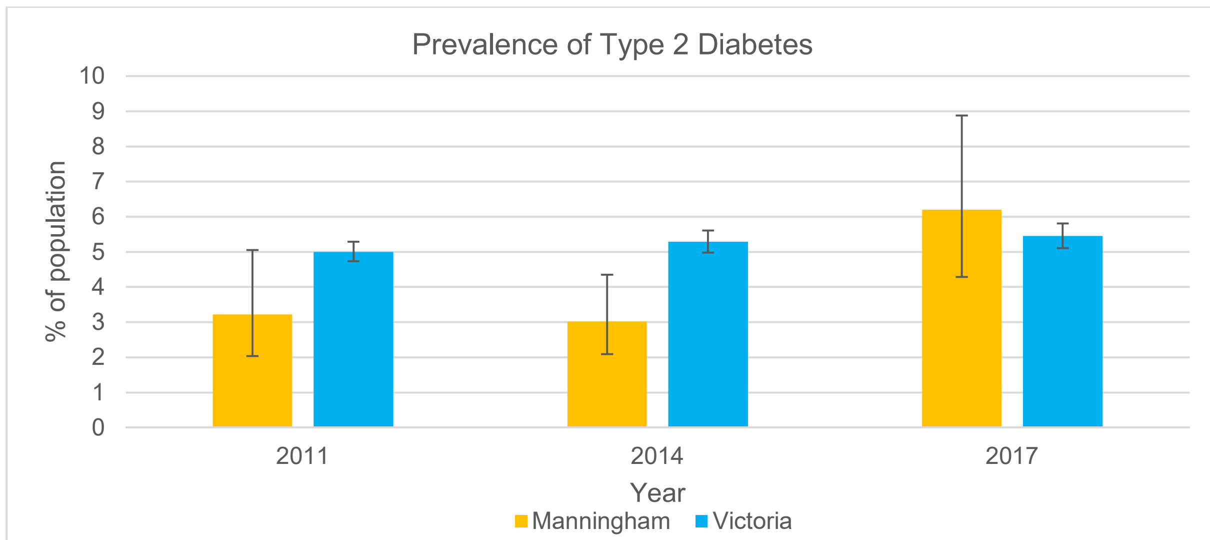


Source: Victorian Population Health Survey 2017

Figure 56. Prevalence of heart disease by sex (2017)

11.1.4. Type 2 Diabetes

In 2017, the incidence of Type 2 Diabetes in Manningham was consistent or slightly higher than the wider Victorian experience. However, in 2014, the incidence in Manningham was lower than in Victoria, indicating a significant increase may have occurred. (Figure 57)



Source: Victorian Population Health Survey 2011, 2014 & 2017

Figure 57. Prevalence of Type 2 diabetes by year

In 2017, men appeared to have a greater incidence of Type 2 Diabetes compared to women (4.7%-12.1% and 2.9-8.9% respectively).

The age-standardised rate of diabetes among Aboriginal and Torres Strait Islander Australians is 18%, or 3.5 times that of non-Aboriginal Australians. In the period 2013 – 2015, hospitalisation rates for diabetes among Aboriginal and Torres Strait Islander Victorians were three times the rate for non-Aboriginal people. *(Australian Institute for Health and Welfare, as cited in EMPHN Needs Assessment Report)*

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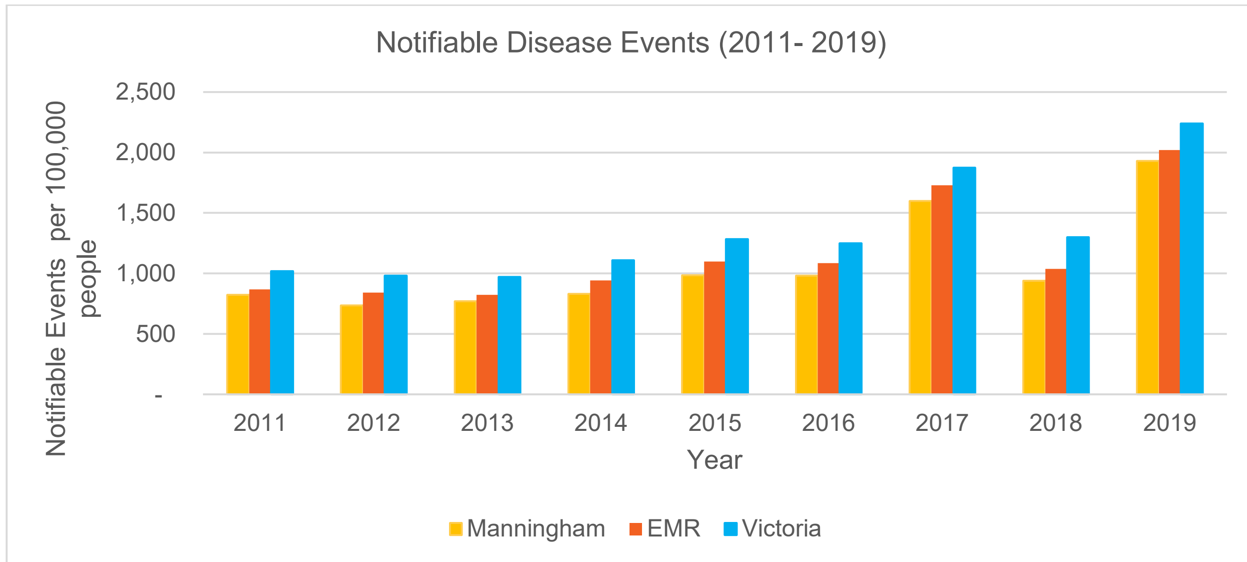
11.1.5. Notifiable Diseases

Doctors, hospitals and pathology clinics are required by law to notify the Department of Health and Human Services when they diagnose particular infectious diseases or medical conditions, including influenza, rotavirus, HIV and Chlamydia among others.

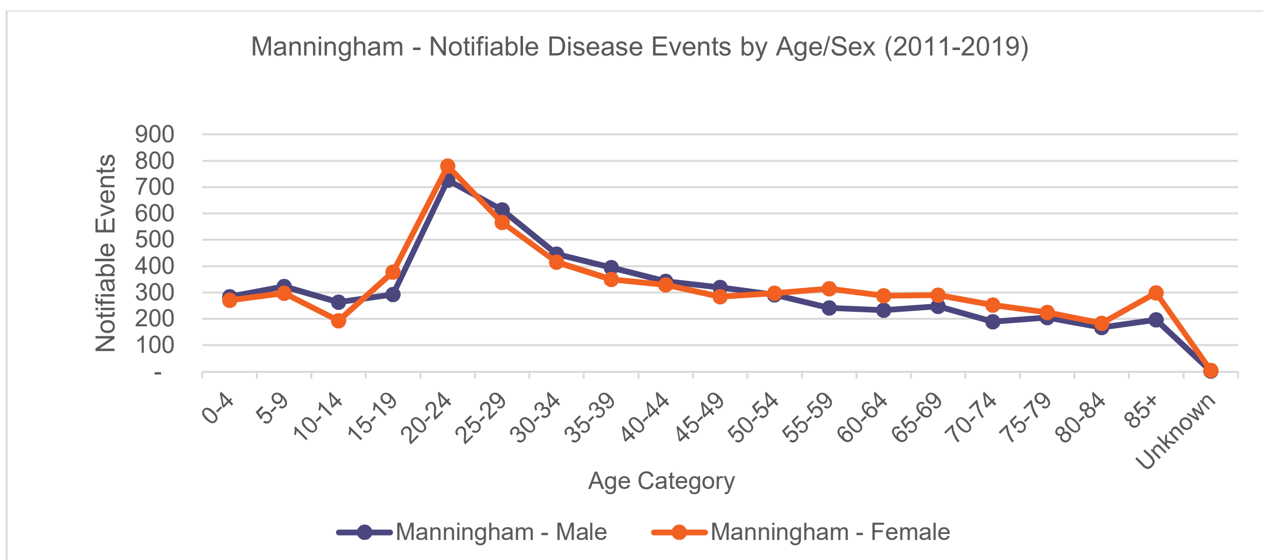
In the period 2011-2019, changes in the number of notifiable events in Manningham aligned with wider changes in the EMR and across Victoria. During the same period, Manningham consistently maintained a lower rate of notifiable events than the EMR and Victoria as illustrated below in Figure 58.



Source: Infectious Diseases Surveillance database

Figure 58. Notifiable disease events by year

Analysis by age for the period 2011-2019 indicates a significant spike in notifiable events among young people (20-24 years) which then gradually tapers off, consistent with the wider Victorian trend. Males and females exhibit a similar profile, with the exception that females aged 55-74 years and 85+ years have a higher notification rate than males. (Figure 59)



Source: Infectious Diseases Surveillance database

Figure 59. Notifiable disease events by age and sex

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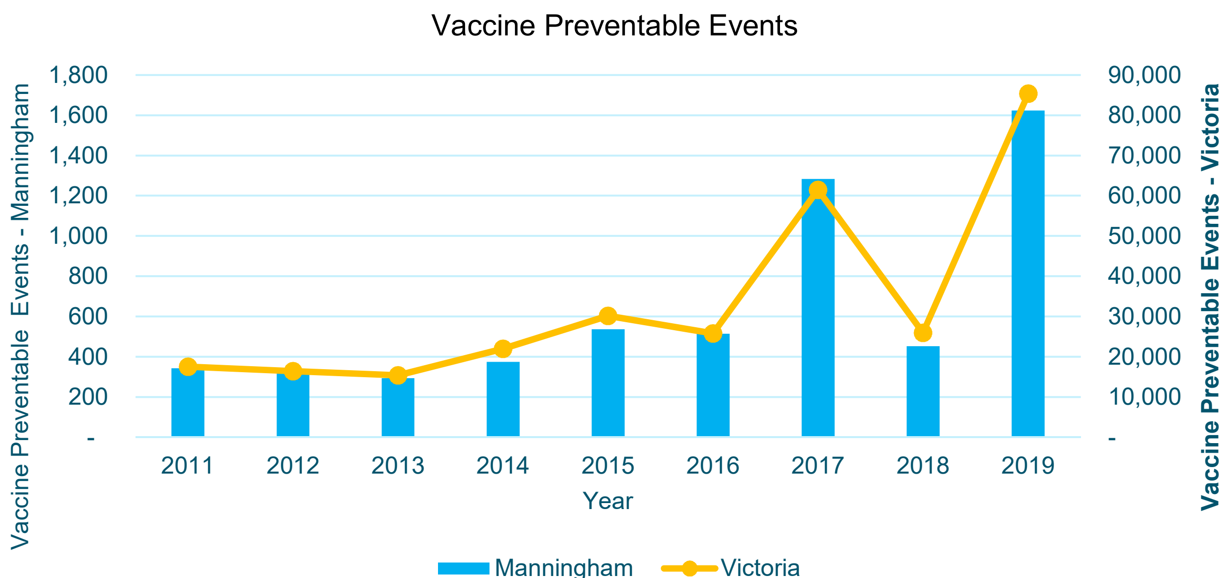
Vaccine preventable events fluctuate in accordance with wider Victorian experience, with spikes in 2017 and 2019 due to significant influenza outbreaks. In years where influenza is less prevalent there are nonetheless 300-450 notifiable events in the municipality which could have been prevented through vaccination (Figure 60).



Source: Infectious Diseases Surveillance database

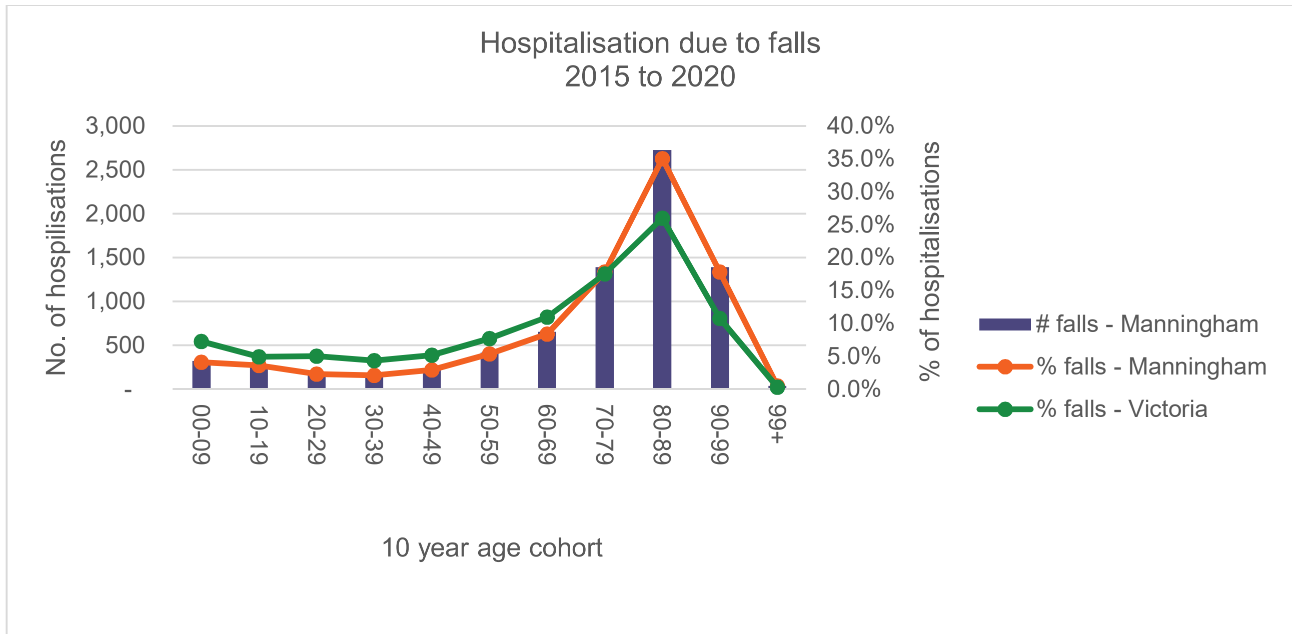
Figure 60. Vaccine preventable events by year

In addition to influenza, key notifiable events in Manningham include Chlamydia, Varicella Zoster Virus (which causes chickenpox and shingles), Salmonellosis and anaphylaxis. More than 250 people have been infected each year with the STI Chlamydia since 2011 and the infection rate has remained fairly static over this period. Notifiable events relating to Varicella zoster virus and anaphylaxis appear to be increasing, whilst 50-70 people have been infected each year with food-borne Salmonellosis.

11.2. Hospitalisations

11.2.1. Falls

Between 2015 and 2020, Manningham experienced 7,789 hospital admissions due to falls. The majority occurred in the 80 to 89 age cohort, representing 35% (2,726 admissions) of the total number of admissions. This number is significantly higher than the Victorian percentage of 26% as illustrated below in Figure 61. As such, falls are a significant cause of injury in older Manningham residents, particularly among older females, with the 80 to 89 age cohort representing 21.6% of the total hospital admissions.

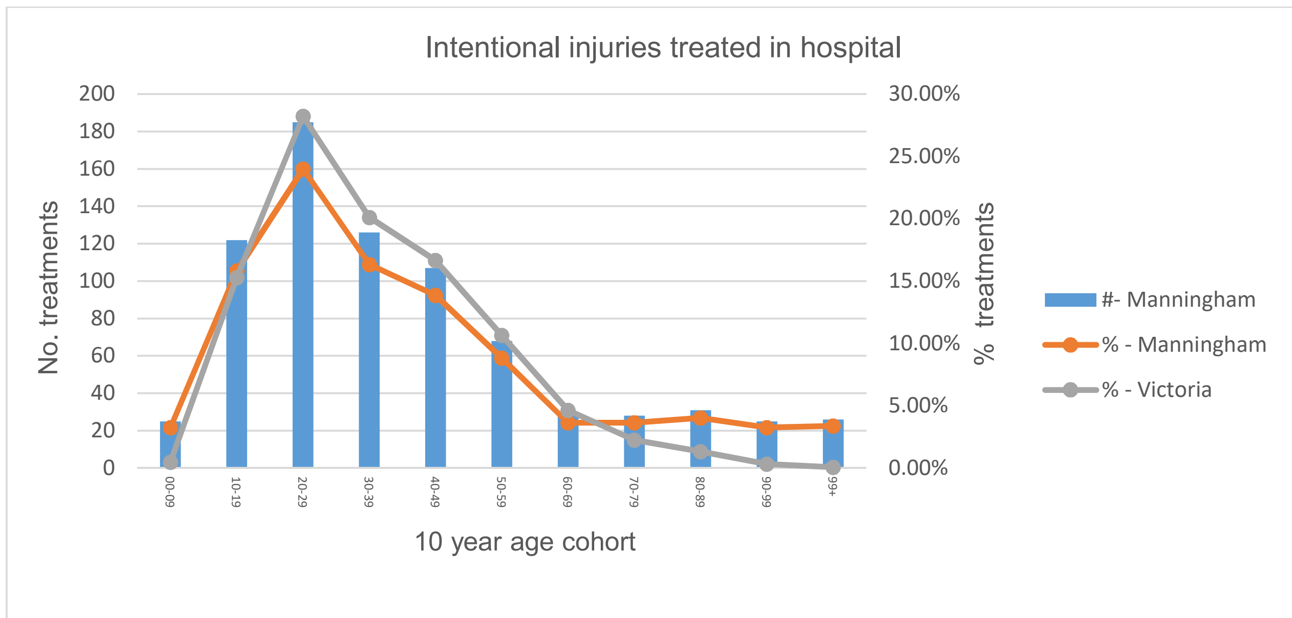


Source: Victorian Emergency Minimum Dataset (VEMD) July 2015 to March 2020, Victorian Agency for Health Information

Figure 61. Hospitalisations due to falls

11.2.2. Intentional injuries

Between 2015/16 and 2019/20, Manningham residents were treated for 771 intentional injuries in hospital. They had either intentionally self-harmed or been involved in an assault. Those in the age category 20 to 29 years accounted for 24% of the total intentional injuries treated. The Manningham trend aligns with Victoria's until the 70 to 79 age cohort, where the percentage of Victorian presentations starts to decline but Manningham's stays stable as illustrated below in Figure 62.



