

Writing narrative action evaluation reports in health promotion – manual of guidelines, resources, case studies and QuickGuide

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Preface

This manual has been produced through the collaborative work of the Narrative Evaluation Action Research (NEAR) pilot project team.

The manual has been developed to assist Community and Women's Health agencies in building their capacity to evaluate health promotion programs and practice using an approach that incorporates narrative evaluation and action research methodologies.

This approach to evaluation serves to 'illuminate' health promotion practice through the creation of 'stories'. These stories can be used to convey the complex realities of health promotion practice as told through the 'voices' of multiple stakeholders. Embedding the production of these stories with an action research cycle facilitates program and practice development.

Narrative evaluation is an invaluable adjunct to the statistical evaluation methodologies used to measure health promotion program outcomes. In combination, these two differing health promotion evaluation perspectives provide stakeholders with varied forms of 'evidence' about the 'whole': what is being done, why, how and its effects on population health, as conveyed by the varied 'voices' engaged in the task of health promotion evaluation.

I recommend this manual as a support for agencies implementing the Department of Human Services Integrated Health Promotion framework.

The collaborative team that worked together to produce this manual is to be commended for the contribution it makes to advancing the practice of health promotion evaluation within the Victorian primary health care sector. Particular thanks are extended to the staff of the participating Community and Women's Health agencies, the university collaborating team and the regional Public Health and Primary Care staff involved in the project.



Brian Joyce
Regional Director
North and West Metropolitan Region
Department of Human Services

Dedication

We dedicate this work to the memory of Marjorie Oke, 1911–2003

Marjorie Oke was an energetic and thoughtful consumer and community health promotion 'researcher-on-the-run', whose contribution to the original Community Development in Health (CDIH) collection of case studies continues to inspire a new generation of health promotion workers. We include an extract from a Vale given at her memorial service, which was turned into an example of a spoken narrative as a resource for the NEAR writing workshops (see Resource J), as well as Marjorie's original narrative case study in the 1988 collection (see Resource L).

Thanks and acknowledgements

Thanks to the members of the Phase 1 Working Development Group including the central and regional departmental health promotion and community health officers and the guiding hand of project manager Karen Goltz, the six agency practitioners and managers from ISIS Primary Care – Anne Cox, Amanda Eade and Keryn McNaught – and the Western Region Community Health Centre – Melanie Block, Caz Healy and Jaime Timmerman, and the university collaborators – Yoland Wadsworth from the Action Research Program, Institute for Social Research, Swinburne University of Technology, Ani Wierenga from the Australian Youth Research Centre, University of Melbourne and Gai Wilson from the Centre for Development of Innovation in Health, La Trobe University of Technology.

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Introduction

'What's the story?' we ask.

It seems a near-universal question – asked in order to weave together the threads that link otherwise separate aspects of human experience. Then we ask: 'And what's the moral of the story?' to ensure we understand and learn the evaluative meanings encapsulated in it, which carry the all-important implications for what we do next: that is, what new actions we might plan on the basis of these observations and reflections.

Narrative-writing and storytelling have seemingly 'taken off' all round the Western world not only in health promotion, or human and community services more generally, but this surge of interest in the narrative is being experienced in the heartland of industry, business and management. In one of the USA's largest companies – 3M – there is a very clear assertion of their value in an article titled 'Strategic stories: how 3M is rewriting business planning'. Shaw et al write:

At 3M we tell stories...We tell stories about how we failed with our first abrasive products and how we invented masking tape... [and about how] one of our scientists, while singing in a choir, wished he had bookmarks that wouldn't fall out of the hymnal--and later created Post-it Notes...we tell stories about the programs and people...to explain what happened and why it's significant.

Maybe our story-intensive culture is just an accident, but we don't think so. We sense that it is *central to our identity* – part of the way we see ourselves and explain ourselves to one another. Stories are a habit of mind at 3M, and it's through them – through the way they make us see ourselves and our business operations in complex, multidimensional forms – that we're able to *discover opportunities for strategic change*... [and] reflect deep thought or to inspire commitment. *[Our emphasis]*

But writing is thinking. Bullet (points) allows us to skip the thinking step... (and) leave critical relationships unspecified...(They) can't demonstrate that we really know what we're doing or where we are going. We can't see the whole picture.

...a narrative logic forces to the surface the writer's buried assumptions about cause and effect. The act of writing a full, logical statement encourages clear thinking and brings out the subtlety and complexity of ideas...When assumptions are made explicit, they can be discussed...

A well-written narrative strategy that shows a difficult situation and an innovative solution... can be galvanizing...When people can locate themselves in the story, their sense of commitment and involvement is enhanced...

Stories are central to human intelligence and memory...A good story (and a good strategic plan) defines relationships, a sequence of events, cause and effect, and a priority among items – and these elements are likely to be remembered as a complex whole.

Harvard Business Review (May–June 1998 v76 pp. 41–8)

The same spirit inspires the participants in the Narrative Evaluation Action Research (NEAR) project not only to 'tell their stories' but to tell them and re-tell them in a way so as to 'real'-ise goals, purposes, impacts and outcomes.

Here is a succinct summing up of the value of narrative action evaluation to a health promotion manager (Anne Cox, ISIS) who describes her own experience as a writer, as well as that as a manager, plus as an observer of practitioners' experience:

I really enjoyed the process of writing – most similar to journaling or emailing when travelling but with much more reflective analysis and digging deeper.

In terms of a management perspective – staff found the process challenging and very time consuming but rewarding as they ended up with a great result. It was great for staff to be able to add three new tools to their evaluation toolbox (narrative writing, action research, reflective practice through redrafting). Team members had the skill (of reflective practice) but not often the time to ask questions and keep digging deeper – why? Why? Why?

I would like to use narrative for evaluation in other areas across my organisation, for example, service coordination evaluation, (as it is) great for using with projects hard to evaluate especially where qualitative detail is helpful, (and it) uniquely conveys complex issues in a simple form accessible to the audience.

(It was a) delight to work with staff (of two community health agencies), who have been self-motivated, energetic, demonstrated skills as health promoters and now narrative writers.

To make it work and continue in an organisation – acknowledge the process takes time and commitment; if we want good evaluation we have to put in the effort; to facilitate skills required across an organisation will need training; and it is an exciting, fun and rewarding form of evaluation.

In this way the manual has been developed to contribute to a greater understanding of practising narrative, evaluation and action research in health promotion within Department of Human Services' primary care sector agencies, funded to undertake integrated health promotion through the community and women's health program.

The manual has been designed with, and for the use of, the multidisciplinary teams of managers and practitioners who have responsibility for planning, implementing and evaluating organisational health promotion programs

The then Department of Human Services Western Metropolitan Region (WMR) office initiated the project entitled the Narrative Evaluation Action Research (NEAR) project, in 2003. A team of university collaborators, auspiced by Swinburne University of Technology, worked together with the two pilot community health agencies and six staff and the department to develop this manual over the course of an annual organisational health promotion planning and reporting cycle. It was revised in 2006 after a second phase of the project trialled and extended the work across ten agencies and 42 staff in the North and West Metropolitan Region (N&WMR).

The three trials conducted in Phase 2 comprised:

- (i) two agencies trialling taking the manual materials and what they had learned in their own Phase 1 training to throughout their own agencies
- (ii) five new agencies repeating the training and receiving consultancy similar to those in Phase 1 (although slightly less intensive)
- (iii) three agencies making DIY self-use of the manual materials without consultancy support or initial training apart from an explanatory workshop.

Phase 3 is now being undertaken with around 14 agencies in the N&WMR. In addition, other Department of Human Services regions have expressed interest in possibly replicating the NEAR evaluation capacity building program with their regional C&WH sectors

What's in this manual?

This manual has four components:

1. A set of guidelines.
2. A resource kit.
3. Twelve case studies as examples of narrative reporting produced by NEAR pilot agency teams.
4. A short summary manual to print off for handy use (**QuickGuide**).

1. The **Guidelines for writing narrative evaluation action reports in health promotion** bring together the three broad research methods – narrative, evaluation and action research – into an integrated approach to assist in the writing of stories of health promotion interventions. During the course of the NEAR project, the demonstrated benefits of applying this integrated approach to health promotion evaluation within the pilot agencies have included:

- development of a deeper understanding of what is being done, why, how and its effects
- building organisational and practitioners' capacity to do this well
- better serving end-user communities and populations
- enhancing reporting, feedback and accountability to demonstrate this to multiple stakeholders, including the Department of Human Services.

The manual highlights both the step-by-step process of getting started and using the methodology, as well as the theory behind the methodology.

2. The **Resource kit for writing narrative action evaluation reports in health promotion** includes an annotated bibliography of useful readings about various narrative methods. In addition, further background information about the Department of Human Services organisational health promotion reporting requirements and NEAR project is included, as well as some handy tools.

3. The set of 12 **Case studies in narrative evaluation action research for health promotion**, written by the staff from the ten agencies involved so far, provide reflexive accounts of health promotion. The evaluative narratives explore varied levels of health promotion programming: whole of agency, program and project level.

4. The **QuickGuide** came about as a result of requests during Phase 2 and provides a succinct point-form list of steps, tasks, the key start-up workshop exercises, the four key resources from the Kit, and a timeline. It acts as a guide to the full manual as well as a handy printed hard copy for DIY readers.

The manual is continuing to be 'in progress' and will be subject to further revision in Phase 3. This will focus on expanding workforce skills to write action evaluation narratives. A Phase 4 is hoped to research fully the evidence base on change to health promotion practice and its impacts and outcomes.

1 Full guidelines – for writing narrative action evaluation reports in health promotion

The story so far...

The challenges of change to research and evaluation methodology in health promotion

Changes in the world; changes in service responses

In the past 50 years there have been great changes in populations and communities.

In response to these changes, health and human services have grown immensely in size and variety.

In health promotion, these changes – such as growth in urban population density, decline in rural populations, growing disparities in people's health status, the demand for community-based first-level-of-contact services and for people's active participation – were encapsulated in the World Health Organisation (WHO) international primary health care health promotion Declaration of Alma Ata (1978) and the WHO Ottawa Charter for Health Promotion (1986). These have provided guiding standard criteria for much community-based work over the past three decades.

Changes to research and evaluation

The above reference to 'in response to these changes' refers to the critical act that takes place between 'what was done before' by health promotion services and 'what is done now instead'. This can be seen as resulting from an act of inquiry, of research, or evaluation; a moment of observation and questioning before new answers emerge. The logic of social research is familiar – observe, question, analyse the answers, reflect, develop new thinking, draw new conclusions and their action implications. But the methods and techniques and the plans for inquiry – the methodologies – are changing as constantly as are communities, populations and societies. Just as services are no longer 'one size fits all', research and evaluation are also having to respond in new ways to understand better what is going on and how to develop creative community and service responses.

Narrative and action research, applied to evaluation, are examples of new methodologies to respond to these changes.

Challenges to health promotion research and evaluation

Health promotion has already reflected some of these societal changes in changes to research and evaluation methods, firstly in its concern to count instances of intervention and measure impact and outcomes. Statistical collections remain a cornerstone of health promotion services' self-understanding, as they do throughout health and human services. Yet quantitative data has been found to only be able to go so far in addressing questions that relate to tracking the impact and meaning of health-promoting interventions or the effects of discrete activities or processes carried out over time, in highly complex and changing individual and local community contexts.

Secondly, there has been a need for methods that will 'capture whole' the connections or meanings that make sense of apparently discrete events or activities: the complex causation and webs of impacts and consequences that are more resistant to simple data collection, interpretation and presentation. A practitioner may record a certain quantity of activity but what does it mean? Suddenly it may only make evaluative sense in comparison to another quantity of activity elsewhere. Yet it is the story of the context of the comparison that 'makes sense'. It is the description of the often-non-visible connections between things rather than the description of the 'things' connected that matters. Some 'thing' may indicate something else, but it is not the indicator or thing per se that matters, but the **comparison** which lies in **the bigger story** of the context.

How then to better capture these larger-scale processes and their effects – especially over time? How to know the world 'whole'?

A methodology to capture the nature of a complex field

In health promotion, researching and evaluating the task is challenged because of the level at which it sets out to make a difference. While some work is small-scale and straightforward, much of the program logic is complex – mirroring the size, complexity and diversity characterising the ‘whole field’ of intervention itself.

Researching and reporting on the operation and success of health promotion logic in real life practice raises new challenges to know what is ‘really going on’, including:

- the need to accurately capture and represent multiple perceptions and realities regarding the ‘same’ thing held by all relevant parties or stakeholders – and the complexities operating between these
- doing this without losing sight of shared purposes and ways of effectively judging and reaching provisional agreement between different courses of action
- the need to more closely track and observe complex causal pathways close-up at the naturalistic points of their taking place and over time; rather than rely on snapshots at a distance which then require high levels of inference and presumption rather than a certain grasp of what actually happened for those intended to benefit
- the needs of those close to health promotion action **and** those at more of a distance encouraging, funding and improving it (as well as challenging it), to know what is going on in the micro-exchanges of health-promoting practice within communities to inform organisational change and planning as well as reporting for accountability
- to mesh with and illuminate other tools and methods, such as the program management sequence (plan, implement and evaluate) and statistical collections that comprise the ways in which services, programs and organisations ‘know themselves’ and receive feedback about their activities and their effects. That is, narrative reporting (**Resource A**) is explicitly intended to illuminate the ‘facts’ and evidence collected in Part 2 of the department’s reporting grid.

One of the ‘new’ methods that is coming to the fore – and is the focus of this manual – is really a very old one: that of **storytelling or narrative**. Here, however, it is related to its embodiment as social research, coming from a rich tradition of ethnography, anthropology, *testimonio* and cultural studies, joining here also with literary traditions to produce a valuable hybrid way of telling important truths by the ‘researcher’-as-narrator to an audience-as-‘community of scientists’ (or practitioner-learners) including communities, practitioners, and contractor-funders.

The other two ‘new’ methods – **action research** and **evaluation** – have developed rapidly over the past 90 and 70 years respectively.

Narrative action research and evaluation for community and population health promotion

Bringing together the three methods of **narrative**, **evaluation** and **action research** into an integrated methodology has been the first challenge of the NEAR project. The project brief (see **Resource C**) required that health promotion agency staff be assisted to use these methods:

- to support their agencies in reorienting primary care service delivery to individual integrated population-focused health promotion and respond to and shape the strategic priorities of the service systems within which they are working
- to retain client and community-centredness in relation to practitioners, policy-makers and

fundlers and 'give voice to the evaluative input of all stakeholder groups'.

All these rationales shaped the kinds of resourcing and exercises provided to assist the narrative writers to successfully produce their case studies.

Narratives for health promotion reporting in Human Services – a brief history

The Department of Human Services Primary Health Program funding reform prompted the introduction of the new planning and reporting requirements for agencies. To attain deeper knowledge of health promotion practice 'whole', a narrative section for reporting against health promotion program priorities was included in the annual reporting template for the first time in 2002–2003 (see **Resource A**). In its first iteration, it required process evaluation and indicators of 'reach'. A planning pro forma then identified priority issues and targets for both planned and opportunistic (or emergent) health promotion work. This was all seen as part of the Department of Human Services cyclical planning and reporting requirements for community and women's health agencies prior to the NEAR project commencing. The narrative requirement was maintained for 2003–2004 and projected for 2004–2006 (see **Resource B**).

The narrative section provides an opportunity for community and women's health services 'to discuss, elaborate and reflect on' the evaluation documented in the audit evaluation grid or cross-tabular matrix. This contains descriptive and quantitative and qualitative indicator material regarding goals, target groups and objectives, each computed against actual impacts, actual reach (process indicators), timelines/by whom, actual staff costs, actual consumable costs and total costs of interventions and strategies.

Complex cross-tabular matrix data of this nature attempt to simplify and 'chunk' real-life health promotion practice. Yet, in answer to the questions 'What does it all mean?' and 'Was it actually of value, merit, worth or significance?', we need ways to identify comparative holistic relativities within the complex real world.

In this context, narrative can be an effective method of 're-chunking' rich, complex life back into a manageable way of understanding the bigger picture of more complex realities. The meanings of more abstracted quantitative and qualitative datasets can then also more effectively be understood. This is a kind of 'hermeneutic' – just as a grain of sand helps characterise a beach, so also the beach helps to contextualise the grain of sand.

The inclusion of the narrative section also created the opportunity and catalysed the desire to develop NEAR as a capacity-building workforce development action research program. In a way, this enabled 'the building of the road' as we 'walked the journey' with selected agencies who were responding to the requirement – in turn, contributing back to the revision of that requirement for the future.

Resourcing health promotion narrative-writing – the NEAR project

In the broader context of the Primary Care Partnership (PCP) strategy, the department disseminated health promotion guidelines and information resources. It also implemented workforce development initiatives statewide to support the organisational health promotion capacity-building work of community health service and women's health service health promotion officers, coordinators and managers. The NEAR project was an innovative regional evaluation capacity-building project conceived within the department's Western Metropolitan Region (WMR) Public Health and Strategic Development. It was developed as the primary vehicle to assist practitioners to acquire the skills needed to write their narrative evaluations – in particular, to assist in retrospective reporting and prospective planning.

Conceived as continuous cycles of planned improvements, practice and evaluative inquiry, the research methodology matching this management approach was identified as action research that would involve research and development by practitioners as active participants.

The WMR invited agencies to participate as pilot sites for a package of training, consultancy and resourcing by a team comprised of WMR regional health promotion staff and university collaborators experienced in these methods.

Key team members

Karen Goltz, WMR Regional Health Promotion Officer, brought to the project her prior experience in health promotion evaluation practice development through teaching, research and consultancy.

The university collaborating team brought together:

- **Yoland Wadsworth**, action research and evaluation consultant and facilitator, and author of popular texts such as *Do it yourself social research* and *Everyday evaluation on the run*, who pioneered what is now called auto-ethnography in community health in the 1980s
- **Gai Wilson**, who has a history of supporting and resourcing the community and primary health sector, particularly with policy and practice development, and has produced an earlier set of case studies
- **Ani Wierenga**, who has experience working with and facilitating individuals' (young people and youth and community work practitioners) understanding processes of change and their own capacity to negotiate them, and who, for this project, has an interest in exploring the method and 'magic' of storying.

Selecting the NEAR Phase 1 pilot agencies

Agencies were requested to meet certain conditions regarding commitment and enthusiasm, which appeared to work well in the pilot to ensure the levels of energy necessary for people to be able to continue throughout the process. This level of enthusiasm not only meant engagement with the training, consultancy and the production and completion of narratives, but also the making of significant improvement to health promotion practice as a result of engaging in the reflexive-writing process. (For the criteria, see later section 'What you bring to the task – Management support').

The agencies were also selected to represent some typical features of health promotion practice. The two agencies that participated in the pilot were the Western Region Health Centre (WRHC) and ISIS Primary Care. The WRHC is a primary health care agency that serves Melbourne's inner western suburbs. It provides a range of services including medical, dental, community health, health promotion, complex/psychiatric disability and drug prevention with other services, such as pathology, co-located. The people who access the WRHC are generally low-income earners from culturally and linguistically diverse backgrounds. ISIS Primary Care is also a large agency with multiple sites serving the middle to outer western suburbs. Its Community Health Program provides allied health services such as speech pathology, physiotherapy, podiatry, dietetics, counselling, occupational therapy, audiology, community health nursing and health promotion. It also provides a diverse range of other services including aged and disability services, medical, dental, alcohol and other drug counselling, problem gambling counselling, family support, a neighbourhood centre and child care.

Selecting the NEAR Phase 2 pilot agencies

The criteria for Phase 1 had proved effective and were re-utilised. Both Phase 1 agencies went on to Trial 1 (train the trainer) in Phase 2, and a further eight agencies were selected for Trial 2 (train consultants) and Trial 3 (DIY use of the manual).

The guidelines that follow

The remainder of these guidelines are written as a 'how to' guide for people wanting to write their own stories. However, practising what we preach, it is important to note that this is still very much an unfolding story and the manual remains a work-in-progress. It is perhaps more accurately described as 'What we did and found helpful so far' with the first two participating agencies.

The NEAR project was originally conceived as a multi-phase project. During 2004–2005, the NEAR Phase 1 pilot project moved into a second phase. In Phase 2, NEAR to FAR (Further Action Research), the manual, resource kit and case studies were trialled more widely with a larger number of agencies, some of which were selected to also trial train-the-trainer processes. A Phase 3 is envisaged both to trial the manual even more widely and also to collect output and outcome data to test whether narrative action evaluation is indeed having longer term effects.

Now read on...

Before you start writing your own health promotion narrative

Some background reading

The resource kit brings together a collection of materials¹ and handouts relevant to the three-fold methodology of evaluation, narrative and action research (**Resource D**).

This is supplemented by some detailed and comprehensive Department of Human Services resources – particularly those produced to support the strengthened approach to funding health promotion programming in Primary Health Program-funded community and women's health, including:

- *Integrated health promotion resource kit* (2003)
- the short, boxed, case studies in *A supplementary report on Primary Care Partnerships community health plans* (2002)
- the monitoring and evaluation sections of *Environments for Health Municipal Public Health Planning Framework* (2001).

Figure 1 summarises some key points about the three methodologies.

Figure 1

The three methodologies – narrative, action research and evaluation

Narrative

At its simplest a 'narrative' is a structured story. Storytelling has a long human history as people have worked to understand and order our human experience in manageable 'chunks'. These 'chunks' are built from the endless flow of empirical sensations and the connections we see between them, as well as our thinking and feeling about them. 'Tellers, writers and actors' do this in order to pass on these experiences and learnings, by word of mouth, by pictures or by written or multi-media forms, for the benefit of 'listeners, readers and watchers'. Then the roles may be swapped as we tell these stories to each other and then hear new stories in response. In turn we may go on and tell different stories or the old stories in new ways.

It is possible to draw from both literary and social science traditions of narrative to better understand the structure and content of good narrative. Narrative's typical character of conveying a progression from a past to a present and possibly a future, meshes well with a process or continuous-cycle model of (action) research.

Action research

Social science also 'chunks' human experience in stories that have 'beginnings, middles and ends'. 'Aim, apparatus, method, results' is essentially a narrative structure of conventional laboratory science just as 'Hypothesis, test, conclusions' is for experimental science. Science also is 'telling its stories' and passing on its knowledge and learning to a 'community of scientists'.

New paradigms of understanding the social world as both continuous and socially-constructed by all participants (kind of analogous to the movie 'The Never-ending Story'!) have yielded a new way of doing social research. A typical way of describing this underlying methodology is in terms of continuous cycles of ACTION – QUESTION – OBSERVATION – REFLECTION – CONCLUSION – PLAN/CREATION – TAKE NEW ACTION and so on. Again, these experiences, conclusions and results of observed new actions

¹ **Please note:** The authors have brought many materials to this training manual derived from their work elsewhere. As you reprint and reuse these materials please take care to include the IP © information for each. The IP © for this overall *Manual of Guidelines & Resource Kit* is reproduced at page ii

are passed on for others' use and reference, not so much as 'The Truth' but as 'these truths' for these purposes, at this time, in this place, among these people ('community of scientists' – but now more broadly conceptualised as a 'community of practice of interested knowers and learners').

Evaluation

Evaluation has been seen as a retrospective process of observation and reflection involving judgements about 'value, merit, worth or significance' (Michael Scriven 1991 *Evaluation thesaurus* 4th ed. Beverly Hills, CA: Sage). In practice, evaluative judgements characterise both retrospective moments (both *formative* – 'how are we going?', and *summative* – 'how did we go?') and prospective moments (both *visionary* – 'how do we want to go?', and impact assessment – 'how do we think this will go?').

In doing so, evaluation can be seen as following the same logical and chronological sequence of all social science-in-action. Indeed evaluation is an inevitable aspect of action research and social science per se whenever decision points are exercised regarding what is of value (which are the best questions? best observations? best theories? best conclusions? best ways of understanding where to go next? etc.). Research and evaluation (and the relative truths they arrive at) in this way are all relative to context and purposes. Far from being 'value-laden', all inquiry, like the worlds it observes and understands, is necessarily in a sense 'value-driven' or displays a values-saturated 'logic'.

© Y Wadsworth (2004) '*Building it in...*'

The challenge is to bring together all three of these into a single integrated methodology. But how on earth can I do that? – we hear you cry! Fortunately, it turns out that after a number of reporting cycles with the initial department narrative guidelines (**Resource A**), you have already been practising a beginning form, which is a very good place to start.

This manual illustrates the structure of a sequence of questions that will ensure you can check that you are writing:

- a 'good story' (narrative)
- a good story that is evaluative (evaluation)
- a good evaluative story that traverses both the past and the future (action research).

But first, a word about the kinds of skills or abilities you may already have.

What you bring to the task

Your experience and natural style

'Oh no, but I'm not a story-writer', you say. Well it seems all but a few people appear to think they are not a 'natural writer'. That was true of the NEAR project as well. Yet everyone ended up writing illuminative and informative narratives that were received favourably by both local and departmental audiences. Again, it turned out that everyone has their own story-writing style; it seems just a matter of finding it and practising it.

What you inevitably bring to the task are your observations and thinking to date, your guiding values and principles, your reflections and tentative (or not so tentative) conclusions, and stored practical wisdom. You may even have already been writing evaluative narratives without even realising.

Your own thinking partners

You also bring all the people around you, with whom you have developed the above small 'r' research and evaluation – perhaps some of whom you correspond with in written form. They

may form a nucleus for a writers' group (see below) – something we found critical to the success of the NEAR project.

