Practitioner insights on obesity prevention: the voice of South Australian OPAL workers

OPAL Collective*

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Summary

Knowledge based on science has been central to implementing community-based childhood obesity prevention interventions. The art of practitioner wisdom is equally critical to ensure locally relevant responses. In South Australia (SA), the OPAL (Obesity Prevention and Lifestyle) program has been implemented to reduce childhood obesity across 20 communities reaching nearly one quarter of the state’s population. Staff from across the State come together at regular intervals to share practice challenges and insights and refine the model of practice. Over a 3-year period 12 reflective practice workshops were held with OPAL staff ($n=46$). OPAL staff were guided by an external facilitator using inquiring questions to reflect on their health promotion practice within local government. Three themes were identified as central within the reflections. The first theme is shared clarity through the OPAL obesity prevention model highlighting the importance of working to a clearly articulated, holistic obesity prevention model. The second theme is practitioner skill and sensitivity required to implement the model and deal with the ‘politics’ of obesity prevention. The final theme is the power of relationships as intrinsic to effective community based health promotion. Insights into the daily practices and reflections from obesity prevention practitioners are shared to shed light on the skills required to contribute to individual and social change. OPAL staff co-authored this paper.

Key words: obesity prevention, community health promotion, prevention, service learning

INTRODUCTION

More than ever, people want to know how to act on the public health issue of obesity. There is an abundance of evidence and opinions about the causes of obesity and what might be done (Doak, 2006; Jebb, 2007; Swinburn, et al. 2007; Bell, 2008; Foresight UK, 2008) but at times this volume of evidence can be overwhelming. Obesity experts writing in The Lancet note: ‘The number of suggested interventions, plus the contested nature of potential solutions, can create a policy cacophony, which makes the task of obesity prevention hopelessly difficult’ [(Swinburn et al., 2011), p. 839]. One source of knowledge about effective obesity prevention is practice insights from practitioners who reflect on the effectiveness of what they are doing. Practitioner wisdom can be too often ignored or relegated as less valuable when compared with the scientific evidence from random control trials, or academic research and evaluation studies (Schon, 1983; Kenny, 2007). However, all types of knowledge are needed to piece together the causative and intervention factors given the tremendously complicated task of understanding the obesity intervention puzzle.

The primary objective of this paper is discussion of practitioner insights about effective practice in obesity prevention, from a group of 46 workers in local government who deliver a childhood obesity prevention program in 20
communities in South Australia known as OPAL, an acronym for Obesity Prevention and Lifestyle. Based on the EPODE model (Borys et al., 2012) which operates in France, OPAL commenced implementation in September 2009 and aims ‘to improve eating and activity patterns of children, through families and communities in OPAL regions, and thereby increase the proportion of 0–18 year olds in the healthy weight range’. This paper reflects OPAL in early 2014. At its commencement it was a partnership program between Federal, State and local governments with a funding allocation of more than $40M over 10 years OPAL placed two full-time staff for 5 years within a local council and provides an annual budget to use at their discretion. At a program level a social marketing process identifies key annual behavior change themes which are taken up at the council level, and are in parallel with a community development process. The rollout of the OPAL Program has been in phases, with six Phase 1 communities begun in 2009, and the other 14 OPAL sites introduced over time.

Three themes have emerged from OPAL practitioner reflection over a period of 3 years (2011–13). The first theme is shared clarity through the OPAL obesity prevention model and discusses the importance of working to a clearly articulated, holistic obesity prevention model. In OPAL this approach is described by an OPAL intervention ‘logic model’; the conceptual paradigm is based on three different models of theory—socio-ecology, social marketing and community development from which are derived practice principles and approaches. The model guides OPAL practice in all the diverse settings in which the Program operates. The second theme is practitioner skill and sensitivity describing the need for practitioner acumen in implementing the OPAL model and in dealing with the ‘politics’ of obesity prevention. The final theme is the power of relationships which reinforces the well-established significance of quality communication and relationship building in effective community-based health promotion (Legge, et al., 1996; Kenny, 2007). The discussion that follows is an interpretation of the perspectives of OPAL practitioners and the central coordination unit with responsibility for management and evaluation of the OPAL program; the paper is co-written by them. It aims to contribute to the pool of knowledge about obesity prevention.

