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## Title Page

## Title

Conducting a rapid health promotion audit in suburban Adelaide, South Australia: can it contribute to revitalizing health promotion?

## Running Title

A case study of a rapid health promotion audit


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## Conflicts of Interest

The authors declare no conflicts of interest.

Health promotion, social determinants of health, public policy, health status disparities

5582

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## Title

# Conducting a rapid health promotion audit in suburban Adelaide, South Australia: can it contribute to revitalizing health promotion?

## Abstract

How health promotion is implemented varies and it is often not clear what activities are in place in a region. Understanding the extent of health promotion activities helps planning activities.

**Methods**

This research involved a rapid audit of the types of health promotion activities in a suburban region of South Australia . This analysis was guided by the WHO Ottawa Charter's principles. To better understand population needs and which health promoting activities may help, an epidemiological, demographic and social determinants of health profile of southern Adelaide described disease patterns and health inequities.

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**Results**

While there was evidence of a range of health promoting activities,  , most concerned individual or behavioural services. A key finding was the small number of activities that the state health department and local health system were responsible for. Alongside local government, NGOs provided the bulk of health promotion activities. In addition, there were no overarching health promotion strategies or coordinating bodies to evaluate the activities.  The epidemiological, demographic and social determinants of health profile found persistent health and social inequities.

**Conclusion**

This rapid audit of health promotion in a region enabled a quick assessment of the current health promotion situation and provided evidence of gaps and areas where policy change should be advocated.

**So what?**

The key findings distilled from this research were designed to inform policy priorities to shift health promotion in southern Adelaide onto a trajectory consistent with the Ottawa Charter and prevent further focus on individualised behaviour change strategies known as 'lifestyle drift'

## Key words

Health promotion, social determinants of health, public policy, health status disparities

Health promotion seeks to redress the focus of health systems on disease that results in little attention given to prevention.[1] The World Health Organization's 1986 Ottawa Charter for Health Promotion, defines health promotion as "the process of enabling people to increase control over, and to improve their health".[2] The Ottawa Charter argued that: "Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love". Thus, the role of health promotion is to enable, mediate and advocate action, including intersectoral

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action, to change the daily conditions of living which in turn determine health and illness. This definition contrasts with expert-led prescriptions to change individuals' behaviour via health education or social marketing.[3, 4]

Health promotion has continued to evolve as both political and intersectoral by nature because health is affected by a range of economic, political and social factors lying outside the health sector.[5] Health promotion requires actions across all policy sectors to address social determinants of health (SDH) such as income, employment, social status, education, physical environment, social support networks, gender, and access to health services.[6] To enact this wider vision of health promotion, the World Health Organisation (WHO) supported the Health in All Policies (HiAP) approach in 2011,[7] which provides methods to stimulate cross-sector policy activity to address the social determinants of health to improve population wellbeing and reduce health inequities.[8] A HiAP approach has been implemented in South Australia since 2007.[9, 10]

Three principles for health promotion underpin the Ottawa Charter, the report of the WHO Commission on SDH and the WHO HiAP approach: an empowering practice of service provision, intersectoral action and advocacy, and place-based co-ordination. Until relatively recently, it was accepted that these activities were core functions of government; principally under the control or stewardship of health departments. In Australia, local governments also are increasingly assigned responsibilities for action to promote health within their respective regions.[11]

However, the Ottawa Charter's five principles (build healthy public policy; create supportive environments; strengthen community action; develop personal skills; and reorient health services) are not easily implemented in an era of neo-liberalism, small government and privatisation, and a biomedical gaze that privileges the individual's responsibility for their own health and illness.[12-14] Neoliberal and biomedical approaches have been operationalised by right and centre-right governments alike to emphasise behavioural intervention.[15] The shift from acknowledgement of the social determinants has been described as lifestyle drift. This is seen to occur when policies and practices acknowledge the importance of social determinants of health, but revert to individualised behaviour change strategies in practice.[16] Lifestyle drift is prevalent in Australian health policy[17] as demonstrated by the many national social marketing campaigns