Your prior knowledge about research and evaluation

Other valuable things you bring with you beside your story-writing experience to date are whatever you may know already about research, action research, evaluation and narrative, your level of interest and commitment in doing this about health promotion, the time you can spend on it, the level of management support for your doing this, and the interest of work colleagues.

Management support

In the NEAR project, it was a precondition for agency selection that applicant community and women's health agencies could address the following preconditions for selection:

- Demonstrated board of management or executive management support for participation in the project.
- Willingness to commit lead agency health promotion practitioners and line managers to engage in the project (two to three or a work group) at the outset. Also, a willingness to involve all lead agency health promotion practitioners, other interested staff and relevant managers to participate in order to facilitate the development of an evaluative agency culture.
- Capacity to release staff to participate in the following pilot project activities between August 2003–July 2004: four project development committee meetings, an agency-based evaluation workshop, consultations with the designated agency evaluation mentor (as determined between the agency and the mentor, for example, five hours over five to seven months), the writing of an agency program evaluation case study and a 'reflexive practice' feedback session.
- Identification of health promotion capacity building as an organisational health promotion priority in the 2003–2004 Organisational Health Promotion Plan.
- Identification of a health promotion program included in the 2002–2003 Organisational Health Promotion Plan, for continuation/further development in 2003–2004, to become the foci for piloting the narrative evaluative methodologies.
- Articulation of a rationale for the agency's inclusion in the project.

These conditions were later identified as crucial to the success of the project. Some of the other consequences of manager involvement have included: a decision to run an annual storytelling reporting day in a community health centre, and an active appreciation of the power of the narrative process (through their own active involvement as a narrative writer) for staff development.

Finding your style

It's worth spending a moment thinking generally about all the things you've written to date.

What would you say is the style you most enjoy or feel competent and comfortable with? Every kind of person has a natural storytelling style – each one of us has naturally preferred ways of taking in input, receiving information about the world, processing it and then acting on it. It adds up to a writing style – whether formal or academic, or dot-point report writing, or long rich evocative letters about families or travels.

Don't worry if it's not immediately obvious or you think it inappropriate. Most people, when asked, can draw out the criteria for what makes a good story and pretty soon are writing in those ways.

And there are plenty of resources to help; such as the following ideas and exercises.

Establishing a writing practice group

You might be thinking of writing the narrative yourself; it may be of interest to others – possibly many others; and it may have the support of a manager. Regardless of the situation, it is useful to start the process (after some preliminary reading and perhaps informal discussion with some friendly colleagues) by arranging a meeting of a small group of people interested in writing health promotion narratives. Even if it's only one or two other people you might know and work with, with whom you could talk it through, it can be an excellent sounding-board. This is a significant factor for successful narrative writing.

Workshopping ideas and orienting to the writing task

A writing practice group can be a good basis for preparing to write.

If you arrange an initial meeting or workshop, you could prepare by reviewing your own narrative sections from previous health promotion reporting cycles. This is what the NEAR project did as a model you could draw from (Exercise 1 – Getting started from where you are at).

Then move on to the following exercises 2, 3 and 4 in a workshop. Do not leave out or skip any of them, as each subtly addresses and prepares you for writing your own narrative.

All of the exercises can be done in a half or one-day workshop. You may find it helpful to do that away from the buzz of the office.

Exercise 1

Getting started – what makes a good narrative?

This exercise has two parts. One preparatory. One in a workshop.
It can be done in pairs or small groups (3–8).

■ *Preparation before the workshop*

What makes a good narrative?

- Select narratives you have already written (or look at those prepared by others in the group), for example, for a previous health promotion reporting cycle.
- Identify one or two stories or draw out aspects from all that make them good stories or exemplary storytelling.
- Think about and record the criteria for a 'good narrative', such as most interesting, well-written, informative and illuminating.

What are good guidelines for writing?

- Now look at the guidelines for writing narratives. These are in **Resource A**, p. 17, Part 1 Appendix 3 Reporting Pro Forma in the document *Health promotion reporting 02–03 and planning and reporting 03–04*, March 2003. Although these guidelines consist of only seven dot point prompts, they contain some important features of the narrative evaluation framework that will be developed further in this project.
- Rewrite those guidelines in the light of what you learned from your 'first go' at using them.
- (See **Resources E and F** for NEAR agencies' examples of doing this).

Reflect on the reading

- Read through the annotated bibliography of 10 narrative evaluation materials (**Resource D**).
- Identify which ideas seem useful to you.

■ *When you meet...*

Talk about what makes a good narrative

- Review together your experiences of writing narratives in the last reporting cycle
or
- Each tell a quick story about something that has happened that day (in the tearoom, on the weekend, at home, etc.)
- Pool all the features that made some stories or some aspects of the stories stand out. (**Resources E and G** address this question)
- Can people say how they would now rewrite or retell their stories differently?

Talk about what makes good guidelines for writing

- Examine how you'd rewrite the initial pro forma guidelines in the light of that experience.
- Draw conclusions about what that might mean for each person's preferred writing style.
- **Resource H** was produced in the NEAR project to guide writing or for writers to check back against. It was found to be very helpful.

Talk about the reading

- Reflect on what you each liked among the ideas in the annotated bibliography of narrative evaluation materials.

These three little tasks – comprising **Exercise 1** – gave the NEAR writers a good start.

Exercise 2

Focusing on health promotion and 'who it's all for' (communities/populations)

This exercise has three parts. It helps orient towards the underlying purposes of the narrative writing: to strengthen integrated health promotion. It is best done in small groups (3–8).

Shifting the terrain to health promotion

i. Generate (quickly, brainstorm-style) as many alternate images, descriptive words or adjectives for health or healthy as you can in five minutes. Turn negative ones (e.g. 'not x' into positive states). Use direct colloquial language if that helps. These are descriptions of **your** health. e.g. 'sunshine, strong, glowing, fresh food, alive, vigor'

ii. Now generate a list of what activities, events, practices or states in your own personal life make you feel like that. Idiosyncratic as you like. Find ways of listing ways that might be surprising or embarrassing! (pool these to ensure anonymity). e.g. 'morning run, a barbeque with friends, native bush hikes, white linen, sleep, going dancing, leaving a difficult workplace'.

iii. Finally, imagine what kinds of activities, events, practices or states would make you feel like this – and that could be achieved if there was someone there to help you realise or organise them (to resource, support, assist you)... like a friendly community health promotion worker, for example! You should not have any preconceptions about this person's role except that they are there to help you do whatever you deem valuable to make you feel in a state or states of health. e.g. 'door knock to organise Tai Chi in local park at 7.00am, small local dance for all ages (no alcohol/smoking), quilting circle, local 'field days' (to learn bike maintenance, rose pruning), establish a self help group against bullying'.....

© Y Wadsworth & Gai Wilson (1992) 'Shifting the terrain to positive health promotion' *Issues in Victorian Community Health* ARIA Inc., pp. 17–21

Exercise 3

Focusing on evaluation

This exercise uses the 'mug evaluation' to evaluate something simple (nothing to do with health promotion!) in order to observe the steps in evaluation and the two major 'moments' of evaluation:

- i. Prospective or developmental** 'open inquiry' evaluation 'what is of value, merit, worth or significance?; to draw out the indicators (to establish) that are implicit.
- ii. Retrospective** or 'audit review' evaluation which checks whether previously identified valued states have been reached or achieved.

It also usefully indicates:

- i. the ease** with which we evaluate
- ii. the everyday** nature of evaluative thinking
- iii how we can inductively generate** or identify evaluation criteria or indicators
- iv how we can then use these** to deductively evaluate against.

In terms of writing evaluative narratives, it also alerts us to the first step of observing the reasons or logic for identifying the all-important comparisons or discrepancies between an 'is'

and an 'ought' (or 'ought not'), between valued and not-valued states. ('It did or didn't work' – 'why?').

The mug evaluation

[*Preparation:* Bring an ordinary unremarkable ceramic drinking mug for use in the exercise (at the beginning). Bring a second mug that is quite different (e.g. plastic) for use in the last step of the exercise.]

In a smallish group, ask each person in turn to say whether they would choose to use this mug (yes or no) if it was in the kitchen cupboard at work and 3 reasons why (or why not). Write these on butchers' paper. (**Fieldwork**)

Reflect on how easy that 'fieldwork' was to do; how asking 'why?' and then 'why' again gets more but is also hard to do; the importance of context (e.g. if 'for a picnic' imagine now how different the values assigned would be); how it also rested on people already having stored the 'evaluative comparative criteria' in their minds; the diversity of views; and how these differing perceptions (values) impact on any idea of its 'real objective value'; note impact of any group dynamics, etc.

Now go through people's answers on the butchers paper and ask people to **Analyse** the evaluative criteria or categories (e.g. size, weight, colour, aesthetics, design, place of manufacture, etc.) and if there's time, indicators of what makes a good mug.

Reflect on what the difference was between these summary concepts and the initial responses (e.g. the categories come from the data and are socially-constructed best by respondents themselves to express what **they** meant i.e. is it 'design' or 'shape' or 'aesthetics'?; it is helpful to clarify, makes it easy to use as a checklist, **but on the other hand** reduces richness, seems more rigid and fixed)

Finally, now use the list of evaluative criteria to evaluate the second drinking mug. Reflect on doing that. E.g. quick and easy but unable to suggest change or improvement. (Use a polystyrene cup to illuminate the latter re. how the criteria are fixed by and dependent on the extent or limitations of the **previous** 'fieldwork' and who took part in it – and thus the list may not have a criterion regarding 'environmental sustainability'.) (**Plan and take new action**)

Summarise the steps by drawing a cycle diagram with the 4 steps round the circle: fieldwork, analysis, plan and take new action. (See also Exercise 4 action research diagram) and by reference to the text [Y. Wadsworth (1997) *Everyday Evaluation on the Run*, Allen & Unwin, Sydney] and its comparative table (page 45). Distribute also a copy of the wall map at back of the book.

© Y. Wadsworth and J. Wexler (1991) *Manual of notes for convening an introductory workshop on evaluation* ARIA Inc.

Exercise 4

Focusing on action research – using strategic questions

This exercise orients to the steps in action research; action research **as** research; the cyclic and change-orientation of action research, and the sequential nature of action research that lends itself to the narrative method.

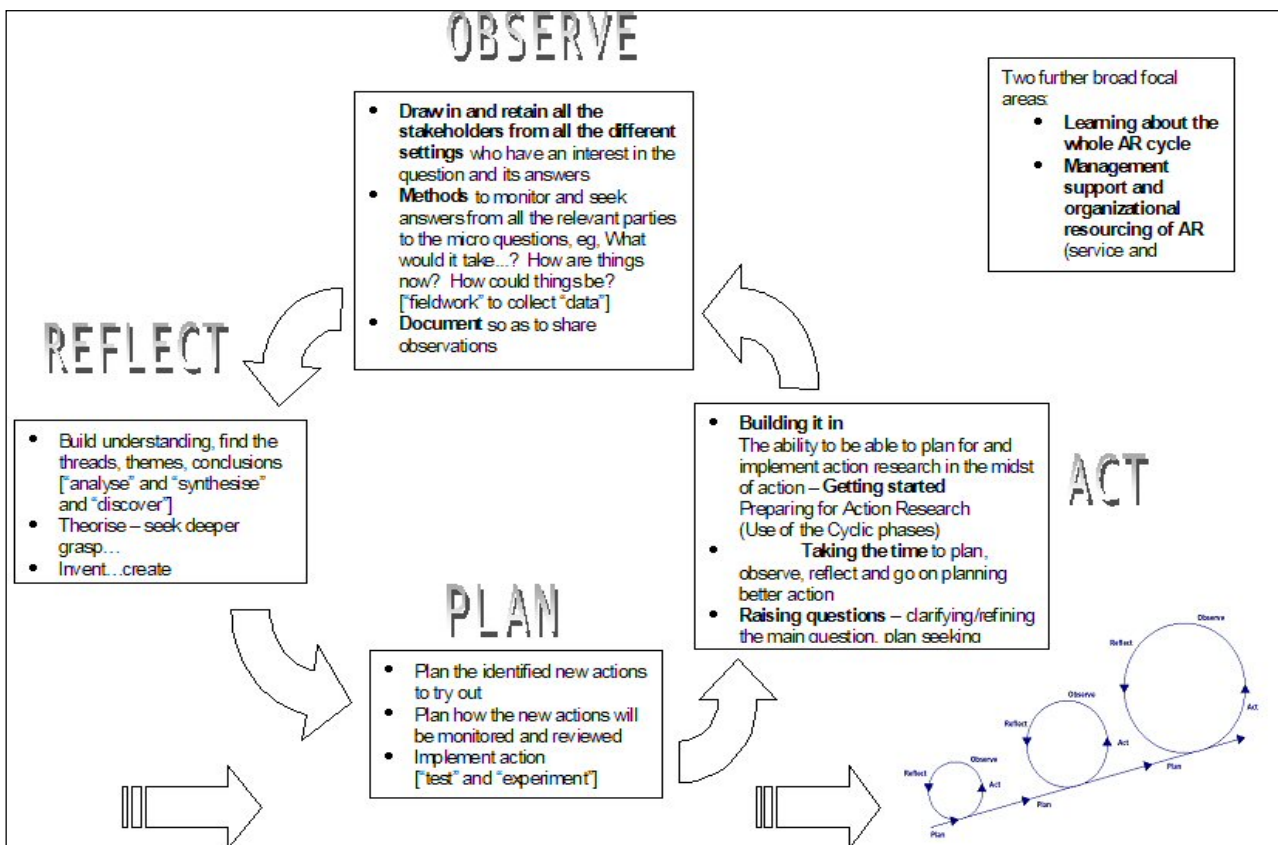
It draws on Fran Peavey's sequence of strategic questions (see **Resource D** Number 5). You may also like to use **Resource H** to do this, as this planner or checklist is the one we are using in all NEAR writing, as it incorporates Fran Peavey's strategic questions.

i. The group chooses an example of a minor topic that is mildly interesting or problematic and also fun. Ideally this should have nothing to do with health promotion as the focus is on the **questions** and what they yield, not on the answers. For example, consider evaluating things like: mobile phone rings, shopping trolleys, conference dinners or the room heating! The mundane. The small scale. Something that can be worked on readily by **everyone** in the group.

ii. Work through applying the string of strategic questions in **Resource D** to the issue chosen. *Spend no more than 5–8 minutes on the task, but try and get a response to each question from each person in the group. Have a timekeeper who can keep saying 'don't spend too much time answering the question – only on whether you see what kind of answers you'd get if you asked it'. Try and move through each question, one after the other. At times you may need to double back, but the important thing is to keep going!*

iii. Reflect on the value of the exercise. E.g. It can get you from 'what is' to 'what could be'; it doesn't just plan visions without a good grounding in both observing and asking 'why' regarding prior experience; it prevents anyone recommending actions others should take and instead supports only self-reliant change that people can make; it gets more alternatives on the table, and it is a systematic way of tapping everyone's views.

Summarise by reference to the wall map at the back of Y. Wadsworth (1997) *Everyday Evaluation on the Run*, Allen & Unwin, Sydney, or the Diagram reproduced below (from Reconnect).



'What is Action Research in Reconnect?', *ALAR Journal* Vol 7 No 2, October 2002, page 69

Now you're ready!

Getting started on writing your own evaluative health promotion narrative

Finding the story

Stories can, of course, be told about everything – from the most micro level to the most macro.

In a way this already happens when people write their quarterly or annual reports, publicity leaflets and service description flyers, or give talks to groups, or just get talking in the staffroom or around the coffee machine. The challenge is to begin formalising the task at this early stage of extending and improving use of this method. Selections will also be made in terms of priorities and time available.

Over a period of time, it may be good to cover all priorities – perhaps in a rolling series – and slowly build narrative as a method throughout health promotion and community health practice. Other forms of narrative that can be used include annual reporting to your own team or centre/service (see Pillsbury's annual Storytelling Day in **Resource D**), talks to professional peers, journal writing, case studies, websites, and oral and cartooned forms.

People found it helpful to write about health promotion initially in terms of the priorities set in the 2003–2004 health promotion planning pro forma. In the NEAR project, practitioners took key priorities and wrote the story of what had been done regarding that priority (see the 12 **Case studies**).

Finding the level

We identified several different 'levels' at which stories could be told:

Inter-organisational (catchment level)
 Whole organisation (agency wide)
 Priority issue
 Program
 Strategy/Project/activity
 Micro-activity/vignette (behind the scenes)

In the **case studies**, each narrative is 'situated' at one of these levels (see **Resource K** for guidance).

Finding the voice and the audience

Before pen can hit paper, the narrator needs to identify, as well as the storyline, **whose** story is being told and who it is being **told to**. This means assessing the purposes for telling this or that story to this or that person or audience. It can also be influenced by assessing the range of judgements the reader may make, such as continuation of a service, funding of it, and related policy-making. It may change which stakeholders are involved, and which are not.

Sometimes a few dry runs and permissions or clarity about safety are needed to get this right. Experience elsewhere has shown that it can help, for example, if funders are clear and supportive about wanting rich and honest accounts of actual practice learning, and prepared to safeguard the accounts coming to them as confidential.

In turn, the climate, permissions and responses from readers, will shape the type of narrative that future practitioners and managers are willing to tell. This will also raise (or foreclose) possibilities for further and deeper reflection, learning and workforce development.

This may also lead to health practitioners seeking multi-storied and multi-voiced accounts – possibly from different standpoints. In the original CDIH case studies, one story was told by the client group through one of its members' own voices (see **Resource J**). Others may need funders' voices included or dialogue between different vantage points.

The **case studies** present different 'voices', 'tellings' and levels (see **Resource K**).

Testing if the narratives are valuable

The following list of questions is helpful as both an objective and a test of whether various writers/narrators **and** various audience/stakeholders were receiving valuable insights from the narrative evaluations:

Communities/populations (end users/beneficiaries)

1. What did I learn from writing or reading this?
2. Did I see my experience reflected in the/this/that story?
3. Is this my story/the story of our group?

Health promotion workers

1. What did I learn from writing/reading this?
2. Did I learn how to create change towards health promotion?
3. Do I see my professional experience reflected in the/this/that story?
4. Is this my story or that of our program/service/centre?

Funders/policy-makers/Department of Human Services

1. What did I learn from reading this?
2. Did I learn how the funded service works towards achieving change towards health promotion of communities?
3. How does this relate to our departmental and professional experience?
4. How might this relate to the stories of the directions in which the Department of Human Services is trying to move in partnership with the funded services?
5. What did I learn about further capacity-building actions that may be needed to move the partnership in these directions?

To these open inquiry questions may be added the audit review questions regarding the narrative guidelines:

1. Was it clear what the problem definition was? – including the program goal, program objectives and the target population groups?
2. Was it clear how solution-generation proceeded? – including the planned health promotion interventions?
3. Overall, could I tell if there was an appropriate mix and balance of both individual and population wide health promotion interventions to address each of the objectives?
4. With regards to capacity building, support and resources, could I identify the roles and responsibilities of the key stakeholders, including community, consumer and carer representatives? Was it clear how appropriate resources were assessed and allocated? Could I tell what were the key capacity-building strategies required to ensure success?
5. Was it clear what evaluation methods were used, what were the process and impact measures and the total budget being dedicated to evaluation and dissemination planning?

Finding support

As well as all the materials and exercises described so far, the NEAR project piloted and found the following four sources of support successful – indeed essential to the success of narrative writing and especially redrafting.

Each other

Health promotion practitioners, both **within** their agencies and **across** the agencies, provided a significant degree of support to each other's thinking through their writing, reading drafts and discussing what worked.

The internal peer facilitation appeared to be a particularly important and effective part of the process. Its achievements included:

- increasing the motivation to write (such as email conversations about the issues that needed attention)
- 'reality checks' and establishing priorities about 'What this story is (or should be) about'
- story shaping and story crafting
- co-authoring and editing
- morale boosting and giving permission to say things
- insider perspective, that is, knowing the situation and the issues
- grounded discernment on how best to say things and discretion about what should be edited in or out
- shared health promotion practice knowledge
- humour and solidarity (to write a story is a challenge that needs sustaining to completion)
- achieving greater depth, more critical thinking, more powerful insights.

Etienne Wenger (2000) has theorised the idea of a 'community of practice' (in contrast to teams) as the modus operandi for creative thinking. These are self-selected, self-starting groups of people, informally bound together by shared expertise and a passion for a joint enterprise, who share their experiences and knowledge in free-flowing, creative ways that foster new approaches to problems.² These are exactly the conditions needed for 'the creative act' of any kind, and the groups working on the NEAR project successfully replicated many of these criteria.

As well the loops extended to Department of Human Services regional health promotion officers, their responses also provided critical feedback (for example, comments at the drafts stage like:

"The work is fantastic. The level of enthusiasm continues to build in agencies."

A skilled external facilitator

i. Department of Human Services regional health promotion officers (RHPOs)

The core role of RHPOs involves offering (before, during and after the NEAR project) facilitation support (consultancy and mentoring) to agencies regarding planning and reporting and the all-important development of quality health promotion practice and programming. RHPOs have also instituted formal feedback processes to agencies following the submission of their annual plans and reports. For example, formal feedback was provided direct to the pilot agencies through post-December reporting meetings conducted at the agency level with managers, lead practitioners and officers. At these meetings, as with those conducted with the other sector agencies, opportunities were created through dialogue to further the development of narrative evaluation practice and organisational health promotion programming.

The consultancy practices that are employed include:

- 'inquiry' questioning to stimulate thinking on further development of the narrative text (fleshing the story behind the story)

² Wenger, EC & Snyder, WM (2000) 'Communities of Practice', *Harvard Business Review* Jan-Feb 2000

- strategic questioning for reflexive practice/action research and implications for program development
- acknowledgment, affirmation and celebration.

In addition, feedback was provided via email and phone conversations with practitioners. Some of this feedback was subsequently discussed with the university collaborator-facilitator. The RHPOs 'local knowledge' (regional sector 'intelligence', the shared history and the quality of the relationships with community and women's health managers and practitioners) means that discussions can be pursued at a 'deep and meaningful' level.

The NEAR inputs need to sit in context with the parallel work that RHPOs facilitate with the sector. This work also helps to build reflexive 'narrative evaluation practice' culture across the regional sector.

Example: The Department of Human Services Community and Women's Health Agency Health Promotion Network

The utility of oral story telling in the development of reflexive practice was captured early last year with the insertion of a narrative presentation as a standing agenda item for network meetings. Practitioners were invited to present and discuss oral 'narratives' of practice or programming. This process contributes to skill development, peer mentoring and dialogue between participants as well as creates a fertile environment for future learning.

The RHPO human resource within and beyond the NEAR collaboration is significant to the current and future sustainability of evaluation capacity-building within the region. The potential significance of developing RHPO resources across the state will be considered in the design for Phase 3 in regard to the statewide rollout and sustainable ongoing access to external facilitation for narrative action research evaluation.

ii. The university collaborator's facilitation

The addition of university collaborator facilitation was a special input for the purposes of workforce development both for agencies and RHPOs (though in this instance the RHPOs were particularly skilled and qualified in the area). It was also a trial of the extent and kind of consultancy necessary to achieve the project outcomes. It was also an exemplar of how practitioners might act as internal consultants.

Getting people started

In the NEAR pilot, approximately seven hours' on-the-phone, in person and site-visiting consultancy was provided to each lead practitioner over five months. The style was 'lean and precise', more 'there' if asked for, and less if not. An initial move was to bring the practitioners together at an early point where there was some uncertainty about starting or proceeding – so that they could energise and mobilise each other (both within agency and between agencies); and again at a later point where new issues of voice and standpoint had opened up. There were two further small group workshops as issues arose.

Early encouragement of writing and then redrafting

An early part of the consultancy was described as 'coaxing out a story'. This focus on learning and reflection may take a while when the more familiar report-writing focuses on accountability. Once a draft was complete, questioning or (gently!) 'interrogating the story' (a phrase which became familiar to writers) seemed to be one of the most significant parts of the external facilitation process. Writers noted several times that while insiders had been useful for other things, an outsider was useful for:

- **Bringing practice into focus** – zooming in, for example, where traditional report-like language obscures the action from reflection, and asking:
 - Who decided that?
 - How did they decide that?

- Why do you think they decided that?
- **Seeking implications** of the things discussed, whether for self-questioning the story in order to reflect on one's own practice beyond a story about 'this didn't work so well', to asking:
 - What are the process learnings that you could apply more broadly to what you do in your health promotion practice?
 - What is your own role in the things that have unfolded?
 - Where is your capacity to change things in this situation?
 - What are the implications for others? For example, 'ok so these things stand in the way – now what pointers can you give as to the possible ways ahead? How can the reader (for example, management) use this to inform their own practice?'
- **Revisiting** again, as the stories changed, purpose, audience and voice.

Thinking about ethics

A one-off kind of resourcing (which could be built into agencies' normal practice as part of quality improvement (QI)) was assistance in the creation of informal ethics tools for data gathering (for example, plain language statement and informal consent form for those doing interviews). See **Resource N** in Section 2.

The preparation of health promotion agencies' evaluative narrative accounts of practice for annual and other reporting purposes is not formal research per se, but rather at the other end of the continuum of 'normal good practice' regarding getting feedback from service users. However, although quality assurance (QA) and QI activities do not, and should not, require formal research-type ethics procedures, informal ethical practice in normal feedback-loop inquiry is entirely appropriate and should be encouraged and honoured. **Resource N** is an example of a simple consent form and plain language statement that might be needed.

Keeping things going

There was a need for some process facilitation, for example, leaving phone messages in case people wanted to talk about where they were up to, or asking what did people need. Most asked to be rung for a 'check in' and that was reported as useful for keeping people moving. Occasionally, practitioners asked 'can we come and see you?' or 'can you come and see us?' Some wanted a lot of coaching; others felt it more straightforward with the tools provided; some were working in areas they weren't so sure about (such as interviewing and analysing themes).