REFLECTIVE PRACTICE IN OPAL

Reflective practice approaches are now commonplace in health and social welfare (Leonard and Sensiper, 1998) and have been integral to OPAL. Bolton describes reflexivity as being the process of ‘bending back’ knowledge, in other words indicating a form of praxis where attention is given to consciously thinking theoretically about what she writes of as the ‘actions, thoughts, feelings, motives, assumptions’ [(Bolton, 2001), p. 31] and using this knowledge to think and act again. In OPAL, reflective practice has assisted practitioners to think and make considered choices using the lens of the OPAL social health model of practice.

The uptake of reflective practice can be traced to the influential work of Donald Schon, author of The Reflective Practitioner. Schon distinguished between types of knowledge that a professional will use in the course of their work. This includes ‘technical and rational’ knowledge which is based in science and the knowledge base of professional disciplines (e.g. in obesity prevention knowledge from the nutrition discipline). He also delineated the characteristics of ‘knowing in action’ as the spontaneous use of knowledge without awareness of conscious thought. This is also known as tacit knowledge; the knowledge gained through experience over time. As Schon writes, ‘knowledge is in the action—that a tightrope walker’s know-how, for example, lies in, and is revealed by, the way he (sic) takes his (sic) trip across the wire’ [(Schon, 1993), p. 17]. A third type is ‘reflection-in-action’ or the art of thinking on one’s feet in response to the situations that arise. Schon says: ‘When someone reflects-in-action, he (sic) becomes a researcher in the practice context’ [(Schon, 1993), p. 20].

In OPAL, reflection-in-action, which happens while the practitioner is going about their work, and formal and informal reflection after the event, have allowed practitioners to undertake the types of reflection Schon refers to above. OPAL practitioners complete formal practice reflection diaries on a regular (almost weekly) basis, entering these into an online project management system, called the Single Platform (see Figure 1. below). This web tool allows all OPAL teams to upload project background, data, processes and success or failures for other (OPAL staff and researchers) to see and learn from. This is designed as a knowledge-sharing tool and the aim is to allow vital evaluation and reflection information to be shared across all OPAL sites and within the State, Local and Federal Government funding bodies. The system also has built-in functionality that guides the practitioner through a series of questions and answers during the project conception stage that have been derived from the theories that underpin OPAL.

Several times per year whole group reflection sessions are conducted by an external facilitator, a university professor with a background in community development in health. The sessions are attended by all OPAL workers in the Program. These sessions occur as large group
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Fig. 1: OPAL Single Platform online project management system—screen shot examples.
activities and they start with the question, ‘what is most pressing on your minds or preoccupying you in your OPAL work?’ This question and the answers it generates are set against the values and principles of OPAL, and begin a process of group dialogue about practice issues. The facilitator plays the role of listening and drawing out meta-themes, which are returned to the group to reflect on further. As one OPAL worker notes: ‘Because we hold regular sessions, teams are confident enough to share the good and bad stories and experiences from their programs—allowing each other to learn from success and mistakes. It is also an opportunity to present problems for the collective group to assist in solving’. In addition, informal reflections often occur through communications with people in the local community and OPAL stakeholders.

Furthermore reflective practices are a means to analyze the every day of practice. Given the complexity of obesity prevention (Bell et al., 2008; Foresight, 2008) a reflective approach is imperative in building a wider pool of knowledge about what works, where, and under what conditions. In the course of reflections it has become clear that OPAL has developed a model and a ‘tool kit’ of resources. In the words of one practitioner OPAL ‘is a giant think-tank bringing together workers who come from varied discipline backgrounds such as nutrition, physical activity, social work, community development, social marketing, and project work’. Three themes in particular are seen to be important for obesity prevention, each of which is explored here in more detail.

THEME 1: SHARED CLARITY THROUGH THE OPAL OBESITY PREVENTION MODEL

OPAL practitioners have used practice knowledge to refine an obesity prevention model. Over 18 months the OPAL team developed a framework for addressing childhood obesity prevention which is defined by the OPAL Logic Model (see Figure 2). Consistent with the typical logic model flow there are four parts to the OPAL program logic model: resources and inputs, activities and outputs, impacts and outcomes. It was designed and refined to ensure consistency in the OPAL approach across the local government sites, but to also allow for innovation and spontaneity to respond to specific community needs. This has been critical given that each OPAL Local Government Area is different. For example, OPAL staff work with communities of different population sizes (6000–68 000), ethnicities, cultures, employment statuses and geographies. There are also varied attitudes and responses to the question of obesity and what might be done for prevention. As shown in the logic model below the outcomes OPAL seeks to achieve are changes in health and well-being and quality of life that result from healthy weight.