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encourgaing individual behavoural change to address public health issues such as smoking, drinking and obesity.[18] Nevertheless, with ageing populations, health inequities and growing impacts of non-communicable diseases (NCDs) including mental ill-health, governments face continuing ethical and fiscal pressures to take health promotion and disease prevention action.[19] Health promotion and disease prevention activities are referred to throughout this manuscript and consist of measures taken to stop or avoid actions that may cause disease including addressing the everyday conditions experienced by the whole of population[20] and not just those with preexisting chronic disease who represent the 'tip of the iceberg'.[18]

Since the conceptualisation of health promotion, the role of government, health promotion policies and practices have evolved in complex ways. Thus, if and when opportunities for policy change arise, it is important for public health research to be able to inform policy with rapid assessments of the 'state of play' within the populations and regions where policies will seek to intervene, and highlight strengths or weaknesses in a manner consistent with a social view of health. While comprehensive data on medical services may be routinely gathered and consolidated to inform policy, it is not the case with the more varied kinds of data that captures the SDH and health inequities that are relevant to policy development for population-based health promotion. Australian scholars[21, 22] and the Australian Health Promotion Association (AHPA) have called for such multi-sectoral data collection to inform policy decision making and practice.[23]

Our research, funded specifically to inform government and health sector policy, demonstrates how such assessments can be made and analysed, at the scale of a sizeable urban region, to provide salient evidence and identify priority areas for policy change consistent with the Ottawa Charter.

### Case study context

South Australia (SA) was internationally recognised for its innovative health promotion practice from the early1980s to the early 2000s (see collection in Author X), including community health services providing a comprehensive range of clinical services, group programs and community development activities.[24] Many of these state government funded community health centres had

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community boards of management, and worked to ensure access, social connectivity and community involvement.[25]

This study took place in the southern suburbs of Adelaide, the capital of South Australia, an area that became recognised internationally through collaborations with the WHO based on the Adelaide Recommendations on Healthy Public Policy[26] and the Healthy Cities movement in the 1990s.[27] More recently, the SA state health department became prominent in their development of a HiAP approach to encourage other sectors to consider health impacts in their policies.[28, 29] The design of the SA HiAP was central, rather than geographically based, intending to improve co-ordination and joint intersectoral action at higher levels of government.

However, at the same time that HiAP was developing, the state government initiated a reorganisation of the health system focused on strengthening tertiary and quaternity health services. During this reorganisation, a 2012 government-funded review of health promotion concluded there was little evidence for its effectiveness,[30] and government initiated severe cuts to the health department's health promotion branch, community consultation bodies, health promotion services and co-ordination.[31] Nationally, the Australian Federal Budget 2014 oversaw the abolition of the Australian National Preventive Health Agency and the National Partnership Agreement on Preventive Health,[15] further undermining health promotion and disease prevention initiatives in the state. The focus of community based work has since increasingly turned to behavioural and lifestyle approaches to chronic disease management, involving private for-profit and primary care services.[31]

The southern region of Adelaide offers a geographically defined area within which the kinds of competing policy imperatives described above have played out. We partnered with community groups, senior actors in health services and the health department, and a range of services in southern Adelaide to investigate the current state of health promotion and identify options for policy change to advance population-based, equity-focused health promotion in the region. From the outset it was clear that there were no readily available data sets to describe conditions in the region for this purpose. This paper provides an example of rapid research to inform health promotion policy by compiling a place-based epidemiological profile and audit of health promotion activities, and analysing these to delineate key priorities for policy, to shift practice

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onto a trajectory of change consistent with the Ottawa Charter. We identify the value and limits of a health promotion regional audit.

## Methods

### Overview

A 12 month 'rapid translation' project was conducted in 2019. The project aimed to identify the potential for enhancement and extension of health promotion activities in the southern metropolitan region of Adelaide. This article reports on the first stage of data collection of the project, which involved two activities that occurred in parallel to understand the context of the area. They involved the collation of health and SDH data and current health promotion activities in the region. Unlike a standard needs assessment that involves the community in many steps of a systematic process ,[32] this audit was a quick desk-based process to inform the current state of health and specifically the health promotion activities available within the southern metropolitan region of Adelaide. This could contribute to a needs assessment.