Source: Victorian Emergency Minimum Dataset (VEMD) July 2015 to March 2020, Victorian Agency for Health Information

Figure 62. Intentional injuries treated in hospital

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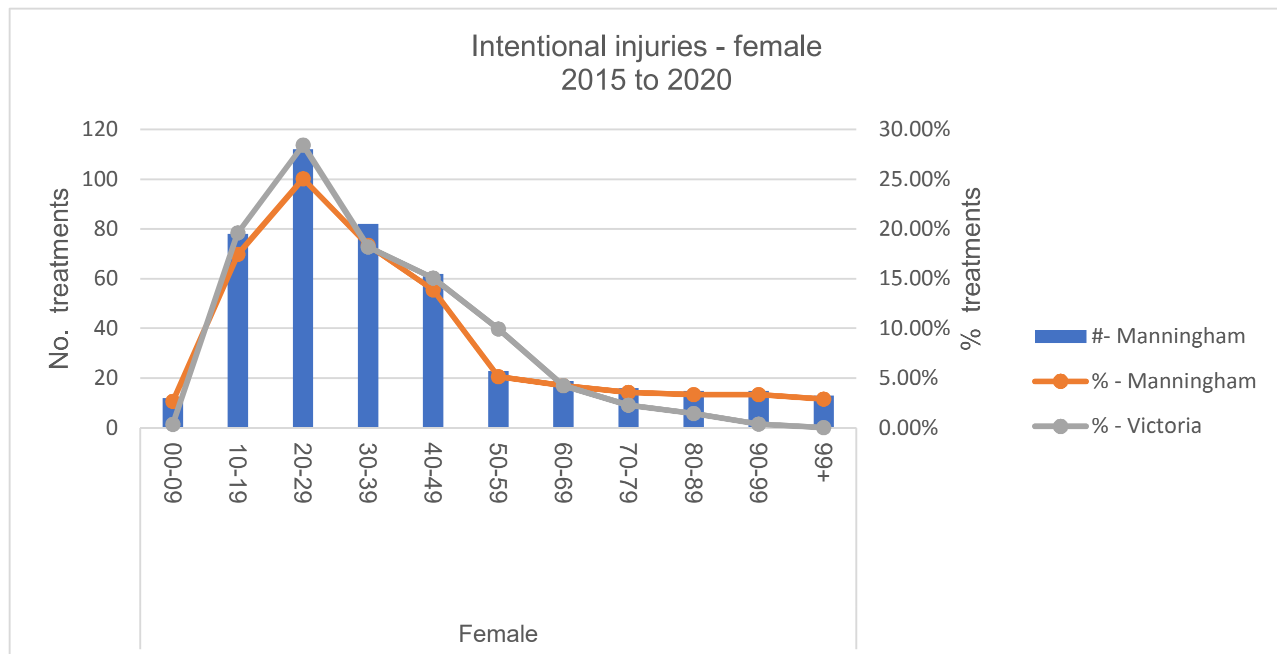
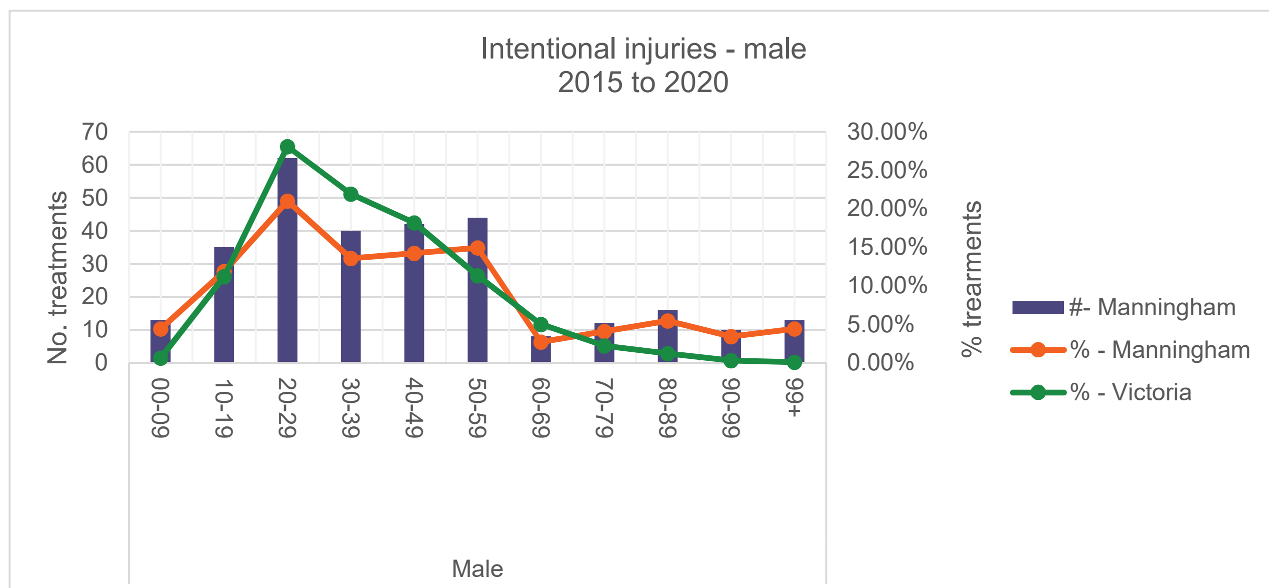
Disaggregated by sex, females accounted for 447 (58%) of the total treatments for intentional injuries from 2015 to 2020, the majority taking place in the 20 to 29 year age group. See Figure 63 below. The female incident pattern is similar to the total treatments illustrated in Figure 62.



Source: Victorian Emergency Minimum Dataset (VEMD) July 2015 to March 2020, Victorian Agency for Health Information

Figure 63. Intentional injuries – female

While males accounted for less treatments for intentional harm, (295 or 38%), their pattern of presentations is much more sporadic. Similarly to the female presentations, most occur in the 20 to 29 age cohort. However, rather than tapering off, treatments start to increase again between the 40 to 49 age cohort and 50 to 59 age cohort. Another small increase also occurs in the 80 to 89 age cohort. See Figure 64 below.

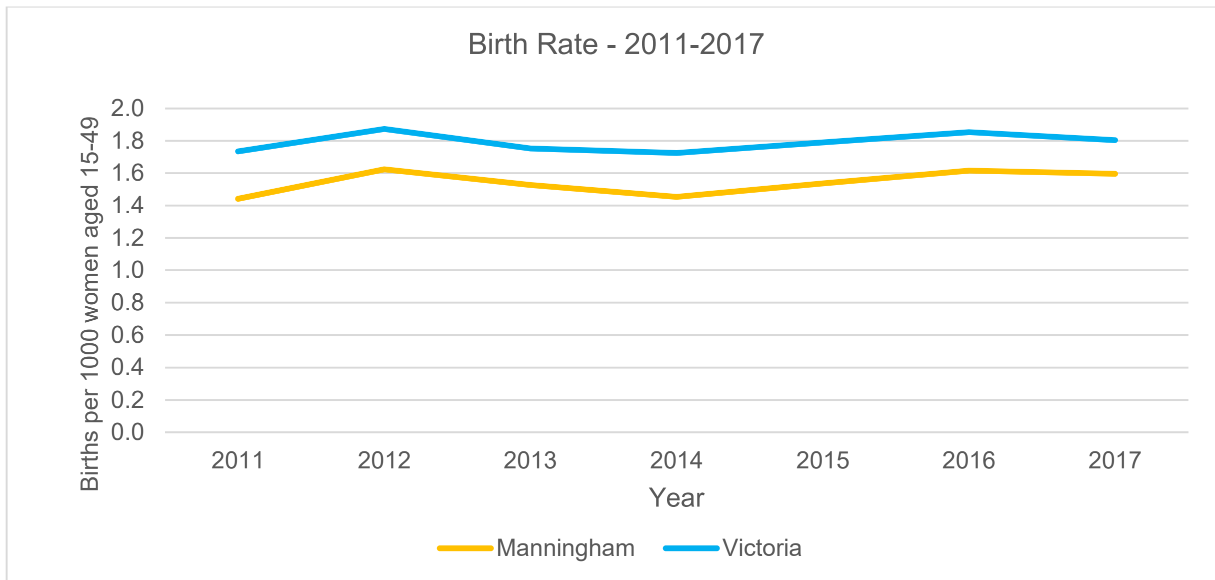


Source: Victorian Emergency Minimum Dataset (VEMD) July 2015 to March 2020, Victorian Agency for Health Information

Figure 64. Intentional injuries – male

11.3. Fertility

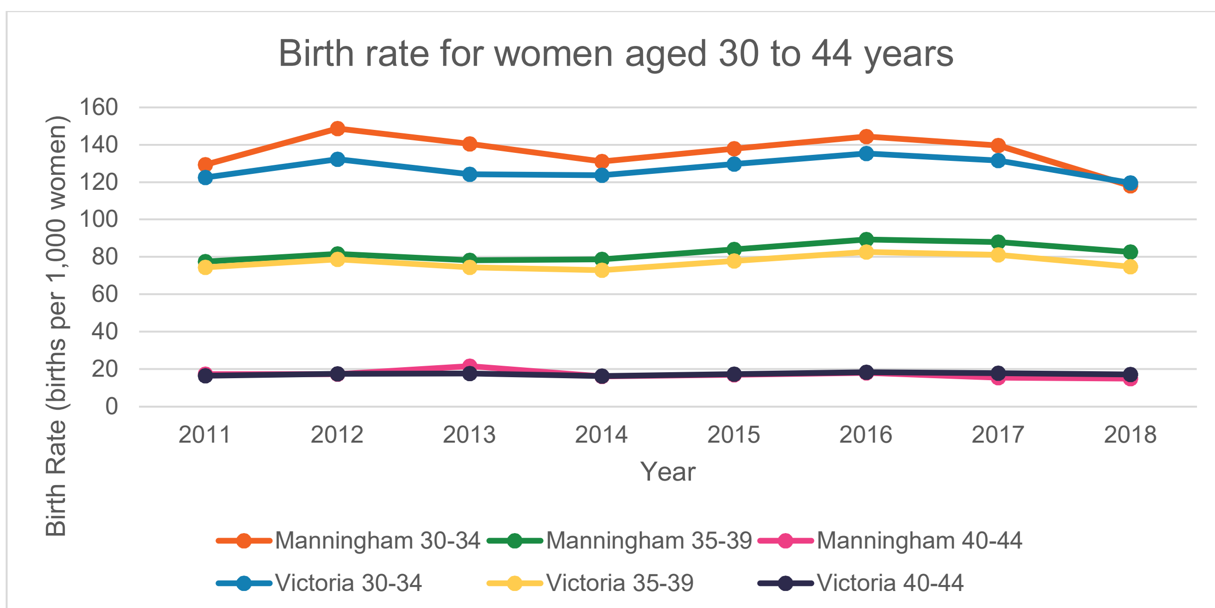
In the period 2011-2017, Manningham's fertility rate tracked the Victorian birth rate, however it was consistently lower than the Victorian rate each year as illustrated below in Figure 65.



Source: Australian Bureau of Statistics, customized query, 2017

Figure 65. Birth rate by year

Disaggregated by age, it is evident that the birth rate for women aged 30-44 years in Manningham is consistent with wider Victorian birth rate, but the birth rate for younger women is significantly lower. (Figures 66 and 67).



Source: Australian Bureau of Statistics, customized query, 2017

Figure 66. Birth rate for women aged 30-44 years

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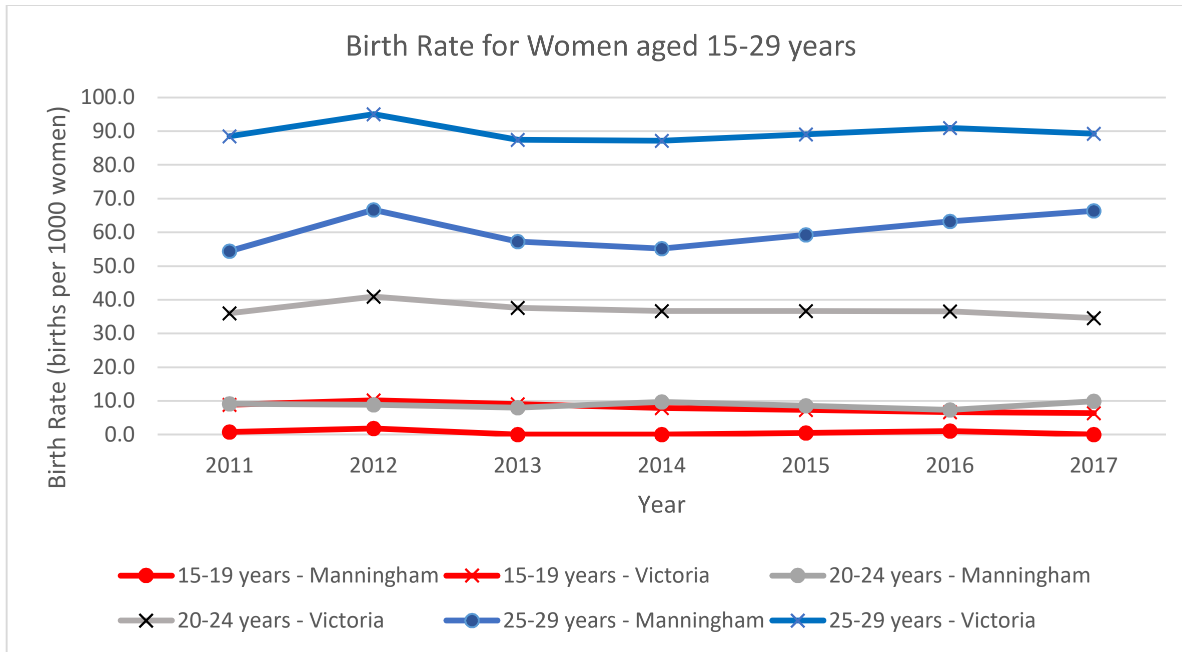
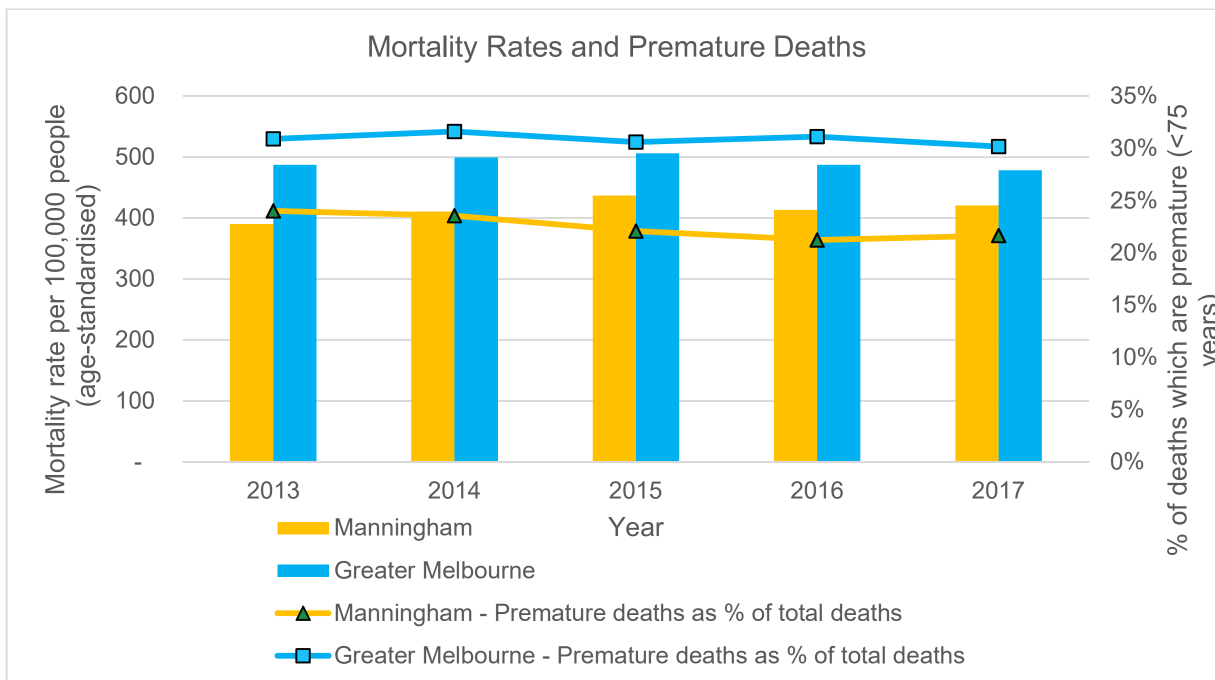


Source: Australian Bureau of Statistics, customized query, 2017

Figure 67. Birth rate for women aged 15-29 years

11.4. Mortality

In the period 2013-2017, Manningham's mortality rate was consistently lower than that of Greater Melbourne. In addition, premature deaths (<75 years) represented a consistently lower proportion of total deaths (Figure 68).



Source: Australian Institute of Health and Welfare

Figure 68. Mortality rate and premature death

Disaggregated by gender, the mortality rate in the period in 2013-17 was *higher* for men than for women in both Manningham and Greater Melbourne.

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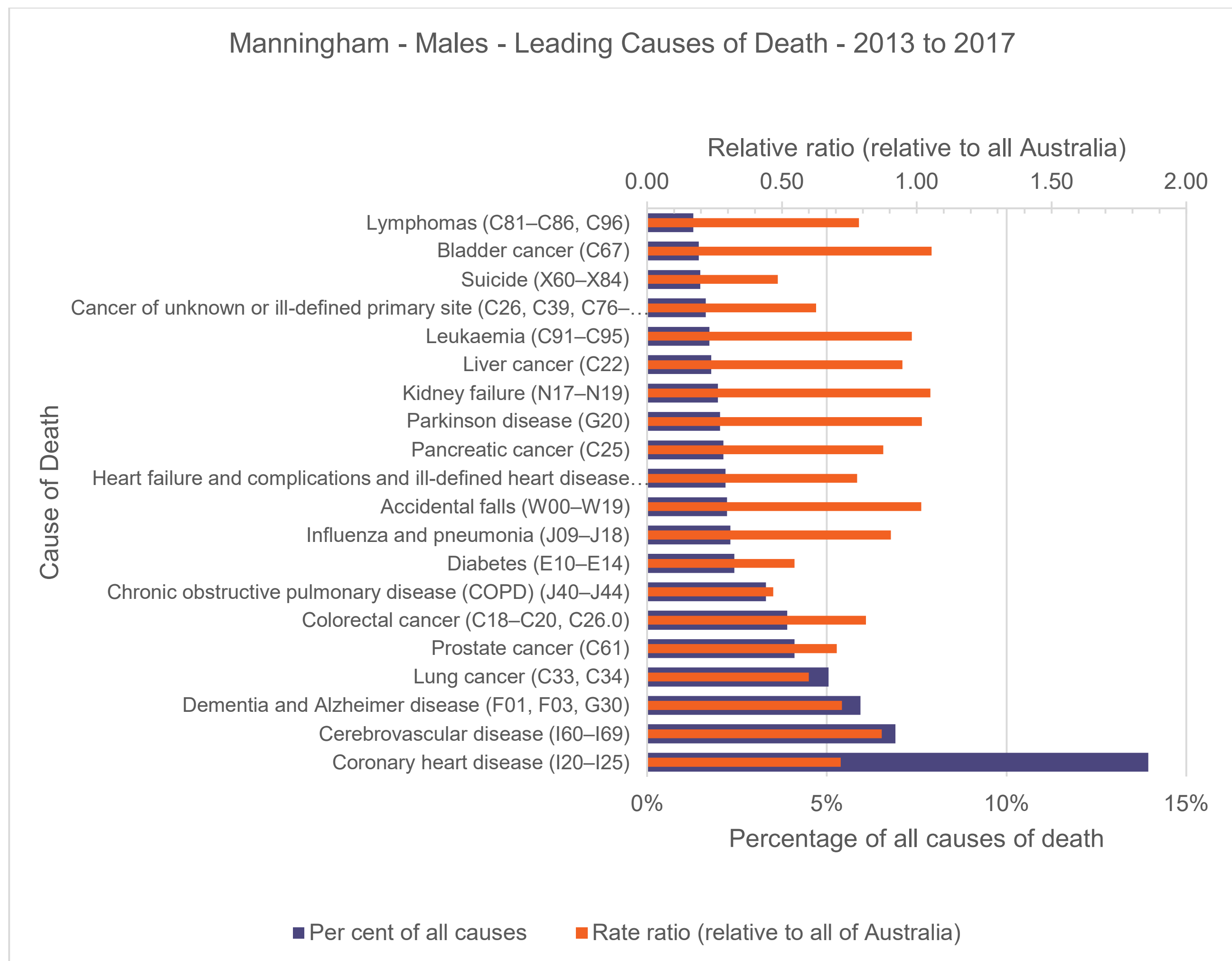
Aboriginal and Torres Strait Islander Victorians have, on average, a life expectancy approximately 10 years less than that of the non-Aboriginal population. *(Eastern Melbourne Primary Health Network, Needs Assessment Report 2018)*

The top 20 causes of death among males in Manningham (2013 to 2017) accounted for 67.7% of all male deaths, with coronary heart disease the most common (14%). However, most causes of male death were at a lower rate of incidence compared to Australia. Bladder cancer, kidney failure, Parkinson's disease and accidental falls occurred at a slightly greater rate of incidence compared to Australia. (Figure 69)



Source: Australian Institute of Health and Welfare

Figure 69. Leading cause of death among males (2013 to 2017)

The top 20 causes of death among females in Manningham (2013 to 2017) accounted for 67.3% of all female deaths, with dementia and Alzheimer's disease the most common (11.8%). Fifteen of the causes of death occurred in Manningham at a lower rate of incidence compared to Australia. Influenza and pneumonia, kidney failure, pulmonary oedema and other interstitial pulmonary diseases, and accidental falls occur at a higher rate of incidence compared to Australia, with accidental falls significantly so. (Figure 70)