Each of the 20 OPAL sites in South Australia guides its intervention strategy selection and design using a combination of three theoretical methodologies: Social Marketing, Ecological Systems and Community Development. As one OPAL practitioner stated ‘theories are used in unison which gives us a rich approach in working with communities’. The Ecological Systems approach brings to the foreground the dynamic interrelations of variables in the social environments (Bronfenbrenner, 1977; Bronfenbrenner, 1979). Human physiology and behavior (i.e. genetics, energy balance, eating and nutritional habits, sleep and exercise regimens); levels of income and food purchasing patterns; the built environment that impacts spaces for play and exercise; food supply and access issues, are some of the contributing factors to obesity. Through applying the socio-ecological approach/model OPAL staff keep a sharp focus on both individual and environmental/structural changes, at the same time. OPAL’s approach is holistic in the active recognition that it takes far more than the health sector to address the challenges of rising obesity rates (Australian Bureau Statistics, 2013; Obesity Australia, 2014). Many other sectors influence behaviors and social environments that have an impact on nutrition and physical activity. For example, through the data entered into the Single Platform more than 35 sectors/industries have been identified.

The OPAL obesity prevention model sets out a mandate to work in partnership with non-health sectors, reflecting the holistic understanding referred to above. Again, the community development perspective reinforces the need for holistic approaches and provides a set of principles to guide practice. These are indicated in the OPAL Program Logic Model referred to in Figure 2. At OPAL’s core, social marketing draws on technical, rational, interdisciplinary evidence to formulate specific themes, which are implemented in all OPAL sites. The development of these themes was guided by the Scientific Advisory Committee (SAC), comprised of 16 leading South Australian academics and chaired by Professor Boyd Swinburn. A practitioner expresses her confidence in this process: The SAC means that OPAL field staff are supported by evidence which gives conviction to decision-making and confidence to deliver. OPAL field staff are further supported by a State Coordination Unit (SCU) who set the strategic direction for social marketing work in conjunction with the SAC. A theme-based message and associated interventions and resources are then developed with advice from the OPAL SAC and OPAL staff. This ensures approaches are broadly suitable for local implementation. OPAL staff determine how best to make
OPAL themes relevant to local communities. The SCU also provides field staff with graphic design expertise so staff can alter existing designs, or create new resources based on local community needs. A practitioner reflects that: 'Generic versions of awareness materials can always be adapted to suit various settings, cultures, ages etc. OPAL is a well-planned, evidenced-based program'.

A consequence of discussing and refining a shared Program Logic Model has been that OPAL's work maximizes a focus on changes at an individual and structural level to prevent childhood obesity. As a practitioner notes: 'The project logic gives the OPAL team an ability to organize their thinking'. In simple terms a socio-ecological model has been divided into environmental and individual impacts to reflect the combination of individual and environment change strategies required. The environmental impacts created in the logic model (see Figure 2) hypothesize an increase in healthy eating and physical activity levels in the target group will result from a change in the environment by increasing the following variables; affordability, availability, accessibility, quality and acceptability.

Another feature of the OPAL program is its positive, non-stigmatizing approach, with a focus on equitable, inclusive and respectful practices. OPAL recognizes the evidence that people ‘at risk’ of becoming overweight or obese are more likely to come from disadvantaged backgrounds. As an OPAL practitioner states ‘When we put an equity lens on our work, this is where it’s most important. Our impact on the lives of those with the greatest need has been achieved by working—when necessary—using a community development approach, which aims to address the issues of affordability and access’.

The OPAL model has six goal areas that relate to healthy eating and physical activity. These goals underpin and guide the work done by OPAL, and are outlined below:

- **Home Meals**—encouraging healthy meals produced in and around the home.
- **Local Food**—promoting growing and sourcing locally produced food.
- **Healthy Outlets**—encouraging a healthy option when out in the community.
- **Parks and Places**—encouraging the community to use the local green spaces and centers.
- **Active Leisure**—promoting more outside play sessions and less screen time.
- **Active Travel**—promoting being active to destinations within the community.