The data collection strategy included two methods of data collection: 1) collation and statistical analysis of existing health and SDH data to form an epidemiological profile of the region, and 2) qualitative document and web analysis to review health promotion activities, services and structures.

## Steering group

All authors monitored and advised on these processes as they proceeded, to ensure comprehensiveness. In addition, a Steering Group established for the research also advised on data collection, analysis and strategies for translation and uptake of findings. This committee consisted of representatives from 15 organisations active in the region, including local government, the state health department, a state government wellbeing agency, a natural resources management board, several non-government organisations, a social services peak body, and the local health network which managed public hospital and community-based health services in the region.

### Epidemiological, demographic and social determinants of health profile

The southern Adelaide metropolitan region encompassed five local government areas (LGAs) and a total population of 407,277 people in 2019. An epidemiological, demographic and SDH

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profile of southern Adelaide was produced that involved analysing data from multiple sources to describe disease patterns and health inequities across the region.[33] The South Australian Population Health Survey (SAPHS) 2018[34] and the Public Health Information Development Unit[35] were the main source of epidemiological data. South Australian Monitoring and Surveillance System (SAMSS)[36] data were also used to identify trends in disease and health inequities over time. Data collated included median age of death, premature mortality, noncommunicable diseases, mental health, communicable diseases, risk factors and SDH. Data on demographics were obtained primarily from the Australian Bureau of Statistics and PHIDU to provide important context for the epidemiological statistics.

Tables and figures were constructed that presented the data for each of the LGAs where available and for the southern region combined where disaggregation was not possible. The sampling methodology for SAPHS uses random digit dialling to obtain a random sample, and data were weighted to ensure that population estimates could be made from survey data.[34] PHIDU data were sourced from ABS and registry data.[35] Data were reported as percentage estimates with confidence intervals, enabling comparisons between LGAs and Adelaide metropolitan areas and comparisons with the South Australian and Australian average. Both data sources provided point estimates and 95 per cent confidence intervals for the areas of interest.

Data sources did not allow for significance testing or calculation of the confidence interval for the difference between sample estimates (standard deviations were not available). We have investigated differences between areas by examining confidence intervals for different areas.

**Health promotion activities audit**

**Data collection and sample**

A rapid desk-top audit occurred over a three-month period from April-July 2019.The health promotion audit provided a method of rapidly gathering evidence of health promotion activities in the community via web based and document sources. The first step was to collate a list of potential organisations involved in providing health and wellbeing activities in the metropolitan region. Three primary sources were used to determine the list, including:

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- The research team and Steering Group members' networks and knowledge of organisations and activities in southern Adelaide.
- The South Australian Council of Social Service membership list was a primary source of information on key organisations in South Australia including non-government organisations and health and social service organisations[i].
- The SA Directory of Community Services[ii].

The initial list of organisations was utilised and snowballing methods including through the Steering Group were critical for identifying additional organisations and community groups without a digital presence who offered health promotion and community wellbeing activities.

The inclusion criteria for activities included all 'soft infrastructure' activities and services occurring in the region that could be classified as health promoting (note, soft infrastructure refers to people and services). The Ottawa Charter definition of health promotion as the process of enabling people to increase control over the determinants of health (e.g. income, education, employment, working conditions, access to health services, physical environments) and thereby improve their health was used to guide the data collection and analysis.[37] Health promotion not only encompasses actions directed at strengthening the basic life skills and capacities of individuals, but also at influencing underlying social and economic conditions to alleviate their impact on populations and individual health.[37]

The activities included in the sample were those targeting the whole population: those who were well, at risk, or people with a pre-existing health condition. Activities needed to be accessible to all, for example commercial activities such as regularly paid gyms were not included in the audit. Organisations that had a coordinating role and facilitated a range of activities were also documented.

- Authors 1 and 2 worked together to analyse the websites and strategic documents (including consumer reports, policies and plans) of each of the listed organisations. An Excel table was created and the following information was collated; Type of organisation (health services; local government areas; community centres; libraries; non-governmental organisations (NGOs) and community groups; services for people with a disability;

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religious and church based welfare organisations; state government departments; schools and childcare centres; sporting clubs and organisations).