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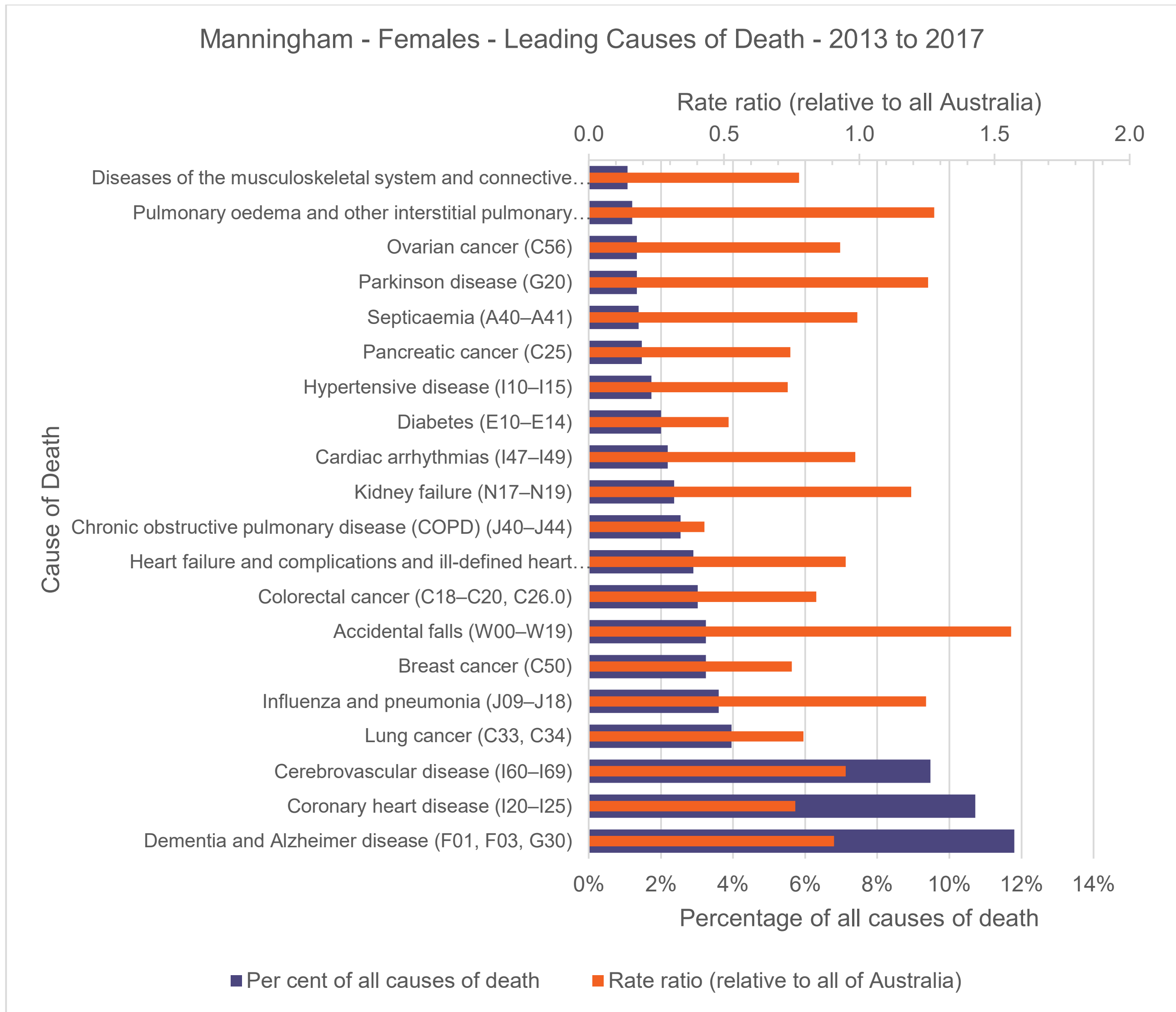


Source: Australian Institute of Health and Welfare

Figure 70. Leading cause of death among females (2013 to 2017)

12. Mental Health

The World Health Organisation defines mental health as “a state of wellbeing in which an individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”.

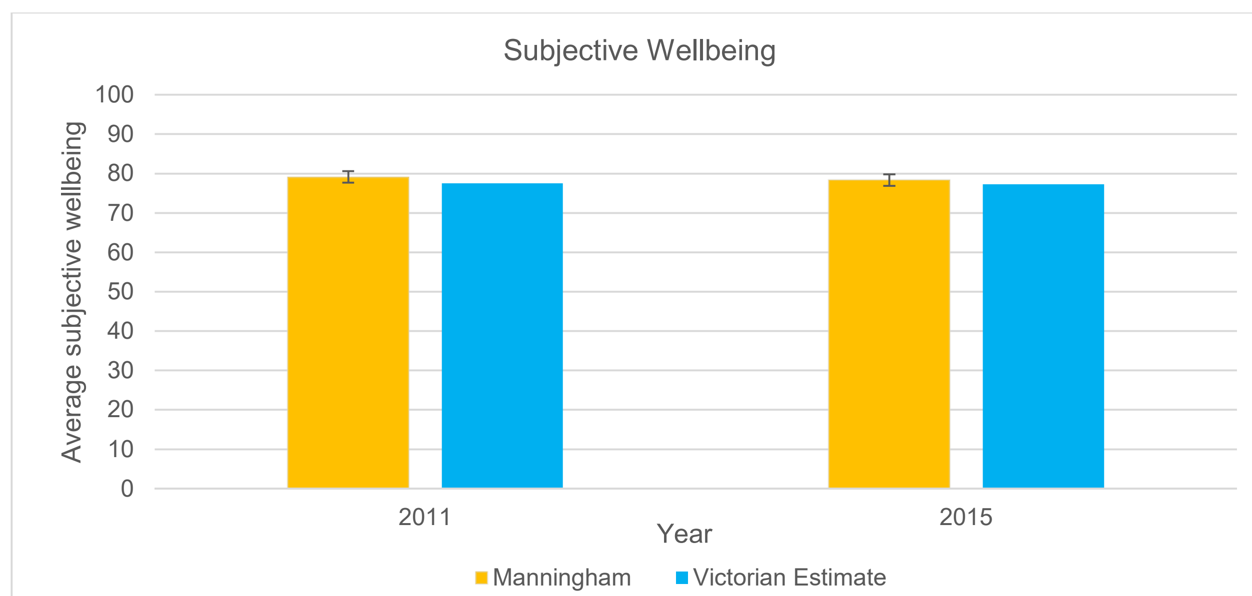
From July 2013 to June 2015, the age-standardised hospitalisation rate for Aboriginal and Torres Strait Islander Australians in Victoria for mental health-related conditions was 23 per 1,000, compared with 15 per 1,000 for non-Aboriginal Australians. The highest hospitalisation rate for Aboriginal and Torres Strait Islander Australians was in the 35–44 age group. *(Australian Institute of Health and Welfare, as cited in EMPHN Needs Assessment Report, 2018)*

12.1. Subjective Wellbeing

According to the Vichealth 2015 Indicators Survey Selected Findings Report (p 27):

> *“Our individual responses to life challenges, transitions and disruptions are shaped by our physical, psychological and social capacity to adapt and restore to a balanced state of wellbeing (Dodge et al. 2012). From a psychological perspective, the ‘homeostasis theory of wellbeing’ considers the personal factors that maintain and regulate wellbeing, and the external factors that influence our ability to cope with stress and support wellbeing (Cummins 2010). Although subjective wellbeing refers to individuals’ perceptions of the quality of their lives, lifestyle factors and demographic circumstances also have predictive influences.”*

In 2015, the average measure for subjective wellbeing among people living in Manningham was 76.9%–79.8%. This result was consistent with Manningham’s 2011 result and slightly higher than the Victorian estimate as illustrated below in Figure 71.



Source: VicHealth Indicators Survey 2011 & 2015
Figure 71. Subjective wellbeing

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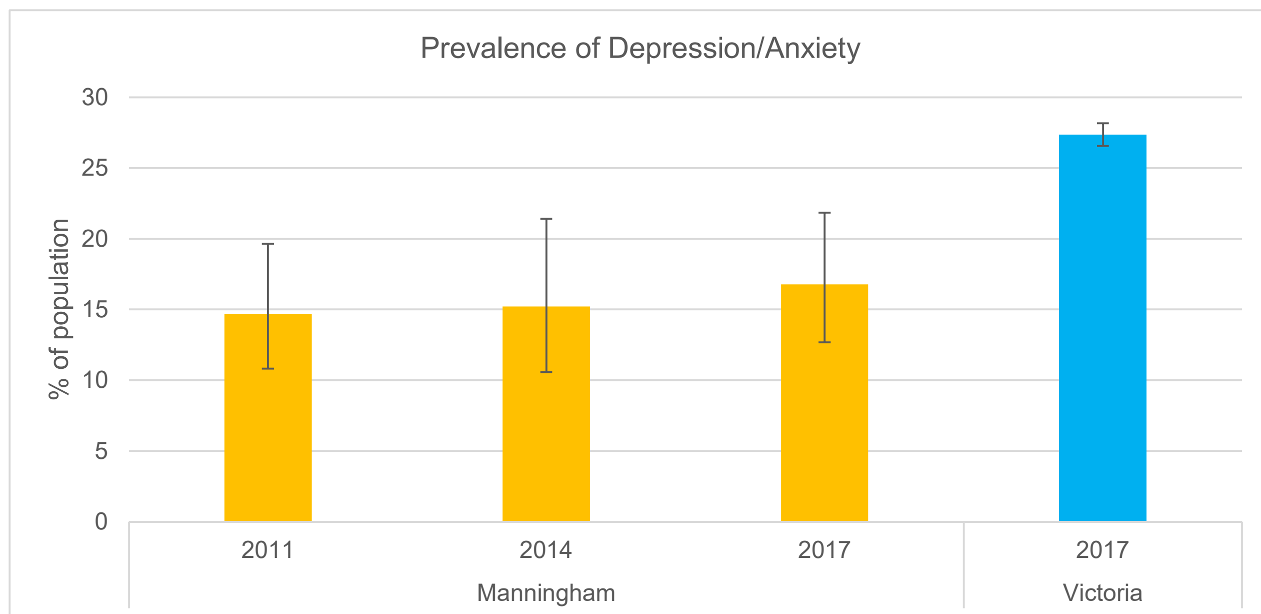
According to the *VicHealth Indicators Survey 2015 Supplementary report: Sexuality,* in 2015, LGBTQIA+ Victorians had a significantly *lower* average measure (73%) for subjective wellbeing than heterosexual Victorians. In the summary and conclusions section (p.10) possible reasons are put forward:

> *The VicHealth Indicators Survey 2015 showed non-heterosexual Victorians reported significantly lower than average levels of subjective wellbeing, life satisfaction and resilience. One possibility for poorer wellbeing and lower levels of life satisfaction among LGB and other non-heterosexual people is that negative social attitudes toward LGB people persist in our society (Flood & Hamilton 2005; Webb & Chonody 2014). LGB people may experience isolation or rejection within their families, schools or local communities, or acts of harassment in public spaces. Even where LGB people have not experienced homophobia directly, wellbeing may be negatively affected by fear of discrimination or stress associated with feeling different or less worthy than others (Meyer 2003).*

12.2. Depression and Anxiety

Manningham residents report a lower level of anxiety and depression compared to the wider Victorian average as illustrated below in Figure 72.



Source Victorian Population Health Survey 2011, 2014 & 2017

Figure 72. Prevalence of depression/anxiety

Disaggregated by gender, Manningham females in 2017 exhibited a higher level of anxiety than males, consistent with the wider Victorian experience. Of note is that males in Manningham appear to experience anxiety/depression at a *much* lower rate than for males across the wider state. (Figure 73)

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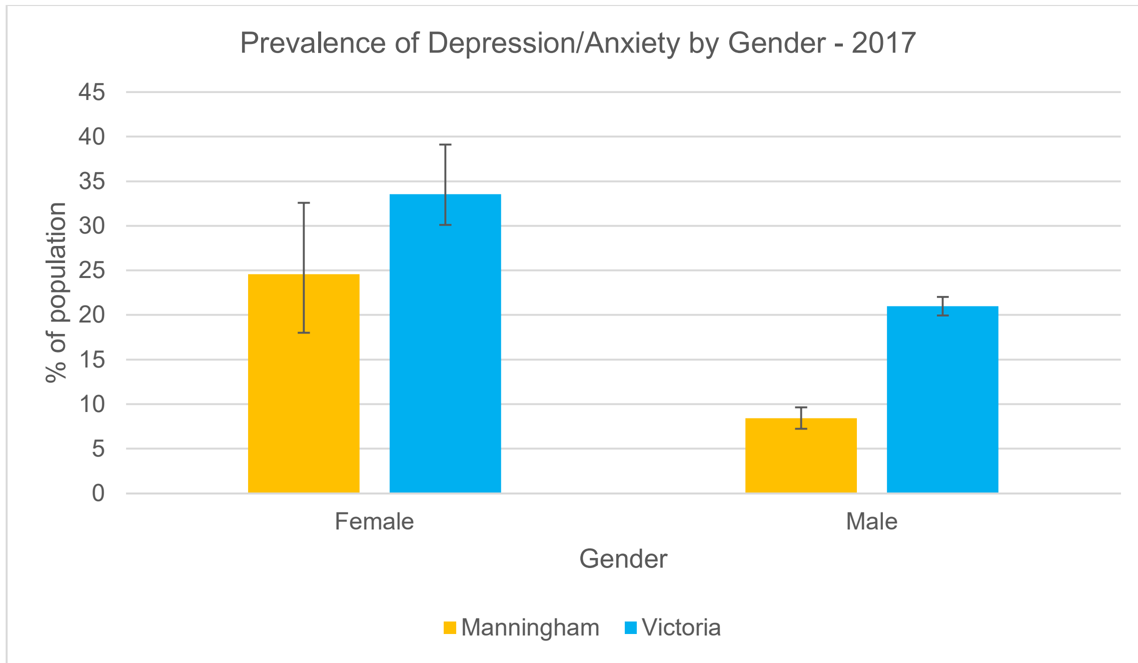


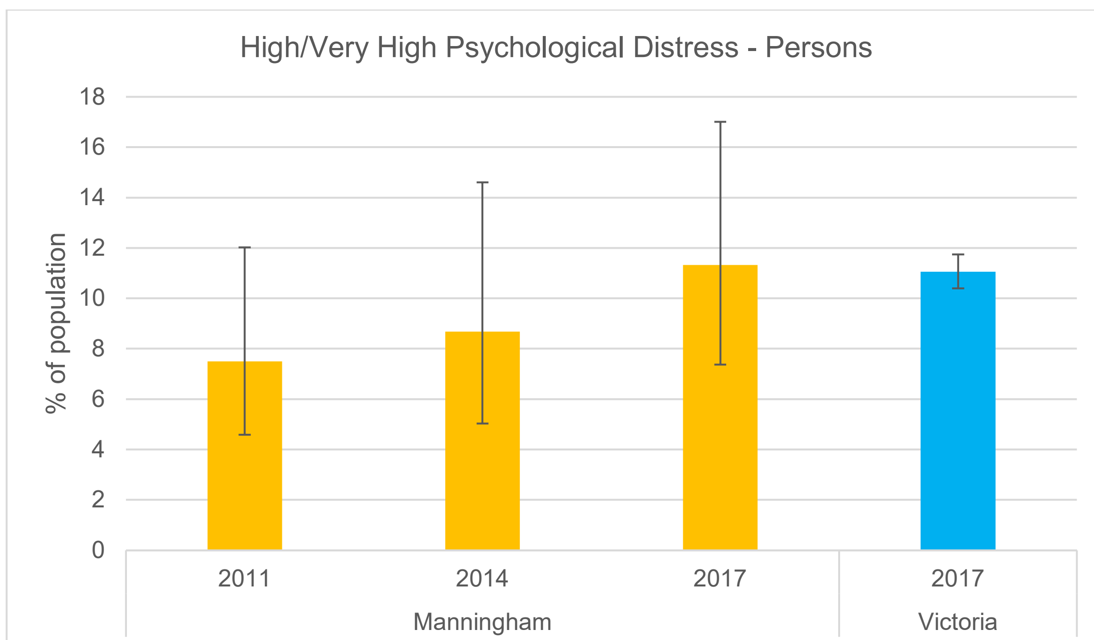
Source Victorian Population Health Survey 2017

Figure 73. Prevalence of depression/anxiety by gender

LGBTQIA+ Victorians are significantly more likely to be diagnosed by doctor with anxiety or depression (44.8%) than the broader community (26.7%). *(Discussion Paper for the LGBTIQ Strategy)*

12.3. Psychological Distress

In 2017, the proportion of people in Manningham experiencing high or very high psychological distress was similar to that experienced in wider Victorian community. It *appears* as though there may have been an upward trend in people experiencing distress in Manningham since 2011. (Figure 74)



Source: Victorian Population Health Survey 2011, 2014 & 2017

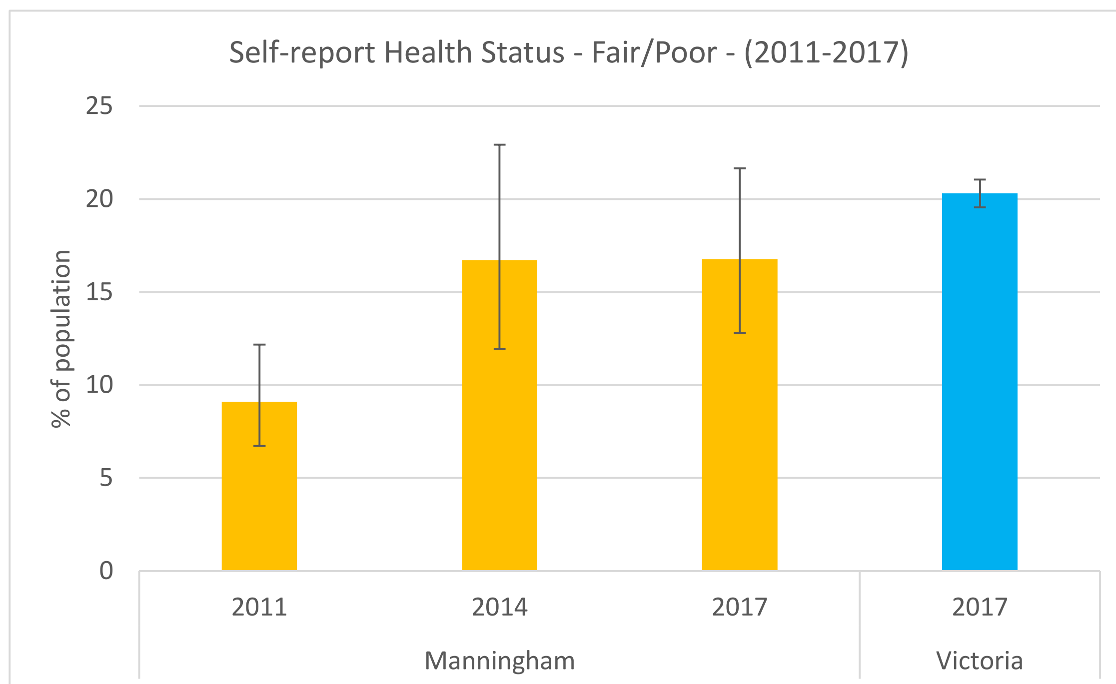
Figure 74. Prevalence of high/very high psychological distress

A significantly greater proportion of LGBTQIA+ Victorians (24.4%) experience high or very high levels of psychological distress compared to the broader community. *(Victorian Discussion Paper for the LGBTIQ Strategy)*

In 2012-13, 32% of Aboriginal and Torres Strait Islander Victorians aged 18 and over (age standardised) reported high or very high levels of psychological distress, compared to 11% for non-Aboriginal Victorians. *(Australian Institute of Health and Welfare, as cited in EMPHN Needs Assessment Report, 2018)*

12.4. Self-reported Health Status

In 2017, 1-2 in every 10 people (12.8%-21.7%) in Manningham reported their health as being fair or poor, consistent with the wider Victorian average (19.6%-21.0%). However, of note is the increase in Manningham of people self-reporting fair/poor health which in 2011 was 6.7%-12.2%. (Figure 75)



Source: Victorian Population Health Survey 2011, 2014 & 2017

Figure 75. Fair or poor self-reported health status

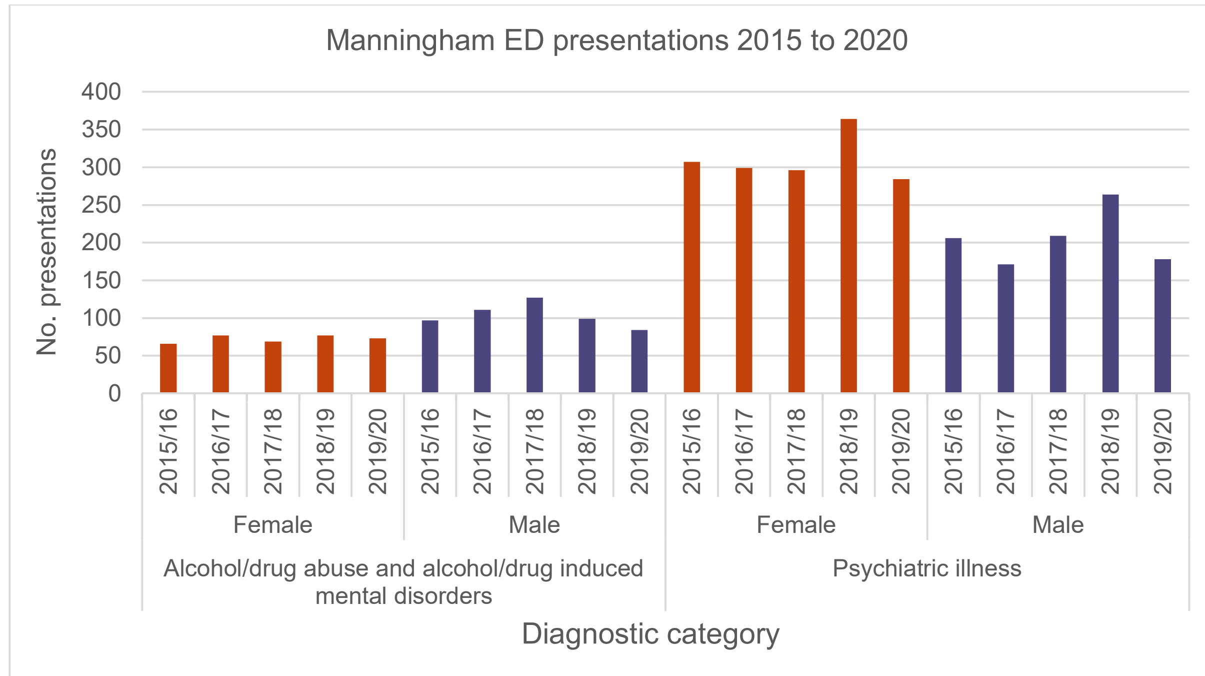
Disaggregated by gender, a slightly higher proportion of women than men in Manningham self-reported fair/poor health in 2017.