To work towards these goals OPAL has a suite of seven strategy areas (see Figure 2) which can be delivered and these cross a spectrum from programs to research and policy advocacy. These strategies ensure all sites consistently use a multi-dimensional approach to their interventions, which enables sound project design, selection and sharing. The consistent use of the seven strategies in all sites allows staff to interpret, describe and communicate the complexity of circumstances in which they work and how they intend to impact on them. OPAL practitioners apply a simple project management path to developing projects on OPAL Themes, Goals and Strategies, as set out below (Figure 3):

The OPAL Program Logic Model is theoretically informed and balances bottom up community development to develop a series of linked projects that achieve planned outcomes. A practitioner reflects that; ‘OPAL staff are encouraged to act as relatively ‘free agents’ in their work, and within their geographical boundaries, have very limited restrictions’. A coherent and shared obesity prevention model has been complemented by time (5 years), place (the right place is local government) and the capacity for practitioner experiences to be pooled through a reflective process.

In hindsight a key factor in the program’s success has been the developmental insights gained from a staged roll out of the OPAL program. The first phase of six councils began in 2009 with the deployment of 12 staff. These first six OPAL sites learnt through trial and error and were in a position to convey invaluable lessons to those who were subsequently employed in Phases 2–4. For instance, the development of OPAL themes and their deployment in Councils, the evolution of a shared logic model and understanding the business of Councils all formed an important foundation for working effectively in local regions. Having established understanding and systems the first OPAL sites enhanced efficiency of subsequent OPAL teams. The State Manager said, ‘It is difficult to imagine how we could have enlisted all 20 OPAL sites from the outset. The gradual phasing in of sites gave us the time we needed to establish the program in a sensible manner.’

**THEME 2: PRACTITIONER SKILL AND SENSITIVITY**

Insights about the OPAL obesity prevention model, as an a priori conceptual map, were accompanied by reflection that putting this into practice required practitioner sensitivity and acumen, especially in interpreting local contextual issues and dealing with the ‘politics’, or twists and turns in obesity prevention. The latter refers to the dynamics within local contexts, which arise from the everyday impacts of intersections of media and popular discourses about food, nutrition and physical activity, power and relationships within agencies, and the processes and dilemmas of implementing preventative programs. In short there is much for a community-based practitioner to negotiate in order to implement an effective prevention program.

OPAL staff are based in one geographical space for 5 years and have needed to understand and work with various interests and changing strategic priorities. Communication at a governance level has been important and in OPAL it has been enabled by formal structures such as the OPAL Local Government Mayors’ Club and annual events with the State Government Health Minister and Local Government representatives. Having the support of elected decision makers in the local government system is intended to provide OPAL with an advocacy voice and provided symbolic support for prevention. OPAL Local Council Managers have shared reflections that it has only been possible to begin to place OPAL outcomes on the agenda of Council through working with the levels of decision-making, internal processes and with an appreciation of organizational culture (which can often be unspoken norms, rules and regulations). As a worker noted in early 2014:

> The tri-level Government funding demonstrates to the wider community that there is an obvious need for and commitment to tackling the obesity crisis.

Once a place is established within the local community, and trust is built, only then can health practitioners look to make change in the fields of policy, planning and long-term strategic thinking. As one practitioner puts it, ‘in the OPAL structure, we are seen as helping to drive policy change from within local government and bringing key staff and elected members on this journey with us—this has worked well as opposed to being outsiders with limited understanding of how Councils work, coming in and trying to force change’. The benefits of OPAL staff having a physical presence within Council offices over 5 years allow them to gain a heightened level of understanding of Council-specific sensitivities and bias. As a result, they can look to align OPAL processes and outcomes with the broader Council agenda. This has relied on gaining acceptance from Council that OPAL is a

**Fig. 3: Project management path.**
positive program. In the words of practitioners: ‘This partnership approach recognizes the differing priorities of Local Government and health but finds middle ground working together for mutual outcomes. Establishing a well-rounded internal Council Steering Group which acts to support OPAL programs, budget and decision-making is vital’. This group is not made up of experts in the field of health—but experts in working alongside community and advocating for positive change. This is well articulated in the following quote from an OPAL worker:

From the outset, walking into the Council (like any large organisation) it has been vitally important to take time to navigate the hidden and visible political landscapes—because during this time we have been able to discover who the real change champions are within Council, and recognise who we can help empower amongst the staff and elected member body to create changes to support population health. Sometimes the structured hierarchy of power within a Council can be very different to the hidden hierarchies of actual decision making.