- Scale of the organisation: for example, a state-wide organisation which serviced multiple areas, or a small local non-government organisation.
- Organisation strategies: any policy or strategic documents which may be about health prevention.
- Type of activities provided: for example, cooking classes or community bus. This provided evidence on which SDH were being addressed.
- Targeting individuals or structural determinants: whether the activities were targeted towards SDH or aimed at behavioural/lifestyle change, or crisis services.
- Groups targeted: what population groups are activities targeted towards.
- Location of the activities: to identify gaps as well as areas for enhancement and compare with the epidemiological profile.
- Whether any evaluation was built in: further points to whether a strategic element was directing the activities.
- Coordinating role: organisations that oversaw activities of more than one organisation.

Descriptive data addressing each category for each organisation was entered into the excel sheet.

**Analysis**

The scope of the review was purposefully broad to capture any health, social and community activities and services, and categorisation of health promotion activities occurred after data collection by the research team. This process of data analyses and categorisation involved synthesising the data from the Excel table into a second table on the types of activities, the organisations responsible and the location (by local government area). The categories in the table were guided by what patterns were occurring in the data. Each activity was assigned under a category heading (e.g. exercise, social and hobby groups). In the next stage, we used the Ottawa Charter's strategies on health promotion as a framework to analyse the health promotion activities and services identified, and make assessments of how and to what extent they were

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likely to contribute to a comprehensive approach to health promotion in the region. We found three of the Charter strategies applicable to analysing health promotion activities and services; whether they: 1) create supportive environments; 2) strengthen community action; and/or 3) develop personal skills, and rearranged the activity categories under each strategy.. In the discussion we address the Ottawa Charter strategies 4) build healthy public policy and 5) reorient health services, which the health promotion audit had limited scope to review. Utilizing the Ottawa Charter as an analytical framework led the analysis and helped to identify which SDH were being addressed by the organisations through their activities, which population groups they serviced, and what is missing in the health promotion system to make it successful in the region. The table was synthesised and is summarised in Box 2. The analysis was conducted by the first and second Author with discussion and input from the research team.

**Limitations and data collection challenges**

This project was constrained by the 12-month grant timeline which caused some limitations in the scope and depth of the research. The desk-top audit was rapid and data collection relied primarily on information available online. Therefore, some information about activities and organisations may have been missed. This research method highlights that where there are no systematic data collection systems on health promotion and prevention activities in a region or state, challenges to informing evidence-based policy for researchers and policy makers arise. This project relied heavily on the local knowledges and networks of the research team and Steering Group in the case study region to overcome the absence of public and readily available data. Given more time, we would advise future audits to incorporate community health needs engagement, although the aim of this audit was to enable a quick understanding of the health promotion activities available in a region. Secondly, due to time limitations only a sample of the numerous churches, schools, children's centres and child-care centres in the region was included in the audit. Although some unique activities may have been missed, we found that the types of services and activities in each sample were similar. Sport clubs were not individually identified in the audit but were classified together in order to identify that they have a role in health promotion, often providing free and affordable avenues to exercise. Collating the specific information of each of these generic clubs would take too much time for a rapid desktop audit.

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Workplaces were not included in the audit, but it is noted that they may provide health promotion activities for their employees.

## Results

### Epidemiological, demographic and social determinants of health profile: key findings

The results from the statistical analysis describe demographic characteristics, prominent individual risk factors and SDH in the region, and the key findings are presented in Box 1[iii]. These data showed that while overall this region fared well compared to the rest of the state there remain areas of persistent concentrated disadvantage and health inequities. Like other areas in Australia the region was characterised by rising NCDs.

**Box 1: Prominent health outcomes, risk factors and social determinants of health for southern Adelaide**

The results in Box 1 highlight factors affecting the health of residents of southern Adelaide and generally match patterns similar to the rest of the state and Australia. However, some of the LGAs stand out as having a higher proportion of low income households who are affected by financial and mortgage stress, higher rates of social welfare payments, higher rates of unemployment, and a higher proportion of people who did not complete high school.