35.7% of LGBTQIA+ Victorians rate their health as excellent or very good compared to 42.5% of the broader community. *(Victorian Discussion Paper for the LGBTIQ Strategy)*

Among Aboriginal and Torres Strait Islander peoples in the Eastern Melbourne region, 33.5% assessed their health as fair or poor, compared to 13% of non-Aboriginal people.

12.5. Emergency Department Presentations

In the period July 2015 to March 2020, there were a total of 3,509 mental health diagnostic presentations to Metropolitan public hospitals by Manningham residents. This number represents 2.81% of all Manningham resident emergency department (ED) presentations for that time period. (Figure 76)



Source: Victorian Emergency Minimum Dataset (VEMD) July 2015 to March 2020, Victorian Agency for Health Information.

Figure 76. Manningham mental health diagnostic ED presentations 2015 to 2020

For the most part, Manningham's emergency department presentations align with Victoria's. However, of note is the number of Manningham females presenting to ED with a psychiatric illness, accounting for 44.84% of all ED mental health presentations compared to 39.55% for Victoria. See Table 10 below.

Diagnostic Block	# Manningham	% Manningham	# Victoria	% Victoria
Alcohol/drug abuse and alcohol/drug induced mental disorders	886	25.68%	60,153	25.44%
Female	364	10.55%	22,013	9.31%
Male	522	15.13%	38,140	16.13%
Psychiatric illness	2,564	74.32%	176,272	74.56%
Female	1,547	**44.84%**	93,517	**39.55%**
Male	1,017	29.48%	82,755	35.00%
Grand Total	3,450	100.00%	236,425	100.00%

Source: Victorian Emergency Minimum Dataset (VEMD) July 2015 to March 2020, Victorian Agency for Health Information.

Table 10. Diagnostic block by gender and area 2015 to 2020

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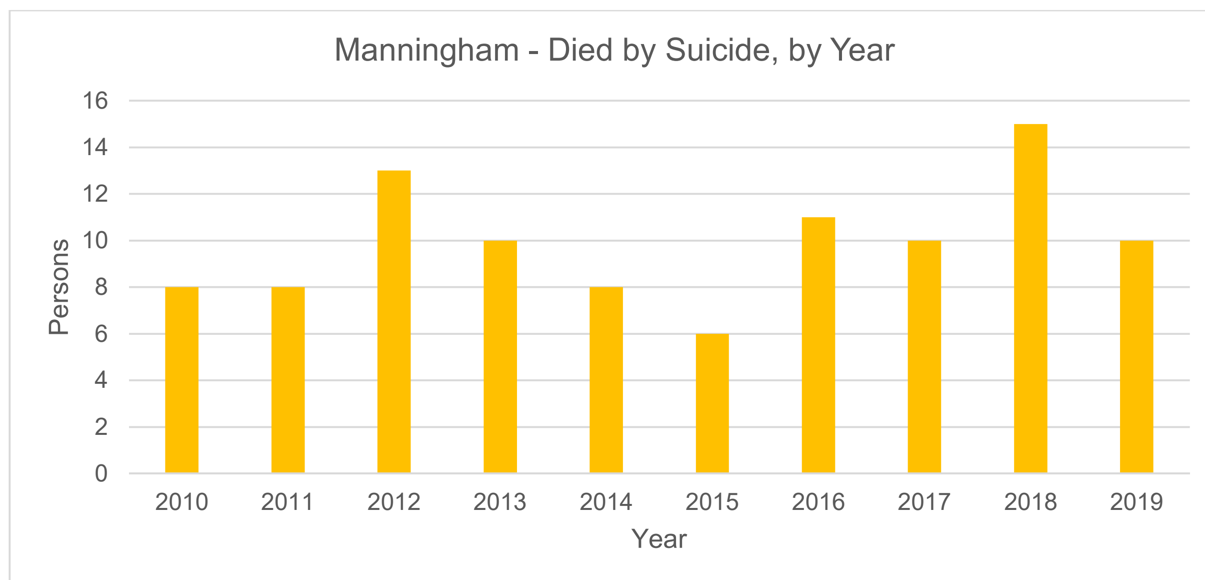
During the same time period, from 2015/16 to 2019/20, a total of 3,380 Manningham residents were receiving treatment in a public mental health service (DHHS, CMI/ODS data, 2015 to 2019).

12.6. Suicide

In the 10-year period 2010-2019, there were 99 deaths by suicide among Manningham residents as illustrated overleaf in Figure 77.



Source: Coroner's Court of Victoria

Figure 77. Died by suicide, by year

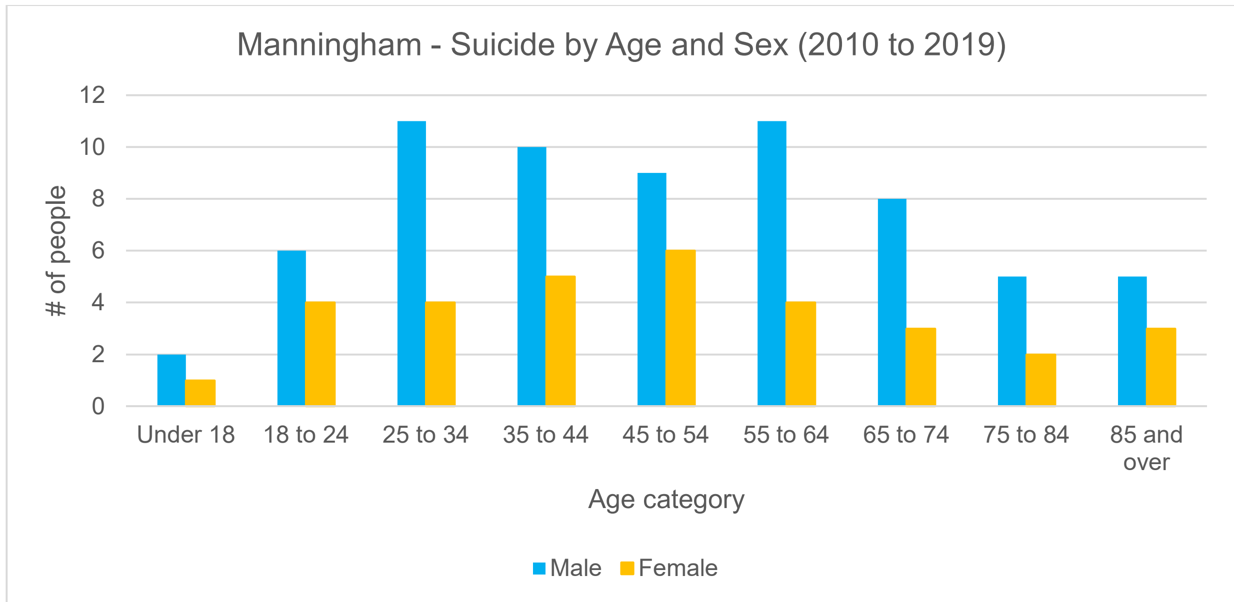
The average annual suicide rate among Manningham residents during 2010-2019, was 8.2 suicides per 100,000 residents per year. By comparison, the rate for Victoria was 10.3 suicides per 100,000 residents and for metropolitan Melbourne it was 9.2 suicides per 100,000 residents. *(Coroner's Court of Victoria)*

Nationally, between 2011-2015 the age-standardised death rate for Aboriginal and Torres Strait Islander Australians by self-harm was *2.1 times* the rate for non-Aboriginal Australians. *(Australian Institute of Health and Welfare, as cited in EMPHN Needs Assessment Report, 2018)*

Transgender young people are twice as likely to have suicide ideation and self-harm than other young people.

In Manningham, two-thirds (67) were male and one-third (32) were female. The age and sex profile of people who died by suicide is illustrated below in Figure 78.

MANNINGHAM

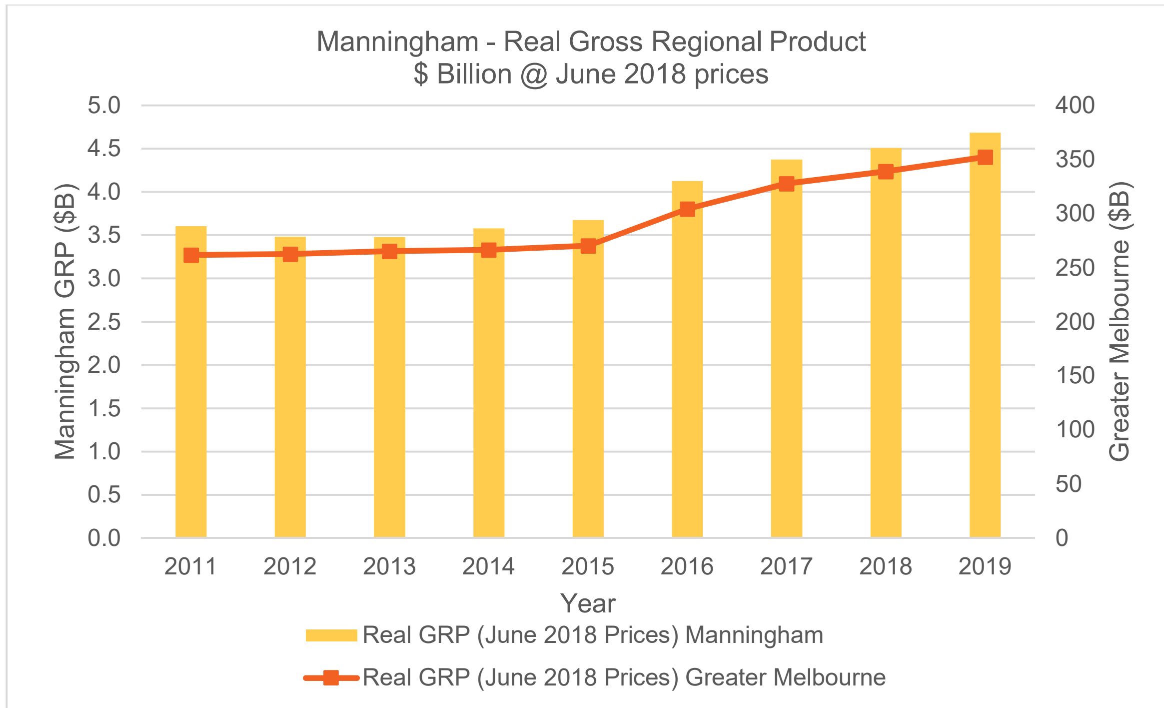


Source: Coroner's Court of Victoria

Figure 78. Died by suicide, by age and sex

13. Employment & Economy

In 2019, Manningham's nominal gross regional product (GRP) was $4.76 billion and had grown 27.4% in real terms since 2015. Manningham's growth in real GRP (expressed in 2018 prices) has closely aligned with that of Greater Melbourne since 2011. (Figure 79)



Source: REMPLAN

Figure 79. Real Gross Regional Product (GRP)

13.1. Employees

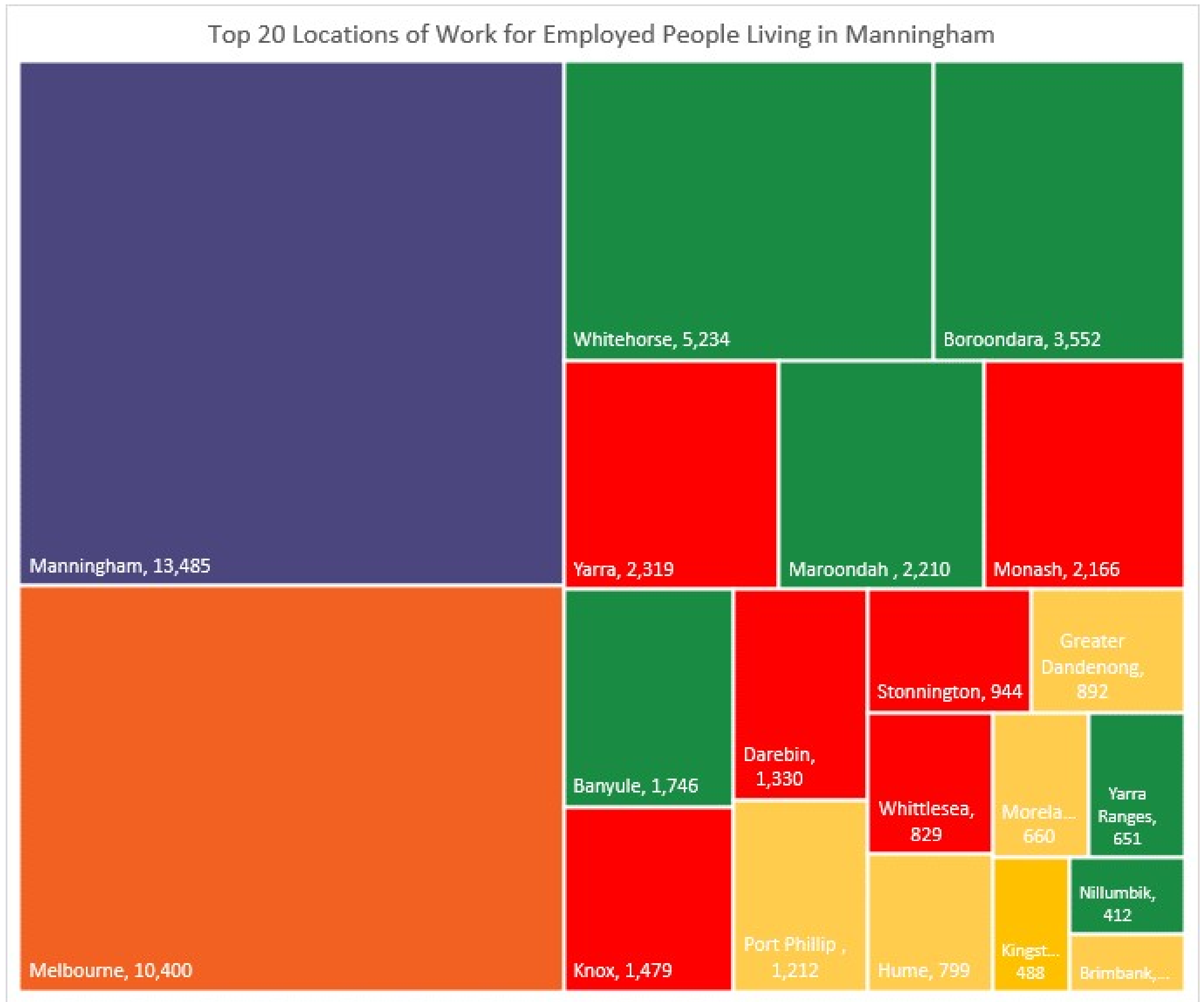
13.1.1. Place of Work

52,531 people living in Manningham are employed, of whom:

- 25.7% work in Manningham
- 26.3% work in LGAs bordering Manningham (e.g. Nillumbik, Whitehorse, Maroondah)
- 19.8% work in Melbourne
- 17.3% work in LGAs bordering those adjacent to Manningham (e.g. Monash, Darebin, Yarra)
- 11.0% work elsewhere

Figure 80 illustrates the top 20 workplace municipalities of employees who reside in Manningham. Together, these municipalities account for 51,120 or 97% all Manningham workers.

MANNINGHAM



Source: REMPLAN

Figure 80. Top 20 locations of work for employed people living in Manningham

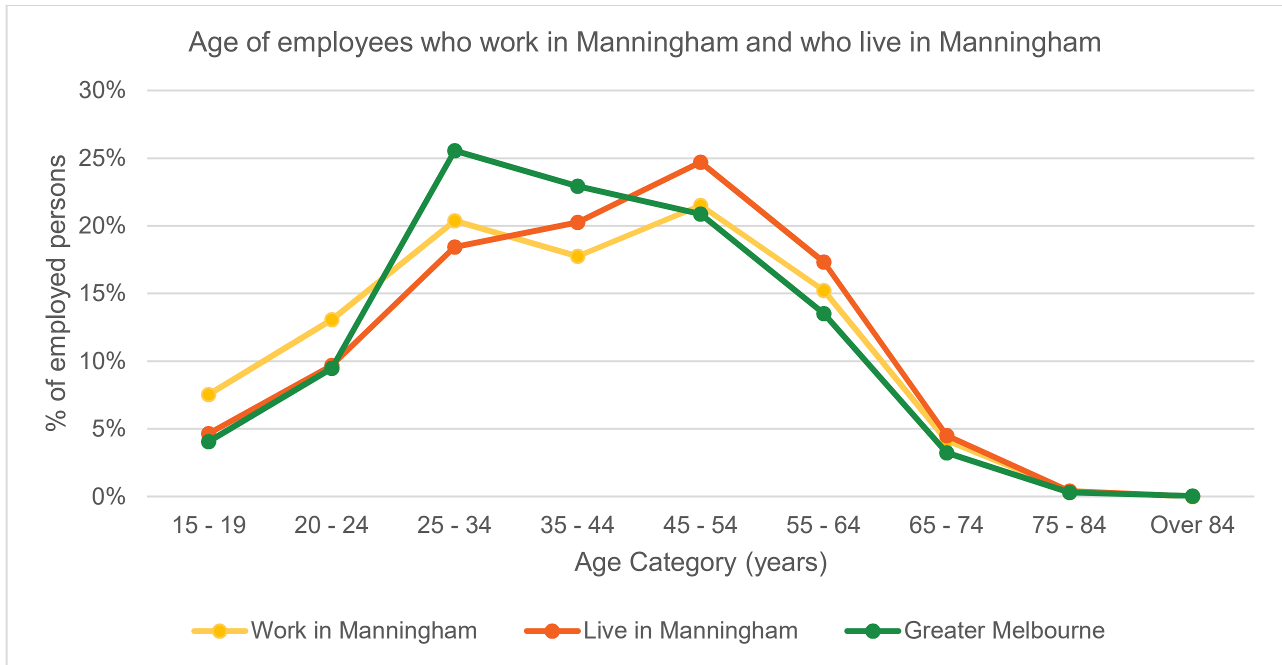
13.1.2. Age

52,531 employees live in Manningham, and Manningham supports 30,572 jobs.