Replicating this resource

Many hours of skilled facilitation and responsive intervention are difficult to prescribe for replication, but the style of support (if readers can call on external or internal consultancy themselves) was characterised by:

- asking questions rather than offering advice, for example:
 - What is the key thing that excites you?
 - Where is the storyline emerging from?
 - How did you start?
- seeing the kernels of brilliance forming in what people were doing
- feeding back perceptions of practitioners' ability
- being explicitly encouraging
- holding back on correcting/giving directional feedback
- creating lots of spaces where people could talk about what was blocking them, where they were going, and what they were discovering.

An example of external facilitation feedback

An expression of appreciation was provided to the practitioner for the way in which:
 ...the draft narrative was grounded in your own practitioner experience; and the way that it questions the assumptions underlying health promotion and [how] the writing has caused you to reflect on your own [assumptions] and raise questions for others.

Near the end I thought you made another really strong point about health promotion – who carries it out now and why the recent changes within this organisation. It may be useful to 'flag' this change up front – so, as well as a personal/professional journey, the narrative also becomes framed as an explanation for some changes that you've made organisationally...

Encouraging self-organising

On the whole, however, we were keen to enable narrative evaluation writers to find their own styles as this will be the case for most health promotion workers writing narratives in future. The focus of the facilitation was to see what needed to be included in a manual that could be a sustainable general resource when personal consultancy to every worker would not. Ironically – after months of careful non-directive facilitation – the one-off situation of editing the case studies for publication set a different standard and writers were pleased to get more directive editing advice. As well, the RHPOs serve as an ongoing consultancy resource. It may be more sustainable in future for RHPOs to be resourced by some form of meta-consultancy (a little like professional supervision).

A narrative planner or checklist

The guiding questions we developed to bring together the action research and evaluation components were used to structure or provide a backbone for the narratives (see **Resource H**) or as an after-writing checklist.

These two uses need to be made explicit, as there is an important caveat here:

- Some writers like to follow this structure to tell their story.
- Some writers need to write their story and then check the planner for anything left out.

Each of us does this by preference and, if the right mode is used, the writer will avoid cramping their style. When in doubt, it can be helpful to start by simply organising your own thoughts about the story and trying to write it out first. If this doesn't work, the planner may be consulted for ideas of what could be in it. In both cases, it is worth checking also **after** writing, to see if all key required elements are in the story.

Finally, time and a timeline!

We can't stress too much how important it is to 'quarry' time from busy doing. The rationale is simple: who wouldn't want to spend time thinking about what they are doing, rather than hurtling ever onwards just doing more of the same.

Managers need to authorise and protect writers having legitimate dedicated time to work on narratives.

Practitioners need to be able to quarantine time in their work plans. A standard amount of time to devote to evaluation is 10 per cent – based on the international professional evaluation community and USA funded standard. For well-established routine services however, it may be less, and for new and innovative work it may be more.

For some writers, a timeline may seem a difficult constriction on what is essentially a highly creative process, while for others it will provide a necessary self-discipline. However, we can report that a timeline, with the insertion of the resources and exercises described at various points, did actually mean everyone in the NEAR project completing to time from the:

- starting workshop (September)
- choosing the case study (October)
- drafting, swapping and feedback (November),
- formal reporting to the department (December–January)
- completing polishing/editing for the companion volume (March–April).

Timeline example

Task	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep–Dec
Meet, discuss ideas for narratives, set date for first training workshop	Date →								
Plan/check/ or revise this timeline	→	→	→	→	→	→	→		
Preparation for workshop – individually or in pairs		→							
Workshop (work through all four exercises), arrange to meet to verbalise stories			Date? →						
Meet in group, or small groups or pairs to verbally tell each other/ clarify/shape the stories			Date? →						
Write first drafts and circulate them				→ Date by which circulated					
Read and make notes/responses as questions (to clarify/explore meanings), set date to meet					→ Dates by which read, and to meet?	→ Date by which to finalise?			
Meet to ask each other questions about the drafts, set date by which to finalise									
Further revision and/or arrange wider circulation of narratives							→	→	→
Other...									

Drafting your narrative (or redrafting an earlier one)

OK! Good luck! Have fun! Some tips:

- Set yourself some page limits – the NEAR project set it at 2,000 words or about five typed pages.
- Sometimes it can help to start with a very short narrative. The boxed example 'Mezza Moo' is only 700 words.
- Even just writing the title can help you get going.
- Or listing five points you want to make.
- Reading **Resource G** What makes a good narrative and **Resource H** Planner, for NEAR narrative writing might be useful.
- Write as freshly as possible. In the NEAR project, some people discovered that some of their 'raw' writing was actually the most powerful, and that you can lose that by over-editing; others found that their first attempts were overly formal and later efforts were more authentic.

Still stuck? Here's some more tips.....

Here's what one practitioner found to be her style:

[Start with] brainstorming points – mostly frustrations; group them into themes and arrange as a story. Embellish the points by including snippets of personal experience, [people's] quotes and opinion. I wrote it in a ...single voice – like I was writing in a diary or Christmas letter to a friend.

Another is advising the new story writers in their organisation that:

On reflection the important thing is to get the story down in one fell swoop. Instead of coming back and doing little bits in instalments. Sit down and get down all your thoughts and ideas [before crafting]. Otherwise it can be really disjointed.

Others suggest:

Think about what you are doing in your work – what's happening? How's it going? – tell your co-workers verbally, then go away and write it down.

Or: it's OK to reflect and not immediately rush into more doing.

Or: write a first version that is very short – even just a paragraph or a page. Keep asking 'what's the story?' 'what am I trying to convey here?'

A good example of a very short narrative...

'Mezza Moo' – Non-Indigenous workers and agencies trying to improve access for Indigenous people

Mary Cigognini

Mary is the Extended Care Manager at Darebin Community Health Service where she wrote this narrative in collaboration with a co-worker Barb Bell. It is an exemplar of a short narrative (around 700 words). In this instance, it was for a writers' workshop facilitated by Jackie Mansourian which worked well as a successful method for getting effective writing flowing. Mary's nickname here is 'Mezza', and the first voice is that of a local Indigenous community member.

"Mezza-Moo, we need more money! The people have told me they want the Kookaburra Club to operate every week. I'm going to start ringing the Department. They need to support

the Community. I will invite them to the next Kookaburra Club. Let them be answerable to the people."

Another day. Energy is high. Discussions over money and the lack of it, access to services, and the elders not receiving CACP Packages are all happening. The need is so great. Sometimes it feels like I am caught up in a whirl wind, my head spinning, a quick intense discussion in the kitchen or in the courtyard – planning, looking at ways to work with other agencies, discussing political alliances and the affect they would have on our programmes.

This is a dream come true for me, an opportunity to work so closely with two respected elders, Shirl and Uncle Reg, to develop and plan new programs for and with the community.

The highs are amazing.

The Kookaburra Club day, is a hive of activity, lots of laughter and time to catch up with family, Aunties, Uncle Cousins, boories and guthers.

"Hey Mezza, come and have a chat, how are you? I love coming down here. We always get a good feed you make us feel so special. Could you have a look at my leg? I scratched it this morning."

"No problems, Aunt' I say, happy that she feels so comfortable and above all, that she trusts me."

With the highs, come the lows.

The organisation required to get the Kooka Day up and running is really a mean feat. The time spent to get things right is exhausting. The community has certain expectation that at times has real impacts not only financially, but in terms of staff support. The flexibility of providing the programs required can at times be difficult for staff to comprehend. This requires time spent creating a culture of awareness.

The biggest frustration is the political arena in which we work. The politics can, and in most cases, do inhibit access and choice for indigenous people. Giving the community an opportunity for their voice to be heard is what we are all about.

Mary continues her story with a reflection...

The above description felt like a piece of writing that powerfully demonstrates the sort of rollercoaster ride staff and organisations can experience working with the Aboriginal and Torres Strait Islander community. The highs can be very high, but the gut wrenching lows can also be very low indeed, and very little of the work, if any, is easy. I ask myself, do we need to do it? And the answer is a very definite, 'YES'. And why is that? It is because in Darebin we have the highest ATSI population in metropolitan Melbourne; they are our Indigenous community; they have the worst health statistics in the country and these statistics have not improved much in a very long time.

There are complex reasons why it is very difficult at all levels. The politics around ATSI controlled services and programs are very powerful, and can never be put aside. The complexity of the communities themselves is difficult to understand as an outsider, and the cultural differences, even if you are not aware of them, can lead to enormous frustration, and many walk away rather than persevering. The complexity of the lives of individuals and families within the communities often means there is no easy answer to anything. And for ATSI access workers, all of the above applies, and more!

Because it is so difficult at all levels to be successful at it, I believe an organisation needs to make a commitment to working with the ATSI community and as part of this commitment it has to employ people from the community. Darebin Community Health has done both. But I don't think we have recognised the stresses involved for our workers. We need to ensure that we support our workers in this work with ATSI communities. This includes cultural training, sharing the work across the organisation and supporting each other. And while we have done this to some extent, we need to do a lot more...

Practising the art

After initial drafting, stories can usefully be swapped for feedback and suggestions. Drafting and redrafting among groups can effectively employ the 'track changes' facility in word processing, whereby several voices can use differing colours.

Improving story-writing style

It was interesting to see the stories that emerged at 'the end' of the six months' timeline and compare them to the first drafts. The first drafts were very serviceable but, after drafting and reflection and redrafting, not only did the literary quality become sharper, but more importantly the quality of the writing as reflexive research and theorising about wider contexts also deepened.

Before and after redrafting practice – the power of reflection

There is a highly significant value in being able to think twice, reflect, 'see the ...context and then muse for a couple of weeks [in order to] think about what extra information we might need', and so on. There is currently much fashionable talk about 'emergence, iterativity' and the value of not getting too-early closure. This translated in this project into the following kind of concrete outcomes. **For example**, in one story's early iteration, blame was assigned for a failed local action on a government agency. On redrafting and reworking the story, the two practitioners realised there was more they could do to lay the foundations for better local partnering with that agency.

In a second example, an early draft read reductively:

...After extensive research the decision was made to consult with the local elderly Vietnamese community to establish their health needs.

The final draft reads more richly and illuminatively both of 'quantitative facts' as well as 'program logic':

We chose the Vietnamese community for this project due to the high population numbers, and the low numbers accessing our services. We wanted to know answers to so many questions. What did the Vietnamese community want from us? Why didn't they use our services? How could we make our services more relevant to their needs?

But the sheer number of Vietnamese people in our neighbourhood was daunting, so we chose a smaller group to begin with. We began by talking to the local elderly Vietnamese community.

In a third example, an early draft listed reductive acronymic dot points about a community worker's achievements including:

IPC tours – 19 participants.

This perhaps means relatively little to an outside reader, however, more context and grounding detail illuminates the reader's understanding of the meaning and significance of what is being described in the final draft:

Nineteen Vietnamese community members have had tours of our centres in the Vietnamese language. [Now] they know where we are and what will happen when they walk in the door.

In a fourth example, major shifts were identified from writing a lot (then even more!) and then having to condense and refine what was being said, letting go of some of the smaller story lines in order successfully:

...to find the broad issues – the main story that I was trying to tell...The first draft was more about the changes that we would need to make to the program – internal changes for us to make. Then when I thought some more about it, the second one was much more about how this connected to some of the broader issues in society [and health promotion].

Another valuable result of reflection necessitated by redrafting narrative evaluations was in one health promotion officer beginning to ask herself whether she was putting her own interpretation on what people were saying. She reflected firstly on how those like herself in health promotion generally place a lot of meaning on the reasons people come to programs (such as social connectedness), but that she realised these were not actually what the different people were telling her was **their** own (varying) reasoning at all. This does not mean social connectedness is not important, just that in this instance a different experience prevails which should be understood accurately.

In a related example, the health promotion practitioner found her story didn't really change much once she 'got it actually written', but that one of the main issues was for her:

Who is this story for? – Was it my reflecting on the [project participants]? [or] The [project participants] reflecting on themselves?

She wondered how she might still put herself in the story but ended up taking out 'a bit of me and put[ting] more of them in there'.

Finally, another practitioner wrote:

The process of documenting your reflections can be powerful and insightful to yourself and others.

Overall, to summarise (as richly and thickly as possible), you might expect your own drafts to experience similar 'morphing'

Figure 4

From first drafts...	To last drafts...
<ul style="list-style-type: none">• Being more formal, more like an organisational plan (goals, objectives, definitions, service descriptions, targets)• More about 'consulting, planning, identifying options, seeking to, and developing'• Tendency towards gloss, jargon, buzz words and concepts from elsewhere/the literature• A focus still on lists, reporting numbers• Dot points, reductive, summarised, abstract, dry, black and white• The 'section 1.3.8' layout style• Summary of facts, issues or recommendations• Rationales/program logic implied• Putting 'best' face forward• Following guidelines headings• More mechanical feel, not situated• Top-down reporting process – had not consulted communities/service users (or sometimes staff)• Tendency to second-guess and assume consumers' views• More 'disembodied': 'It was done...'• Focus on message-sending re snapshot of what was done• Negative conclusions re attributed short-loop causality, speculation re others, may remain with old theory• Anger and frustration about 'them' blocking an 'us'• More of a sense of futility and impossibility about the change task• Conclusive re 'what done', may not show why recommendations suggested	<ul style="list-style-type: none">• Being more expressive and 'page-turning' (invoking curiosity re 'what happened next?', or insight 'oh so that's what's going on')• More about actually engaging with the direct needs of communities• Tendency to honestly explore practice, and 'unpack' concepts so their meaning is more 'real' in local setting• Numbers used more to illuminate story points• Detail, rich pictures, 'thick description', people's words in quotes• More colourful informative headings• Explanation of emergent situations and their resolution or ongoing action• Rationales/program logic more explicated• Showing learning and progression to 'better'• Following story's own 'headings'• More organic feel, real-life settings• More bottom-up approach including seeing need to consult communities/service users (and staff involved)• Tendency to be cautious re analysing consumers' views• More 'embodied': 'I did...' or 'We tried...'• Focus on what was learned from experience in process• Deeper more insightful conclusions re complex causality and multi-contexts, may develop valuable new theory• More see how to work alongside, getting to know the 'other'• More on how to engage/work with/inform 'them' and what already achieved• Illuminates 'what done' but also can show 'what came next' and what is yet to come

Beyond story-writing style – to improved health promotion practice

Every time we encounter the power of this kind of work we are surprised anew at just what can be achieved in terms of a method not merely yielding information for the reader but critically important insights for the writer. The message goes on being: if you take the time to stop and think, reflect, question and 'have second thoughts', the work will benefit from the deeper level of understanding and insight than if one continues to hurtle forward doing just 'what worked last time'.

One of the earliest pieces of feedback we received in the NEAR project was an exchange between two senior staff that revealed both the value of tangible feedback, the deeper meanings able to be revealed, and a return to first principles:

(1st staff member)

When we could actually sit down and look at it, I felt like we'd come a long way in what was actually a difficult year in health promotion

(2nd staff member)

In terms of evaluation, the tables would have been unsatisfactory on their own – two lines only to talk staff about a whole program area. This provided a chance for us to elaborate.

(3rd staff member)

This year's plan [much less but more depth, was]...in priority areas. The first thing [will be] to do a needs analysis.

One agency manager also confirmed the value of structured narrative evaluation and observed that uses of language like 'it was decided' can have an affect of distancing the reader from what actually happened in the work, but that:

[Just] the asking of the questions 'who, what, why':

...Makes you look a lot more closely at what actually happened... You start asking 'who decided, why?' [and] What was the power situation? Was it collaboration? One person? Were they asking the right questions...? It snowballs – that's the best way I can explain it. Asking the questions does open the door to reflective practice. Some people do it naturally, others don't. [But] once you start questioning beneath the language – Boom!'

A discussion of even 'just' a title showed it can powerfully illuminate an element of program logic or practice theory in the making. In the course of such an exchange – which resulted in the evocative title 'Will I ever get to see feet? The challenges of integrating wholistic health promotion into the daily practice of allied health providers in a community based setting' – a practitioner found herself naming what she understood to be most valued practice as *integrated* rather than add-on, when she concluded:

I think [now] that rather than trying to combine professional specialisation with community HP, I think I have tried more to integrate wholistic (or 'real') HP into SP daily practice.

A NEAR consultant noted too that narrative writing might draw on literary stylistic elements but that the real test of value comes in the contribution to services themselves. That is, narrative writing, as reflexive practice, may be leading directly to changes in thinking and hence to service improvement as a result of people taking time out to think more deeply about what they are doing:

The language and style closely reflects what seems to be happening in the reflective process as time and drafts pass – so stylistic changes in stories **seem to indicate shifts in understanding too.** (Our emphasis)

Another practitioner noted:

I also attempted at that stage to incorporate the action-research model so it was thinking of **possibilities for change**, not just an outpouring of frustrations. **And deeper.** The actual writing was only part of it. The having to put it into words... the process of writing, facilitated thinking and deeper reflection. I was able to think through possible solutions to the barriers and frustration that we'd experienced. **The process created that opportunity.** (Our emphasis)

Finally, yet another practitioner concluded that changing from 'anger, frustration, blame, no solutions [and] feeling stuck' had given way 'through reflection' to a situation in which:

I've certainly moved on... [to] understanding, acceptance, [and being] solution-focused, excited.

Twelve examples for inspiration

Some health promotion practitioners found the best way of all for 'getting' the narrative style and approach was from reading others' stories. Hence, the six NEAR Phase 1 lead practitioners are making available publicly the six crafted stories they wrote and six more NEAR Phase 2 lead practitioners are doing the same.

These are now published and available in **Section 4** Case studies in writing narrative action evaluation reports in health promotion.

The next exciting instalment...

From NEAR to FAR to OAR

Finally, NEAR is a story in its own right. This manual of guidelines, resource kit, QuickGuide and the 12 case studies are the story of NEAR so far. The next 'chapter' in its development is a broader process beyond both the two agencies in the Phase 1 NEAR project, and the ten agencies in the Phase 2 NEAR and FAR project, to a Phase 3 to both 'roll out' the workforce development more widely and also begin to research more thoroughly the evidence of impacts and outcomes.

Thus, this manual also remains an ongoing work-in-progress.

For more information about how you might become involved in Phase 3, please contact:

Karen Goltz
NEAR Project Manager
Regional Health Promotion
Department of Human Services North and West Metropolitan Region

2 Full Resource kit – for writing narrative action evaluation reports in health promotion

Resource A

Initial Department of Human Services narrative guidelines 2002–2003 (Extract)

Community and Women's Health Services

(Insert Agency Name) Integrated Health Promotion Organisational Plan – Reporting 2002–03

PART 1 Narrative

Agencies are required to submit a narrative section for priority issues **identified in their 2002–03 Integrated Health Promotion Organisational Plan**. Use the prompts below to guide this narrative.

- 2002–03 priority setting process, for example: What was the rationale that the priority was based on? How was the process based on population health and wellbeing data provided in the PCP Community Health Plan, Burden of Disease, Municipal Public Health Plans and relevant local needs assessments?
- In setting organisational health promotion priorities, what was the decision-making process?
- Problem definition process, for example: Was the goal, objective and selection of target population group realistic?
- Consumer and community participation, for example: How were the key population groups involved in developing/implementing and participating in the priority?
- Solution generation process, for example: Was the mix and balance of interventions (including both individual through to population interventions) appropriate to achieving the goal and objectives stated for the priority area?
- Planning for and conducting evaluation strategies, for example: What was different, how was change observed? What were the evaluation processes? From the evaluation are there any implications for future priority setting processes?
- Capacity building, for example: Were there enough resources – time, infrastructure, personnel and community participation to achieve the goal and objectives? What were the enablers and barriers? If not, do these need to be developed or should different interventions, objectives even program goals be planned for?
- Any other comments?

Resource B

Revised narrative guidelines 2003–2004 and 2004–2006

2003–2004

Community and Women's Health Services
Organisational Health Promotion
December Reporting Pro Forma



***(Insert Agency Name)* Integrated Health Promotion Organisational Plan - December Reporting 2003-04**

Guidance for Narrative Requirement

Agencies are required to submit a narrative section for EACH priority issue identified in their 2003–04 Integrated Health Promotion Organisational Plan. Use the headings and prompts below to guide this narrative.

- **2003-04 priority setting process**, for example: What was the rationale that the priority was based on? How was the process based on population health and wellbeing data provided in the PCP Community Health Plan, Burden of Disease, Municipal Public Health Plans and relevant local needs assessments? In setting organisational health promotion priorities what was the decision-making process?
- **Consumer and community participation**, for example: How were the key population groups involved in developing/implementing and participating in the priority?
- **Problem definition process**, for example: Was the goal, objective and selection of target population group realistic?
- **Solution generation process**, for example: Was the mix and balance of interventions (including both individual through to population interventions) appropriate to achieving the goal and objectives stated for the priority area?
- **Planning for and conducting evaluation strategies**, for example: What was different, how was change observed? What were the evaluation processes and methods? From the evaluation are there any implications for future priority setting processes?
- **Capacity building**, for example: Were there enough resources – time, infrastructure, personnel and community participation to achieve the goal and objectives? What were the enablers and barriers? If not do these need to be developed or should different interventions, objectives, even program goals be planned for?
- **Budget**, for example: What is your budget expenditure to date for each of your identified priority areas? How is the budget being monitored and recorded? How was the evaluation processes costed?

Any other comments?

Revised narrative guidelines 2004–2006

Extract from: *Information Resource Community and Women's Health Program June 2004 Health Promotion Planning and Reporting 04–06*

Attachment 2: Organisational Health Promotion Evaluation reporting pro forma (for July 2005 and 2006)

Introduction

The Organisational Health Promotion Evaluation reporting requirement for 2005 and 2006 involves using the attached pro forma. The same pro forma can be used for each reporting period (for example, 2004–2005 and 2005–2006) and requires two mandatory components to be completed for each Priority nominated in the 2004–2006 Organisational Health Promotion Plan and for the use of the flexible funding component including:

Part 1: Narrative

Part 2: Summary Reporting Grid

Both Parts 1 and 2 are **required for** each Priority and for the use of the flexible funds.

The Organisational Health Promotion Evaluation report (**with all components compiled into one document**) will be submitted to the relevant regional office by 30 July 2005 and 30 July 2006. The Agency CEO or Manager should sign off each report and submit it to the relevant regional office electronically by email or on a CD/disk. The region will forward an electronic copy to: Michelle Lasek at email: michelle.lasek@dhs.vic.gov.au

Agency Name: (insert Agency name)

Part 1: Narrative

1. TITLE: Eg: Identifying PCP HP priority
2. INTRODUCTION Eg: Summary description of problem definition and Organisational HP Goal
WHO (and how many) were the key stakeholders (agencies/organisations and consumers)?
3. HOW was the program implemented? Eg: Summary of solution generation.
4. WHAT was revealed ACTUALS vs ESTIMATES? Eg: Process and impacts achieved, successes and unexpected outcomes, enablers and barriers, and lessons learned. Review contributions to 2004–2006 IHP Catchment Plan and Organisational HP plan. How is what was achieved by July 2005–2006 different to what was planned for in 2004?
5. CONCLUSION

Resource C

Project information resource

Department of Human Services Project description

Western Metropolitan Region

Integrated health promotion evaluation capacity building: the Narrative Evaluation Action Research project

1. Purpose of this document

This document has been prepared by the Public Health and Strategic Development Unit, Department of Human Services, Western Metropolitan Region, to provide Community and Women's Health Agencies with information about the *Department of Human Services Western Metropolitan Region Integrated Health Promotion Evaluation Capacity Building: Narrative Evaluation Action Research Project (NEAR)*. The information detailed in this resource has been drawn primarily from the NEAR project brief.

2. Background

The Department of Human Services introduced a new approach to funding health promotion programming in Primary Health program funded Community and Women's Health (C&WH) agencies in 2002–2003. Agencies are required to commit between 15–30 per cent of their annual primary health budgets to integrated health promotion. Strengthened planning and reporting requirements have been instituted that require each C&WH agency to develop and submit an Organisational Health Promotion Plan to the department at the commencement of each financial year. Progress reports on plan implementation are required at the end of the second and final quarters of the financial year and submission of an Organisational Health Promotion Report at the close of the financial year. In 2003–2004 planning and reporting will be required to cover 100 per cent of an agency's health promotion funding from the C&WH programs.

To date, the department has supported this primary health reform process through a range of workforce development initiatives. Workforce development represents an important component of capacity building for integrated health promotion within systems and organisations. Workforce development strategies help to ensure that practitioners and organisations engaged in health promotion have the abilities and commitment to respond to and shape the strategic priorities of the service systems within which they are working.

Practitioners in Western Metropolitan Region (WMR) have expressed a need for further workforce development in planning and evaluation to support their agencies in reorientating primary care service delivery to include integrated population focused health promotion. A significant number of the C&WH agencies in the WMR have identified organisational capacity building as a key integrated health promotion priority.

The WMR has established a partnership with three tertiary education provider/s in order to develop, implement and evaluate a health promotion evaluation workforce development program that is responsive to the organisational learning needs of WMR C&WH agencies and supports them in addressing the planning and reporting requirements of the department.