Obesity prevention literature discusses the concept of the local environment as being one key to influencing an individual’s health and therefore Local Government can be seen at the center of the local environment, creating policies, plans, facilities and infrastructure within communities (Victorian Department of Health, 2013). For much of the OPAL staff’s initial years working within Council, they have been a resource to this agenda, assisting staff and Elected Members understand and see its practical application in their district. Working in and with Councils has reinforced to OPAL staff that qualified health experts are not always the best placed professionals to drive change within communities—although they certainly can provide valuable advice at the very least. This way of thinking recognizes the role of Local Government to create community change and the elements for doing so should be primarily focused on having teams which can be responsive to the needs of Local Government and negotiate ways to achieve mutually beneficial outcomes for population health.

OPAL Managers have also reflected that being skilled in message delivery around political subjects has been another vital element in their role to create change. The word ‘obesity’ in itself is of a sensitive nature, and the OPAL program invests time into staff training and resources to ensure a positive and non-stigmatizing approach to healthy weight can be simply communicated throughout the life of the program. This is done through training, question and answer resources, media training, reference materials and more. Further, OPAL staff are given very flexible work environments whereby they can act in response to their environment—and adapt appropriately for best outcomes. Hence the OPAL model and staff are able to navigate away from negative assumptions about obesity health promotion and healthy weight as required.

The OPAL team was encouraged to reflect on how these lessons can be adapted to other ‘like’ programs entering the field of health promotion in communities. The question was posed as to how practitioners could learn from the OPAL experience in order to ‘fast-track’ outcomes with local government. The considered response was that the concept of fast-tracking significant change is unrealistic and inevitably seen by local government as ‘knee-jerk’ and ‘cost-shifting’ exercises. OPAL’s success to date reworking in local Council has been its longevity and its recognition that understanding how Councils work is vitally important to creating outcomes.

When reflecting on lessons in best managing the politics of obesity prevention the elements of success include: establishing political support and advisory structures as early as possible and agreement on these from all parties; communication strategies within local government and beyond; continuing to share the ‘how’ of successful outcomes from interventions in other like council districts—particularly to build support and persuade where there is resistance. These practices require skills and awareness and investing time to work across agencies and levels of government.

THEME 3: THE POWER OF RELATIONSHIPS

Relationships have been a key factor in OPAL work. This is not surprising given that community development is one of the underpinnings of the OPAL model. It is well established that effective community-based health promotion is built on strong and quality relationships (Legge et al, 1996; Ife, 2002; Kenny, 2007). Positive relationships facilitate cooperation and exchange of resources and they generate the conditions where ideas can be expressed and put into action. This includes supporting individuals and groups who are working for change and may be champions in creating new social norms (Saunders, 2005; Verity, 2007).

Across each OPAL site relationships crisscross networks, families, organizations and groups and government workers ([Commonwealth of Australia, 2009], p. 34]. At a community level OPAL works closely with members of the local communities to create change in various settings. What OPAL staff have learnt is that success within communities has been enhanced by the benefit of the 5-year contract. This gift of time has enabled OPAL practitioners to base their first 6 months exclusively on ‘introducing OPAL’ to the community, engaging to appreciate the local context, and to begin the process of
relationship building with community groups and stakeholders. OPAL practitioners agree that the momentum of the OPAL program often gains traction 18 months in—the time it takes for teams to build trust with the local community and vice versa. This has meant that local Council sites have dedicated time to listen and understand work already occurring within the community, as well as analyzing gaps and barriers which exist. Finding shared interest and common ground with stakeholders has, in turn, allowed a solid base to augment work that is already occurring across communities.

One practitioner stated ‘a shorter lifespan of the project would have seemed like we were imposing and we may not have been so accepted by Councils’, while another stated ‘5-years has allowed more strategic work to be done and for healthy weight outcomes to be deeply embedded into Council practice and thought processes.’ Phase 1 and 2 OPAL Managers working on the ground in Council since 2009–10 reported that after 3 years working within Council they felt significant work had been done, however wholesale changes to community health which could be demonstrated in evaluative performance were yet to come. It was only after those initial 3 years of investment that they could start to make ongoing and sustainable changes within Council through established two-way trust and strategic alignments of OPAL goals to Council agendas. OPAL practitioners believe that this 5-year investment into local councils sets them apart from other Government programs that historically have moved in-and-out of the local Council space with lifespans of between 1 and 3 years.