A greater proportion of young people (15-34 years) are *employed* in Manningham, compared to those of the same age who live in Manningham or Greater Melbourne. This suggests that a significant proportion of young people employed in the municipality live outside of Manningham. (Figure 81)

A greater proportion of employees aged 45+ years *live* in Manningham, compared to those of the same age who *work* in Manningham or Greater Melbourne. This suggests a significant proportion of older employees in Manningham work outside of the municipality.

MANNINGHAM

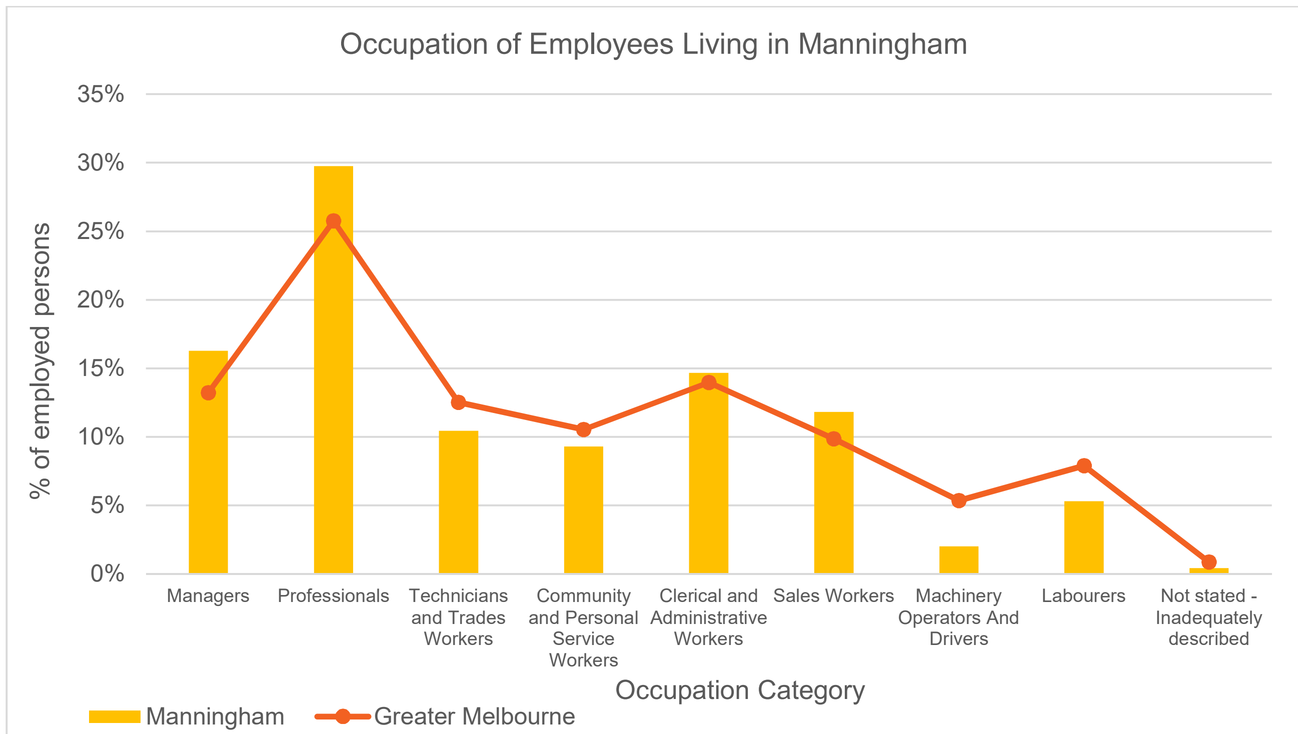


Source: REMPLAN

Figure 81. Age of employees who work in Manningham vs employees who live in Manningham

13.1.3. Occupation

A greater proportion of managers, professionals, administrative and sales workers live in Manningham, compared to Greater Melbourne. A lesser proportion are employed in traditionally blue-collar roles (trades, machinery operators, laborers). (Figure 82)



Source: REMPLAN

Figure 82. Occupation of employees living in Manningham

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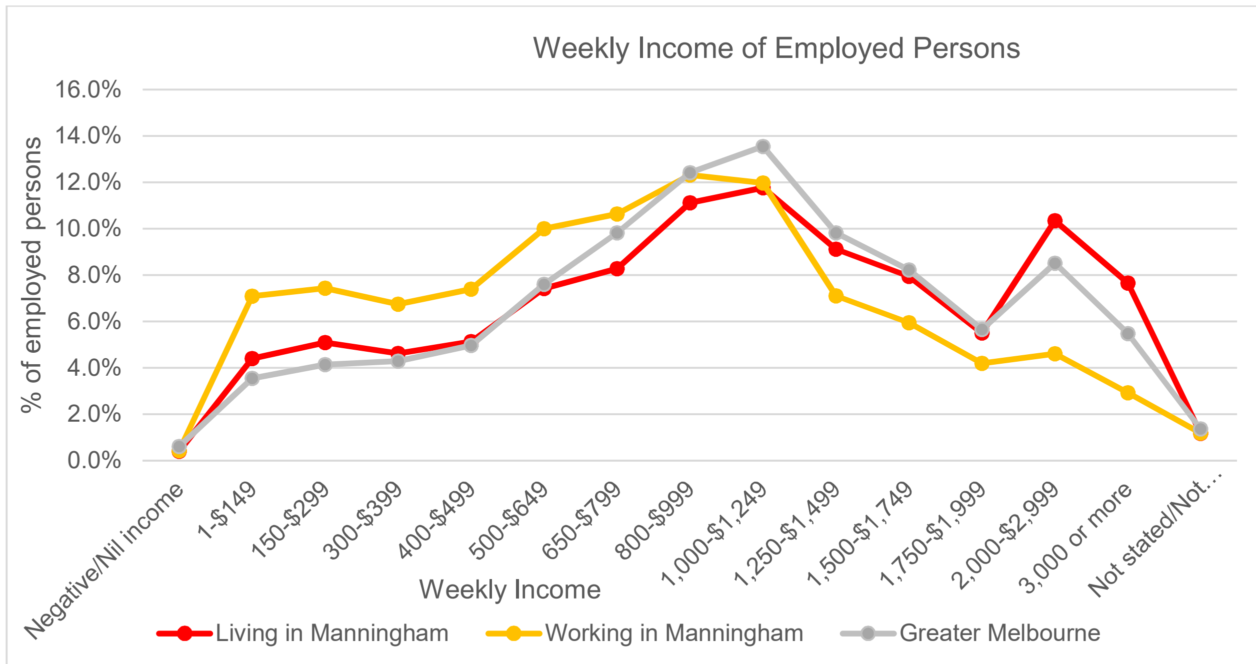
13.1.4. Income

A greater proportion of people who *work* in Manningham tend to earn less (<$1,000 per week) than employees who *live* in Manningham or work across Greater Melbourne.

The proportion of employees who live in Manningham earning $1K-2K per week is consistent with that of Greater Melbourne. A significantly greater proportion of employees who live in Manningham earn $2K+ per week, compared to greater Melbourne. (Figure 83)



Source: REMPLAN

Figure 83. Weekly income of employed persons

13.2. Businesses

13.2.1. Industries

Manningham supports 30,572 jobs across a diverse range of industries, with retail, health care and social assistance, education and training, and construction being its largest sectors.

From 2011 to 2016, almost all sectors increased their number of employees, with the exceptions of wholesale trade and manufacturing. In that period, the total number of people working in Manningham increased by 11.3% or 3,104. (Figure 84)

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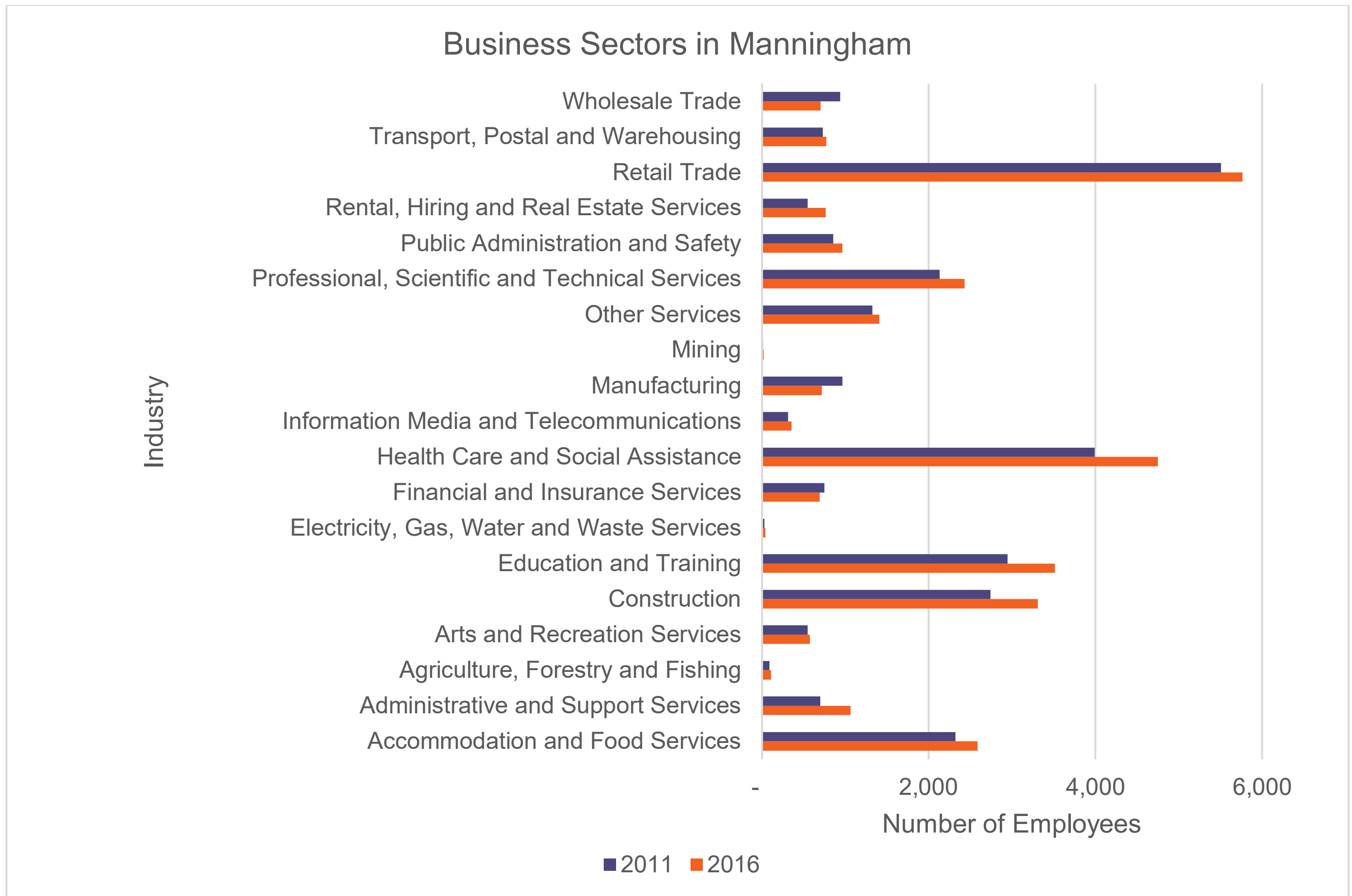

Source: REMPLAN

Figure 84. Business Sectors in Manningham

13.2.2. Size

In 2019, more than two-thirds (67.2% or 9,633) of Manningham private businesses were non-employing (e.g. sole traders), and almost one-third (31.6% or 4,532) had fewer than 20 employees. Larger private businesses of 20+ employees were 166 or 1.2%.

In the period 2017-2019, the number of private businesses in Manningham grew by 870 or 6.4%, largely to new non-employing businesses (i.e. sole traders). During the same period, the number of large private businesses (200+ employees) reduced from three to zero. Further investigation is required to determine whether the businesses reduced in size (thereby being reported in the *20-199 employee* business category, moved location or ceased operating.

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HEALTH NEEDS ANALYSIS

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This section considers the data contained in the previous chapter of this report to analyse how Manningham is performing against each of the priority areas identified in the Victorian Public Health and Wellbeing Plan 2019-2023. In some cases, additional data has been sourced in order to provide a more nuanced understanding.

This chapter is designed to support an informed, inclusive conversation in Council, with community, local organisations and government agencies regarding the priorities for Manningham's new Municipal Public Health and Wellbeing Plan.

A number of frameworks exist to support the identification of priorities and target cohorts, and which enable an understanding of the complexity of factors which contribute to health outcomes. Each framework provides a different and helpful structure for considering public health challenges and responding to them. Two key frameworks are:

1. **Environments for Health**

   Growing evidence exists that the local environments in which people live have a profound impact on their health. Environments for health is a systems approach which considers the health and wellbeing factors originating across any or all of four environmental dimensions:

   1. Economic environment
   2. Social environment
   3. Built environment
   4. Natural environment

2. **Social Determinants of Health**

   According to the World Health Organisation (WHO), the social determinants of health are the conditions in which people are born, grow up, live, work and age. They include:

   1. The need for policies to prevent people from falling into long-term disadvantage;
   2. How the social and psychological environment affects health;
   3. The importance of ensuring a good environment in early childhood;
   4. The impact of work on health;
   5. The problems of unemployment and job insecurity;
   6. The role of friendship and social cohesion;
   7. The dangers of social exclusion;
   8. The effects of alcohol and other drugs;
   9. The need to ensure access to supplies of healthy food for everyone;
   10. The need for healthier transport systems

   These conditions influence a person's opportunity to be healthy, his/her risk of illness and life expectancy. Social inequities in health – the unfair and avoidable differences in health status across groups in society,- are those that result from the uneven distribution of social determinants.

These frameworks provide a structure and shared language for Council, the community and partners to explore the social and environmental contexts in Manningham which impact upon the health and wellbeing of residents. They also enable the development of grounded, complementary interventions by a range of partners which, together, will have a greater chance of achieving the target health outcomes.

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14. Tackling climate change and its impact on health

A range of factors are considered in assessing Manningham's progress in tackling climate change including CO_2 emissions, waste, water consumption and the natural environment.

14.1. CO_2 Emissions (9.1)

The methodology used by Climate Snapshot to calculate municipal emissions has changed with the result that emissions data is only available for two years (2017/18 and 2018/19). Consequently, the data provides a useful baseline but does not enable meaningful trend analysis.

The municipality's annual CO_2 emissions increased by 45,000 tonnes or 3.9% in the 12 months from 2017/18 to 2018/19, from 1,140,800 tonnes to 1,185,800 tonnes. Two-thirds of the increase was due to commercial (gas) emissions and approximately one-third due to residential gas and electricity increases.

Transportation accounts for the largest proportion of emissions (35.5%) followed by residential consumption (33.0%).

Annual commercial CO_2 emissions due to gas consumption doubled from 40,900 in 2017/18 to 80,100 tonnes in 2018/19. Further investigation is required to determine the drivers of the increase.

Annual residential CO_2 emissions per capita increased from 3.01 tonnes in 2017/18 to 3.10 tonnes in 2018/19, with two-thirds of the change due to increased gas consumption.

A range of opportunities exist to support a reduction in CO_2 emissions through:

1. Awareness and education to support behaviour change e.g. purchase of energy efficient appliances (ceiling fan vs air conditioner); turning off lights when not in use.
2. Encouraging active and public transport for local trips
3. Improving the thermal efficiency of older housing stock (e.g. retrofitting with insulation, installation of double/triple glazing; establishment of shade structures on northern/western facing walls)
4. Exploration of enhanced energy efficiency measures for new developments (e.g. passive ventilation)

Manningham Council's CO_2 emissions have reduced by 25% since 2008/09 primarily due the introduction of LED street lighting, solar electricity generation capacity and a limited number of hybrid vehicles.

14.2. Waste Tonnage (9.2)

Since 2011/12, total waste tonnage in Manningham has decreased by 4.4% to 46,259 tonnes, despite a 10.7% increase in population. During the same period, green waste as a proportion of total waste has increased from 29% to 34%. These changes indicate a greater understanding of waste issues in the community and demonstrate a willingness to change behaviour in order to reduce waste.

14.3. Water Consumption (9.3)

Total annual water consumption in Manningham increased by 9.0% from 2014/15 (8.84 Gigalitres) to 2018/19 (9.64 Gigalitres), before decreasing by 3.7% in 2019/20 (9.28 Gigalitres). (9.3)

In 2019/20, residential consumption accounted for 89% of all water consumption in Manningham. In 2019/20, the average daily consumption per person of potable water in Manningham was 174 litres – the lowest level since 2011/12 – though significantly higher than Yarra Valley Water's target of 155 litres per day.

Recycled water is reticulated to 462 residential properties and 1 business and accounts for 0.4% of all annual water consumption in the municipality.

14.4. Environment

The eastern part of Manningham is urbanised whilst the western part consists of bush and large rural blocks. This unique mix of 'city and country' results in a diverse mix of environmental needs across the municipality ranging from deer control, fire risk mitigation, the management of bushland reserves and community education. Council's education programs and environmental management practices are protecting and leveraging its natural environmental assets, particularly in the western part of the municipality.

Manningham has endorsed Melbourne's Urban Forest Strategy which seeks to increase canopy cover across the urban area from 22% to 40% percent by 2040 as part of adapting to climate change, delivering healthier ecosystems and better community health outcomes. An opportunity exists for Council to partner with a broad range of community and environmental organisations to help deliver this in the eastern part of the municipality.

14.5. Health impacts

Some of the health impacts of climate change are already known whilst others are undoubtedly yet to emerge. Furthermore, climate change health impacts intersect with a range of other priorities in the VPHWP. Some of its potential impacts include:

1. Reducing injury
    a. Elevated temperatures may lead to increased heat stroke among vulnerable cohorts (e.g. older people), exacerbated by the heat island effect of highly urbanised areas.
    b. Injury and mortality resulting from more frequent and severe extreme weather events such as bushfires and floods.
2. Healthy eating
   Drought, extreme weather events and other factors may result in reduced affordability and accessibility of healthy food - particularly for vulnerable cohorts - and increased incidence of obesity and disease and reduced mental wellbeing. Such weather events can also impact upon growing one's own food, particularly in high density dwellings which lack provisions for residents to grow vegetables on the rooftop.
3. Active living
   Elevated temperatures and extreme weather events may impact upon participation in recreation, sport and active transport, resulting in an elevated risk of obesity and disease and reduced mental wellbeing.
4. Mental wellbeing
   Existential stress regarding the future; financial stress due to economic dislocation caused by climate change, and the impact of extreme weather events may take a significant toll on mental health.
5. Sexual and reproductive health
   Uncertainty – economic and existential – may reduce fertility rates as people become less willing to bring children into a world grappling with climate change. This, in turn, will have significant

economic and social impacts as the population ages and less young people are entering the workforce.

6. Tobacco, Alcohol and other drugs
   Tobacco harm, harmful alcohol and drug use, and violence may increase due to the economic challenges created by climate change and the toll it takes on mental health.

The need exists to explore the current, emerging and potential health impacts of climate change in more detail and to incorporate emerging evidence into policy, program and project responses. Rather than a ‘once off’ exercise, this exploration be should embedded into all relevant processes and include partner organisations.

Manningham Council’s achievements to date in reducing its CO_2 emissions are commendable, as its decision to declare a climate emergency in 2020. The significant increase in residential emissions as measured by annual CO_2 emissions per dwelling is of concern and presents an opportunity for Council to take a leadership role reducing community emissions. Within MC, an opportunity exists to embed climate change into health and wellbeing planning process in order to better understand and respond to its emerging impacts on the social determinants of health and health outcomes.