The tertiary sector partners providing services to the project are:

Dr Yoland Wadsworth

Adj Prof and Convenor
Action Research Program
Institute for Social Research
Swinburne University of Technology

Ms Gai Wilson

Coordinator
Centre for Development and Innovation in Health
Australian Institute for Primary Care
Faculty of Health Sciences
La Trobe University

Dr Ani Wierenga

Lecturer and Research Fellow
Australian Youth Research Centre
The University of Melbourne

3. Rationale

The Department of Human Services has developed health promotion program planning and reporting pro forma to be used by C&WH agencies. The planning pro forma requires that agencies articulate an organisational vision, priority issues, supporting rationales, problem definition, goals and objectives, solution generation, intervention mix, requisite capacity building and evaluation and review processes. Reporting is required to address measures of process and impact in the year 2003–2004. Reporting will be extended to encompass outcome evaluation in subsequent reporting cycles. Narrative accounts of programming are also a reporting requirement.

The application of narrative constructivist and action research evaluation methodologies within organisational practice contexts has proved to be beneficial in facilitating organisational health promotion program and practice knowledge development. The strength of narrative constructivist methodology rests in its capacity to give voice to the evaluative input of all stakeholder groups. Narrative or 'storied' evaluative accounts are produced. Embedding these evaluation practices within an action research spiral contributes to program development and practice improvement by linking actions, reflection, questioning, conclusion and option generation and to new actions.

4. Goal

It is intended that this project will build the capacity of C&WH agencies to evaluate and report on organisational integrated health promotion programming through the application of action research and constructivist case study evaluation methodologies.

5. Objectives

The objectives of the workforce development project are:

Phase 1

- a) To collaborate with lead practitioners from selected C&WH agencies in the development of health promotion narrative and action research program evaluation practices and processes for trial implementation within their organisational settings.
- b) To develop a 'train the trainer' toolkit/manual that documents the methodologies and processes employed within the participating agencies for subsequent dissemination to other agencies.

- c) To produce in collaboration with the participating agencies documented integrated health promotion evaluation case studies for inclusion in the toolkit manual.
- b) To facilitate the collective engagement of lead practitioners from the participating agencies in critically reflecting on the implementation of action research and case study narrative evaluation methodologies within the organisational planning, evaluation and reporting cycles of C&WH agencies in the WMR.

Phase 2

- c) To develop and implement a series of 'train the trainer' health promotion evaluation workshops across the C&WH agencies in the WMR.
- d) To facilitate the collective engagement of lead practitioners from across the region in critically reflecting on the implementation of action research and case study narrative evaluation methodologies within the organisational planning, evaluation and reporting cycles of C&WH agencies in the WMR.
- d) To produce a documented series of agency integrated health promotion evaluation case studies for publication and dissemination.

6. Key stakeholders/partnerships/participants

Key stakeholders:

Department of Human Services WMR
Public Health and Strategic Team
Regional Health Promotion Officers
Primary Health and Support

- Invitations to participate in the project will be extended to all of the C&WH services in the WMR. Criteria will be employed to guide the selection of three agencies to participate in Phase 1 of the project. Refer to section 10 of this document for a discussion of the preconditions for agency selection.

The agencies in the WMR that are currently funded through the C&WH service funding include:

Western Region Health Centre
ISIS Primary Care
Djerriwarrh Health Service
Doutta Galla Community Health Service
Women's Health Information Centre
Women's Health Victoria
Young People's Health Service (Centre for Adolescent Health)
Victorian Foundation for the Survivors of Torture
Women's Health West

7. Key deliverables

To achieve the aims and objectives of the project the project partners will deliver the following services:

Phase 1

- a) Conduct needs assessment consultations to identify organisational learning needs with the selected agencies for the purpose of informing the development of the health promotion evaluation workshop/mentoring program.

- b) Develop and implement a series of agency based/focused workshops on the application of narrative evaluation and action research for the purpose of evaluating integrated health promotion programs within the participating agency.
- c) Provide mentoring consultancy to the participating practitioners and support peer consultancy in the implementation of the evaluation methodologies within their organisational planning, evaluation and reporting cycles for 2003–2004
- d) Collaborate with participating practitioners to produce a collection of integrated health promotion evaluation case studies for dissemination.
- e) Conduct a collective 'reflexive practice' conference for the purposes of sharing practice knowledge gained about and through the process of applying constructivist evaluation methodologies and action research evaluation within the organisational planning, evaluation and reporting cycles for 2003–2004. This 'conferencing' occasion will involve the key practitioners from participating agencies and interested practitioners drawn from across other C&WH agencies in the west.
- f) Develop initial guidelines and resource kit for producing narrative evaluation documentation that outlines the methodologies and processes employed within the participating agencies for subsequent use with other agencies in Phase 2. The integrated health promotion narrative action evaluation case studies generated during the course of the project will be included within the manual.
- g) Evaluate the project and provide a brief written evaluation report to WMR (8–10 pages)

Phase 2

- b) 'Train the trainer' health promotion evaluation program development. Design a series of trainer-the trainer workshops based around the application of the 'train the trainer' toolkit/manual produced on Phase 1 of the project. Half-day formats (four hours).
- c) Implement the 'train the trainer' program with lead practitioners from the C&WH agencies across the region.
- d) Conduct collective 'reflexive practice' conferences with lead practitioners from across the C&WH agencies for the purposes of sharing practice knowledge gained about and through the process of applying constructivist evaluation methodologies and action research evaluation within the organisational planning, evaluation and reporting cycles for 2003–2004.
- e) Collaborate with lead practitioners from across the region to produce a monograph collection of integrated health promotion evaluation case studies for dissemination.
- f) Evaluate the project and provide a written evaluation report to WMR

8. Roles and responsibilities

- a) The Department of Human Services WMR regional office is the organisation that has purchased the services required to complete the project. Karen Goltz is the Regional Health Promotion Officer (RHPO) designated as the lead regional contact and project manager for WMR.
- b) A Project Development Group comprised of representation from key stakeholder organisations will be formed by the WMR Public Health and Strategic Development Unit. This group will collaborate on the project's development, implementation, evaluation,

and communication mechanisms. This project group will meet four times over the course of the 12-month pilot phase.

9. Preconditions for agency selection into the project

All C&WH agencies in the WMR will be invited to submit expressions of interest to participate in the project. Expressions of interest will need to address the following preconditions for selection:

- Demonstrated board of management or executive management support for participation in the project.
- Willingness to commit lead agency health promotion practitioners and line manager/s to engagement in the project (2–3 or a work group). It is preferred that all lead agency health promotion practitioners, other interested staff and relevant managers within an agency also participate to some extent in order to facilitate the development of an evaluative agency culture. Identification of the particular relevant staff (the 2–3 or small group) at this early point in time is required.
- Capacity to release staff to participate in the following pilot project activities between August 2003–July 2004: four project development committee meetings, an agency based evaluation workshop, consultations with the designated agency evaluation mentor as determined between the agency and the mentor (five hours over 5–7 months), the writing of an agency program evaluation case study and a 'reflexive practice' feedback session.
- Identification of health promotion capacity building as an organisational health promotion priority in the 2003–2004 Organisational Health Promotion Plan.
- Identification of a health promotion program included in the 2002–2003 Organisational Health Promotion Plan that has been identified for continuation/further development in the 2003–2004. It is intended that this agency program would become the foci for trialling the evaluative methodologies over the course of the pilot phase.
- Articulation of a rationale for the agencies inclusion in the project

10. Project enquiries

Enquires about the project can be directed to:

Karen Goltz
RHPO Near Project Manager
Regional Health Promotion
Public Health and Strategic Development
Department of Human Services Western Metropolitan Region
email: Karen.Goltz@dhs.vic.gov.au

September 2003

Resource D

Annotated bibliography of useful readings

Contents

1. CDIH's Resource Collection of Case Studies
2. Clifford Geertz and the notion of 'thick' description
3. Frigga Haug's memory work technique
4. Ron LaBonte and Joan Feather's story dialogue method
5. Fran Peavey's strategic questioning
6. Pillsbury USA's annual storytelling day
7. Michael White's narrative therapy and the role of witnesses in richly re-telling the story
8. Reconnect's quarterly AR reporting
9. Most significant change technique
10. The University of Kansas Community Tool Box's narrative evaluation outline
11. Appreciative Inquiry/Strengths-based approach

1. CDIH's Resource Collection of Case Studies

The six case studies in this 1980s collection were the precursor work to the NEAR case studies (**Section 4**). They offer rich, textured accounts of community development practice and give voice to the participants in that practice. Each story is told firsthand by those involved. It was reflected upon and explored by others in a workshop setting and finally written down by the participants. The stories, with their strong authorial voices, capture the motivations, frustrations, excitement and sense of achievement that the first generation of practitioners and participants felt. The language is direct and colourful and the voices active and engaged. The stories are about people speaking for themselves, of their own health experiences and changes in their lives. The collection offers six compelling examples of reflective practice and showcases the power of community development in action. It inspired practitioners throughout the rest of the 1980s and some until the current time.

We feature one whole case study at **Resource L** – Northcote Hydrotherapy Case Study, by Marjorie Oke.

Reference

Community Development in Health (1988) *Resources Collection*, CDIH, Victoria.

2. Clifford Geertz and the notion of 'thick' descriptions

Another idea that underpins narrative or qualitative work is the notion of 'thick' description. Anthropologist Clifford Geertz (Geertz 1973) suggests that when we write about settings, cultures and communities, it is too easy to tell stories that are over-simplified, abstracted and impoverished. The alternative, Geertz suggests, is to seek detailed, 'thick' or 'rich' descriptions of the practices, accounts of lived experiences and meanings of those being written about. Such 'thick' descriptions go beyond apparent surface factor and present detail sufficiently rich to grasp the significance to a person.

For the purposes of this project, a 'thin' description might be one that is written about the actors - in this case staff and service users – giving little sense of their experiences or understandings, and little attention to what they find important. A thick description, on the other hand, would be one that seeks the explanations, meanings, understandings of those involved (or who are writing about their own). This would result in a much more complex story, but it is also more likely to be grounded and useful, and lead to transferable learnings.

References

Geertz, Clifford (1973) 'Thick description: towards an interpretive theory of culture' in Geertz, Clifford, (ed.) *The interpretation of cultures*, New York: Basic Books.

Denzin, Norman K (1989) *Interpretive Interactionism*, Newbury Park, CA: Sage Publications

3. Frigga Haug's memory work technique

The memory work technique rests on writing and reviewing individual memories from the past in order to generate greater individual and collective understanding both about the past situations and also regarding current issues surrounding a nominated area of interest. It rests on the assumption that what is remembered is remembered because it is, in some way 'problematic' [or 'important'] and in need of review [or 'can be valuable if reviewed'] (Fran Crawford 1992). Originated by Frigga Haug in Germany, the technique has been used in health settings by Glenda Katroulis and Yoland Wadsworth in Melbourne, Susan Kippax in Sydney (in Psychology) and Pam Oliver in New Zealand.

The technique works through 'externalising' memories, taking them from the 'private' to the 'public', and framing and then reframing them. Individuals write their memories. Then, in small groups, they each read their own story to the group. Together the group thinks about, reflects on, analyses and interprets the stories, drawing out aspects of content and discourse, language and ways of being and seeing. The stories are then refined. The stories are written out like a mini short story using just a few paragraphs or less than a page.

The process and the outcomes are non-judgemental, and entirely based on participants' own subjective interpretations and descriptive expression.

There does not need to be 'take-apart' type analysis or justification. People make their contribution and then the group thinks about what it means and how it helps them understand something more. The 'researched' are 'the researchers'. They are sharing the experiences and discovering from them how they were made, how our memories are made by the world around us. Together the group has the opportunity to 'rewrite current history-in-the-making' and see the world, now, differently, in order to generate both more understanding about and greater freedom about the situation.

Reference

Crawford, F., Kippax, S., Onyx, J., Galut, J. and Benton, P. (1992) *Emotion and gender: constructing meaning from memory*, Sage, London

4. Ron LaBonte and Joan Feather's story dialogue method

LaBonte and Feather have developed a grounded practical approach to knowledge creation in health promotion. The story/dialogue method begins with someone's story/narrative constructed around a theme. A structured dialogue follows the telling of the story where open questions – about what, why, so what and now what – move the discussion on from descriptions of what happened to explanations for how it improved health, to a synthesis of key lessons, to some articulation of new actions.

LaBonte and Feather argue that this method generates practice based theory which can be used for evaluation and research.

The story/dialogue method, by basing itself on the day-to-day experiences and understandings of practitioners and community members, can create a better balance between the knowledge and power of institutions and professionals, and the knowledge and power of communities. Epistemologically, Ron LaBonte draws on the constructivist methodology (1997 p. 67) and Denzin's interpretive interactionism:

"...[going] beyond mere fact and surface appearance. [To] present detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description... inserts history into experience. It establishes the significance of an experience or the sequence of events for the person or persons in question." (1997 p. 10)

Reference

LaBonte R and Feather J (1996a) *Handbook on using stories in health promotion practice*, Prairie Region health Promotion Research Centre, Canada.

LaBonte, R (1997) *Power, participation and partnerships for health*, Victorian Health Promotion Foundation, Carlton South

5. Fran Peavey's strategic questioning

Action research is a methodology that has taken up the challenge of researching desired changes during the process of the inquiry itself. Additionally, it then treats answers to questions as worthy of testing, and then moves to trial ideas in practice in a form of 'naturalistic experimentation'. By not restricting its questions to only asking about 'how things are or have been', and by being clear about its purposes of wanting change or improvement to some situation, service or program of activity, it is able to move to ask a different kind of question.

Drawing on Fran Peavey's term – we could name these kinds of research questions 'strategic' questions. Fran has produced a systematic and comprehensive framework (which follows in summary and revised form) for assembling both retrospective and prospective questions. In action research, all these questions can be asked in the course of an inquiry. Fran has developed a 'question string' or sequence of questions that begin with 'how things are now'-type questions, but does not stop there.

The questions then proceed to match the different steps around the action research cycle and have the important capacity to move to 'how things could better be'-type questions. This could provide a useful structure for telling a narrative story. (We have used it in **Resource M** – the more elaborated narrative planner or checklist.)

The Strategic Questions sequence

Thus there are **first level questions**:

- describing the issues and situations
- observation questions
- evaluative questions
- analysis (and synthesis) or reflection/theorising questions
- 'how do you feel about this?' questions
- and a threshold or liminal question – do you want change or not (to what extent)?

Then there are **second level questions** that move from 'what is now' to 'what could be' including:

- visioning questions
- what-would-it-take to change the story (or theory) questions
- alternatives-seeking questions
- consequences-considering questions
- action questions
- support questions.

To these could then be added monitoring and audit questions – taking the narrative process full-circle to level one observation questions again. [This bibliographic entry is ©Yoland Wadsworth in association with Fran Peavey 2003.]

See **Resource M** – A planner or checklist for narrative action evaluation writers, for our application of these questions in the NEAR project.

Reference

©Fran Peavey (1994) 'Strategic Questioning', *By life's grace*, New Society Publishers, Philadelphia, PA, USA pp. 86–111 **See full text on:** www.crabgrass.org/strategic.html

6. Pillsbury USA's annual storytelling day

This is a simple idea that has worked well in the context of a large agency (about as big as an amalgamated regional community health service). Teams of workers meet in advance of an Annual Storytelling Day to select a story from their year's work that they feel exemplifies that program team's work. It might be a poignant vignette from a client's life or encounter with the service. It might be a story of having gone up a wrong track and found the way to a spectacular breakthrough in understanding how better to respond to community needs. It might be a funny story with a moral to it. On the day, nearly 200 workers assemble in a large auditorium. The atmosphere is celebratory. Each tells or acts out their story to loud applause. It takes up to two hours, and is followed by refreshments. An observation would be that workers are gradually realising that some of the stories are their clients', and next it is anticipated that clients, consumers and community groups will take their place as part of the Storytelling Day too.

7. Michael White's narrative therapy and the role of witnesses in richly re-telling the story

Stemming from his work in narrative therapy, Michael White talks about the role of the 'outsider-witness group' – those who are intentionally gathered for the purpose of listening, then reflecting and richly re-telling the story of another. If listening well, an audience may point out connections that the storyteller did not realise, or make visible the layers in the story that were not immediately obvious to the teller.

White (White 1997:93–5) outlines a three-step process: the telling, the re-telling (by the outsider witness group while the person at the centre of the narrative is audience), and a reflection by the storyteller where they register their new thoughts and insights.

In this project some of these insights would translate as recognising:

- the importance of reflection in good practice
- the value of encouraging a culture of reflection
- the centrality of the stories people tell in way they define themselves, their projects and their work
- the significance of making spaces where people can enrich, thicken and deepen the narratives that surround their own professional practice
- the potential of such spaces for making and claiming practitioner-knowledge; and the vital role of co-workers (and management) and service users who listen and reflect on each other's stories
- and the power of structuring questioning and narrative as 'scaffolding' (Vygotsky) to move from a 'here' to a re-understood new story 'there'.

References

- Carey, M and S Russell (2003) 'Re-authoring: some answers to commonly asked questions', *The International Journal of Narrative Therapy and Community Work* (2003) No 2
- Morgan, Alice (2000) *What is narrative therapy?* Dulwich Centre Publications, Adelaide SA
- White, Michael (1997) *Narratives of therapists' lives*, Adelaide, SA, Dulwich Centre Publications.

8. Reconnect's quarterly AR reporting

This is an important government reporting precedent. For more than eight years, action research has been 'the way we do things around here' in a national youth homelessness prevention program called Reconnect.

Each quarter, the Commonwealth Department of Family and Community Services requires a half-page narrative on approximately two formally-designated current action research questions. These tell a story of having noticed something, planned some changes, observed

them, reflected on them, and come up with some new actions, which in turn have been trialled. This is the familiar AR Plan-Act-Observe-Reflect cycle.

Reference

See the F&CS website for the Reconnect *Action Research Kit* that includes some examples:
http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/youth-reconnect_action_research_kit.htm

9. 'Most significant change' technique

First developed by Rick Davies in Bangladesh in 1994 and given life in Australia by Jessica Dart, this technique has particular application for storying social processes within a field of development or agriculture. It arose as a response to the failure of the logical-descriptive/indicators evaluation approach (especially to enable satisfying agreement around pre-constructed objectives, or meaningful and usable quantitative measures), combined with a need for genuine organisational learning. It works to avoid alienating partner-stakeholders and generalised but too-abstract analytic or formalised descriptions, by 'simply' asking people to identify positive or negative changes observed over a period of time within a given domain of interest (for example, a program or activity). The people are then asked about which change they find most important and why (Sigsgaard 2002).

The outcome of the exercise will be a number of recorded 'stories' about change using concrete detail. (For example, people do not write 'consumer participation has improved significantly during the last year'; instead they write 'today clients can publicly say they were critical of the centre because they did not trust us. This time last year we had only one formal complaint because people said it would only upset staff if they did complain'). Some of the resulting stories can be related back to objectives, but it has the additional value of being able to illuminate areas not captured in a priori rationales and matrixes or unintended consequences set in train.

Reference

For those interested in reading more, the key text is now available on open access through Jess Dart's company ClearHorizon's website: <http://www.clearhorizon.com.au/site/index.htm>
Sigsgaard, Peter (2002) 'MSC (Most Significant Change) approach – monitoring without indicators', *Evaluation Journal of Australia*, Vol 2 (new series), No 1, August pp.8–11

10. The University of Kansas Community Tool Box narrative outline for evaluating initiatives

This is a set of steps very similar to those of myself and Fran Peavey's sequence, including identifying stakeholders, describing the program, its stage of development and logic, indicators and sources of evidence for justifying, evidencing or explaining conclusions, recommendations for next actions, and communicating information to funders for support and accountability. For this project they would be another way of inserting a structure or procedural steps for constructing a comprehensive and systematic narrative.

Reference

The University of Kansas Community Tool Box's narrative outline for evaluating initiatives; summarised and adapted from <http://ctb.ku.edu/tools/evaluateinitiative/narrativeoutline.jsp>
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11. Appreciative Inquiry/Strengths-based approach

While these are not narrative evaluation methods per se, they each draw on and have much in common with both narrative and action evaluation.

Appreciative inquiry (AI) is an action research approach pioneered by David Cooperrider that encourages groups and individuals to ask appreciative questions in four steps around an action research cycle – the characteristic ‘4D approach’:

- Discover** Appreciating. Identifying the best of what is – ask: What gives life?
- Dream** Envisioning. Picturing desired futures – ask: What might be?
- Design** Co-constructing. Strategising to enact – ask: What should be the ideal?
- Deliver** Sustaining. Delivering destiny – ask: How to learn, adjust and improvise?

This formulation of the AR cycle starts in the ‘research’ (‘Discover’) moment of the ‘action – research’ cycle, or in ‘Observe’ in the Plan – Act – Observe – Reflect cycle; or at Level 1 questions of Fran Peavey’s strategic questions sequence.

Strengths-based research or evaluation and practice (such as that of St Luke’s in Bendigo Australia) is similar to AI in its focus on ‘seriously optimistic’ questions which foreground the strong, the good, and the positive, particularly in their work with children, families and communities. Their methods for ‘noticing the change’ ensure growth-augmenting feedback, often reversing lifetimes of discouraging feedback. In no longer seeing children, families and communities as ‘having a problem’ (or even as being ‘challenging’), the approach moves away from both victim-blaming and from stopping at environment-based justification of no change.

These two constructivist approaches work on the basis of ‘positive evaluation’ (Wadsworth 1991). That is, when you ask people (or your self) about the value, merit, worth and significance of anything, it always involves people observing the ‘bad/not working/poor’ implicitly in terms of comparative frames of reference or images or memories of ‘good/working/excellent’. Thus we could just as easily ask after the positive states – hence reversing the comparisons. There are links here both to capacity-building and to narrative and narrative therapy, for example in the work of Michael White, where

the focus is on retrieving even a small memory of ‘a plus’ (a strength exhibited, a survival accomplished, a capacity retained) and building from there.
(This bibliographic entry is © Yoland Wadsworth 2005)

References

- Cooperrider David L. and Suresh Srivastva (1987) ‘Appreciative Inquiry in Organizational Life’, *Research in Organizational Change and Development*, Vol.1, pages 129–169.
- Cooperrider, David and Whitney, Diana (2001) *Appreciative inquiry: A constructive approach to organization development and social change*, Taos, New Mexico: Corporation for Positive Change, n.d. – summary material available on the website of the International Institute for Sustainable Development: <http://www.iisd.org/ai/>
- McCashen, Wayne (2005) *The Strengths Approach*, St Luke’s Innovative Resources, Bendigo

Resource E

An agency reflection on 'first time' narratives

How ISIS undertook the challenge of reviewing a 'first time' narrative evaluation

Step 1. Self-blame – 'We're not good storytellers', 'We don't know what we're doing' 'I hope what we've written is all right and acceptable'.



Step 2. Reassessing the situation – 'This template is just not working for us – and looking at others – the template really hasn't worked for them either'?? Why not?



Step 3. Realisation – 'One-size-fit-all templates just don't work – we need more background information and guidance before we consider developing a narrative that is reflective of what a narrative should look like.'

Our thoughts about the key features of a good narrative

What is a good narrative? (prior to reviewing the texts on narrative writing)

- Communicates a clear insight into the mind of the writer.
- Is about providing information to the reader enabling them to visualise and/or picture the story line/story in a clear, concise manner.
- Provides clear information that sets the scene.
- Identifies a clear and concise process or order of events.
- Is written in a 'script like' way.
- Describes 'the decisions' that are made along the way.
- Clearly conveys all of the barriers that occurred along the way.
- It tells a story – a story that starts and ends wherever you're at, at that point in time (decided by the narrator of the story). The narrator and its participants determine the method in which the story is told.

What is a good narrative? (following review of texts on narrative writing)?

- Contains description, explanation and reflection.
- Is written by **your** experience, it is **your** point of view. It reflects how what you did affected the actions of others, why you did it and how it impacted on others.
- It is written from the view of 'I' or 'we' **not** 'he' or 'they'.
- Don't make other's story your story.
- It is written in a context so it is meaningful – it doesn't assume the readers know everything (project, your position, role, background, work environment).

It provides a context

- Who was involved?
- What actions you and others did.
- When and where actions took place.

Explains how decisions were made

- What personal/professional skills contributed to the projects success? If lacking, what skills were required?
- Explains why you chose the action.
- Was there consensus with other workers/participants or any disagreements?

Other

- Before writing a narrative you need to be clear of the purpose and target audience. What do they want to know (critical knowledge of practice, impacts, lessons, decision making processes)?

What was lacking in the [first set of] agency's narratives – according to our definition of a 'good narrative'?

- Too structured.
- Weren't certain whether we were required to report/record a narrative that was reflective of all of the individual initiatives within the plan and/or an overarching statement/narrative about the priority area.
- Too unwieldy – each plan had multiple strategies and interventions and to write a narrative on all of these would have been far too unwieldy (i.e. different service providers undertaking different strategies in the plan – 'how do you really gather all of that information?').
- Needed to really separate the 'quantitative plan' from the 'narrative' to really get the information required in a narrative.
- Time – very time consuming – how much time do we allocate to evaluation when there are so many other competing demands?
- How should the narrative be written? – 'A reflection of the HPO', reflection of all participants?' Confusion+ +
- How can we engage the reader?
- There was recognition that it was incredibly difficult to capture so much work and information in 1.5 pages.
- Our understanding of 'narrative' was poor and this was reflected in the narratives developed.
- The narratives didn't tell a story (not informative, particularly to the individual who wasn't totally informed about the background etc. of the initiative).
- No flow – very rigid in nature.
- Headings used which created a document that was very 'formal' – and one that didn't allow for the casual flow of information and insight.
- Didn't capture the flow of how things really did happen.
- There was poor insight into the mind of the 'writer'/'facilitator' (including the discussions, decisions made, what hindered particular decision making).
- We made our information fit into 'what we thought was expected of us'.
- Information provided was superficial (there was no explanation of what was really going on 'behind the scenes').
- The headings didn't help – they provided a structure – in which we automatically used to create a series of structured 'dot points'.
- Weren't really sure of what level of detail was wanted – 'will Department of Human Services really read our story if we include too much information?'.