Whilst attention to relationships has intrinsic value, it is also necessary because of the crowded context of contemporary health promotion. One mechanism used by an OPAL team to engage with stakeholders is the establishment of a local OPAL Think Tank. The Think Tank brings together all relevant players in the local community, including service providers, who can impact on the current theme that OPAL is promoting (i.e. active travel, breakfast, etc.). After presenting the evidence on why OPAL is promoting flexible approach to hard data; a tension not lost on the OPAL team. It has taken more than a generation to create the obesogenic world we live in; realistically it will take more than a generation to reverse this. For the OPAL practitioners, the reflective process has been a time for the group to ask ‘so what . . . what have we achieved and what have we learnt, as well as “How can we share it and how can we build on it”’.

Five years in, practitioners can now see clearly that the Federal, State and Local political support structures established early in OPAL’s delivery framework and the Program Logic model, coupled with working strategically alongside political structures established within local council communities, have been vital to building the relationships within local government which can best support community health outcomes. All OPAL sites are actively encouraged and enabled to share experiences, knowledge and insight across all jurisdictions. Local government

A relationship approach in community-based obesity prevention requires certain worker qualities. It relies on skilled and respectful communication, a commitment to be responsive to cultural diversity, local needs and opportunities, and being actively seen in the local context. This is recognized in the recruitment process for the OPAL Council Managers with emphasis given to experience and knowledge in community development principles and a passion for capacity building. Being genuine and honest in the work with community stakeholders was identified as a core attribute of OPAL practitioners. This includes acknowledging that OPAL staff are not experts in every health-related subject, nor do they have all the answers. As one worker expressed it ‘it requires the capacity to be uncomfortable’.

In summary OPAL work requires practitioners to engage and manage varied types of relationships ranging from connections with young people, families, community members, teachers, community organizations, doctors, business owners, council staff, local councilors and more. OPAL practitioners agree that striking a balance between what OPAL wants to achieve and what stakeholders desire is key to successful community-based change initiatives—again a characteristic of OPAL’s flexible approach to health promotion.

CONCLUSION

The UK Foresight Report into obesity prevention states: ‘significant inroads into the population levels of obesity will require decades and, therefore, the enduring success, or not, of interventions can only be measured over the years to come’ [(UK Foresight Report, 2008), p. 9]. Health Promotion is criticized for focusing too much on process and outputs, instead of ‘hard data’; a tension not
values OPAL with 34 of 40 Council leaders (Mayors, CEOs and Line Managers) reporting in a 2013 survey (68% response rate) that OPAL was either very successful or successful. Likewise, amongst the cacophony of obesity prevention initiatives, OPAL is a program that resonates with its 40+ OPAL practitioners.

The reflections discussed in this paper highlight the importance of recruitment of practitioners who understand an ecological approach. OPAL would not work if it was led by people whose belief system on the causes and solutions around childhood obesity was fixed in a medical model and/or individualist philosophy. Furthermore, given the importance of political awareness and influence as well as building and maintaining positive relationships with community and a broad range of stakeholders, appropriate people skills are crucial and should be built into job descriptions and recruitment and training—not sacrificed for budget or timeframes. OPAL staff believe that continually asking questions about how well you understand the core business plans, goals, challenges, language, and culture of non-health sectors that influence health is important. What do you know about local government, and if your understanding and experience is limited, where can you seek more information? What community development and stakeholders relations skills do you have and how could you improve them?

Supportive leadership is essential and particularly someone who is respectful and sensitive to the challenges at the local level. In being, effective leaders need to understand the importance of relationships, with staff as well as stakeholders, as well as the model. On reflection, OPAL practitioners have stated that the State leadership has empowered local council teams to make their own decisions and to operate autonomously. Central leadership continually encourages innovation and sharing and gives backing for tough negotiations with funding partners where required. This level of autonomy and scope is underpinned by the rigor of a very clear ‘logic model’ that ensures a consistent but locally appropriate approach.

Being based in local government was considered by practitioners as contributing to effectiveness and the process of negotiating this arrangement was seen to be important. A partnership that is negotiated between tiers of government through a relationship building process, rather than imposed with limited consultation, is more likely to be successful. Staff have had time to understand the sensitivities and visible and hidden dimensions of the politics of local government; it provides a greater understanding of the inner workings of a council and the community and therefore serves for better preparation on how and who to influence.

Whilst being clear about the outcome sought OPAL has enabled flexibility in how these outcomes are achieved. Prescriptive initiatives will not be sustainable long term. It is also clear that every council, and community they serve, is unique and constantly changing. The only way forward is to advocate for a health promotion approach based on principles that can be tailored or adapted to a local context. Any initiative that is overly prescriptive will meet with local resistance and will not be sustainable.

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