15. Reducing injury

15.1. Transport Accidents (7.4)

The number of deaths due to transport accidents is rightfully a key policy focus for government. However, in addition to road deaths, there are many more people who are injured – often seriously. In 2018 in Victoria:

1. 213 people died
2. 3,493 people were seriously injured
3. 10,735 people were injured in some other way.

In recent years, policy thinking regarding road deaths has shifted from the concept of the “road toll” to “lives lost”. The common understanding of a “toll” is the cost that has to be paid in order to use a road and is, therefore, something which is simply an inherent, unchangeable fact. In contrast, the concept of “lives lost” implies that all road deaths can and should be avoided and that efforts should focus on reducing road deaths to zero. *(Transport Accident Commission)*

The impact of losing someone to a road accident is devastating for family, friends and work colleagues and ripples out through their acquaintances, neighbours and others.

The impact of a serious injury can have a similar effect, with many months or years of rehabilitation and, in some cases, permanent physical or cognitive impairment and lasting psychological impact.

Up to 30% of people who have an accident experience a negative psychological response, including acute anxiety disorder, driving phobia, PTSD and major depressive disorder. *(Harrison 1999)*

Even ‘other injuries’ can result in significant physical pain and have significant economic consequences and psychological impact.

According to the VicRoads interactive crash statistics website, in the five-year period from 2014 to 2018:

1. nine people died on Manningham's roads
2. 250 people were seriously injured
3. 771 people sustained other injuries
4. 983 people were uninjured as a result of a transport accident.

During the same period, there were 475 claims to the Transport Accident Commission involving hospitalisation, of which 399 were for less than 14 days, and 75 for more than 14 days.

The Transport Accident Commission website states that ten (10) people died on Manningham's roads during the five-year period from 2014-2018. Those who died included:

1. 7 females (70%) and 3 males (30%) compared to 27% and 73% respectively in metropolitan Melbourne.
2. 3 people (30%) were <30 years of age (metropolitan Melbourne: 31%), and six people (60%) were >60 years (metropolitan Melbourne: 29%).
3. 4 people (40%) were pedestrians (metropolitan Melbourne: 24%) and 2 people (20%) were drivers (metropolitan Melbourne: 34%).

The small population of fatalities in Manningham makes it difficult to draw meaningful conclusions in comparison to metropolitan Melbourne, however female fatalities appear more likely in Manningham compared to the state of Victoria, as do fatalities involving older people and pedestrians.

Among those hospitalised as a result of a traffic accident in Manningham:

1. 50% were female (metropolitan Melbourne: 46%); 34% were aged 60+ years (Greater Melbourne: 23%); and, 55% were driving the vehicle (metropolitan Melbourne: 47%). This indicates that in Manningham, serious accidents are more likely to involve females, involve older people, and may be more likely to involve single passenger vehicles. The significantly greater proportion of people aged 60+ years is most likely a consequence of the municipality's older age profile. Further investigation is required to determine whether or not it is older females driving alone who are most at risk of serious injury.
2. 21% were aged 25 and under (25% for metropolitan Melbourne).
3. 3% were riding a bicycle (5% for metropolitan Melbourne), reflecting the higher level of car usage compared to active transport.

Areas of further investigation include:

1. Analysis of key locations with a high incidence of accidents and identification of options to respond.
    a. Consider opportunities to lengthen *pedestrian walk time* to improve safety for older pedestrians, young families, possibly based on a slower walk speed.
    b. Investigate and advocate for innovative measures which can reduce transport accidents on major arterial roads (e.g. making traffic accident data available to users via GPS services to encourage drivers to modify driving behaviour in risk areas; use of variable speed limits based on time of day/driving conditions/traffic volume)
2. Consider measures to promote and reward safe, active travel (walking, public transport, grade-separated bike paths) to enhance sustainable use of local road network, and reduce congestion on major arterials.
3. Stronger partnerships with the State Government and other organisations to support local delivery of transport safety programs (e.g. Towards Zero)

16. Preventing all forms of violence

Crime (7.2)

According to the data, Manningham continues to be one of the safest municipalities in Victoria, consistently experiencing a crime rate which is half the Victorian average and which has varied each year in accordance with the Victorian trend.

Manningham experiences the same types of crime as elsewhere in Victoria, albeit at a lower rate. In 2019, there were 3,830 criminal incidents in Manningham with:

1. p*roperty and deception offences* the most common (72.0%) and representing a significantly greater proportion than the Victorian average (61.4%).
2. *crimes against the person* represented 13.6% of incidents, which was less than the Victorian average (16.3%).
3. All other incident types *(drug offences, public order and security offences, justice procedures offences and other offences (e.g. traffic))* accounted for the remaining 14.4% of offences (Victoria: 22.4%)

Since 2011, there has been a 37.6% increase in the number of offences in Manningham, which is greater than the overall increase of 28.5% across Victoria.

Of particular note is the increase from 2011 to 2019 in the number of *justice procedure offences (from 84 to 307 offences)* and *crimes against the person (from 342 to 522 offences)*.

In 2019, almost half (46.5%) of *justice procedure offences* were due to *breaches of family violence orders* and one-third due to *breaches in bail conditions*. In 2019, 61.7% of *crimes against the person* were due to *assault and related offences*, with the next most common being *stalking, harassment and threatening behaviour (*12.6%).

To support Manningham's continued status as one of the safest municipalities in Victoria, opportunities exist to:

1. Build community capacity to prevent, prepare and respond to crime through, for example, enhanced cooperation with Neighborhood Watch and the development and delivery of "Know Your Neighbour" programs.
2. Strengthening planning and environmental design process to ensure that safety considerations are appropriately considered (e.g. Crime Prevention Through Environmental Design (CPTED)).
3. Enhanced information sharing, cooperation and partnerships with local police
4. Advocate for additional resources through State and Federal channels, as appropriate.

Family Violence (7.3)

In March 2020, Manningham ranked 76 out of 79 Victorian Councils based upon the rate of family violence incidents (550.2 incidents/100,000), making it the 4th lowest in the Victoria.

Since March 2016, the number of family violence incidents recorded annually by police in Manningham has ranged from 706 to 770. In the 12-months to March 2020, 708 family violence incidents in Manningham were recorded, representing a 5% decrease since 2016 (744 incidents). In the same period, Victoria recorded a 12% increase in recorded family violence incidents. Further investigation – with a particular focus on different age cohorts and culturally diverse communities within the municipality – is required to understand their experience of family violence and their attitudes to reporting.

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Of the 708 family violence incidents in Manningham during the 12-months to March 2020:

- females were the *affected family member*(s) in 72% of cases.
- males were the *other party* in 76% of cases.

The experience of family violence in Manningham is largely that of males perpetrating violence on females, as is the case across Victoria.

In the 12-months to March 2020, people of all ages were affected by family violence in Manningham, as was the case across the state. However, in Manningham older people (aged 45+ years) represented a significantly greater proportion of those affected (40%), compared to Victoria (30%). This is likely due to the municipality's older age profile which, according to population modelling, will continue to grow as a proportion of the total population over time.

People aged 55+ years accounted for 20% of affected persons, yet only 12% of other persons (i.e. perpetrators). Further investigation is required to determine if elder abuse is a factor among people aged 55+ years who experience family violence, especially given the incidence of dementia which is forecast to increase and which makes older people even more vulnerable.

Furthermore:

1. LGBTQIA+ Victorians are more than twice as likely to have experienced family violence (13.4%) compared to the broader population (5.1%).
2. People with disability are more likely to experience family violence (Women with Disabilities Australia).

The intersection of gender, disability and sexual orientation may create an increased risk for family violence.

In 2020, people of all ages were responsible for family violence in Manningham, as was the case across the state.

The only acceptable rate of family violence is *zero*, and therefore the data clearly indicates that family violence is a problem in Manningham. Potential opportunities include, among others:

1. Building a deeper understanding of family violence in culturally diverse and religious communities living in Manningham (e.g. Chinese, Iranian, Sunni Muslim) and among older people who may be victims of elder abuse through both research and training opportunities.
2. Advocate for resources for prevention and support services.
3. Build community capacity to recognise, prevent and safely respond to family violence.
4. Explore opportunities to work in different local settings to build community awareness of the issues, and confidence to take appropriate action.
5. Support deeper partnerships between police, local organisations and community groups to create a strong local network of peer support to lead local efforts.
6. Work with the community to build more awareness of the various forms of family violence and continue to build capacity around calling out disrespect and attitudes which condemn violence against women e.g. delivery of bystander training; supporting the "Call it Out" campaign which encourages males to take responsibility for their actions (and for males to hold their male friends accountable); and, self-defense classes for women.
7. Develop and deliver innovative projects and programs to increase accessibility to crisis and longer term accommodation for women who are escaping family violence.

Perceptions of Safety (7.1)

In 2015, the majority of Manningham residents (91.8%) felt safe walking alone during the day, consistent with the wider Victorian average. However:

1. Fewer females felt safe walking alone during the day (86.8%, compared 97.3% for males).
2. 1 in 4 people aged 75+ years did not feel safe walking alone during the day.
3. Victorians with disability are only *half as likely* to feel safe walking alone during the day compared to Victorians without disability.

After dark:

1. 29.7% of females felt safe walking alone, compared to 83.1% for males.
2. Approximately half of people aged 35-44 years and 55+ years felt safe walking alone, whilst 70% of those aged 25-34 and 45-54 felt safe.
3. Victorians with disability are *one-third less likely* to feel safe walking alone after dark, compared to Victorians without disability.

Perceptions of safety are dependent upon an individual's gender, age and disability status. A lower perception of safety – particularly during the day – may result in individuals choosing not to engage in activities that could benefit their mental and physical wellbeing.

The overwhelming majority of females in Manningham feel unsafe walking alone after dark – consistent with the wider Victorian experience – which is likely to reduce the opportunities to engage in activities which support their health and wellbeing (e.g. personal fitness).

Older people are one of two cohorts most likely to experience loneliness (the other being young people). Their lower perception of safety - especially during the day - limits their ability to enjoy walking and social interaction within close proximity to their residence.

People with disability feel less safe walking alone during the day and after dark than people without disability, which is likely to have a significant negative impact upon their willingness to independently engage in social, economic and health activities which support their health and wellbeing.

Opportunities to increase perceptions of safety and/or address its potential behavioural impact of those most affected include:

1. Exploration of issues at the local neighborhood level which may impact perceptions of safety for key cohorts (females, older people, people with disability, people from culturally diverse backgrounds), and development of plans to address any identified issues (e.g. street lighting, non-permeable vegetation).
2. Support for accessible initiatives (e.g. walking clubs) at a neighborhood level which bring people of all generations - particularly older people – together for low-impact recreational activities (e.g. walking) that build confidence, support and connection. Leverage existing initiatives, where possible e.g. Heart Foundation's existing program to support walking groups in LGAs could partner with local Neighbourhood Houses to amplify reach and impact.
3. Explore opportunities to improve perceptions of safety for key cohorts after dark at recreational and sporting centres.

17. Increasing healthy eating

A healthy diet is a foundation of healthy physical and cognitive development in children and adolescents and for maintaining a healthy weight in adult life and older age. It can be a protective factor against some types of cancer, diabetes, cardiovascular disease and stroke. Conversely, a poor diet can be a risk factor.

The food we choose to eat is influenced by individual factors such as level of education, socio-economic status and cultural background, as well as environmental factors such as the accessibility of (un)healthy food.

The Australian Dietary Guidelines provide advice regarding the types of food to both eat and avoid. The Guidelines recommends roughly five serves of vegetables and two serves of fruit each day depending upon gender and age, and on whether pregnant or breastfeeding.

Fruit and Vegetable Consumption

Vegetables **(10.1.1)**

According to the *2017 Victorian Population Health Survey,* with regard to vegetable consumption in Manningham:

1. around one in ten people (2.9%-11.1%) in Manningham consumed the recommended daily serves of vegetables. Women were twice as likely as men to eat the recommended daily serves of vegetables (women: 4.5%-19.2%; men: 1.8%-4.3%).
2. 16.0%-25.7% of people ate 3-4 serves of vegetables per day, with women more likely to do so (20.1%-34.9%) compared to men (8.5%-20.4%).
3. Almost two-thirds of people (58.4%-71.4%) consumed only 1-2 serves of vegetables per day, with men more likely to do so (63.3%-81.8%) compared to women (48.1%-68.9%).
4. 2.3%-10.4% of people reported consuming no daily serves of vegetables.

The Manningham sample in the Victorian Population Health Survey is too small to provide a reliable breakdown of vegetable consumption by age. However, across the Eastern Metropolitan Region the level of vegetable consumption was fairly consistent across all age groups.

There was no significant change in the number of serves of vegetables consumed daily in Manningham from 2011 to 2017.

In summary, the Manningham community generally eats insufficient average daily serves of vegetables, with women tending to eat more serves than men. The situation remained largely unchanged throughout the period 2011 to 2017.

Fruit **(10.1.2)**

According to the *2017 Victorian Population Health Survey*, 4-5 out of every 10 people (38.6%- 51.8%) in Manningham ate the recommended daily serve of fruit – a figure which has not changed significantly since 2011. Disaggregated by gender, those eating the recommended daily serves include:

1. 46.6%-65.3% of women (Victoria: 45.6%-48.1%)
2. 25.5%-42.4% of men (Victoria: 38.0%-40.6%)

At least 4 out of 5 Manningham residents eat *at least* one serve of fruit daily.

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Women tend to eat more fruit on average, with 46.6%-65.3% eating at least two serves per day compared to 25.5%-42.4% for men. Since 2011, there has been a significant reduction in the proportion of men eating two or more serves of fruit per day. (2011: 45.6%– 64.0%; 2017: 25.5%-42.4%).

Half the Manningham population eat sufficient average daily serves of fruit, with women tending to eat more serves than men. The situation remained largely unchanged in the period 2011-2017.

In 2017 in Manningham, 1.7%-5.6% of the population consumed the recommended amount of fruit *and* vegetables each day, consistent with the wider Victorian average. Women were significantly more likely than men to meet the daily guideline for fruit and vegetables (females: 2.1%-8.7%; males: 0.5%-4.3%).

Overall, women in Manningham tended to have a better diet than men in terms of their daily average consumption of fruit and vegetables, although the level of fruit consumption is closer to the recommended daily intake compared to vegetables. The Manningham Food Security Plan 2016-21 survey results suggests that lower fruit and vegetable consumption in the municipality is a consequence of cost (take away food is often cheaper), availability (healthy food options may be less accessible/available), time and personal preference.

Whilst still insufficient, the daily consumption of fruit is nearer to the amount recommended in the Australian Dietary Guidelines, in part due to the lower requirement of two daily serves and the enjoyment that many people take in eating a piece of fresh fruit.

Water Consumption (10.1.4)

The Victorian Government's *Better Health Channel* recommends varying quantities of daily water consumption depending upon gender and life stage. It recommends that adult men should drink 2.6 litres per day (10 cups) and that adult women should drink 2.1 litres per day (8 cups). Water is essential to maintain hydration and support the healthy functioning of all living cells in the human body. Mild to moderate dehydration can cause headaches, urinary and kidney problems, whilst more severe dehydration can cause seizures, hypovolemic shock (low blood volume) and even death. Maintaining a healthy level of water consumption is critical during exercise and hot weather.

According to the *VicHealth Indicators Survey 2015*, people in Manningham consumed on average 4.7 – 5.5 cups of water per day, consistent with the Victorian average consumption of 5.4 cups per day. Men in Manningham consumed an average of 5.3 cups per day, whilst women consumed an average of 4.8 cups per day.

Disaggregated by age and gender, women drink more consistently across age groups, ranging from a low of 3.9 cups per day (75+ years) to a high of 4.8 cups per day (35-44 years) - *note that the sample size was too small to report on water consumption for women aged less than 35 years*.

Men water consumption varies more markedly by age, with younger men drinking significantly more water than older men. A significant reduction occurs from 35-44 years (7.0 cups per day) to 45-54 years (4.1 cups per day) and the lower level is maintained across older age cohorts.

In 2015, 1.3% - 6.6% of people in Manningham consumed no water per day, consistent with the Victorian average of 3.1%.

Overall, most men and women drink insufficient daily quantities of water to support optimal health. Advocating for the installation of additional water taps at parks across Manningham may assist in encouraging more active travel and recreational activities.

Takeaway Food (10.1.3)

According to the *VicHealth Indicators Survey 2015*, 7.0% - 15.7% of people in Manningham ate take away meals or snacks at least 3 times per week, consistent with the Victorian average (10.2%).

14.4% of Manningham males ate take away meals or snacks at least 3 times per week. The sample size was too small to gain any insight into consumption by females and across different age groups. Further investigation is required to identify particular cohorts with a high consumption of take away meals or snacks (e.g. tradespeople) to enable the development of targeted responses.

Victorians with disability were one third more likely to eat takeaway food regularly than people without disability. *(VicHealth Indicators Survey 2015 supplementary report - disability).*

Food Security (10.1.6)

In the 2017 *Victorian Public Health Survey*, respondents were asked whether there were any times during the previous 12 months when they had run out of food and could not afford to buy more. In 2017, 1.4%-5.9% of Manningham residents experienced food insecurity (Victoria: 5.8%-6.7%), with a greater proportion of females affected (2.6%-10.8%) than males.

Overall, the data provides a range of insights in relation to healthy eating in Manningham. These include:

1. A very small minority is eating sufficient daily serves of fruit and vegetables.
2. The majority are drinking water and eating fruit and vegetables – however not in sufficient quantity.
3. Women tend to have a healthier diet with a greater proportion consuming more average daily fruit and vegetable serves than men.
4. Consumption of fruit, vegetables and water has remained static since 2011, however one notable change is some men are eating less *fruit* than previously was the case. Further investigation is required to determine the prevalence of low fruit and vegetable consumption among young children and the attendant health risks.
5. Takeaway and snack food consumption is consistent with the Victorian average. However, people with disability are one-third more likely to order takeaway food, and 14.4% of Manningham males consume takeaway at least 3 times per week. Over the medium-long term, this has a potentially negative health risk (e.g. obesity), as evidenced by the fact that coronary heart disease is the leading cause of death in Manningham.
6. The presence of food insecurity – particularly among women - in a municipality which is widely regarded as relatively affluent demonstrates that Manningham – like most other places – is home to people who are vulnerable, experiencing disadvantage and in need of support. The COVID-19 pandemic is likely to increase the incidence of food insecurity across the municipality due to increased unemployment or under-employment and to women fleeing family violence.

The evidence indicates a need to:

1. Increase water, fruit and vegetable consumption across all age groups, with a particular focus on men.
2. Increase water consumption among older people.
3. Increase support for food security among vulnerable cohorts – particularly during the COVID-19 pandemic.
4. Explore the drivers of the gendered difference in fruit and vegetable consumption patterns.
5. Focus on both individual behaviour change and on influencing food environments to increase the availability of healthy foods and reduce the availability of unhealthy foods.

18. Decreasing the risk of drug resistant infections

The emergence of drug resistant infections poses a significant risk to the health of humans and animals. The National AMR Strategy outlines an approach to mapping the emergence of drug-resistant infections and working with key sectors (GPs, pharmacists, hospitals, pharmaceutical companies, the agricultural sector, veterinarians) in order to prolong the effectiveness of our existing antibiotics and provide the vital time required for the development of new medications.

At the time of writing, it is unclear what role(s) local government is best placed to play in the effort to reduce the risk of drug resistant infections. An opportunity exists to explore this issue further with other municipalities in partnership with relevant State and Federal government agencies.

19. Increasing active living

A significant body of research establishes the link between physical activity and:

1. reduced risk of all-cause mortality, heart disease, stroke and diabetes
2. reduced mental health burden

Increased levels of physical activity are a protective factor for health whilst also providing opportunities for social connection.