What was lacking/positive in the [2nd agency's] set of narratives – according to our definition of a 'good narrative'?

- Able to reflect on the outcomes of the initiative and identify opportunities for improvement
- Not jargonistic
- It was a factual account of events rather than a flowing 'narrative'.
- This narrative showed how really difficult it is to capture so many initiatives utilising this type of format.
- Similar to the others' narrative – it was written in a form that was difficult to follow i.e. inadequate background information to set the scene for the unformed reader.
- Narrative was not written from the actual service provider's perspective.

Suggestions [reflections] for the more effective narrative writing as a form of evaluation in a community health setting

- It was a very 'new' and different method of reporting and evaluating – thus the provision

of an 'example narrative' would have been useful.

- Further consultation about 'narrative' and the expectations of organisations in delivering narratives as a form of evaluation.
- The 'one size' fits all (i.e. community health utilising the same format as used by PCPs) narrative templates should have been reviewed (for appropriateness) prior to being utilised by community health organisations.
- Feedback about some of the features of a 'good' or 'bad' narrative (as displayed in the narratives forwarded to the Department of Human Services at the end of the reporting period) – would be useful to get some idea about what to think about/look for when utilising this method of reporting.
- Need to know who our audience is. What do they want to know? Level of detail? If audience wants self-reflection – need to have separate narrative written by each initiative leader (rather than HPO interpretation).
- Fantastic that we've been given an opportunity to have some input into the development of future narrative templates. However, this should have occurred at the beginning of the reporting process.

Postscript

Another agency later noted the difficulties of telling an honest narrative about a politicised issue (that was also complex) and where there was strong emotional investment in the issue. One response (suggested by the experience of a further agency) would be to continue to try and 're-frame' and retell the story until a shift takes place to a new way of seeing the situation that can be shared but still does justice to the actual experience. Try asking – 'what can we learn from this?' (dig deeper).

Resource F

Some questions to guide narrative evaluation

The two agencies in the first phase of the NEAR project provided the following advice regarding approaching the guidelines for narratives writing. The Planner (Resource H) represents the NEAR project's combined wisdom on an overall framework of questions to guide narrative evaluation writing.

[1] First agency's advice

Agencies are required to submit a narrative section for priority issues identified in their 2002–03 Integrated Health Promotion Organisational Plan. There should be one narrative written for each priority issue. The narrative report provides you with an opportunity to discuss, elaborate and reflect on the evaluation documented in part two.

You may like to use the following prompts to influence your narratives:

Reflecting on Planning Process

- Reflect on the quality of planning and consultation in prioritising the health issue.
- Did the identified issue change in focus over time?

Reflecting on Implementation

- How do you feel the implementation of the interventions went?
- Reflect on any learnings or barriers related to work on the priority issue.
- How realistic or achievable were the goals, objective and strategies and target group chosen?
- How effective and representative was the participation of key stakeholders and the community in planning, implementation and evaluation.
- What could you have done better?

Reflection on Evaluation Processes

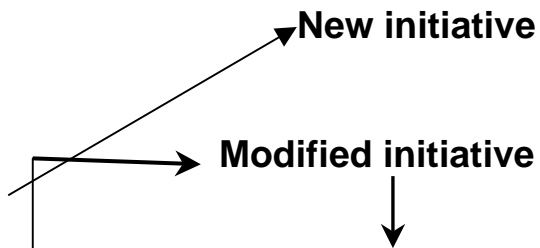
- How effective and realistic were your evaluation processes?
- Were there differences between planned and implemented evaluation processes?

Reflection on Future Action

- What could you do differently to address this issue next time?
- What resources/ capacity do you need to further contribute to this issue? (time, infrastructure, personnel, community participation)
- What are you going to do next about this issue?
- Any other comments.

[2] Second agency's advice

Narrative evaluation story telling



- At what stage is your project at?
- What have been some of the significant events that have occurred along the way (if you choose to, these could be plotted on a continuum)?
- What were some of the highlights/barriers that occurred along the way?
- How did you personally respond as a result of the events, highlights and barriers (for example, changed the direction of your initiative)?
- How did others respond (key stakeholders, consumers, community participants, co-workers)?
- If changes were made – how did you and/or others feel about these?
- What has been the outcome of this change (for participants, community, self)?
- If you could do this again, what would you do differently (assuming that this initiative is complete)

- What is your future vision/expectations for this initiative?

Resource G

What makes a good narrative?

At its simplest a narrative is a story; a spoken or written account of connected events in order of their happening. The art and practice of narrating is about telling a story that *communicates* this (the events, the connections, and the order of happening). Both spoken and written narratives can draw on each other's devices – the 'dramaturgical' (the stage, the movie, the schoolhouse) for the spoken; the 'literary' (the book, the paper, the letter) for the written.

Without time to delve deeply into textual theories and approaches (for example, rhetoric, formalism, structuralism and semiotics, critical discourse analysis, narratology, genre and post modernist discourse theory :-) or even generative approaches (techniques for writing, heuristics), analytical approaches and the synergies between these, this short practical brief conveys the basics of writing a narrative evaluation using an action research approach to change and improvement.

What's the story?

Choose what type of story to write – is it a health promotion mystery? A thriller? Comedy? Redemption story? Are you Jeremiah thundering forth with a message of doom to shock the folks out of their myopic complacency? Or are you Mills and Boon with a romantic and heart-warming love story of silly human misunderstanding leading to loss of Eden climaxed by reunity and hope? Or do you want to tell several of these stories? What exactly is your story going to illuminate about the project or program? Encapsulate the basic story in an inviting title. Now tell it in one sentence as if to a curious person you meet at a party – 'what's the story?' Write it in a paragraph or two as an abstract. What is it about? What's it really all about?

Who are you telling this story to?

Think about who you are writing your story for and orient the story to *them*. Are they interested in this story do you think? Why? What interests them most and why? What drives them? What do they know and think right now about the 'evaluand' of your story? Do you have to bridge a gap between them and their world – 'where they're at' – and your story? What is the nature of that gap?

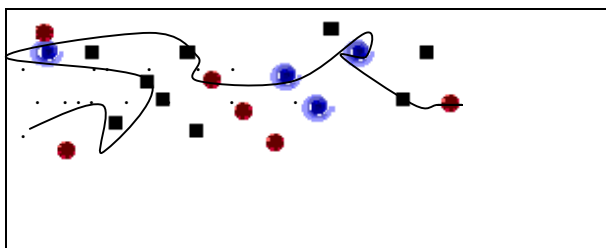
Use the story, genre, language, examples, terminology and style appropriate for them to best *'get it'*.

Who's telling the story?

Whose story is it? Decide on the way you want to tell your story – is it your personal voice? A warm collegial voice? A cool professional voice? A disembodied scientific voice? A bit of each? Is it 'I' or 'we' or 'them' or a combination? Is it your story to tell? Which is the best story for *you* to tell? Do you want others to tell parts of the story with you? Is it multivoiced? What feels like the 'right' voice to tell it in?

Give the story a basic structure

What is the storyline? Of all the possible things you could say, which stand out for you as the highpoints or features that are **connected** in this story? Is it a straight logical line? Or is it more like a circle. Or does it go round in circles? Was it a circuitous story with false starts and dead-ends? Hold on to the main plot as you go up all those sidelines. There may be a lot of data, detail, and numerous things you could say – the 'dots'. You are finding the 'story' between them that you want to tell – identifying the lines or **threads** of the story', and the dots or **features** of the story.



A start...

What was 'the start'? Capture your listener's attention. State the problem. Even dramatise the beginning a little (even if it's to say how unremarkable it seemed at first). It will often involve a contrast between things. Orient your reader. You want them to ask 'what happened next?'

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Who are the players? The characters. These may include disease states or physical environments, abstract populations or real communities! Characterise them. Give them a 'voice'. Make them 'speak' to the reader. Check the cast of players are each introduced at the right time in the story. Who (or what) was there at the start? Who or what came later...And what were their roles? What parts did they play? Were there unexpected changes to the lead characters? Do they speak to us? Can we see ourselves in them? Can you personalise to achieve this?

Now **the setting** (or settings). Characterise them too. What is in the background? Can we see, hear, smell, and feel the stage, the backdrop or environment? Does it touch us? Is there anything interesting going on 'behind the scenes', 'off stage', in the audience, outside the 'theatre'?

...a middle...

Having jumped into the action, what is the unfolding story? (Make the 'middle' as absorbing as possible)* What exactly has happened or is happening?

Identify progress or lack of it. There may well be complication. Were there stops and starts or stages? Events, highlights, surprises, barriers? Foreshadow or refer back to them. Show how the evaluative thinking unfolded and the data, evidence, observations, explanations and how theory/theories developed. It can help sometimes to give a heading to each paragraph to work out whether it would read better if their order was rearranged (to prevent the story being literally 'all over the place'). Maybe some paragraphs are about the same thing and it's better to combine them (or even reduce them if one or two can tell it best). Maybe you want a little bit of repetition to heighten the telling of the story...

...an end

What was the end of the story you are telling? (Even if the end is only provisional – a 'current' end. It might even be a never-ending story... :-)) Work out what is the degree of certainty and closure or/and emergence and change still going on around the conclusion/s. Make the end as satisfying as possible, whether it is conclusive or not...the story needs resolution. Have people got the 'take-home' message/s in how you've conveyed the story (without rather woodenly announcing them)? Indicate any possible futures that might follow... What *could* come next? ('Stay tuned for the next exciting episode...!')

***Create credibility by evidence and rich 'thick' description**

Throughout your story use rich complex detail, nice turns of phrase, a bit of colour, crisp vignettes and illuminating direct quotes and graphical presentation. Build the evaluative story with the necessary data and attention to rigour, thoroughness, etc. Don't lose important detail that the reader needs in order to 'get it' re: the points you are making. And don't give so much extraneous detail they get lost. Reduce superfluity. Simple sentences. Precision. Show, don't tell. You are aiming to deepen the reader's understanding. Take them along with you on the research journey of 'discovery'. Give surrounding contextual information that helps them make this deeper sense of it all. Ask: What is going on? – What is *really* going on? This is a gestalt or hermeneutical approach to illuminate the figure by the ground and vice versa. The power of narrative rests in the sequencing of reasons, reasoning and explanation.

Find ways to surface the undiscussibles. Be as transparent as possible. Is this the whole story? Or are there other truths, other perspectives, controversies, paradoxes, contradictions, or 'stuck spots' in this story? Would it be useful to show them – even feature the conflict as well as the false starts, your original hunches and how they got

transformed? Dramatic contrast may help ('On the one hand we/or others thought such and such... but on the other hand we knew/found/noticed such and such...'). If your reader knows about these and doesn't see that you do too, or how you have responded to them, will your story be less plausible, less evidenced, less credible? Modest statements of obviously overwhelming conclusions will convince better than overstated weak conclusions.

Research shares with both literature and theatre an important potential characteristic of narrative:

"It can show you things you have never seen before and will never forget."³

References

Scan down to Narrative Paradigm and open Ch 23: <http://www.afirstlook.com/main.htm>

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http://www.alfred.north.whitehead.com/AJPT/ajpt_papers/vol03/03_rankin.doc

An appreciation and critique of Foucault, Damien Broderick, Melbourne University

<http://www.lib.latrobe.edu.au/AHR/archive/Issue-February-1998/broderick.html>

See an exemplar: **Resource J** 'Marjorie Oke and the Hydrotherapy story (Vale)' as an example of an engagingly-written narrative.

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³ <http://www.learner.org/exhibits/literature/index.html> [do not under any circumstances click on the door!]

Resource H

A planner or checklist of questions for narrative action evaluation writers

To bring together the elements of narrative, evaluation and action research

Firstly... two design issues:

Who were the stakeholders?

Who are the interested people/stakeholders/or participants? Who is involved already? Who should be? Who could or should also give their views as part of this story? Or who else should be here telling this story with you?

What were the practicalities?

Together with those others/stakeholders/participants, consider where, when and how would be the best way to capture and share these observations and experiences.

Retrospective evaluation

Firstly, looking back to see how things have gone so far...

What was being evaluated?

Name the area of activity, interest, issue, 'claim, concern or issue', practice or project...

What did we observe?

Looking at the whole... and

Looking at the parts...(for example, a range of activities that make up a program; or different parts of a work area; or different aspects of a project). Describe for each what you have – so far – seen, observed, noticed or heard about it... Why are these things being done? Why like this? Who identified the need (the participants, you, or the organisation)? What were the hopes?

What was its value? – 'Open inquiry evaluation'

Evaluate value, merit, worth or significance so far...

Overall, how is it going? Is it working well? (or not) What makes you say that? Describe what you've seen, observed, noticed, learned etc. (...and what others have seen, learned etc. too). Try answering using a three-column matrix format: [1] Good or not so good? [2] I know because before (we observed) [3] Now its changed in the following ways....

Did we achieve our objectives? – 'Audit review evaluation'

You may have set out to achieve certain goals or objectives in relation to this activity, interest, project. What were they? What were your planned indicators and targets or signs of achieving them? Were they met/achieved do you think? What happened? What were the actual outputs and outcomes? Try answering using a three-column matrix format: [1] We set out to... (goals, etc) [2] Our indicators/targets were... [3] Achieved or not achieved? You might refer explicitly here to the statistical reporting accompanying the narrative report.

Why was it like this? – Analyse/Think/Reflect

Stop and reflect on (or analyse) what you think you are seeing. What do you think was going on here if you saw that sign? Why you think those signs or reasons actually made it good or not? What do you think was really going on here? What is your reasoning or logic about this? How do you explain successes or problems?

© Yolanda Wadsworth in association with Fran Peavey (2006) *Building it in...*

How did we feel about it?

Now stop and reflect on how you feel about it. What made you feel like that was a good (or bad) sign? Why did it seem like it was right (or wrong)? Good or bad?

A threshold or liminal question..... Did you want change or not to change?

Looking back, did you want to change or improve the activity, project, etc.?
What did you learn?

Prospective evaluation

Now looking forward from 'what was then' to 'what could be'...

What was the vision?

How did you clarify your vision about what you either had hoped for then (and still hope for now) or, with hindsight, what you thought you would do differently or what would be better (or even better)?

What needed to change?

What change or changes did you decide would be needed to bring the situation towards the desired/ideal/something better? What did it take to make that happen? What actions, steps, pathways...? Who else needed to be involved?

What alternatives were there?

Were there alternatives you considered? Even seemingly 'way out' ones or suggestions that seemed at first impracticable or unworkable. This was the creative 'out of the square' moment. Did you listen to soft voices, different-from-us voices, and community voices belonging to the least powerful or most stigmatised, and possibly ones you disagreed with?

What were the consequences that led to your choice/s?

What were the consequences of going down these different tracks? What was the affect of taking up the idea? How did you feel about doing this? What were the responses to it by all the stakeholders? What were its strengths, weaknesses, opportunities, threats? Which had the most energy attached to it?

What actions came next?

When you settled on a course or courses of action, who did what personally? How did people collaborate? What were the actions that you or they could see could be taken next? ...And which you or they **really wanted** to take?

What support did you need?

When you identified your part in it, what did you personally, or each other person or collaboratively, need in order to actually **do** it? What did it take – what support, assistance, information, resources, people and etc. was needed?

Monitor... and...

What are you seeing now? Now you were giving it a go.... Did you monitor – observe, describe and evaluate it? What changed as a result of your work?

And what have you decided to do next?

Yes! ...It's an action evaluation research story! An ongoing story...

Resource I

Extract – A practitioner reflects on the value of narrative action evaluation

1. Allows time for true reflection

The process of **documenting** your reflections can be powerful and insightful to yourself and others. Almost like a diary:

“The support to use the action research model for evaluation gave me the time to think more deeply about what was happening with the Safe and Strong program and relate it to broader issues of health such as access to transport and social support in the [local government area].”

...interviewing the [community participants] also gave them time to reflect on their participation. It was empowering for them to know their contributions and thoughts were being valued.

2. Richer, more in-depth form of evaluation adds enormous value to our typical evaluation measures focused on hours of service delivery time or client numbers

“...After all, what has more impact when reading an evaluation: how many times someone can put their foot up and down on a wooden block in 15 sec or a quote like this: 'Well I'm going to Sydney for 8 days to stay with my nephew. [before] I couldn't get up an escalator. I was scared to go anywhere. But now I can actually go somewhere.'”

3. Provides greater insight into the valuable role of community health: the close connection it has with community people and the difference it makes to people's lives.

4. Less jargonistic; more honest; more engaging and more interesting to read.

Challenges

- Time consuming. One to two weeks full time work for each story including arranging interview time, tape recorded interviews, transcribing interviews, preparing drafts. Forwarding drafts to original participants to approval.
- Deciding on which voices to include or in determining **who** is telling the story. Who owns the story and also who decides which voices to include?
- “I found it confronting to show my evaluation to those I interviewed as I had not done this before. However, really useful to check out if I was on the right track.”
- Making the narrative concise and therefore sticking to the word limit.
- Lack of feedback: Project team didn't provide any feedback on our drafts. Often raised further questions which helped us realise the complexity of the process.

Recommendations

- Narrative evaluation is a very valuable and valid tool in the mix of evaluation strategies in community setting.
- It is however very time consuming, so we would need to be selective and considered in when and how it was used. Need to be very clear what the purpose is for and whose story you would like to relate.
- Would need strong management support and recognition for the process to be successful.
- Consider incentives for health centre to utilise this model. Showcase or forum for the stories.

Resource J

Marjorie Oke and the hydrotherapy story (Vale)

Marjorie Oke was a significant figure in the community, health and self help health scene for many years from the 1980s. She was a member of the Health Issues Centre Committee of Management and an Ambassador for Health for the Victorian Health Promotion Foundation's 'Active At Any Age' program. Through these – and many other areas of activity, Marjorie's sense of responsibility and desire to take the message of self-determination and holistic health and the part that could be played by supportive professionals, meant she seized the opportunities to contribute wherever and whenever they appeared. She was also a great teacher via the telling of stories.

We have reproduced at **Resource L** her group's contribution to the first CDIH collection of case studies. The following is an extract from a Vale after Marjorie's death soon after the NEAR project had commenced, which was contributed by Yoland Wadsworth to a Memorial Service at the YWCA on 29 August 2003.

It was circulated as a narrative format example for the NEAR project training workshops' purposes.

The Northcote Hydrotherapy Group. Such an incredibly ordinary name for something that became – with Marjorie Oke's vision, drive and the energies of more than 20 people – so truly remarkable.
Northcote: yes
Hydrotherapy: yes
And yes, a group.

But in reality so so much more:

- more like a wholistic life support system
- a comprehensive vitality-enhancing system
- an exemplar of health development or health promotion practice

First up, swimming skills were relearned (or learned from Marjorie for the first time by women and some men in their 70s, 80s, and 90s).

Massage and physiotherapy exercises were initially received from the professionals – but small grants were then sought to enable the skills to be taught to and then shared among group members using a trainer-the-trainer approach (before we knew that term so well either).

Friendships were formed, everyone had a place.

More small grants were applied for – for bus trips not just to the pool but also to interesting places otherwise inaccessible.

As soon as funds were found, no time was wasted and off people went to the Ballarat Begonia Festival, to Phillip Island, Lorne, and Hanging Rock.

Disabilities were overcome, crutches and walkers and even wheelchairs were dispensed with ...and another job was created for a group member, as tour organiser.

Diets changed (effortlessly) as recipes and food were shared on picnics, bush walks, at meals together and birthday celebrations.

Over food, stories were told, emotions shared, memories and current realities of love and violence, work and marriages, childbirth and death.

The group became a survival system.

Poetry was written.

Cheap tickets discovered for arts and entertainment events... a play could be attended.

More modest sums were hunted down by Marjorie – this time for a newsletter, and a journalist job created for a group member for whom this had once been their career.

Then the group started to become its own formal education system. Seminars were attended. Information exchanged. Interesting people met and listened to. Members began giving guest lectures to public health university students on the benefits of this kind of holistic self-help effort which was supported at critical moments by helpful health professionals who worked 'with and for' not doing 'to and at'... A group secretary role emerged and morphed – when a letter arrived from a funder addressed to 'the Administrative Officer' – because that sounded a bit flash and a bit of fun! People enjoyed themselves. Mutual respect multiplied.

Health bloomed...

It was their group.

And then one day at the pool a younger woman with a camera was welcomed.

A small grant submission for precisely \$673 was written in 'spidery old lady's writing' (in Marjorie's words) to fund Meme McDonald's photography and taped stories, ...and a professionally published Penguin book of oral history with exquisite photos of the honest beauty of ageing ensued.

And then a calendar...

And the possibilities went on... and on...

... unfolding... unfolding... unfolding

This was not a group – it was a complete organisation.

A virtual village! A true community.

Marjorie practiced her 'whole systems research on-the-run for whole health' for more than a decade. Not even a bus could stop her – though there was one that damaged her savagely.

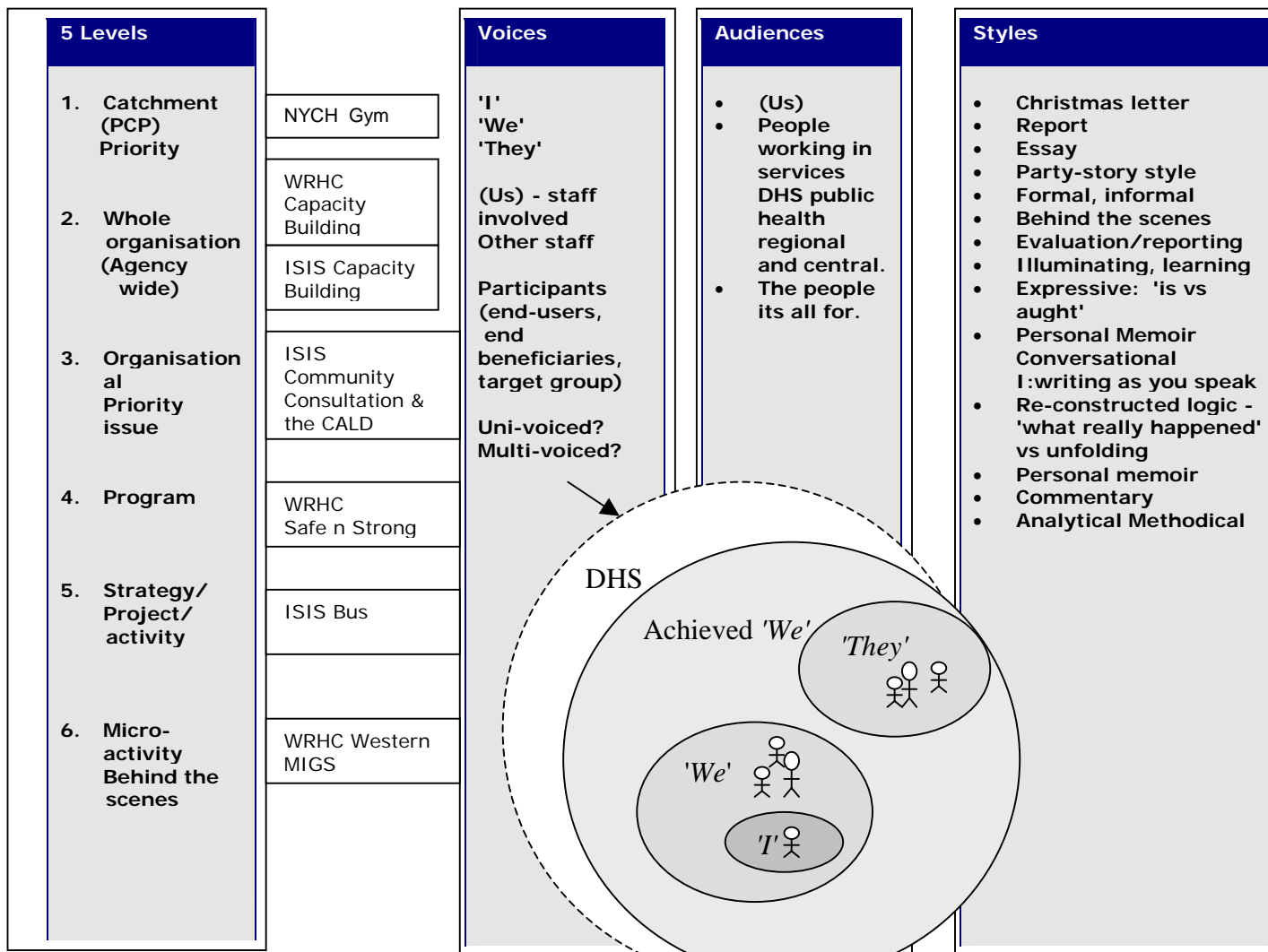
Vale Marjorie. We will never forget you.

Resource K

Map of levels, voices and styles

A NEAR working document: a map (locating the different narratives)

The 12 case study narratives (**Section 4**) are pitched at a range of levels, drawing upon different voices, and written in different styles. Each narrative also speaks to several audiences/stakeholders. This map may assist other narrative writers locate their story, their voice and their own audience/s. The examples given are mostly from NEAR Phase 1.