### Health promotion activities audit

**Diversity of health promotion activities**

The rapid review of organisations in the region revealed a great diversity of activities and services aimed – in some way – at improving the health and wellbeing of residents and the community. A summary of the activities is presented below (Box 2) under three strategies in the Ottawa Charter for Health Promotion, including:

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- Create supportive environments: Health promotion activities aimed at improving the living conditions of individuals and communities, including the SDH.
- Strengthen community action: This is fundamentally about the community having opportunities to participate in having control over their own environments and health, including community empowerment and community development.
- Develop personal skills: Health promotion which supports personal and social development through providing information, education for health and enhancing life skills in all areas of life.

Most of the activities captured in the first stage of data gathering for the audit fell outside of this definition, as they were individual health and social crisis support services, and not focused on disease prevention or aimed at addressing the SDH or improving community wellbeing. After research team discussion, these were removed from the final list.

**Box 2: Summary of health promotion activities identified in the audit**

**Organisations providing health promotion activities**

Numerous organisations were identified as providing health promotion and community wellbeing activities in the region. Organisations included state and local government, schools, early childhood centres, churches, non-government organisations, community groups, associations/foundations/trusts and sport clubs. Government made up approximately 30% of organisations responsible for activities, while non-government made up the rest (predominantly not-for-profit).

**Types of health promotion activities by organisation**

**Health Department and regional health system**

Public health system infrastructure in the region included two major hospitals, Aboriginal and Torres Strait Islander specific health services, and family and children's health services. Important to note, however, is that there are no Aboriginal Community Controlled Health Organisations operating in the region.

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A key finding was the small amount of disease prevention and health promotion activities that the state health department and local health system were responsible for coordinating and delivering in the region.

Most health-promoting services identified fit under the following categories: immunisations; information for people with non-communicable diseases on 'healthy lifestyles'; web based resources for a range of conditions; support services such as transition packages to support older people to live in their own homes; drug and alcohol counselling; health professional training; and mental health support (e.g. a hotline). There were some health promoting services run out of the Aboriginal health services and family and children's services such as parenting and carer groups and workshops, and extra support for groups identified as more in need, such as Aboriginal and Torres Strait Islander people, refugees, young parents, and the LGBTQI+ community. These tended to fall under the category of 'developing personal skills' in the Ottawa Charter strategies for health promotion.

**State government departments other than health**

The audit indicated that state government departments outside of health were involved in providing more health promotion activities than the health sector. Although the activities were often not named under prevention or health promotion terms, they addressed a range of SDH. The state education department responsible for all schools, early childhood centres and children's centres oversaw activities including preschool, a family learning together program, disability support, respite, mentoring for future education and work, drug and alcohol counselling, and migrant and refugee support. The human services department provided some health promoting services, such as school sports programs and drug education programs, home assist packages for the elderly, counselling and support for Aboriginal and Torres Strait Islanders, career pathways advice, counselling, concessions, housing for the homeless, and legal advice. The planning, transport and infrastructure department promoted walking safely to school, and provided a cycling route planner and elderly safe driving lessons. The Office for Recreation, Sport and Racing provided resources and funding for physical activity including sports club funding and the organisation of vacation swimming lessons.

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### Local governments

Local governments were responsible for much of the health promotion activity in southern Adelaide that fell under the three Ottawa Charter categories. Local government infrastructure and services such as libraries and community centres were common activity sites which diverse organisations and community groups used for free or low cost. Examples of some of the activities included: exercise groups, social and hobby groups, food safety training, parenting and family groups/workshops, awareness raising activities and cultural and community events, adult education workshops, infant and social groups and learning programs for children, nutrition and cooking programs, community lunches or affordable shared meals programs and community gardens.

### Non-government organisations and community groups

Alongside local government, NGOs provided the bulk of health promotion activities. However, the activities were predominantly targeted toward people with or at risk of poor health, and/or living in poverty. NGOs are responsible for many vital social and health care services and crisis services, which were excluded from the analysis, as they did not fit the Ottawa Charter definition of health promotion. We found examples of the health promoting activities they were responsible for under each of the three strategies. For example, under 'creating supportive environments': there were programs for people living in poverty, including providing housing, clothing, furniture and homewares, activities for people with a disability such as social visits, skills development, work assistance, education support, transport, and food relief. Under 'strengthen community action': community advocacy groups, consumer alliance groups such as for older people. Examples under 'developing personal skills' included: financial assistance, employment and training, counselling for specific groups (mental health, domestic violence, parents), legal advice, exercise programs, and nutrition education.