The *Australian Physical Activity Guidelines* (Department of Health) detail the recommended levels of physical activity to support health and wellbeing for different age groups. The Guidelines recommend the following for people aged 18-64 years:

5. Doing any physical activity is better than doing none. If you currently do no physical activity, start by doing some, and gradually build up to the recommended amount.
6. Be active on most, preferably all, days every week.
7. Accumulate 150 to 300 minutes (2 ½ to 5 hours) of moderate intensity physical activity or 75 to 150 minutes (1 ¼ to 2 ½ hours) of vigorous intensity physical activity, or an equivalent combination of both moderate and vigorous activities, each week.
8. Do muscle strengthening activities on at least 2 days each week

19.1. Level of Physical Activity (10.2)

According to the *2017 Victorian Public Health Survey*, half of the adult Manningham population (43.3%-56.8%) met the *Australian Physical Activity Guidelines*, consistent with the Victorian average (50.0%-51.8%). There was no significant difference between the proportion of males and females who met physical activity guidelines (males: 42.9%-62.8%; females: 38.4%-56.8%).

Almost 1 in 5 Manningham residents engaged in no physical activity each week (i.e. 0 days per week with at least 30 minutes of activity), consistent with the Victorian average.

In 2015, Victorians with disability were 40% less likely to be physically active than people without disability. The gap widens with age: people aged 18 to 34 years were 20% less likely; people aged 35–64 years were 30% less likely; and people aged 65+ years were almost 50% less likely. *(VicHealth Indicators Survey 2015 supplementary report – disability).*

The Australian Physical Activity Guidelines for Children and Young People (5-17 Years) recommend accumulating 60 minutes or more of moderate to vigorous physical activity per day involving mainly aerobic activities. However:

1. In the period 2012-2018, the percentage of Manningham students commencing primary school whose physical health and wellbeing was on track declined from 88.5% to 77.8% *(Australian Early Development Census 2012, 2015, 2018)*
2. In the period 2014-2018, in the Inner Eastern Melbourne region, only one in every four young people did the recommended amount of physical activity every day, consistent with the Victorian average *(Victorian Student Health and Wellbeing Survey 2014, 2016 & 2018)*.

The COVID-19 pandemic is likely to put downward pressure on the levels of physical activity among young people - especially during lockdown – as well as increasing sedentary recreational screen time beyond the recommended maximum of two hours per day.

19.2. Types of Physical Activity

In terms of the type of physical activity undertaken, the preferences of Manningham residents align broadly with those of the wider Victorian community. According to the *Victorian Population Health Survey 2015*, in Manningham:

1. one-third (26.0%-37.9%) engage in organized physical activity such as through a sports club , or a leisure, fitness or indoor sports centre. Disaggregated by age, those most likely to participate in organized physical activity included young people aged 18-24 years (58.7%) and older people aged 65+ years (42.5%-44.7%). The data suggests an opportunity may exists to encourage even more older people to engage is organised physical activity.
2. two-thirds (64.4%-76.0%) engage in non-organised physical activity such as walking, jogging or running, and gym or fitness. Participation in non-organised activity is fairly consistent across all age groups, however it reduces significantly between people aged 65-74 years (74.2%) and people aged 75+ (59.6%), highlighting their preference for organised activities.

Across Victoria, there was no significant difference between male and female participation in organized physical activity (27.6% and 29.6% respectively). However, females have a preference for fitness, leisure or indoor sports centres, whereas males are more likely to be a member of a sports club.

Across Victoria, people with disability participate in non-organised physical activity at a lower level than people without disability (59.9% and 73.4% respectively), however participation is relatively consistent across all age groups. The situation is similar for organized physical activity, with 20% of people with disability participating, compared to 31% of people without disability.

19.3. Obesity (10.1.5)

According to the *2017 Victorian Public Health Survey*, in Manningham a significantly greater proportion of people are of normal weight based upon BMI (39.0%-52.8%) than compared to Victoria (37.1%-38.9%). Nonetheless, 22.7%-34.4% are classified as overweight and 12.4% – 21.8% as obese.

Disaggregated by gender, men in Manningham are more likely than women to be overweight (men: 27.4% - 46.0%; women: 15.1%-28.57%), whereas men and women exhibit similar levels of obesity (men: 11.2%-25.6%; women: 10.8% -22.4%). These facts correlate with the wider Victorian experience.

62% of Aboriginal and Torres Strait Islander peoples aged over 2 years living in the Eastern Melbourne region are overweight or obese *(EMPHN Needs Assessment Report, 2018)*. Whilst small, Manningham's Aboriginal and Torres Strait Islander population grew by 48% to 209 people from 2011 to 2016.

Significant links exist between obesity and coronary heart disease, cerebrovascular disease and diabetes among other diseases. In Manningham, coronary heart disease and cerebrovascular disease account for more than 20% of male and female deaths.

A number of potential barriers exist which may influence physical activity levels including perceptions of safety, costs and inclusiveness of the sports club or organisation.

An individual's perception of safety – as measured by their level of comfort walking alone during the day or after dark – may impact upon their willingness to leave their house to engage in physical activity.

Older people (75%) are more likely to feel unsafe walking alone during the day, whilst the majority of females feel unsafe walking alone after dark. People with disability are more likely to feel unsafe walking alone both during the day and after dark.

A lower perception of safety may influence a person's willingness to:

1. Walk, jog or otherwise exercise outside alone during the day.
2. Engage in indoor or outdoor physical activity after dark, possibly due to concerns regarding transport to/from the venue (e.g. having to walk to one's car alone after training with a team).

Cost may be a barrier for individuals and households with low incomes. Costs such as membership fees, uniforms and transportation may exclude some people from joining sporting clubs, or engaging in fitness activities at a recreation centre, gym or other sporting facility.

The level of inclusiveness of sporting clubs may impact their appeal to people of diverse backgrounds. For example, 44% of LGBTQIA+ Victorians report feeling the need to hide their sexuality or gender identity in public. A potential consequence is that they may be less likely to join sporting clubs and other health and fitness organisations unless there is a culture of inclusivity. Muslim females wearing hijab are also more likely to be drawn to sports clubs and other health and fitness organisations where they feel welcome and comfortable exercising.

The need exists to support increased physical activity among all age cohorts in Manningham, and to explore how health and fitness settings can be more inclusive of diversity. Possible consideration may include:

1. The extension of innovative programs designed to build the inclusivity of Manningham's sporting clubs and recreational facilities.
2. Improved lighting and other measures at sporting venues to create new opportunities for women and older people to feel safe engaging in physical activity after dark.
3. Support for successful existing initiatives (e.g. walking clubs) to extend their reach, and support for the establishment of new initiatives which encourage physical activity (and social connection) at the local level.
4. Installation of more water fountains at parks.
5. Targeted programs for individuals and households with low incomes, LGBTQIA+ people and people with disability to increase participation in organised sport.
6. Other potential initiatives to promote physical activity and active transport include:
    a. Development and promotion of mobility maps to support improved access for people with disability and older adults.
    b. Provision of a Scooter Program/Recharge Service aimed at enhancing participation and access for people who use motorised scooters or other devices.
    c. Exploration of the concept of community bikes/scooters for loan (similar to the city initiative)
    d. Investigation of alternative accessible transport options including car share and ride share schemes

20. Improving mental wellbeing

The World Health Organisation defines mental health as:

> *"a state of wellbeing in which an individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".*

Almost half of all Australians aged 16-85 years will experience mental illness at some point in life, and one quarter will experience an anxiety condition *(Department of Health)*. Many people who experience mental illness are able to continue to live, work and play provided that they receive appropriate support. However, people with more serious mental illness may be particularly vulnerable to social exclusion due to difficulties in finding and retaining employment, stigma and other factors. In some cases, a person may feel that suicide is the only way out.

The VicHealth Indicators Survey and the Victorian Population Health Survey includes a range of indicators relating to mental wellbeing, including subjective wellbeing, psychological distress, life satisfaction, and anxiety and depression.

At the time of writing, there are indications that COVID-19 is having a significant impact upon mental health in the community. Mental health service providers have reported a significant increase in demand due to financial stress, isolation and loneliness, and uncertainty about the future.

Many providers have transitioned to a tele-health model of service delivery, however such a model is unlikely to serve the needs of all cohorts. For example, older people who may have limited technology skills; people from culturally diverse communities and people with low-incomes.

20.1. Subjective wellbeing (12.1)

Wellbeing is a subjective measure of an individual's quality of life. It measures a deep and enduring sense of satisfaction, as opposed to a momentary burst of happiness *(VicHealth Indicators Survey – Indicator overview – Wellbeing)*

According to the *VicHealth Indicators Survey 2015*, the average measure for subjective wellbeing among people living in Manningham was 76.9–79.8 out of 100, consistent with Manningham's 2011 result and slightly higher than the Victorian estimate (77.5). However:

1. LGBTQIA+ Victorians reported a lower average measure (73.6) than heterosexual Victorians (77.5). (*VicHealth Indicators Survey 2015 Supplementary report: Sexuality)*
2. Victorians with disability reported a significantly lower average measure (69.6) than people without disability (77.8). *(VicHealth Indicators Survey 2015 Supplementary report: disability)*
3. People with a very low income reported a significantly lower average measure (71.6)

20.2. Life satisfaction

The VicHealth Indicators Survey asks respondents to think about their own life and personal circumstances and to rate their level of satisfaction on a scale of 0-10.

In 2015, the life satisfaction rating for people in Manningham was 7.9, compared to 7.8 for Victoria. When disaggregated by gender, males in Manningham had a significantly higher average level of satisfaction (8) compared to Victorian males (7.7). Females in Manningham reported the same average level of life satisfaction as Victorian females (7.9).

Disaggregated by age in Victoria there was uniformity across age cohorts (7.7 for people aged 18 – 64 years, increasing to 8.1-8.2 for older cohorts). In contrast, young people aged 18-24 years in Manningham reported a significantly lower average life satisfaction (7.4) which then gradually increased to 8.1 for 45-54 years and then plateaued.

In 2015, according to VicHealth, people living in Manningham:

1. with disability reported a lower average level of life satisfaction than people without disability (7.0 and 8.1 respectively)
2. with a low household income of $20K-$40K per annum reported a lower level of life satisfaction than people with higher household incomes (7.7 and 8.0-8.2 respectively)
3. from an English-speaking background reported a higher level of life satisfaction than those from culturally diverse communities (8.3 and 7.7 respectively).

Factors influencing wellbeing (and life satisfaction) include stress, pain, personal resources such as income, and the presence or absence of a partner *(Mead and Cummins 2010, as cited in VicHealth Indicators Survey – Indicator overview – Wellbeing)*.

Manningham's experience reflects that of the wider state, where higher education levels, higher annual household incomes, or those residing in the least socio-economically disadvantaged areas, reported higher levels of wellbeing. Conversely, people who were unemployed, had lower annual household incomes or were from culturally diverse backgrounds reported lower levels. *(VicHealth Indicators Survey 2015 – Selected Findings, p. 11)*

These findings suggest a range of opportunities exist, including:

1. Further exploration of the drivers for lower wellbeing and life satisfaction outcomes among young people, older people, people with disability and people from culturally diverse communities living in Manningham.
2. Support for local efforts which build local connection, reduce loneliness, and provide opportunities for physical activity.
3. Support for local initiatives to reduce loneliness among young people and provide access to meaningful employment opportunities.
4. Delivery of appropriate, targeted services to vulnerable and marginalised communities to deliver enhanced health, wellbeing and economic outcomes.

20.3. Psychological distress (12.3)

The Kessler psychological distress scale (K10) is used for mental health screening in population surveys, based upon the level of anxiety and depressive symptoms a person may have experienced in the previous 4 weeks.

According to the *2017 Victorian Population Health Survey*, 7.4%-17.0% of people in Manningham were experiencing high or very high psychological distress, similar to the wider Victorian community (10.4%-11.8%).

However, 24.4% of LGBTQIA+ Victorians experienced high or very high levels of psychological distress compared to the broader community. *(Victorian Discussion Paper for the LGBTIQ Strategy)*

In 2012-13, 32% of Aboriginal and Torres Strait Islander Victorians aged 18 and over reported high or very high levels of psychological distress, compared to 11% for non-Aboriginal Victorians. *(Australian Institute of Health and Welfare, as cited in EMPHN Needs Assessment Report, 2018)*

20.4. Depression and anxiety (12.2)

According to the *2017 Victorian Population Health Survey*, a significantly lower proportion of Manningham residents experienced depression and anxiety (12.7%-21.9%) compared to the wider Victorian average (26.6%-28.2%), and it had remained fairly static since 2011.

Disaggregated by gender, women in Manningham were almost twice more likely to experience anxiety and depression than men (women: 18.0%-32.6%; men: 5.0%-14.0%). Across Victoria, women are more likely to experience depression and anxiety than men (women: 32.4%-34.8%; men: 20.0%-22.0%), although the difference is less significant.

A significant difference exists for men in Manningham (5.0%-14.0%) compared to the Victorian average (20.0%-22.0%). Further investigation is required to determine whether this is due to reduced incidence of depression and anxiety, or to non-reporting.

Dementia often presents with comorbidities of anxiety and depression which require management. Manningham's older age profile means that a significant number of residents already live with dementia and that this is likely to increase in the future. In 2017, there were 2,840 people with dementia in Manningham and this figure is forecast to increase to 8,044 by 2050 *(National Centre for Social and Economic Modelling, 2016)*. In the period 2013 to 2017, dementia was the leading cause of death among females in Manningham.

20.5. Hospitalisation due to Mental Health

From July 2013 to June 2015, the age-standardised hospitalisation rate for Aboriginal and Torres Strait Islander Australians in Victoria for mental health-related conditions was 23 per 1,000, compared with 15 per 1,000 for non-Aboriginal Australians. The highest hospitalisation rate for Aboriginal and Torres Strait Islander Australians was in the 35–44 age group. *(Australian Institute of Health and Welfare, as cited in EMPHN Needs Assessment Report, 2018)*

20.6. Suicide (12.5)

Nationally, suicide is the leading cause of death for people aged 15-44 years, and young people are more likely to die from suicide than in a car accident.

Ninety-nine Manningham residents died by suicide in the period 2010-2019. Manningham's suicide rate during the period was 8.2 suicides per 100,000 people, less than the Victorian average of 10.3 suicides per 100,000 people and the Melbourne Metropolitan average of 9.2 suicides per 100,000 people.

A greater proportion of people who died by suicides were females *compared to the Victorian average*. Females accounted for one-third of completed suicides in Manningham, compared to one-quarter across Victoria. Males accounted for two-thirds of death by suicide in Manningham.

In Manningham, people of all ages died by suicide, however of particular note is the significant proportion of older people (40% were aged 55 year and older).

BeyondBlue has estimated that up to *30 attempted suicides* occur for every death by suicide, which suggests that almost 3,000 attempted suicides *may* have occurred in Manningham in the period 2010-2019.

Nationally, during the period 2011-2015 the age-standardised death rate for Aboriginal and Torres Strait Islander Australians by self-harm was *2.1 times* the rate for non-Aboriginal Australians. *(Australian Institute of Health and Welfare, as cited in EMPHN Needs Assessment Report, 2018)*

In summary, some population groups are particularly vulnerable to mental health challenges, including people with disability, LGBTQIA+ people, and people with very low incomes (10,760 households or 24% of all Manningham households). Further investigation is required to understand the experience of people from culturally and religiously diverse backgrounds.

Early indications are that the COVID-19 pandemic is having a significant negative impact on mental wellbeing with major support services (e.g. BeyondBlue) reporting a significant increase in demand for their services. In August 2020, the Victorian Government announced an additional $55 million in funding for mental health services to ensure people are able to access the required support. In addition, in August 2020, the Victorian Coroner's Court announced there had been no increase in the number of people who had died by suicide since the start of the COVID-19 pandemic.

Uncertainty, periodic lockdown and economic hardship are likely to continue for some time. Together, these factors are likely to keenly impact upon individuals with existing mental health illness, and result in some people experiencing mental illness for the first time. Furthermore, the pandemic may result in an increase in the harmful use of alcohol, tobacco and other drugs as a coping mechanism by some people experiencing mental illness.

Potential opportunities for exploration include:

1. Initiatives which build neighborhood connection and trust, and reduce social isolation and loneliness.
2. Initiatives targeting vulnerable cohorts to support their participation in initiatives which support health and wellbeing (e.g. sport and recreation, skills training).
3. A focus on addressing the known contributors to violence against women, to prevent such violence before it occurs.
4. Measures to de-stigmatise mental health and create a community conversation about how best to support one other.
5. Advocacy for additional resourcing to support access to mental health services.
6. Reduce barriers to participation on community events and festival by people with a disability (mental health).
7. Support vulnerable or socially isolated people to access services and navigate service systems.
8. Increase cultural safety and support for diverse communities.

21. Improving sexual and reproductive health

The United Nations Population Fund defines good sexual and reproductive health as:

"a state of complete physical, mental and social well-being in all matters relating to the reproductive system. It implies that people are able to have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so."

21.1. Sexually Transmitted Infections (STI) (11.1.5)

Chlamydia is a common sexually transmissible infection which can be treated with a single dose of antibiotics if detected early. However, if left untreated, Chlamydia can cause pelvic inflammatory disease in women which can lead to chronic pain and infertility. More than 250 people have been infected annually in Manningham since 2011. Females represent 52% of cases, and 70% of cases are aged 15-29 years, which is consistent with the Victorian average.

Gonorrhea is the next most prevalent STI in Manningham, with 20 to 84 people infected annually since 2011. Infections have been at their highest level for the past two years (2018: 77; 2019: 84). In

Manningham, males account for 80% of cases, and infections occur across a wider age range than for Chlamydia. This experience is consistent with the Victorian average.

A small number of Syphilis infections (<13) have been detected annually since 2011, with the number of cases trending upward in the past 3 years. In Manningham, males account for 95% of infections and infections occur across a wider range of ages (86% of cases aged 15-44 years). This experience is consistent with the Victorian average.

A number of infections are transmissible through sexual contact, injecting drug use and other means:

1. Four people have acquired HIV since 2014, the last of which was in 2018. (Manningham – all male; Vic: 97% male)
2. 60-70 Hepatitis notifications occur annually, with Hepatitis B representing more than 80% of notifications since 2016.

STIs are more prevalent among young people, however people of all ages are affected. Syphilis and Gonorrhea overwhelmingly affect males and the upward trend in the number of infections in recent years suggests that safe sexual practices are becoming less prevalent. Attitudes towards safe sexual practices may be influenced by the availability of anti-retroviral and post-exposure prophylaxis, which reduce the perceived risk and consequences of contracting HIV/AIDS.

21.2. Fertility (11.2)

In the ten years to 2019/20, the average number of annual births in Manningham was 1,083. Manningham's birth rate has consistently tracked at a lower rate than the Victorian birth date. In 2018, Manningham had a birth rate of 1.3 births per 1,000 women aged 15-49 (Victoria: 1.6 births per 1,000 women aged 15-49).

Manningham's lower birth rate is driven by a range of factors including the choice among younger women (<30 years) to delay parenthood and the municipality's older age profile. The older age profile may be due, in part, to the limited availability of affordable housing in Manningham for younger people who are wanting to start a family. The birth rate among Manningham females aged 30-44 years is consistent with the Victorian average.

21.3. Cervical Screening (10.4)

Cervical screening detects the presence of abnormal cells in the lining of the cervix, thereby enabling early treatment and better health outcomes. Most cervical cancers are caused by Human Papilloma Virus (HPV), a common virus spread through sexual contact. Young people – male and female - are now routinely vaccinated against HPV as part of the National Immunisation Program. Nonetheless, cervical screening remains a vital tool in the fight against cervical cancer, and is now performed every five years since advanced screening was introduced in 2017.

LGA cervical screening rates are available up to 2015, after which screening rates in the public domain are available at State level. In the period 2010 – 2015, approximately two-thirds of women aged 20-69 years in Manningham participated in the program, slightly higher than the EMR and Victorian average.

Victorian data on participation in cervical screening programs by age indicates that younger women are much less likely to participate, perhaps due to the nature of the testing procedure or because they may have already been vaccinated against HPV.

The evidence indicates that a need exists for ongoing education, particularly among young people and men who have sex with men (MSM), regarding the need for safe sexual practices.

22. Reducing tobacco related harm (10.6)

Nationally, tobacco use remains the leading cause of preventable health burden in Australia.