Abbreviations

CALD – culturally and linguistically diverse
 ISIS – ISIS Primary Care
 NYCH – North Yarra Community Health
 PCP – Primary care Partnership
 WRHC – Western Region Health Centre

Resource L

The Northcote Hydrotherapy case study

(extract CDIH collection 1st Edition 1988)

Older, healthy and mobile

Joyce Spokes, Helen Lewis, Estelle Cotter, Eileen Larkin, Beryl Grover, Kathy Rush, Marjorie Oke, Iris Wileman, Ann Graham, Lina Cintino, Ida Dolinko, Elsie Warren, Cathy Tibbett, Del Brown, Lois Shugg, Sam Watchorn, Sheila Baldwin, Ada Handyside, Ethel Butcher, Val Goad, Reg Warren, Cliff Dodd, Shirley Wilson, Rosei Visione, William Atkin, Doug Butler, Peggy Stenterg

© 'Older Healthy and Mobile' (1988) *Community Development in Health Case-studies in Community Development in Health Resources Collection*, 1st edition, Community Development In Health Project, Northcote, Victoria

This case study focuses on the evolution of a health centre run hydrotherapy group into an independently run self-help group.

The group, largely composed of older women who are on full pensions, has since expanded its activities to include bus trips, newsletter production, massage and the publication of a book. The self-help group fulfils the physical, emotional and social needs of the group.

The group has taken the concept of self-determination further by lobbying for funds to ensure the provision of appropriate resources.

People in the group have shown remarkable improvement of health. The undeniable changes in physical health are a result of hydrotherapy and massage. The improvement in mobility, the companionship and friendship of others has enhanced their sense of empowerment and purpose to lead a full and active life for as long as possible.

Background

In the early 1980s the physiotherapist from the Northcote Community Health Centre (NCHC) in Melbourne was treating people for a variety of health concerns – repetitive strain injuries (RSI), arthritis-related pain, injuries related to car accidents and incomplete movement ability. The physiotherapist found that some of her patients were not responding to the treatment, which she was giving them, so she decided to try hydrotherapy, that is, gentle exercises in warm water. This proved to have beneficial results and soon the physiotherapist was taking two groups of women to hydrotherapy at the YWCA pool.

“many going to hydrotherapy...had difficulty getting on and off trams and buses, and many could not walk very far...”

The two groups were quite mixed – there were a variety of new and older migrants, as well as Australian-born women, between the ages of thirty to eighty-four. Our group consisted of mostly older women on pensions, who lived in the northern suburbs – Northcote, Thornbury, Fairfield. Many of those going to hydrotherapy at this time had difficulty getting on and off trams and buses, and many could not walk very far – so the physiotherapist had to pick them up and take them home again.

It wasn't long before the physiotherapist's faith in hydrotherapy started proving its value. Recently when we met to talk about our involvement, one person summed it up when she said:

“We all feel that the exercises have been wonderful, not only the exercises, but also being at the pool with people means a lot.”

‘Health wise’ we are all much better, everyone is ‘swinging’ more freely from the hips, much pain has disappeared or lessened and people are saying how ‘young’ we are all looking. In fact, many who came to the sessions with walking sticks, back braces and such, and those whom

we had to push and pull onto and off the bus are, after regular hydrotherapy sessions, able to walk to the trams or bus stops; once again use public transport; do their own shopping and some have even put away their walking sticks!

The following comments are typical of what hydrotherapy and being together has done for us:

"I have four of my disks in my lower spine worn out with arthritis, and my knee as well, so a few years ago, my doctor suggested hydrotherapy. Up till that time, my life was miserable because I had to wear a metal brace to be able to walk... my life and health since then has changed for the better, it keeps me going... we became like a 'close family'... I don't know what would I do without my friends..."

"...there's a youthful energy in our group...that gives people the will to carry on."

"I suppose God gave us water for many purposes, healing and faith, pleasure and business, a power of strength in its own right, so why not? To bring better health and happiness to sufferers of arthritis, disabled people, and a lot of social happiness to many lonely, forgotten and sick people."

"... the group in the baths, even doing our exercises in the baths is much more fun than standing there doing them on your own..."

We all feel that we have really proved something, not only to ourselves, but to our doctors. A common experience amongst members of our group has been going to doctors with a complaint, and being told: "Oh it's just old age". Well, we're tired of being told that and now we have found something that we can do for ourselves. Everyone tells us how much better we look, there's a youthful energy in our group; an enthusiasm, goodwill, good spiritedness and friendship that gives people the will to carry on.

Some members of our group have been told by their doctors that hydrotherapy is a waste of time and doesn't do any good anyway. Now members can go and show their doctors that it didn't waste their time and that it was worthwhile. Doctors need re-educating on a whole lot of things and our group is doing that.

On our own

We had been going to the pool with the physiotherapist for about eighteen months or so, when she told us that the doctors were referring so many new people to hydrotherapy that she couldn't cope with all the numbers. She then suggested that we organise ourselves.

We were happy to do this, but it meant that we had to hunt around for another pool because up until then the Health Centre had been subsidising us at the YWCA. As we were all pensioners, we felt we couldn't afford the three dollars a week that the YWCA charges.

Therefore, we looked around at various pools and found that we were either unable to get a convenient time or had to go in with the school kids, and one pool was designed in such a way that we basically had to be contortionists to get in and out of the water. The Melbourne City Baths, however, had just been renovated and were beautiful: nice, airy and sunny. We found that we could get in at the time we wanted at a pensioner concession rate. As one group member had a swimming qualification, the City Baths were willing to accept her as the leader; she was responsible for the group and led us through the series of exercises that the physiotherapist had shown us. The physiotherapist advised her on what exercises to do with people who had particular problems. Now, another member takes turns leading the group in exercises and when these two members are away, the group does exercises without a leader! Every now and then various members introduce new exercises that they have heard of, such as exercises for incontinence or for the eyes; we just learn different things as we go along.

"as one group member had a swimming qualification, the city baths were willing to accept her as the leader; she...led us through the series of exercises that the physiotherapist had shown us."

The City Baths provided a good environment, but we did have a few problems getting the water to be the right temperature. We lobbied and carried on a two year campaign with letter writing to the manager and the Melbourne City Councillors, but they said they couldn't do anything because the other people who practiced swimming in the big pool needed it cooler than we did for hydrotherapy. We then found out that the Box Hill Baths had three different temperatures, so we dug the manager out and asked him to find out how they do it. With this information the Melbourne City Council was able to finance the desired changes in their next budget. They eventually got it right, but if we hadn't kept up our moaning and groaning, it wouldn't have happened.

"with this information the Melbourne City Council was able to finance the desired changes but if we hadn't kept up our moaning and groaning, it wouldn't have happened."

Introduction of massage

Recently we've introduced massage into our activities. This came about because one of our members had been having face massages and had found it to be beneficial. So we applied to the Women's Trust Fund for funding to learn massage and were successful in receiving a small grant. The Health Centre made a room available for us to use for massage and a masseuse came there to teach and massage us. We soon realised that the amount of funding which we received was not enough, so with the assistance of the Local Council and Community Health Centre, we obtained more funding which lasted until Christmas. In 1986, we gained a self-help health grant from the Ministry of Health to further our activities.

When we are massaging each other, if we have any doubts about what to do, we ask the masseuse:

"What about this or that?"

and she'll come over and check something out. She keeps her eye on us, and new members are treated by her before we get to work on them. She advises us what to do.

Most people who have the massages find that they are very good for pain and tension as the following demonstrates:

"... since we've introduced massage into our group, my neck gets done every week, my face gets done every week my sides are better; I don't get the aches and pain anymore..."

One person in our group, who is in her eighties, lives in a very stressful home situation and comes every week to have the tension massaged from her neck and shoulders. Someone suggested that she should sort out her problems and not depend on massage. However, her situation is very difficult – looking after her husband who suffers with emphysema; so she has her massage and finds that it helps her to cope for another week.

Everybody involved in the massage works together, the Health Centre's physiotherapist and our group are very thorough about the medical side of what we are doing.

"most people who have the massages find that they are very good for pain and tension..."

Since we started the massage, five men have been referred to the group, although they are not doing hydrotherapy – only massage. One of the men used to have very swollen ankles: the flesh just stood out around them but with massage the swelling went down. One of the others has spondylitis, a condition in the spine which results in pins and needles in the feet – this is what he has to say about massage:

"the combination of the hydrotherapy, massage and the company has given us all a sense of 'youthful' energy."

"...my feet, although still with pins and needles are only about a quarter as painful as they were. One time I couldn't bear to stand up, on account of the loss of blood in my feet, they were more or less dead. They're not now..."

The combination of the hydrotherapy, massage and the company has given us all a sense of 'youthful' energy.

The early development of our self-help group

In the early days when we started going to hydrotherapy, we were simply an informal group of women. However, in 1984, whilst on the way to the baths with the physiotherapist, one of our members said:

"Oh, I haven't seen this part of Melbourne for so long – it's lovely to go here."

A few of us felt it would be great if we could take trips together and get out more, especially those who have great difficulty with mobility. We knew that we could get the Council bus on the weekend – but we needed to pay for a driver. We all thought that having each other's company would be good. As one of our members said:

"You go up shopping, you never meet anybody you know...that's the point – loneliness..."

We spoke to the physiotherapist about the idea of bus trips and she agreed. One of our members went to see the Council's Recreation Officer, who gave us a form to apply to the Department of Sport and Recreation for funds for a driver. At first people in the group did not have very high expectations or enthusiasm about getting the funds – they were not accustomed to asking the Government for money, usually they were the ones paying out.

The physiotherapist helped us with the submission and the Health Centre offered to receive the funds on our behalf (as they are an incorporated body) and provide us with the services of their treasurer and auditor. We were successful in this submission – we got \$1000! It was at this time that we came to call ourselves the 'Northcote Hydrotherapy Self-Help Group'.

We wasted no time. Our first trip was to the Begonia Festival in Ballarat; since then we have had trips to Point Leo, Phillip Island, Lorne, Hanging Rock and other areas. One of the members has taken on the job of tour organiser; she arranges the bus, maps and program for the day. These outings have been successful in getting people out of their homes and encouraging people to be active in the company of others, as demonstrated by the following quote:

"... we had our lunch at Stevenson's Falls. Before that we went for a walk to see the water falling down. I shall never forget that view. Some of the very 'brave girls' climbed to the top."

Recently we learnt that Arts Access has 'Ease Tickets' which help groups on low income and people with disabilities to have cheaper admission to entertainment. This is really wonderful for us as we can now, individually or as a group, enjoy theatre, which was once beyond our means. The play 'Seven Little Australians' was our first outing. We are happily looking forward to many more such pleasurable times.

"...we were once isolated and in some cases living alone, we now have each other's support."

Great friendships have developed amongst us all; where we were once isolated and in some cases living alone, we now have each other's support. In particular those who have come from overseas, places like the British Isles, Poland and Italy feel warmly accepted and part of the group. They talk of Northcote as their home.

Our committee

We have what; technically, can be described as a 'committee meeting'; once a month we get to the baths an hour earlier and talk about how things are going and what we've arranged. For example, our 'tour leader' asks us to suggest where we would like to go; or our 'submission writer' reads what she has written. If there is anything contentious, we sort it out at these

meetings and get a majority decision on it. No-one goes off and makes decisions on behalf of the group, everything comes back to the group – it's a democratic process.

We also meet to plan our newsletter and from time to time everyone contributes things that interest them. We use the Health Centre's photocopier for the newsletter, but pay for our own paper. Our editor, who is eighty-four, was once a journalist, poet and cartoonist.

Educating the community

In October 1987, the Director of Wyuna Nursing Home asked if some of their clients could attend our hydrotherapy classes. Those that came had severe disabilities: they came in wheelchairs, were lifted into the pool by nurses and held all the time they were exercising.

They joined in our 'hokey-pokey' exercise and one woman, who had very little use of her arms, amazed the nurses by being able to get her hands under her chin. The nurses could also faintly hear her singing 'hokey-pokey', whereas they had previously thought that she had lost her speech ability.

"...we are in the fortunate position to pass on our experiences to the community in the form of a book."

It's important to us that people in nursing homes be integrated into activities like ours, as we feel that this would improve their lifestyle.

All our members feel that we have gained great benefits from being involved in hydrotherapy, massage and self-help. Now we are in the fortunate position to pass on our experiences to the community in the form of a book. We were inspired by the work of a photography student from the Australian College of Photography, who approached us at the baths and asked if she could take photos for her assignment, entitled 'From Dark To Light'. This title was symbolic of her change of attitude to being old. When she met us she was afraid of old age:

"but since meeting you all, I have grown from a dark attitude to a light attitude to old age, I am not afraid anymore."

We decided that it would be wonderful if that theme could go everywhere and so we applied to the Consumer Health Forum for some funding to establish our own book, entitled: *Growing Older Is A Lifelong Process. Enjoy It!*. We were successful and are currently working on the book. The same photography student (who has now completed her course) is helping us put the book together – she is doing some taped interviews and we are using her photos.

The future

For the past three years we have been talking to the Northcote Councillors about a pool for hydrotherapy. There have been some discussions between the City Engineer, the Town Planner and the Health Centre. Plans have been drawn up and leaving nothing to chance (or the experts) we made it our business to see the plans and suggested changes, so as to ensure that the needs of older people are taken into account.

Unfortunately, at this time the Council does not have the funds for their plan, but we keep our fingers crossed and hope that we might, one day, have a hydrotherapy pool in Northcote.

In summary

Our group is probably successful because of the support from the Northcote Community Health Centre – Committee and staff – who were and are happy to help us. Our physiotherapist who took us to hydrotherapy was certain that we would be able to develop as a self-help group. We could ask her for advice, as well as other staff members, who were prepared to give their time when we called. We have always felt that they loved us and were happy to see us developing and carrying out new ideas.

We knew we had good medical care and advice when we did think up new ideas. We have never been a sub-committee of the Health Centre, we have always made our own decisions; we talk things out and have become more articulate. We are pleased to be independent and not waiting for someone else to organise us. In our group, people are willing to do the jobs which need to be done, like writing the newsletter, being the tour leader and sending 'get well' cards.

"...we have always made our own decisions...we are pleased to be independent and not waiting for someone else to organise us."

Being independent is very important to us, we are all determined to die in our own beds and not go into nursing homes. There are only two of us who have home help and with the future development of the Home and Community Care Program and the extension of the Domiciliary Care Program we should be able to have our wishes fulfilled.

Perhaps, indicative of what this group has done for its members is the example of an eighty-seven year old member who recently took a trip to China with her son, and then went onto Queensland on her own. She has no help at home, and can still find the energy to look after her great grandchildren – even more remarkable considering that when she joined the group she had two walking sticks, calipers on her knees and a brace on her back, all of which in her own words she:

"...hung them on the wall and said: you bloody stay there."

You could question whether it's the company and outings, or the massage or hydrotherapy which has had such beneficial results, but really it's a combination of all of these. As one member said:

"You get in there and you forget everything, whereas when you're home, you sit around and you're thinking everything and you make yourself ill."

"...an eighty-seven year old member...recently took a trip to China with her son...when she joined...she had two walking sticks, calipers on her knees and a brace on her back..."

Sometimes it can get very lonely in Northcote, even though some of us have lived here for over sixty years, when we go up the street we might not meet anyone we know. Our group will continue going probably until we drop dead, or as long as we can get onto a bus or tram. Our ambition is to spread this message of self-help, dignity and independence to senior citizen groups, health centres and such places around the country. Our work should help to do that.

Resource M

When training your own trainers (DIY) to extend skills in writing narrative action evaluation

The further development of this DIY **Resource M** as a manual for trainer/consultants will comprise a focus for an anticipated Phase 3 of the NEAR project. One recommendation that came from feedback to NEAR Phase 2 is that it be worked up into a formal training module by an accredited workplace learning provider.

In the interim, for those keen to continue to expand the use of narrative action evaluation writing, we suggest creating your own four-step process and resources based on this manual and particularly the QuickGuide (Section 4).

An introduction

The NEAR project is a workforce professional development process comprised of:

- i. An initial on-site **reconnoitre** by the 'trainers' or facilitators, with those keen to learn about the writing of narrative action evaluation reports.
- ii. The development of ongoing support by a peer writer or/and a **peer writers' group** (which may include the trainer or/and the consultant).
- iii. Followed by an on-site **'start up' workshop** to provide the basic orientation, skills and confidence to commence.
- iv. Some **ongoing mentoring** by an experienced consultant or user of NEAR processes as well as the peer worker/s.

i. The reconnoitre

Firstly talk with those wanting to write their own narrative action evaluation reports.

Find out:

Why are they interested in learning more about how to write narrative action evaluations?

What has attracted them to the idea?

What do they hope to achieve?

Have they had any similar experience in the past?

Have they read and used the NEAR Manual in Phase 1 (2003–2004)? Or in Phase 2 (2004–2005)?

Would they say they are familiar with the four-part manual? (Guidelines, Resource Kit, QuickGuide and Case Studies)

Is there strong support for them to do this? (from a manager, co-worker or co-workers group) (See the Management Support guidelines in Section 1).

ii. Support by a peer writer or/and a peer writers' group

This was found to be a crucial method for sustaining the narrative-writing throughout. Best if a 'critical friend' – that is, someone who is 'with you' in supporting your health promoting endeavours, but who can also ask questions that help in clarifying issues and focusing on the 'right' story and 'right' (best) way of telling it – especially as you revise and reframe it to achieve depth, meaning, further insight and clarity.

Read the Section 1 pages 25–26 for more on achieving a 'community of practice' of 2–6 peer writers.

iii. Holding the 'start up' workshop

The NEAR training process involves preparation for and the holding of an initial workshop to orient to the key elements of the work so writers will have the basic skills and confidence to commence.

Read the Guidelines Section 1 Exercises 1 to 4 for coverage of these elements.

It is important not to skip any one of these exercises as we have found it leads to the loss of that skill element.

The key skill elements are:

- knowing what is a good narrative
- having a strong grasp of the concept of integrated health promotion
- being able to retain a client/community focus
- understanding the nature of evaluation
- and the nature of action research.

Another important start-up element is to establish a Timetable (and try and stick to it!). Read Section 1 'Time and a Timeline'.

iv. Resourcing by a trainer-consultant

Read Section 1 pages 27-31 for insight into the role of the key facilitator or supporter-resource person with experience of the key elements (good narrative, integrated health promotion, client/community focus, the nature of evaluation, and of action research).

You might like to prepare an overhead PowerPoint presentation if you are using this approach in your own agency. You may need it to show managers, practitioners or clients/community.

Two PowerPoint examples drawn from the NEAR project are included on the front page of the Department of Human Services Health Promotion 'Evaluation and Dissemination' website:

- Kerry's ISIS workshop example – **Narrative Evaluation Action Research**
- Jaime & Melanie's workshop example – **N.E.A.R. Narrative Evaluation Action Research**

Resource N

Example of plain language description and consent form (ethics)

If you are preparing to write a narrative action evaluation that requires initial additional interviewing or other use of primary research methods (such as that used in the [2004 Case Study](#) with the 'MIGS group' in the [Case Studies Section 3](#) of this manual), you may find it helpful to develop your own informed consent form and plain language statement.

Here are two exemplars developed from those used in NEAR Phase 1 (thanks to Jaime Timmerman):

Plain language description

Narrative Action Evaluation (NEAR) project

[Write name and contact details of person being interviewed, etc.]

[Write on letterhead your name and contact details as interviewer, etc., and the date]

Dear

Re.: -----
Description of the [*insert short title*] project I am asking you to participate in

Thank you for your willingness to consider participating in evaluating the ----- [*insert name of activity, group, course, project, program, etc.*]. Your involvement will include you being able to share your stories and experiences during an informal interview with me. I have chosen to write a story about the ----- [*repeat name of activity, etc.*] because I believe it could teach us and the wider community of health workers about health promotion programs and good project outcomes.

The story telling (or 'narrative') style evaluation of the ----- [*repeat name*] is part of a bigger evaluation project called the NEAR project. This involves gathering information to write stories about what has been happening in particular community health promotion projects. It is being conducted by ----- [*insert name of your community health agency*] with the support of the State Department of Human Services and with assistance from Melbourne and LaTrobe University consultants.

The NEAR project will help us reflect on, and better understand, the impacts of our work. The stories that you share with us about your experiences are likely to help us to shape future program work.

Writing stories by interviewing participants is a different way of evaluating programs for Community Health Centres. Therefore this project is being used as a trial to see how we can best evaluate in the future. This means that the stories we write about ----- [*repeat name of activity, group, course, project, etc.*] may also be published to help inform work in other organisations, and in other communities as well as our own. The outcomes of the NEAR project, including the story I will write, may be part of a published collection of resources, to assist others to use narrative or storytelling as part of their own evaluation strategy.

Your participation in this storytelling project is entirely voluntary. Your own way of telling this story is important and I won't press you to answer any question you don't like. If you want I can change your name in the story to make you more anonymous, however even if you do

change your name it is important to be aware that the project might still be recognisable to others. Alternatively you may prefer to keep your name attached to the things you share – as these are your views and stories and you have a right to them being published in your name if you wish. We could negotiate this as we go along.

You will have a chance to read what is written from your story to ensure it is true, fair and useful. You may change any statement or story that is attributed to you, so that it better reflects your understandings or experience.

If you change your mind about taking part, you are free to withdraw at any stage with no negative effect for you. The Health Centre will be grateful for your participation whether you continue or not.

Once again thank you for considering participating in this project. If you decide to sign the attached form to take part, you might like to keep this page. If you have any questions about the project at anytime please call me during office hours on (--)-----[insert work phone number].

Regards

-----[sign your name]
Health Promotion Coordinator
Unovoce Community Health Centre

Consent form

Narrative Action Evaluation (NEAR) project

I would like to be interviewed for the *NEAR Story Telling project*, and for my stories to be included in the narrative or story that is written about:

[insert name of activity, group, course, project, program, etc.].

I am aware that it is being used to help evaluate the project but that it may also be published. I understand that I will have a chance to read what is written, and to help make it true, fair, and useful. I also understand that I may change any statement or story that is attributed to me, so that it better reflects my understandings and experiences. I recognise that I will be able to choose to use my own name with the things that are written, or to have a measure of anonymity by changing my name. I also understand that even if I do change my name, the project might be recognisable to others. I have read (or heard read to me this and) the Plain Language Description.

Participant's signature:

Participant's name (PRINT): -----

And participant's contact details (mail address, email or/and phone) to receive any written material associated with your storytelling):

Today's date: -----

Resource O

Supporting narrative evaluation in a community health setting

Paper to the 2006 Health Promotion Conference, Alice Springs

Melanie Block, Physiotherapist
Jaime Timmerman, Health Promotion Coordinator
Western Region Health Centre

Please note:

The PowerPoint accompanying this presentation appears on the Department of Human Services website Health Promotion – Evaluation and Dissemination front page, under NEAR.

Aim:

The Western Region Health Centre (WRHC) NEAR project aimed to increase the capacity of staff to be able to produce quality narrative evaluation stories using an action research method.

Background

NEAR uses story telling to discuss evaluation results which have been found using an action research method. Perspectives within stories can be from many viewpoints including that of participants, staff, agencies or project partners. This project was implemented at WRHC, a large Victorian community health service located in the inner west of Melbourne. At WRHC, health promotion is an organisational wide commitment, which includes specifically funded health promotion staff and those working on health promotion projects under a range of managers through differing funding sources. This project occurred after three WRHC health promotion staff participated in Phase 1 of a regionally-based NEAR project funded by the Department of Human Services in 2003–2004.

The project was created with management support. They considered there were a number of potential benefits for their staff to be involved in the project such as increased skills in writing and evaluation. Managers also considered NEAR to be a form of evaluation which is relevant to their programs' key target groups and would suit the way workers interact with clients. They considered NEAR to be a medium which gives clients a voice, more meaningful evaluations than quantitative methods and results in information which is easier for clients/stakeholders to understand. Management also considered NEAR to be beneficial in giving funding bodies a more in-depth insight into the nature of programs and their outcomes.

Methodology

The project utilised a peer education and mentoring model and involved two mentors. Due to the structure of health promotion at WRHC, a lot of energy was invested in obtaining management support to identify and release suitable staff to be involved in the project.

To be involved in the project, staff needed to have a health promotion project ready for evaluation and be willing to complete a narrative for that evaluation. Five staff and one student were involved in the project. Five of the participants were familiar with the concept of action research through their professional training but none had been involved in the use of narrative for evaluation.

The NEAR project included the development and conduct of a three-hour group workshop, a 1½ hour group review session and individualised support to participants.

The workshop was developed by reflecting on the learning experience of the mentors in phase 1 of the department funded NEAR project. Major concepts, practical examples and activities were selected from the NEAR manual which was produced by the department funded project.

The manual and the [PowerPoint presentation](http://www.health.vic.gov.au/healthpromotion/hp_practice/eval_dissem.htm) accompanying this paper are available at www.health.vic.gov.au/healthpromotion/hp_practice/eval_dissem.htm

In addition WRHC created new material to be used when training staff; this included an activity exploring steps of the action research model in relation to a completed narrative.

Outcomes

To date two narrative pieces have been completed and a third is underway. One narrative, completed by an experienced worker, captured in great depth individual participants' voices and experiences. Whereas the other, which was completed by a student (with staff support), was more of a summary of opinions rather than a story capturing individual perspectives.

Despite the small number of narratives produced, the benefits of this project have however gone beyond the original aim of the project. Staff who participated in the project have applied the skills they have learnt very broadly. It has influenced one staff member to change her internal reporting methods to a more narrative style and staff have used the tools and skills they learnt to teach their colleagues NEAR principles. In one team there are two additional staff now working on narrative research pieces. In addition the staff involved in the project have also advocated for the use of NEAR methodology in other organisational evaluations.