### Coordinating role

No overarching coordinating body for health promotion activities in the study region was identified. Local governments were found to have a limited coordination role for their region through the statutory mandated Regional Public Health Plans. These plans and other local government documents were unlikely to use the term 'health promotion', preferring the terms

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‘wellbeing’, or ‘community wellbeing’. Priority areas within the Regional Public Health Plans included taking health into consideration in urban infrastructure planning; ensuring there were opportunities to be active; planning to mitigate climate change impacts to communities, assets, and the environment; community development; and public health protection through regulatory measures. Local government therefore played a major role in coordinating and planning disease prevention activities and strategies in their area and did this directly or in partnership with other organisations. Examples of partnerships included local government working with community groups to run multicultural events, the police to organise safe neighbourhoods, schools for immunisation clinics and local groups for neighbourhood development programs.

No other organisations were identified as responsible for the overall coordination of health promotion. Some state government departments conducted health promotion projects, but none co-ordinated health promotion activities. For example, the Department of Planning Transport and Infrastructure organised community road safety activities and funded recreation and sport facilities, but did not have a broader or strategic coordinating role.

## Discussion and Interpretation

The findings from the research conducted in a suburban region of Adelaide, South Australia highlighted the existence of a range of activities that were health promoting and addressed the SDH, according to three of the Ottawa Charter strategies to promote health: create supportive environments, strengthen community action, and develop personal skills. However, there were no overarching health promotion strategies or coordinating bodies identified, and the activities that existed demonstrated a drift towards individual or behavioural services and activities, which is in line with international trends [3, 38, 39]. Most of the health promotion activities identified were either individual or group activities. The activities were aimed at treating or managing physical and mental health conditions, but few tackled the broader and more structural SDH that were identified as areas of concern in the regional population health and SDH profiling (e.g. housing affordability, food security, unemployment, persistent areas of disadvantage). Most disease prevention services were aimed towards at risk or unwell populations, while profiling of the population indicated that socioeconomic disadvantage was linked to poorer health. Lifestyle drift was evident despite activities and structures in place to address the SDH, such as HiAP. The

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literature suggests this is occurring due to the complex web of relations including funders, government and residents along with the neoliberal focused environment that health promotion workers have to work within.[40] Vague policies and policies that cover only the public sector have also been identified as possible reasons.[41] A multi-stakeholder focus that aims to bring in many different sectors and groups may also contribute by diffusing the responsibility away from the government and onto different stakeholders, and ultimately back on individuals.[41] Lifestyle drift is a concern, and we need to move beyond lifestyle/behaviour health promotion to address the SDH to improve population health and health inequities.

The audit pointed to the need to further examine the strategies in the Ottawa Charter which relate to health promotion at a strategic level. We argue that the two strategies in the Charter that the audit and the regional profiling are unable to examine but are required to improve health promotion are: 1) Building healthy public policy, and 2) Reorienting health services. The strategy to build healthy public policy recommends that health should be on the agenda of all policymakers in all sectors, that health promotion policy "is coordinated action that leads to health, income and social policies that foster greater equity".[37] Ramirez et al. Brennan Ramirez, Baker [42] have identified that in conjunction with local level activities the commitment and support of healthy public policy requires strong national leadership which can set up the structure for health promotion to filter down to local level. "Reorient health services" refers to the health system and health sector taking responsibility for health promotion, and reorienting beyond their responsibility to provide clinical and curative services. To date in the study region it has been noted that government health policies have continued to privilege medical care and individualised behaviour-change strategies.[31] The health sector in this study was found to be responsible for least amount of health promotion activity in the region.