Smoking rates have been steadily declining, with the *Victorian Smoking and Health Survey 2018* finding that 10% of adults in Victoria report being daily smokers.

Smoking has been linked to a range of diseases:

1. Smoking causes most lung cancers, and can cause cancer almost anywhere on the body including lips, tongue, mouth, nose, esophagus, throat, voice box, stomach, liver, kidney, pancreas, bladder, blood, cervix, vulva, penis and anus.
2. Smoking is the main cause of chronic obstructive pulmonary disease (COPD)
3. Smoking is a major cause of heart disease, stroke and blood circulation problems
4. Smokers have a 30-40% increased risk of developing type 2 diabetes

These diseases accounted for 41.8% of deaths in Manningham in the five-year period from 2013 to 2017.

In 2017, fewer people in Manningham smoked daily or occasionally (5.3%-13.7%) compared to the wider Victorian average (16.0%-17.5%).

Across Victoria, the incidence of smoking among males is *almost twice* that of females. In 2017, it appeared that a greater proportion of males in Manningham smoked (5.3%-18.3%), compared to females (3.5%-13.8%).

Despite the overall decrease in tobacco use, a number of concerning trends exist among young people, LGBTQIA+ people and Aboriginal and Torres Strait Islander peoples:

1. According to the 2017 survey of Victorian Secondary Students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances:
    a. 3% of Victorian 12-15 year olds were current smokers
    b. 8% of Victorian 16-17 year olds were current smokers
2. LGBTQIA+ Victorians are more likely to smoke (17.8%) than the broader community. *(Victorian Discussion Paper on the LGBTIQ Strategy)*
3. 33% of Aboriginal and Torres Strait Islander people aged 15 years and over in Eastern Melbourne smoke, as do 31% of pregnant Aboriginal and Torres Strait Islander people. *(EMPHN Needs Assessment, 2018)*

The evidence suggests that tobacco use is relatively low overall in Manningham, however a number of cohorts exhibit a higher level of use, notably LGBTQIA+ people and Aboriginal and Torres Strait Islander peoples. Furthermore, research undertaken in NSW *(Culturally and Linguistically Diverse Priority Populations – Formative Research for Tobacco Control Program, Cancer Institute NSW, 2018)* explores the drivers behind the higher prevalence of tobacco use among some culturally diverse communities (e.g. Arabic, Cantonese, Mandarin and Hindi speaking communities).

In addition, tobacco use among school-age children remains unacceptably high.

The need exists to work with these key cohorts to reduce the uptake of smoking, and to support reduction and cessation among existing smokers. In addition, consideration might be given to exploring the use of e-cigarettes and shisha, and to developing a deeper understanding of tobacco use within the Chinese community.

23. Reducing harmful alcohol and drug use

The consumption of alcohol and other drugs is a major cause of preventable disease and illness. In 2017/18, there were more than 4,000 deaths in Australia due to alcohol-related harm and 1,740 deaths due to illicit and pharmaceutical drugs.

Alcohol is widely available, socially sanctioned and deeply embedded in Australian culture. Whilst many people are able to safely enjoy alcohol, a significant proportion of the population risks short and long term harm due to harmful consumption levels.

Cannabis is the most widely used illicit drug in Australia, however methamphetamine has also emerged in the past decade as a significant risk to the health of users. The non-medical use of pharmaceutical drug use is also an increasing public health problem in Australia.

Links between the harmful use of alcohol, mental health and family violence are well established.

23.1. Alcohol (10.7.1)

In the period 2011-2015, 12 to 14 people died annually in Manningham due to alcohol-related causes. In 2016, the figure increased to 18 people, with the majority aged 65+ years suggesting the deaths may have been as a consequence of lifetime risk of drinking alcohol at harmful levels.

During the period 2011/12–2017/18, Manningham had a consistently lower rate of hospital admissions due to alcohol than the EMR and Victoria. However, Manningham's admission rate varied considerably from year to year with 27 per 100,000 people (2015/16);45 per 100,000 people (2016/17) and 35 per 100,000 people (2017/18). The admission rate for alcohol in 2017/18 for the EMR and Victoria were almost equal at 57.0 per 100,000 people and 56.5 per 100,000 people respectively.

In 2012/13, the hospital admission rate for both male and female Manningham residents was almost identical at 39-40 admissions per 100,000 people. Since then, admission rates for males have been consistently higher for males, although both male and female admission rates have varied considerably from year to year. In 2017/18, the admission rate for males was 41.7 per 100,000 people, and 28.6 per 100,000 for females.

People of all ages are admitted to hospital due to alcohol. Admission rates vary across age cohorts, and within each age cohort significant variability year on year:

1. In 2012/13, the admission rate for 15-24 year olds was near zero per 100,000 people. However, in the intervening years it varied in the range 17.5 – 23.7 admissions per 100,000 people, before spiking to 45.8 in 2016/17, and reverting to near zero in 2017/18.
2. 25-39 year olds and 65+ year olds have had the most stable year on year admission rates at 31.6-51.3 admissions per 100,000 and 32.3–47.0 admissions per 100,000 respectively.
3. For the five years of the six years from 2012/13, 40-64 year olds had the highest rate of hospital admission.

In 2018, 51.5% of young people (Year 8 and Year 11) in the Inner Eastern Melbourne region (Victoria: 51.8%) report having drunk alcohol (more than a few sips) on at least one occasion. *(Victorian Adolescent Health and Wellbeing Survey).*

In 2017-18, it was estimated that 11.3-14.8% of Manningham residents aged 18+ years exceeded the recommended daily maximum of two standard alcoholic drinks, putting them at significant lifetime risk of alcohol-related disease or injury. This figure was consistent with the estimated figure for Greater Melbourne (12.7-13.3) and Victoria (14.2-14.7) *(Social Health Atlas of Australia, PHIDU).*

Across Australia, young people (42%) and people with mental illness (19%) are more likely to exceed the lifetime risk guidelines than the population as a whole. *(Australian Institute for Health and Welfare)*

According to the *VicHealth Indicators Survey 2015 Supplementary report – LGBTIQ*, more LGBTQIA+ Victorians drank at levels that put them at risk of short-term harm (5+ drinks) compared to the broader community:

- 53% of gay men compared to 41% of heterosexual men
- 35% of LGB women compared to 20% of heterosexual women

However, there was no difference in the proportion of LGBTQIA+ and other Victorians who reported drinking at levels that put them at very high risk of short-term harm (11 or more drinks in one session).

In 2017, Manningham had a relatively low liquor outlet density (26.2 outlets per 10,000 people) compared to the Victorian average (45.5 outlets per 10,000 people). *(AOD Stats)*

Assaults involving alcohol have trended upward since 2010/11 as have calls to the DirectLine referral service seeking support in relation to alcohol use.

23.2. Other Drugs (10.7.2)

23.2.1. Illicit drugs

Manningham's hospitalisation rates due to illicit drugs peaked in 2014/15 at a level slightly higher than the EMR and Victorian averages. In the period 2015/16 – 2017/18 hospitalisation rates stabilized, with Manningham's rate significantly less than that of the EMR and Victoria

Disaggregated by gender, the Manningham peak in 2014/15 was largely due to male admissions, with females showing a corresponding reduction during the same year. Since then, the admission rate for males has trended downward, whilst the admission rate for females has trended up significantly.

In 2017/18 in Manningham, young people (15-24 years) were hospitalised due to illicit drugs at the highest rate of all age groups (35.3 per 10,000 people).

In 2018, 12.1% of young people in Inner Eastern Melbourne reported having used marijuana or other illegal drugs at least once, which was higher than the Victorian average of 10.3%. *(Victorian Adolescent Health and Wellbeing Survey)*

In the period 2015-2018, 58-65 calls were made to DirectLine seeking support in relation to methamphetamine use. In 2018, 55% of callers were female, and calls were made by people from all age groups. Calls from Manningham residents regarding methamphetamine use constituted almost 60% of all calls made to DirectLine regarding illicit drugs.

In 2019, drug offences in Manningham were at a rate of 92.0 incidents per 100,000 people, compared to 256.1 incidents per 100,000 people for Victoria. More than two-thirds of recorded incidents in Manningham related to the possession and use of drugs, consistent with the Victorian average.

23.2.2. Pharmaceutical Drugs

The pharmaceutical drugs most likely to result in hospitalization among Manningham residents include benzodiazepines, opioids, antidepressants, antipsychotics and other sedatives.

For Manningham residents, since 2015/16 hospital admissions due to pharmaceutical drugs have been slightly higher than for illicit drugs. In 2017/18, the admission rate to pharmaceutical drugs was 17.5 per 10,000 people, compared to 16.4 per 10,000 for illicit drugs.

In 2017/18 in Manningham, opioids were the pharmaceutical drug most likely to result in hospital admissions, at a rate of 4.9 per 10,000 people. This rate was less than that of the EMR and Victoria (7.3 and 6.4 respectively).

Overall, with regard to alcohol and other drugs in Manningham:

- The proportion of the residents with lifetime risk due to harmful alcohol consumption is consistent with the wider Victorian average. Furthermore, specific population groups are at greater risk of harm to due alcohol consumption, in particular young people and LGBTQIA+ people. The relatively low outlet density indicates that most harmful alcohol consumption occurring in Manningham is likely to be occurring at home, rather than at licensed venues.
- The link between mental health and the harmful use of alcohol is well established. As previously stated, the COVID-19 pandemic is already having a significant impact upon mental health. This fact, in conjunction with evidence of increased alcohol advertising and consumption during the pandemic, is likely to result in an increase in harmful alcohol consumption among those most vulnerable.
- Illicit drugs are an issue in Manningham as evidenced by the relatively high rate of young people requiring hospitalization (compared to other age groups). However, calls to DirectLine regarding methamphetamine use indicate that it is not only young people who are impacted by illicit drug use.
- Pharmaceutical drugs are an issue in Manningham, as evidenced by the fact that the hospitalization rate exceeds that for illicit drugs.
- Further investigation is required into the prevalence of drug use (illicit and pharmaceutical) among different age and gender cohorts; the types of drugs used and the reasons for use. Furthermore, there is a need for greater understanding of the relationship between pharmaceutical drug use and suicidality, particularly among females.
- Opportunities to support existing Victorian campaigns designed to reduce the uptake of illicit (e.g. Victoria's Ice Action Plan) and pharmaceutical drugs; to support initiatives designed to support the reduction and cessation of drug use, and measures to minimize harm among drug users; initiatives designed to prevent inappropriate alcohol and drug use.

24. Recommendations

Rather than being a relatively affluent municipality with “not much to see” in terms of health and wellbeing challenges, it is clear that the Manningham community experiences all the challenges of other communities. Furthermore, municipal, regional and Victorian data indicates that some cohorts experience health and wellbeing challenges more keenly: people with disability, women, young people, Aboriginal and Torres Strait Islander people, LGBTQIA+ people, people with diverse cultural backgrounds and older people. Preliminary evidence on the impact of Covid-19 suggests that the vulnerabilities of these cohorts has been further exacerbated by the effects of the global pandemic,

The data indicates that all 10 priorities are of relevance to Manningham. Furthermore, the relationship between the ten priorities is complex, as Figure 80 below attempts to illustrate.

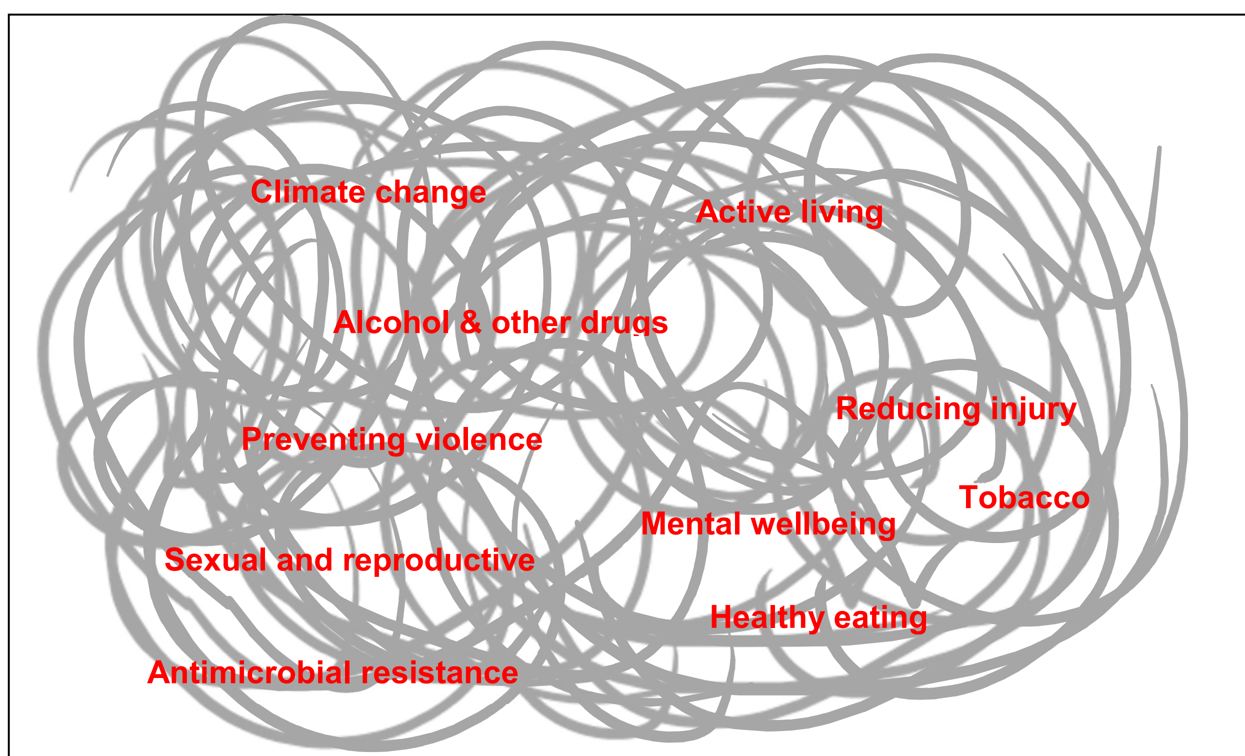

Figure 85. Relationship between Victorian Public Health and Wellbeing Plan 2019-2023 priorities

It is suggested that consideration be given to mapping (based upon the research available) the relationships between the ten priorities and the social determinants of health to more clearly understand the relationship between, for example:

1. the availability of affordable housing and depressions/anxiety
2. climate change and healthy eating
3. household income and physical activity

The insights from such analysis will enable a more nuanced understanding of the wider policy and program options available to Council and its partners to achieve health and wellbeing outcomes.

Focusing on all ten priorities in the new municipal public health and wellbeing plan is likely to lead to a myriad of actions and a dispersal of effort, with the result that limited impact is likely to be achieved against each priority.

A more effective approach will be to select a limited number of priorities supported by a limited number of actions, thereby enabling a concentration of aligned effort by Manningham and its partners and a greater likelihood of achieving positive, sustainable impact.

Whilst all ten priority areas are both important and of relevance to Manningham, a number of them have risen to the surface as a result of the needs analysis. Table 9 below outlines the suggested priority level for each of the 10 priorities with an accompanying rationale.

Priority	**Suggested Priority Level**	**VPHWP Focus Area**	**Rationale**
Climate Change	Higher	Yes	Climate change continues to be the greatest existential threat to the human species, despite being overshadowed in recent time by COVID-19. Local efforts to continue reducing CO_2 emissions; build community resilience; increase the tree canopy to reduce heat in the urban environment, and to understand and respond to the emerging health impacts, among other things are vital.
Preventing Violence	Higher	No	Family violence can have devastating short and long term impact upon those affected. Despite Manningham's status as a safe municipality, 708 family violence incidents were recorded by police in the 12-months to March 2020. Furthermore, justice procedure offences have increased over the past five years, of which almost half are due to breaches of family violence orders. Those affected are overwhelmingly female and include people of all ages. Indications are that COVID-19 is increasing family violence due to financial pressures and lockdown.
Healthy Eating	Higher	Yes	The maintenance of a healthy diet is one of the most significant protective factors against obesity, heart disease, diabetes, cancer, stroke and other diseases – all of which are significant causes of mortality in Manningham. The evidence indicates a significant opportunity exists in Manningham to increase fruit, vegetable and water consumption – particularly among males and vulnerable and disadvantaged cohorts.
Active Living	Higher	Yes	An active lifestyle is one of the most significant protective factors against obesity, heart disease, diabetes, cancer, stroke and other diseases. The evidence indicates that opportunities exist to leverage Manningham's natural assets, footpaths, walking trails, bike paths and sporting infrastructure to increase sport, recreation and active transport – particularly among cohorts with lower perceptions of safety walking alone (people with a disability; older people; females after dark).

Mental Wellbeing	Higher	No	The evidence indicates that up to 2 in every 10 residents are experiencing high or very high psychological distress; almost 100 people completed suicide in the past 10 years (and up to 3,000 *may* have attempted suicide); that dementia rates are high and increasing (depression and anxiety are often present as co-morbidities), and the municipality's significant older population is likely to be at risk of social isolation and to experience loneliness. Early indications are that COVID-19 is having a negative impact on mental wellbeing.
Alcohol and Other Drugs	Moderate	No	Short-term risk of harm from alcohol consumption occurs to a lesser extent in Manningham compared to the EMR and wider Victoria. Assaults involving alcohol have trended upward since 2010/11, as have calls to the DirectLine referral service for support regarding alcohol. Manningham residents are hospitalised due to illicit drug use at a lesser rate than the EMR and wider Victoria, and at approximately half the rate of admissions due to alcohol consumption. The number of calls annually to the DirectLine referral service have remained largely unchanged since 2011. Hospital admissions due to prescription drugs are on par with admissions due to illicit drugs. Alcohol and other drugs have a significant impact on Manningham and early indications are that COVID-19 is having a negative impact on alcohol consumption.
Reducing Injury	Moderate	No	Fatalities and serious injuries caused by road accidents have a significant and permanent impact on the victims, their families, friends and colleagues. The majority of serious accidents in Manningham occur on the main arterial roads which have higher speed limits and greater traffic volumes. VicRoads has legislative responsibility for the planning, design, construction and maintenance of these arterial roads – including safety measures. Furthermore, the Victorian Government continues to invest significant resources in improving road safety through education, road improvements and traffic policing across the state. Manningham has an important advocacy role to play in improving safety on its arterial roads. Falls are responsible for a greater proportion of deaths among older women in Manningham compared to the wider Australian average. The municipality's ageing population coupled with an increasing incidence of dementia indicates this should be a priority for further

			investigation and action.
Anti-microbial Resistance	Moderate	No	Preventing and delaying microbial resistance is a global challenge. Important work already underway in agricultural, veterinary, pharmacies, hospitals and GP settings. Further investigation required to determine the most effective role for local government.
Sexual and Reproductive Health	Moderate	No	A range of effective programs in place including sex and sexual health education in schools; high participation rates in the HPV vaccination program for young girls and boys; and, high participation in the National Cervical Screening Program for women aged 20-69. In addition, contraceptives are readily available at a range of outlets including supermarkets, service stations, convenience stores and pharmacies, and at venues such as bars and clubs. Nonetheless, sexually transmitted infections remain a concern – particularly among young people - with more than 250 annual notifications of Chlamydia, and an increasing incidence of syphilis and gonorrhea among males.
Tobacco	Moderate	Yes	Manningham has a lower incidence of daily and occasional smokers compared to the Victorian average. However, particular cohorts have a higher prevalence of smoking including LGBITQA+ people and some culturally diverse communities.

Table 11. Suggested Priorities

The data underpinning the analysis is quantitative in nature and in many cases - despite being the most recent data available - it is nonetheless a few years old. It is therefore recommended that consultation be undertaken with service providers, community, government agencies and other interested stakeholders in relation to all ten priorities and that the data contained in this report be used as a starting point for a conversation. Insights based upon the lived experience of community and the experience of local service providers, along with the broader perspective of government agencies which are working across multiple LGAs will provide a richer set of data on which to select key priorities for the next public health and wellbeing plan. The consultation process will also enable the identification of good work already undertaken by the community and service providers, and help to engender a greater level of commitment among partners to engage in genuine partnerships and to align efforts in service of the agreed priorities.

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