The narratives produced have been used for a number of purposes to lobby for funding. For example, one narrative evaluated WRHC's SHARE project, which aims to reduce stigma associated with mental illness by increasing levels of understanding. It involves mental health clients discussing their experiences and stories of mental illness with secondary school students. As part of the process of creating the NEAR narrative the participating mental health clients were interviewed. Project staff then used quotes from the interview to demonstrate how clients had grown since joining the program. To quote an example:

"Things have changed for me since SHARE.... I know a lot more about myself now and am able to deal with things a lot better than I was able to".

Another of the narratives is being used as a tool for new and existing staff to better understand the program discussed in the narrative and its meaning to participants. This narrative identified further areas to explore and has formed the background for future evaluation. Excerpts from completed narratives will also be used to report to funding bodies such as the Department of Human Services.

The narratives have also led to a greater emphasis on project sustainability as workers are more aware of the stakeholders' perspectives. Two of the staff reported that their projects would not have continued unless the evaluation had occurred, as they learnt how much the project meant to the stakeholders. Staff found NEAR valuable in capturing the voice of the target group, they stated: "you get bogged down in 'process' and lose sight of (the client's perspective)". Participants in the project thought the style and informal questions worked well with their target groups. Staff stated: I was "surprised about how well the process worked with the consumers." I received "much more personal responses from the consumer than I thought".

The narratives were practically useful in telling the story from the clients' perspective. Using the SHARE project as an example, the following quotes from clients participating in the project show how the voice of the clients is evident.

"It's been very cathartic for me. I think I've learnt something about myself, that I'm capable of doing something that's really hard. If I can do what I did with SHARE, I can do other hard things."

"I was a teenager when I knew something was wrong with me. If I had something like SHARE when I was in school it would have been much easier for me.... I looked in books but it was not very helpful. It's much better hearing someone's personal experiences."

"I was able to express things that I have kept inside me for a long time."

Through the narratives the motives for clients participating were also expressed:

“I wanted to make high school students more aware of mental health. I was in high school when I was first sick.”

“I’m very happy to share my personal story. I’m not ashamed.... All of our stories are different and hopefully the students will be able to relate to someone.”

“My hope is that more people will understand that we’re just ordinary people with an extraordinary problem.”

The WRHC NEAR project has also resulted in some unexpected organisational outcomes. One of the participants who had successfully completed a narrative intends to evaluate the residential rehabilitation program she leads with NEAR methodology. Managers within the agency have also encouraged the use of NEAR methodology with a new Diabetes Outreach position and a research project soon to be evaluated.

From the mentors’ perspective NEAR seems to give participants increased enthusiasm for evaluation as they enjoyed using a different methodology for evaluation. They saw the point of this style of evaluation compared to quantitative evaluation which doesn’t always capture the true nature of work in the community setting.

Conclusion

The NEAR peer training provided at WRHC has met its aim: ‘To increase the capacity of staff to be able to produce quality narrative evaluation stories using an action research method’. Additionally it has led to team and organisational benefits beyond the scope of the project. Organisationally NEAR has given a greater voice to stakeholders and clients. We found that training was most effective for staff that had a set project ready to evaluate and clearly understood the purpose of the evaluation.

NEAR is a valuable tool in a community setting to evaluate programs. It is most valuable when supported by management, adequately resourced, based on a set project and used as an evaluation method to complement quantitative data. In addition NEAR was found to be a particularly good methodology to gain perspectives or [the] voice of the consumer/community member. NEAR training can be delivered successfully by staff familiar with concepts of action research, evaluation and narrative and with the assistance of tools such as the NEAR manual.

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3 Full Case studies – in narrative evaluation action research for health promotion

Preface

The narratives, primary health care and health promotion

These narratives are selected accounts of episodes in the unfolding story of primary health care practice in community health services in the western region of Melbourne. Over the course of the NEAR project (phases 1 and 2), so far around 40 sturdy and illuminative narratives have been written. The selection of narratives here have been written by 13 women and one man with responsibilities for health promotion and community health programs, projects and staff within their agencies. They critically reflect on the philosophy and principles of health promotion as well as the complexities of practice. In the process of generating these stories, the practitioners have challenged and interrogated themselves and their peers, their practice and their organisations. They have asked difficult and confronting questions, explored previous decisions and approaches and then commenced the task of writing with new insights.

The narratives explore a range of aspects of health promotion at various levels within large stand-alone community health agencies, to give a snapshot of contemporary health promotion practice. An often contested term, 'health promotion' is most frequently conceptualised as a process that enables people to increase control over and to improve their health. It is predicated on a thorough understanding of the determinants of health and, therefore, recognises that improving health is not only the province of health services. Health promotion is characterised by actions ranging across a spectrum from individual services to social and community action.

Consequently, health promotion can be incorporated into policies and structures at the whole agency level, be reflected in strategies to address priority issues, function at a program level with discrete projects flowing from it, and be captured at the micro level with 'behind the scenes' activities. The narratives describe the implementation of aspects of health promotion at most of these levels, ranging from the challenges experienced by one health promotion coordinator in trying to create a comprehensive whole agency approach, right through to the voices of consumers actively engaging in their own project.

The NEAR project

The opportunity to develop the narratives was provided by the NEAR pilot project, a workforce development initiative of the then Department of Human Services, Western Metropolitan Region. NEAR aimed to build the capacity of practitioners and managers to evaluate and report on their health promotion activities by using an action research narrative evaluation methodology.

The two agencies selected to participate in the first pilot were the Western Region Health Centre (WRHC) and ISIS Primary Care.

The WRHC is a primary health care agency that services Melbourne's inner western suburbs. It provides a range of services including medical, dental, community health, health promotion, complex/psychiatric disability and drug prevention with other services, such as pathology, co-located. The people who access the WRHC are generally low-income earners from culturally and linguistically diverse backgrounds. ISIS Primary Care is also a large agency with multiple sites servicing the middle to outer western suburbs. Its community health program provides allied health services such as speech pathology, physiotherapy, podiatry, dietetics, counselling, occupational therapy, audiology, community health nursing and health promotion. ISIS Primary Care also provides a diverse range of other services including aged and disability services, medical, dental, alcohol and other drug counselling, problem gambling counselling, family support, a neighbourhood centre and child care.

Six practitioners in these agencies, each reflecting aspects of their practice, each from different perspectives and each with different voices, created the first six narratives over a period of about 6–8 months from September 2003 to April 2004.

The ten agencies selected to participate in the second phase were Banyule Community Health Service; Darebin Community Health; Dianella Community Health Service; Djerrivarrh Health Services; ISIS Primary Care; North Yarra Community Health Service; PANCH Health Service; Plenty Valley Community Health Services; Western Region Health Centre; and Women's Health West. These services also provide a similarly wide range of services and programs, differing in content according to local characteristics, to the two agencies participating in Phase 1.

More than 40 practitioners wrote narratives in Phase 2 between December 2004 and December 2005, as well as involving many more of their colleagues. Of these, seven contributed six narratives to add to the case studies collection that follows.

All of these narratives are a reminder of the potential for primary health care and health promotion to make a powerful difference to people's health, their lives and their communities, and the power of developmental narrative evaluation to enhance the chances of this happening.

Gai Wilson

For the Editorial Team

***Yoland Wadsworth, Ani Wierenga and Gai Wilson
in collaboration with Karen Goltz***

From obligation to inspiration – shifting the culture of health promotion in a community health centre

Sharon Laurence

Sharon has been working as a dietitian for over 10 years and as one of the WRHC Health Promotion Coordinators for the past two years. The development of the health promotion strategic plan is one of her key roles.

Over four years of working at the Western Region Health Centre (WRHC) I have seen an enormous transition in the awareness and profile of health promotion within our organisation. When I started there was no health promotion officer position. I was employed initially as a dietitian and my job focused on providing individual dietary counselling and group education. I was seeing predominantly English speaking, middle aged people with diabetes or high cholesterol, who invariably had a weight problem. At lunchtime I would step out into the streets of Footscray and be confronted by an incredible diversity of people, from Vietnam, Africa; people with a mental illness; and people begging for money for food amidst the myriad of fast food outlets. I often asked myself: 'As a community health dietitian am I really making a difference? What can I do to really address the needs of the most vulnerable in this community? Are people aware of our health service and is it relevant to them?'

It seemed that talking incessantly to individuals about what they should be eating was far too simplistic. It is from this perspective that my interest in health promotion arose.

Since this time I have observed and participated in building health promotion capacity at our centre. The transition has been driven by a new political environment; the availability of health promotion training; management support; and the determination of committed individuals. However, persistent challenges and systemic issues make advancing health promotion difficult. In this narrative I will tease out some of the fundamental issues which continue to stifle health promotion in the community health setting, and reflect on some of the ways I think we could re-configure and strengthen our efforts.

To do effective health promotion I think management support is critical. The culture and senior level management must really value it and support staff. The rejuvenation of 'health promotion' from the Department of Human Services, our major funder, has assisted greatly. The endorsement by DHS of an 'integrated health promotion model'; the increased accountability required for health promotion expenditure; the delivery of the regional health promotion short course; and the requirement to submit organisation-wide health promotion strategic plans, have all really put health promotion on the management radar.

Our centre management has embraced these changes. For many of us who have been frustrated by past funding agreements modelled almost exclusively on clinical care, we now feel better able to embrace the 'social model of health' and talk again about the value of community development. WRHC now has a structure in place to recognise and support health promotion from a management level. Our first senior level health promotion position was created in 2002. A health promotion steering committee was formed with broad management representation; ten people completed the health promotion short course.

Before these changes health promotion activity was dispersed and piecemeal across the organisation. Health promotion was commonly driven by an individual's particular professional area of interest, or determined by an 'expressed' need recognised at a clinical level. The practice of health promotion was limited to 'health education' in heart health and diabetes education classes, and for those personally inclined to attend 'groups'. Health professionals worked consistently and creatively in planning health education to diverse groups in the community; however, an 'integrated' health promotion approach was effectively discouraged

due to funding and reporting constraints. When I first commenced in community health all of my health promotion time was to be coded as either time facilitating a 'group' or time preparing for a 'group'. As such, creative accounting was required to attend a municipal public health planning meeting or to advocate on behalf of clients for better access to public transport. All of these changes have done much to better coordinate and raise the profile and understanding of 'integrated' health promotion for staff, and to legitimise and increase opportunities for health promotion at the grassroots.

Another great strength over the past two years has been the encouragement to develop external partnerships. Integrated health promotion is all about working in conjunction with other organisations to advocate for issues that create healthy environments. As a dietitian four years ago I worked on the tail end of the era of competitive tendering. There was a reluctance to work with other community organisations without charging them for your service and costing out your hours. I recall the frustration of seeing a succession of intellectually disabled clients from a local community residential unit come for weight loss counselling. I felt the most effective approach would be to meet with the local cook and provide input into their menu policy. Unfortunately within the constraints of the 'illness' model and the quest to 'count' client numbers, this approach was not feasible. A change in the political agenda now encourages inter-agency collaboration. Our relationships with external partners are strengthening all the time through the Primary Care Partnerships, the Municipal Public Health Plan, Community Associations, and initiatives such as 'Best Start' and 'Neighbourhood Renewal'. In many project areas 'in kind' collaboration has had exponential benefits.

One of the important cultural shifts has been the renewed focus on the cycle of planning and evaluation. In the past, health promotion/education was segmented within professional groups. Physiotherapists promoted physical activity through exercise classes, podiatrists ran shoe-shopping tours and counsellors ran stress management classes. We all have a tendency to conduct what we are good at in a familiar format and then advertise externally to see who may be interested. In contrast, taking the preliminary steps to understand your community, identify the most vulnerable, and configure your program to make it culturally relevant and accessible is quite difficult to do. It can take a lot of time and is something we are not very familiar with. The new focus on strategic health promotion and priority issues in the strategic plan have attempted to shift this 'reflex' action approach to health promotion. There are currently three multidisciplinary teams across the organisation that meet fortnightly to address the priority issues of 'food security', 'physical activity' and 'mental health'. These teams are guided by the health promotion coordinators and the health promotion plan. The introduction of the software program QIPPS has also encouraged the documentation of all the steps within program planning models. Within the past six months 10 staff have undergone training to operate QIPPS, and there are now six programs documented on the database.

Although there has been much progress over a short time there are still a number of systemic issues that can make health promotion a slow and sometimes grinding process. The reality is that WRHC is a primary care service firmly locked into the daily business of providing direct care to individual clients. The Maribyrnong community has some of the highest burden of disease, significant rates of mental illness, and enormous numbers of families living in crisis. It is constantly difficult for staff to lift their head from long waiting lists, acute mental health episodes, and the management of diabetics running on blood sugars of 30 plus. In the fortnightly 'food security' meetings that I facilitate there are currently nine registered members. Out of the eight fortnightly meetings that have occurred, attendance is typically less than half. When meetings are disjointed and assigned tasks are delayed, the momentum and productivity of the group suffers. As a health promotion coordinator this is very frustrating; however, on deeper reflection there are some obvious reasons why health promotion often runs second fiddle to more immediate client-based concerns.

The majority of our staff in Primary Care Services have client loads which take up 70–90 per cent of their time. Health professionals employed to provide client services operate in a completely different context to health promotion. Client work is task-orientated; the rewards are immediate and it is usually time limited. Health promotion is conceptual, has a planning

focus, is multifactorial, and very long-term. Essentially client services are more reactive and health promotion is more proactive. Community health staff work very hard and work with some of the most disadvantaged people in the community. When a health professional has only 3–4 hours a week to do health promotion, it is easy to see why health promotion is put on the back burner.

Furthermore, staff turnover is very high. The health promotion short courses were excellent in motivating and providing a new understanding about health promotion to many of our staff. The reality, however, is that there is close to a 40 per cent staff turnover each year. Given health promotion is not generally part of health professionals' primary training, there is an ongoing need to upskill, mentor and train new staff.

The other persistent challenge in sustaining health promotion is providing sufficient incentive and accountability for staff. Despite important changes in improving the management for health promotion, the health promotion coordinators are responsible for the implementation of the plan, but not for the staff funded to do the work. The direct line managers are, instead, service delivery managers in mental health, community health or counselling. Although there have been significant gains in including health promotion responsibilities within staff performance reviews, specific guidance in health promotion is difficult for managers when their primary accountability relates to direct care. This in part arises because responsibility for health promotion is quite difficult to define. Health promotion is currently facilitated by multidisciplinary teams. Typically, when there is no project worker appointed to the team, you tend to see the responsibility and accountability for the health promotion work diffused. Similarly, individual staff contributions for health promotion within teams are rarely recognised or valued as much as their direct care work. As a health promotion coordinator working alongside our direct care colleagues, I have often felt that many consider their health promotion time as a personal favour — an additional task on top of their already busy work loads, rather than really acknowledging it as an important part of their role: 'Sorry I am an apology for today's meeting, Dick has chest pain and I need to drive him to the hospital'.

When I reflect on some of the best health promotion work that has occurred over my time at the WRHC, it has usually occurred through project workers with dedicated time and responsibility to manage projects that are externally funded. The 'Sharing Food, Gaining Health' project at the Vietnamese temple, the African Women's Sewing program, the Fresh Kids program in local primary schools, and Women's Only swimming programs are some really good examples of this. Project workers have clear ownership, responsibility and motivation. They are usually recruited because of their expertise and inspiration. My sense is that further development of health promotion will require greater leadership and responsibility of this nature.

I believe that a project worker model would facilitate integrated health promotion better. The current system spreads funding for health promotion across a large number of positions. In reality this translates into 3–6 hours per week for most individual staff. In addition to the barriers described above, we now require our health promotion to be evidenced-based, to encompass more than health education and to include advocacy, planning and influence in local settings and environments. This is excellent in theory; however, it can be overwhelming for many struggling to manage their waiting lists. I believe dedicated project workers focused on key priority issues would have more time to build networks, and to focus on planning and intersectoral issues that would facilitate the integrated model better.

For a project leader model to work best, I think there needs to be an internal recruitment process that ensures individuals with the most expertise and interest are given responsibilities for health promotion. The individual may not necessarily have qualifications in health promotion; however, they would be willing to undertake further training and above all would be inspired by the model and keen to learn. An internal recruitment process would increase the desirability, status and responsibility of these positions. It also releases responsibility for strategic health promotion from other health professionals who are most interested in client-based work. In the current system individuals who feel obliged rather than inspired by health

promotion can often impede rather than facilitate the process. To work effectively, I think a project leader would need to commit at least two days a week to a health promotion project. This position would ideally align with the 12-month health promotion planning cycle. It would be advantageous for a variety of people from different health disciplines to have an opportunity to take on these projects, depending on the nature of the health promotion project.

Organisation-wide strategic health promotion based on this project worker model would still require input and direction from other staff. Other staff, clients and external organisational partners could still be involved through representation upon project steering committees. The steering committee could oversee the health promotion work undertaken by the recruited project worker.

WRHC, as part of the community health sector, has achieved a lot over recent years by working towards a strategic health promotion agenda. Community health centres are uniquely placed at the grass roots, have great potential to engage community people and have a real understanding of the social, environmental and physical issues that affect people's lives. In collaboration with local council and government agencies, community health staff are key advocates or mediators for community people. In addition to the long history of providing accessible and affordable primary health care, community health does have an important role in advancing public health and advocating for some of the social determinants that affect people's health, and prevent the onset of disease and disability.

Will I ever get to see feet? The challenges of integrating wholistic health promotion into the daily practice of allied health professionals in a community based setting

Amanda Eade

Amanda has worked at ISIS Primary Care as a health promotion officer since 1998. For the last three and a half years she has been the Coordinator of Health Promotion.

Background and history

As a health promotion practitioner working in community health, I can remember that when I first started I wanted to 'change the world, achieve health for all' and make my community 'a safer and healthier place to live in'. I know this sounds very much like the gallant white knight riding into the sunset, but this was my goal and dream. It wasn't about 'numbers or figures', it was about people in a community; hearing and learning their stories and working with them to create a healthier, safer and more supportive place to live.

This is partly a story about the personal growth of a new graduate developing into a skilled health promotion practitioner with a strong commitment to sharing those skills with others, as well as a story about the journey of a community health organisation striving for health promotion to be integrated into everyday practice — the transformation of a team of health educators to health promoters.

I was employed as the first and sole health promotion officer in a community health organisation of 240 employees and was excited at the thought of entering into a workforce of allied health providers with years of experience, skills and knowledge. I presumed that 'on the ground' health promotion was embraced by all. Needless to say, my expectation was that everyone was thinking 'prevention, social model of health and empowerment'. I was about to enter into a new reality!—one of intra- and inter-agency politics, endless and competing demands, and varying levels of interest from other workers.

When I initially spoke to service providers, many said they knew exactly what health promotion was; it was about 'education, running groups and campaigns'; they had been 'doing it for years'. It was quantified by numbers, recorded on their data collection form. Many had 'never heard' of community consultation, the 'social model of health' or a 'multi-strategic approach'. I was working with service providers who had been doing what they thought was health promotion, but was really outdated health education. How was I going to convince them that health promotion was so much more than that?

We needed a health promotion framework, 100 per cent management support, health promotion education, and cultural change.

Change wasn't going to happen overnight. It took a good three years for health promotion to become embedded into all layers and levels of the organisation. Firstly, a Health promotion framework was created; with the support of Community Health Program (CHP) management, it was implemented. We had six health promotion working groups each addressing a health promotion issue. Every service provider in the CHP participated. We developed guidelines for planning and evaluating health promotion, created supportive policies and procedures and included health promotion in position descriptions. Health promotion became integrated into the organisational corporate objectives and a regular agenda item at program meetings, CHP annual planning, and staff induction days.

Now, six years on, we have come a long way and I'm proud of our achievements. Of course health promotion is still a challenge, and we are not at the end of our journey, only just getting started! Yet nevertheless, with a new state political environment and an extremely

supportive executive and management system, we now have a dedicated and skilled health promotion team and an annually reviewed health promotion framework. Staff are encouraged to do quality health promotion. They are beginning to 'work with the community, address community need and use a multi-strategic approach in partnership with key stakeholders'. The Health Promotion Team offers service providers help, support and guidance. This occurs through one-to-one consultation, education workshops, provision of demographic and evidence-based data, a series of health promotion kits, access to internet sites, text and publications.

But does all that sound easy? Looking back we can see what we have achieved, but to get there, there was a lot of learning. For example, firstly there was the journey to realisation that not everyone does 'do' health promotion — and perhaps it wasn't working just to insist on that when it was not really true.

Service providers and health promotion

As health promotion practitioners our expectation had been that **everyone 'does' health promotion**. At the initial meeting with a new service provider we would explain something like:

"You have 75 health promotion hours for this financial year. Our health promotion priority areas are: Mental Wellbeing, Overweight and Obesity and Capacity Building. You must ensure that a program plan is written before commencement and evaluation occurs throughout. In undertaking any project, you need to consider a multi-strategic approach in collaboration with other organisations based on evidence and community need. We will also need your bi-annual report in early December."

This is a challenge for the most experienced health promotion practitioner who is competent in health promotion methodologies, evidence-based practice, project management and community consultation. Now imagine a speech pathologist or podiatrist trying not only to conceptualise health promotion but trying to address these priority areas using a project logic/preventative approach. 'Mental health, obesity, capacity building; what's that got to do with feet or speech?' they ask.

We reflected and thought that for many health service providers, the core training is underpinned by a 'medical model'; that is, working within a curative or illness framework. Health promotion is rarely integrated into undergraduate health curriculum. This perhaps results in highly skilled practitioners who may not be as knowledgeable or skilled in preventing the 'grassroot causes' of the condition, or addressing health holistically from a social/community model.

For many, just the words 'health promotion' are vague or scary. It's a whole new language to learn. 'Goals, objectives, strategies, collaboration, multi-strategic approach, key-stakeholders, capacity building – what does that mean?' people wonder. While we like to think that health promotion is 'everyone's business', not everyone shares the same view of what health promotion is. While it's an expectation that everyone should do it, we began to wonder if everyone can do it, at least at that point in time.

Health promotion is a unique discipline and there are specialist skills required to facilitate high quality health promotion initiatives. As health promotion practitioners we want to encourage other disciplines and sectors to participate in good health promotion practice. However, we are also conscious that influencing behaviour-change and creating supporting environments is not as easy as 'popping a pill' or 'handing out a brochure'. A minimal skill level is required for health promotion to be proficient and effective. While we need the support and knowledge of people from different disciplines and sectors, we also risk resistance and animosity if they feel forced into doing health promotion. This is a dilemma we as health promotion practitioners have needed to confront. We asked ourselves: How do we address this? We found that while

there wasn't an easy answer to this there were some strategies worth considering and I have summarised these at the end of this narrative.

Competing priorities for service providers

I recently met with a new podiatry staff member. 'Will I ever get to see feet?' she asked. What a classic statement! It illustrated for me the very real challenge of the competing time available for health promotion and primary care. It is difficult for service providers, with the small number of health promotion hours they have, to prioritise health promotion. Their strong commitment to clients and long client waiting lists often takes precedence.

Convincing service providers that health promotion is just as important as primary care is a huge challenge. 'When I see a client I know I'm making a difference...I can see the change and I feel good about it...with health promotion how do I know it's working?...How do I know I'm doing it properly?', service providers have asked.

Health promotion is different from primary care; it is conceptual; and visible health outcomes are unlikely in the short term (if at all). Explaining to service providers that when doing health promotion, 'the process is just as important as the outcome', isn't easily understood when they normally see a client, produce immediate results and feel a sense of achievement and reward.

The importance of structures and systems

While service provider skill, knowledge, interest and understanding of health promotion are major barriers to implementing effective health promotion, the system in which individuals work can also be a barrier.

In the past, funded health promotion time was recorded as either an 'indirect service' (pre-planning) or 'direct service' (group work). Each service provider had an annual target for the number of group programs they needed to implement. This structure supported and rewarded group programs and limited health promotion that did not sit under 'health education and skill development'. Although it was an expectation that **all** service providers would practice health promotion, as it's a part of our 'philosophy', 'the system' really wasn't working to support this. We found too much of our time was being absorbed addressing resistance from service providers who felt that they were not able to achieve effective health promotion due to available time, skill and 'out of control' waiting lists.

Added to this was another challenge faced by the majority of service providers in that 85–90 per cent of their targets are primary care, with the remaining allocated to health promotion. So while service providers prioritise primary care, so does the system: 1 have 40 health promotion hours – and you want me to divide that time into 1/3 planning, 1/3 implementation and 1/3 evaluation – it's just not enough time' service providers say.

Thus in one breakthrough attempt to improve our system this year, we have enabled service providers to nominate how much health promotion they would **prefer** to do. This restructure in time allocation has allowed us to recognise the 'champions' in health promotion and has enabled service providers who are more skilled and passionate in health promotion to do the work. For many, this has been extremely empowering and has meant, as one put it: 'The organisation is finally recognising my work – this is what I do and I now have the time to do it well'.

Dollars and sense

In community health we spend an amazing amount of time justifying every health promotion dollar. We account for every minute and hour and spend hundreds of hours accounting, justifying and quantifying it into a number. Then there's the writing up of the plans and reports – huge tasks. Yet I still don't understand why – if primary prevention is the key, and we

know it saves lives — does it get such poor funding and why does every penny require such intense rationalisation? Service providers comment:

“So many forms to fill in, so much paperwork ... I don't have this level of planning, reporting and justifying for my primary care hours.”

There are other ironies in these strict reporting requirements. As health promotion practitioners, we realise that not only do we fight the little fights everyday, but we are also 'at war' with the bigger sharks — tobacco giants, alcohol companies, gaming centres. We see that these rely on our target group (disadvantaged) to be caught in their grip and yes, we know that we get a small percentage of their taxes for treatment and prevention, but how are we going to fight them with our minimal health promotion dollars? We now think that the government needs to get serious about health promotion. It needs to fight the big sharks as well as support the little fish!