### Many activities but little coordination and leadership

The most striking finding from the research was that while there were numerous activities that could be included under the banner of health promotion there was very little evidence of any effective co-ordination of activities, nor co-ordination that would support intersectoral action in line with the HiAP approach. The withdrawal of the health department from health promotion in

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2013[31] appears to have left a vacuum. There was some isolated evidence of intersectoral coordination at the state and local government level consistent with the HiAP approach, such as the Education department working with local government on community gardens in public schools, and the Environmental department and Education department working together on sustainability in schools. However, while local government was able to co-ordinate activities within its boundaries to some extent, the existence of five local government areas in the study region meant that there was no co-ordination across the region. The existence of mandated Regional Public Health Plans holds some promise for improved intersectoral regional co-ordination, showing in theory, a commitment to coordinated actions through utilising their infrastructure and capacity to focus on disease prevention and improving community wellbeing. Again, there was little evidence of the HiAP approach being implemented at the local government level.

Many of the health promotion activities and services documented in the audit were provided by charity or not-for profit organisations. As expected, few health promotion activities were led by the state health department and local health network. This follows on from the government's disinvestment in health promotion.[30] This research highlights the extent that the NGO sector has picked up these activities after government disinvestment, although with a lack of guidance and overarching direction and coordination. Sanson-Fisher and Campbell[43] found that funding streams dictate the direction of NGO services that often have no overarching coordination. They found that such conditions push competitiveness over collaboration. A study of NGOs around the world found a common pattern of NGOs working in isolation rather than collectively.[44] It appears that in the absence of state government leadership, the activities of NGOs and local governments remain overlapping (in some cases) and uncoordinated, as found to be the case in this study. This further highlights the need to maintain adequate databases and community consultation which enable regular needs analyses of the region, including health status, health inequities, social determinants of health, and gaps in available health, social, and environmental services, and to improve organisational accountability.

There is no national health promotion body in Australia. A National Preventive Health Agency was established in 2007 but this was abolished by an incoming politically conservative government in 2010. Most Australian states have a central unit responsible for their health

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promotion activity but this unit was disbanded in South Australia[31] along with the formal withdrawal of the relevant policy – the SA Health Primary Prevention Plan 2011-2016, illustrating the extent of the state's relinquishment of a leadership role in health promotion. At the time of writing, however, the state Health Promotion Branch had just been relaunched in 2021, under Wellbeing SA. In 2019 a change of government resulted in the establishment of a Wellbeing SA agency. Still in the early stages of strategic planning during this study, the new agency stated a renewed commitment to prevention in the health sector. Like HiAP, Wellbeing SA is a statewide agency and does not take a geographically based co-ordinating role. This is an important development, as the role of health authorities in offering leadership and stewardship to encourage other sectors to take health promoting actions has been noted by the Commission on Social Determinants of Health[45] and by Author X[46] in their analysis of health sector roles in terms of health equity. Our study confirms that comprehensive health promotion requires Federal and state strategic leadership to ensure that while regional and local health promotion strategies focus on action in local communities the broad strategic approach focuses on building healthy public policy. Such policy would concern issues such as taxes on unhealthy products, healthy urban planning, affordable housing and cost of living expenses, and climate action to ensure a sustainable future.

## Conclusion and implications

Previously in South Australia there were clear policies that outlined health promotion goals and strategies and the roles of those involved. We found that at the time of the audit no organisation was coordinating health promotion and community wellbeing activities in the study region. Gaps were particularly noticeable in activities addressing social determinants of health and instead a focus on behaviour change activities and crisis services was observed. We also found little strategic planning and accountability in the system. We identified a need for a co-ordinating structure to monitor and direct health promotion and community wellbeing activities in the region in combination with support and structures at the state and national level. A rapid assessment of health promotion in a region proved to be a valuable tool to quickly understand the current situation and provide evidence of gaps and areas for change. However, such an audit will be most effective when it is conducted as part of a national and state wide health promotion

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strategy which includes action to promote healthy public policy and so enable all the strategies proposed by the Ottawa Charter to promote health.

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[ii] https://sacommunity.org/

[iii] The full report *Healthy South: Population Health and Social Determinants in Southern Adelaide. Southgate Institute for Health, Society and Equity. 2020* can be found here: https://www.flinders.edu.au/content/dam/documents/research/southgate-institute/Population-healthand-socialdeterminants-in-southern-adelaide-report.pdf

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