My conclusion now is that health promotion may need to be valued and understood more within the health sector. I now know that a disproportionate amount of health dollars are allocated to the acute sector and that within the community health budget only about 15 per cent is allocated to health promotion. It's no wonder that health promotion is seen to take a back seat. Community health and health promotion are just not SEXY!

The way forward

So how can we build on our health promotion work within the current challenges of community health? How can we try to achieve 'health for all' when we are busy treating people who are already ill, dealing with the fallout from the lack of preventative strategies? How can we produce effective health promotion programs with minimal funding and time allocation, spread thinly across a range of diverse workers? How can we get our funding bodies to consult with 'on the ground' health promotion practitioners about the processes, structures and systems we need in place to progress health promotion rather than hinder it?

We have thought about this for some time and decided that despite the challenges there is a lot we **can** do. We can start by:

- Working toward ensuring that health promotion is seen for what it really is – a valuable opportunity to break the cycle of preventable illness and disease by addressing the social inequities in health.
- Recognising the health promotion champions in our organisation and rewarding them with more funded hours and great projects to work on, thus spreading our work less thinly.
- Mentoring and coaching service providers who are passionate about health promotion but not necessarily skilled.
- Documenting our work and presenting the positive outcomes and key learnings to show local/state governments that our work is worth funding and building on.
- Working in partnership with other organisations as key stakeholders on vital committees.
- Advocating for health promotion to be incorporated into relevant undergraduate degrees.
- Working as advocates for the community.
- Hoping that those who dictate the structures and systems we work within read this story and want to learn more about existing barriers and work with us to remove them.

I think that community health, situated at the 'coal face' of the most underprivileged communities in Australia, may be in a unique position to effect change in areas of great need. Health promotion in this setting could be a most effective tool in preventing disease and supporting well communities. In addition, with the changes in health promotion planning and reporting, we now appear to have the capacity to encourage and nurture inter-agency partnerships, work with our community at a grassroots level and work within the social model of health. True health promotion is within our reach.

Health promotion and fish sauce

Anne Cox

This story was written by Anne Cox, Director of Community Health Services at ISIS Primary Care from a solid beginning made by Eleni Karantzias, Health Promotion Officer. Anne has worked in Community Health Services for many years as both a service provider and a manager. Contributions were also made by other staff who participated in the real life events.

This is the story of a community health service struggling to provide accessible and appropriate services to its community. The story is a process of discovery rather like cooking without a recipe and finally adding that elusive ingredient. Like fish sauce to soup. The magic ingredient adds just the right amount of salt and flavour. Although fish sauce (Nuoc mam) smells strong by itself – and many would claim it could not possibly be palatable – without it, the dish just doesn't work.

Brimbank is a local government area in the western suburbs of Melbourne where 8.3 per cent of the population comes from a Vietnamese background.

ISIS Primary Care (IPC) is a community health service in Brimbank committed to responding to community need. Our long-term aim is to increase community and consumer involvement in all levels of our service planning, implementation and evaluation. We chose the Vietnamese community for this project due to the high population numbers, and the low numbers accessing our services.

We wanted to know answers to so many questions. What did the Vietnamese community want from us? Why didn't they use our services? How could we make our services more relevant to their needs? But the sheer number of Vietnamese people in our neighbourhood was daunting, so we chose a smaller group to begin with. We began by talking to the local elderly Vietnamese community.

In 2001, a group of service providers and a health promotion officer began to prepare for a Vietnamese community consultation. Links were made with a couple of local Vietnamese community leaders and a Vietnamese access worker at the local Migrant Resource Centre. These people were invited to meetings to assist in planning the consultations. We relied on them for advice but this began to set some limits to our consultation. Were we narrowing in too quickly without considering wider opinion? How could we access older Vietnamese people? How could we overcome language and cultural barriers? How could we be sure the voices we heard were representative of the wider community?

So the questions mounted – it all seemed very difficult and this group of health practitioners was inexperienced and unsure. The committee of 13 was large and unwieldy. Progress was slow.

Perhaps for convenience and ease, and with increasing pressure to get something done, the Vietnamese-Chinese Elderly Association of Errington Community Centre (with 700 enrolled members) was chosen as a ready group to consult. It was thought that focus groups would be the most culturally appropriate and viable way to collect the information about needs, and a consultation tool on the theme of 'access to health services' was put together.

Consultations occurred in November 2001. If only the difficulties experienced could have been foreseen at the planning stages!

The senior citizens group's consultation commenced with them receiving a general health information talk, at their request, followed by the sharing of a culturally relevant lunch cooked by the local Buddhist temple trainee chefs. Some of the audience then participated in two focus groups. The male focus group was conducted amidst card playing in the larger room. The female members' focus group was held in a smaller room with fewer distractions.

The focus group findings were disappointing. Relatively few people participated. People were there to attend senior citizens, to mix and have fun with friends, and most were not interested. Some participants saw the focus groups as an opportunity to get their questions answered about IPC services and their health issues. The distractions were many, especially in the big room with card playing all around. The consultation tool did not give us answers in the way we had hoped it would. How could we really connect with the elderly Vietnamese community? How could we encourage people to express their feelings and thoughts when we couldn't find ways to do this appropriately in their culture? How could we ask questions that facilitated answers that would provide the information we wanted?

Unfortunately these questions were overlooked and a report was produced with recommendations based on a consultation that had many flaws. A group of health professionals and a health promotion officer took responsibility for implementing these recommendations but, unfortunately, an opportunity to ask questions, to dig deeper and to persist in making true contact with the community was missed. It was no wonder that a few months later this group of staff was flagging in their task.

Finally the group became more realistic about what could be achieved and decided to act on several of the reports' recommendations by initiating some strategies that were to have some positive outcomes for ISIS.

We approached the Vietnamese community leaders and worker with the proposal of conducting a Health Education Program for the Vietnamese Elderly Association at ECC. We proposed that this could involve seven weeks of one-hour presentations on a health topic of interest.

The program had been marketed through culturally specific methods including Vietnamese print media, ethnic radio programs and displaying flyers (in Vietnamese) at popular local Vietnamese shopping precincts. We also found out that word of mouth was perhaps the most successful method of advertising for the Vietnamese community. The number of participants at sessions increased as more people heard about the sessions from their families and friends.

An average of about 14 people attended each session, with some being more popular than others. Some presenters were very popular with the audience especially those of high standing. Reputable and professional guest speakers seemed to be popular. We wondered if the Vietnamese community values authority figures highly?

The service provider and guest speaker worked with an interpreter for every session. Translations were made of written information. The wording used in the evaluation was kept simple and to a minimum, and was translated into Vietnamese language by a Vietnamese volunteer. Almost all questions were tick box type questions. The information gathered however was not very useful. In retrospect, due to low literacy levels in this community, a questionnaire may not have been the best choice. Observation and oral feedback from participants and leaders may have been a more suitable method of evaluating the success of this initiative.

Soon we realised that we still may have been missing the mark. Did we still not understand some cultural norms of the Vietnamese community? Members seemed so obliging in their involvement in our work. But was the community simply being polite and eager to please? How were we ever going to be confident that we had achieved a true sense of the community's needs and wants? Why did we feel like we were just not getting through?

Even with all our efforts, we still didn't feel certain we were getting where we wanted to be.

Never an agency to give up easily, we continued with our strategies to make our services more accessible and 'Vietnamese friendly' in Brimbank. At each IPC campus, information was provided in 16 main community languages – one of these being Vietnamese. We recognised the need for Vietnamese speaking staff and employed bilingual staff in various programs

including Gamblers Help, podiatry and maternal and child health nursing. And we also continue to actively recruit bilingual staff.

We persisted in participating in new projects relevant to our diverse community. In 2003 the Culturally and Linguistically Diverse Local Diabetes Resource and Service Project, a 12-month Department of Human Services funded project that was a partnership with Migrant Resource Centre North West Region Inc., was carried out. The project focused on Type 2 diabetes, and conducted research with three local ethnic communities, piloting three projects. A Vietnamese CD production of short stories and an ethnic radio campaign was one of the outcomes of the project.

Another new program was begun in 2003 by the speech pathologists at Deer Park. Young Vietnamese children comprised approximately 25 per cent of the caseload. The successful 'Time to Talk' Parent Program was adapted for a Vietnamese parent group. The program recognises the pivotal role parents' play in helping their children learn and talk. Through videos, discussion, books and role-plays, parents learned to use everyday situations to maximise learning and language opportunities with their children. The program has achieved excellent results with children who were language delayed or simply 'late talkers'.

Still we felt we could do more. We desperately needed help from someone who really had the skills and inroads to the community! IPC was able to allocate funding to a Vietnamese community development position and we employed a bilingual Community Development worker in August 2003.

The Vietnamese-speaking Community Development Worker has achieved an enormous amount in the short time she has worked with us and so have we with her.

IPC has held a stall at the Moon Lantern Festival with 31 requests for information. A 20-minute radio Australia interview late in December 2003 had 100,000 listeners world-wide and a transcript in Vietnamese language of this interview was placed on the World Wide Web. A pilot program for elderly Vietnamese is in the planning phase in partnership with various other local agencies. It will include planned health and wellbeing sessions with Tai Chi.

This time around we are more confident that this is what our Vietnamese community wants and that it is being provided with a style that suits them. Nineteen Vietnamese community members have had tours of our centres in Vietnamese language – they know where we are and what will happen when they walk in the door. A local Vietnamese Services Guide in Vietnamese language is being developed.

Three years of hard slog have paved the way in building links with the Vietnamese community in Brimbank and the Western Metropolitan Region of Melbourne. The employment of a Vietnamese community development worker has changed many things – lines of communication are now open and some effective work has begun.

Now new questions continue to arise. How can we ensure that this work is not seen as the responsibility of this one worker, but that all IPC staff retain responsibility and commitment to working with the Vietnamese community? How do we ensure that our learnings are remembered and applied to our work with other local culturally and linguistically diverse communities?

So how is the recipe for soup going at IPC? Have we found that magic ingredient yet? Perhaps we have in ways we never could have imagined. And perhaps we will continue seeking that elusive ingredient for years to come. I do know that the soup is starting to taste better to all of us.

'It's not just the icing on the cake, it's the actual cake'

Melanie Block

Melanie is a physiotherapist and member of the WRHC health promotion physical activity coordination group.

Introduction

Over the last few years the physiotherapists working at the Western Region Health Centre (WRHC) noticed a growing number of older people presenting with problems such as neck or shoulder pain. On discussion it was revealed that the greatest issue threatening their independence was not so much pain per se, but:

“...basic skills, like getting in and out of a chair and going up and down steps and being able to walk safely.”

The physiotherapists created an exercise group for these clients called 'Safe and Strong'. Inclusion with other groups was considered, such as COTA's (Council on The Ageing) over-50s strength training. However, they were either too advanced or easy for these clients.

Safe and Strong started with a small group ranging from 3–10 participants who lifted weights, did balance exercises, and later moved on to use more advanced equipment like the treadmill. Throughout the year people came and went; however, four participants attended consistently week in and week out.

What is going on?

I am one of the physiotherapists at WRHC who has been involved on the periphery of the Safe and Strong group. As physiotherapists, we considered this group successful; however, we had not investigated why, how and for whom. To further explore this I interviewed the four participants who have persisted with the program and might have made the most observations over time — Jack, Elsie, Georgette and Alfonse. I aimed to explore their experience, and ask why they continued coming, what they felt was good about a group setting compared to exercising at home, and what had worked for them. I also interviewed Marianne, the physiotherapist, who ran Safe and Strong, to identify her beliefs and observations.

Their stories

Jack

Jack is 77 and has lived in the inner West all his life: 'I graduated from Footscray, West Footscray to Sunshine'. He lives alone but is within walking distance of his daughter's house. Jack was active as a younger adult riding his bicycle from Footscray to shift work. He lived through the depression and has vivid memories of 'Dudley flats', the shanty towns that lined what is now Footscray Road. This is also connected with his strong interest in the trade union movement.

What happened to Jack? Jack began by reporting how he'd fallen, prior to doing the exercise class:

“Where I tripped that day I would have tripped over a cigarette paper almost, because I was shuffling.”

Jack now has less fear of falling and he is now active:

“In the wintertime I was criticised by many people for finishing my walk in the dark...I didn't think I could fall over again because I was so much stronger, more confident...I would say of the people that walk in the park where I walk I am the oldest.”

How does that make him feel?

"Pretty good because I can do what I want to do...I sometimes go to the country for a day, or even a week...by train. I have friends in the country. I had a week away and it was very good. I could walk every day and go visit the shops and fit in with their routine."

Elsie

"I'm 82. I was born in North Carlton and lived 50 years in Footscray. My husband was a plumber. I met him in the dancing school when I started. This teacher said 'you go over there and dance with that little chap'. I said 'I'm not going to dance with that little chap'. Anyway I did..."

Elsie now lives alone. She first came to physio because of her neck. She began the Safe and Strong exercise because:

"I thought I'd try that because I do go to the gym but sometimes I get giddy and feel that maybe I'd be better to try the physio because the exercises weren't as severe or strong...I was a dancing teacher for 40 years, I've done exercises all my life so I wasn't prepared to give up doing it because I'd had a hip replacement and couldn't get around."

The fascinating part of Elsie's story is how she began exercising at the Footscray Swim Centre, and her determination to keep exercising after her total hip replacement.

How did she feel?

"I couldn't get around...It knocked my confidence I couldn't cross the road or anything...I felt terrible, terrible I couldn't go any where I just lay...I asked about swimming...I kept that up for 12 months. I used to look at the people going up those stairs doing the exercises. If only I could go up those stairs and go to the gym, and anyway eventually I got up there. I felt terrible but I managed."

And how have things changed?

"Well, I'm going to Sydney for eight days to stay with my nephew. [Before] I couldn't get up an escalator. I was scared to go anywhere but now I can actually go somewhere...I have always been so independent, now I'm able to maintain my independence. That's the most important thing for living alone...It's mind over matter; also its confidence, it's a confidence thing."

Furthermore, Elsie's activities extended through the people she met at the Footscray gym:

"She told me to come there (The University of the Third Age) to try bridge...and [now] I'm going to philosophy classes ... it's only \$25.00 for the year."

Georgette and Alfonse

Alfonse and Georgette met at a cafeteria in Melbourne University. Georgette was born in Egypt and Alfonse in Italy. Georgette speaks six languages and was a school teacher. Alfonse was a fashion designer.

Georgette came to the Safe and Strong program after having a:

"broken bone on my thigh on the left side...I had an operation."

She initially went to exercise at Braybrook and then moved to Footscray as it was closer to home:

"we haven't got a car... we come and go home by taxi."

Alfonse came with Georgette:

"because I take my wife with me and I do the exercise too; I like the exercise and to move. But the point is because my wife can't walk properly."

One of the reasons Georgette continues to go to the program is:

"because the exercises are very good and I believe, whatever they do, that one day I will get rid of my stick. I am improving very slowly, very slowly."

Alfonse has noticed small changes. Georgette, he says:

"is better because she enjoys the exercise ...she walks better, she don't have the pain like before because a long time before it was worse but now I think it is better.

I feel better because when you live with a person and they suffer it is not good, I don't feel good... Because I love my wife I feel the same thing she feels."

Alfonse has also discovered some benefits for himself by attending the class:

"I realise when I do the exercise on the floor and up the leg it is the best exercise. I suffer with pain on the right side; when I do this exercise it disappears for 3, 4 or 5 days."

These stories exemplify the impact that getting stronger and more active can have on the lives of older people. As Marianne, the physiotherapist, says about the impact of the exercises:

"It's not just the icing on the cake, it's the actual cake."

Why start?

All the participants began exercise as a result of ill health, except for Alfonse. This shock was perhaps significant enough to cause them to act. Jack said:

"That gave me the motivation to plod along because I was frightened that if I kept going like I am I will become a useless vegetable."

Marianne provides an alternative explanation as to why people are willing to start in the Safe and Strong group:

"I think it's quite important that the person giving the treatment and leading the group is the same person, or at least quite familiar to them, because I think that is part of how it works."

Within a health promotion context both theories raise questions. To have greater preventative impact it is preferable to promote physical activity before it is necessary to seek help from a physiotherapist. I wondered if someone like Jack would attend an exercise group before he experienced such a fright. Would people attend without a facilitator like the physiotherapist to encourage attendance? Who else could act in this role? These are the kinds of questions I would like next to explore.

Previous exercise

When I see older people walking with a stick I find it hard to imagine them as young people, dancing or cycling, yet all the participants were physically active when they were younger. Elsie thinks this is important:

"It all comes down to exercise all your life, doesn't it? People who don't exercise find it much harder to start later in life."

This idea is consistent with the current research suggesting activity during adulthood is an individual determinant of physical activity for adults (Trost et al., 2000). Past adult experience may also add to the hope displayed by members of the group. Georgette:

"Because the exercises are very good and I believe, whatever they do, that one day I will get rid of my stick."

This implies that those not previously active may need more support to attend and to continue classes.

Transport

What separates Jack, Elsie, Georgette and Alfonse from other clients is that they are able to transport themselves to the class. We have not collected data on those unable to attend due to transport; however, anecdotally, it appears to be a major deterrent.

The WRHC is situated near good public transport; however, many clients do not feel confident to use it and cannot afford taxis. This is a key problem and needs to be addressed so as to ensure that those with the least support and opportunity can attend. We could explore seeking cooperation with the local council for use of its community bus service or providing a volunteer driven mini bus. It may also be valuable to contact the local bus companies about their policies on carrying older passengers.

Benefits from the class setting

Participants reported coming to the class for many reasons, including motivation, expert attention, discipline, trust, security and not 'throwing in the towel'. Jack commented:

"It's something to look forward to get there and to be guided by people who recognise what is wrong with me, what was wrong with me."

Socialisation

Interestingly, the social aspect of the group was not emphasised in the interviews and no one was familiar with the name 'Safe and Strong', suggesting either a lack of identification as a group, or as a group with this title.

The lack of 'group formation' and socialisation may be for several reasons. Is it because the primary purpose for attendance was for exercise only? Do the clients in this class see no common bonds between themselves? Or are they socially connected elsewhere? Is it due to the structure of the class; little opportunity to discover the bonds; for example, over a cup of tea? Or could it be that people's capacity or interest is limited due to health, social issues or stage of life? These are also questions we would like to pursue.

Elsie suggested we could improve on the social side, especially to encourage those who find it difficult to keep coming:

"You have to have a reason, like Arthur Murray's (dance school) had their Friday night party."

When asked if there was anything she would like to change about the group Marianne, the physiotherapist, also thought '*a cup of tea*' every now and then would be a good idea. She was able to identify the attitude preventing this:

"Me rushing off ...The push to be efficient and get things done."

The idea of having a 'cup of tea' seems worth trialing. It could be linked with a short discussion; for example, on footwear to prevent falls. Alternatively a volunteer from the class or an external volunteer could assist. This may place the focus on the 'group' rather than the physiotherapist.

A busy class is a good one

The Safe and Strong group has varied in numbers over the year. There seems to be a general feeling that a busy class is preferable. Alfonse:

“When there are more people for me it is better because there is more happiness; when there is 1, 2, 3 I don't like it much.”

What next?

Participants like Jack, Elsie, Georgette and Alfonse have benefited significantly from the program. Their improvement has been essential for activities of daily living (*'It's ... the actual cake'*).

We need to investigate, however, why people choose not to attend/drop out. To improve the program, issues such as transport, group size, past experience with exercise, and an occasional cup of tea need to be considered.

The Safe and Strong program at WRHC will fill soon. This raises the question of access to exercise programs for older people. Placing resources in this area is important as one in three older people fall every year. Research supports the implementation of multi-component exercise groups in the prevention of falls (NARI, 2000) and that long-term sustainability is better for older people when exercising in a group setting compared to at home (King et al., 1998).

To drive this issue the WRHC may be able to seek partnership with other organisations such as local council and COTA. The next physical activity health promotion planning cycle or community health business plan is the appropriate place to discuss whether access to physical activity for older people should be prioritised. The WRHC could consult with older people and use the findings and questions raised in this evaluation when planning and designing future exercise programs for older people.

References

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'From cross about crossings to safely walking school bus' Community health acting constructively and cooperatively for win-win solutions

Keryn McNaught

Keryn is the health promotion coordinator at the Hobson's Bay campus of ISIS Primary Care.

A VicRoads decision to remove the crossing supervisor subsidy for one tenth of the 40 supervised crossings in Hobsons Bay was very disconcerting to service providers at the local community health centre. In fact, surprise and almost disbelief would be closer to the mark! The reason given for the proposed reduction in funds was, 'insufficient numbers of children using the crossings during supervised hours'! Responses were swift.

"The reduction in funding will mean that they're going to close down some of our school crossings – and I want to do something about it!" (Community health staff member)

The local council also released a media statement on this issue, which supported staff apprehensions:

"All of the affected school crossings are located on major arterial roads carrying large volumes of traffic, including trucks, which far exceed the VicRoads criteria for the minimum number of vehicles per hourCouncil strongly opposes the decision, which potentially may affect the safety of our children and other crossing users."

Forming the working group

A small group of concerned staff, including two physiotherapists, one psychologist, a podiatrist and a health promotion officer, established a working group. Their purpose was to identify and implement strategies that would address this issue. While the group knew that they could not stop the closure of school crossings ('the rules were the rules' according to VicRoads), they felt confident that they could do something about ensuring that local children continued to have access to 'safe' walking routes.

Through reading and listening to local media reports, the working group was aware that many of the adjacent councils had been successful in receiving funding to establish a number of 'walking school bus' programs in their municipalities. They felt that a program such as this had all of the features that they were looking for, to enable them to address serendipitously both issues of community safety and childhood obesity (priority issues for both local council and community health services).

National, state and local support

It seemed like perfect timing. On a national level, there had been a lot of promotion and media interest on overweight and obesity issues. Media headlines and emotive statements had certainly made the public sit up and listen:

"Obese and overweight children – what are we doing to our next generation" (*The Age* newspaper, 2003)

"There is clear evidence of increasing levels of overweight and obesity among Australian children. They are fatter than American children, with almost a quarter of those aged between two and seventeen classed as overweight or obese." (*Virtually healthy* newsletter, 2003)

On a state level, VicHealth had provided funding to interested local councils, to implement the 'walking school bus' program in their municipalities. The Department of Human Services and the Commonwealth had allocated a portion of their budget to addressing the issue of overweight and obesity.

On a local level, ISIS Primary Care had included overweight and obesity and mental wellbeing as key priority areas in their organisational health promotion plans. The evidence from other similar projects indicated that the benefits of a program such as the 'walking school bus' could have a positive impact on both of these. Moreover, the ISIS Primary Care organisational health promotion plan also mirrored, quite closely, priority areas in the local Municipal Public Health Plan and Community Health Plan.

It all sounded very easy, especially as the key stakeholders were speaking the same language.

"All of the key stakeholders are in the same intellectual space as ourselves (working group members)."

Should be simple, we thought!!

Convincing key players to participate in the program

Our first challenge was to convince local council of the worth of the walking school bus program. The push to pursue the council was fuelled by discussions with the primary funding body:

"You've really got to get the local council on-side, they're the ones that can do something about the footpaths, they do safety audits, they have volunteer programs and public liability insurance, they have the whole gamut of divisions in the council, such as engineering departments, sport and recreation departments, which can be drawn on to better manage/oversee the process." (VicHealth)

The council had also been identified as one of the key stakeholder groups in our internal health promotion plans, however, when the plan was drafted, no discussions were held with the council to verify their participation. The group felt quite deflated and annoyed when they approached an officer from local council, to discuss the council's possible involvement in the program, and were informed by them:

"We were aware of the funding through VicHealth to pilot the walking school bus program – but chose not to follow through with it. It is not something the council is going to take on at this point in time.

We have heard so many mixed reports about it that we're really reluctant to take it on. We would support yourselves to get this going – but we don't want to be the key agency to drive this."

The group was very aware that no other community health organisations in Victoria had instigated the walking school bus program independently, that is without the financial backing of their local council or state funding bodies. They felt that we were confronted with a challenge that no one else had ever faced.

Community need and support

Although the original impetus to get the walking school bus program up and running started out as a personal challenge for the working group, it soon became apparent that other groups had been thinking along the same lines. Apparently several of the local primary schools had approached the council, requesting their support and assistance to get the program started in their schools. Council had informed us of these requests, in the hope that we could provide the

support that the schools needed (the council were well aware that we had included the walking school bus initiative on our health promotion plans – thus the reason for the phone calls).

While the schools had recognised a need and were motivated enough to begin the work towards change and improvement, they were struggling to gain support from a vital strategic partner, their local council. The struggles experienced by the local community fuelled our goal to develop positive and cooperative working relationships with our local council. We knew that our current relationship with the local council, 'could be better', and we hoped that the walking school bus program would be a step forward for all of us.

Planning mismatch

Establishing the walking school bus program in our local area has continued to be a huge challenge and one that has involved confusion, frustration and many dead ends, or as one of the working group members more aptly put it:

"I feel like we're going around in circles – we don't seem to be getting anywhere."

So why has the process been so difficult? Reflecting on what has happened so far has revealed many interesting insights about establishing and maintaining effective partnerships. The working group recognised that although local council needed to be one of the key partners in the program, their involvement was our expectation, rather than the result of a true partnership. So effective initial communication with council was clearly one of the group's downfalls, but so is the mismatch in local and state planning and reporting timeframes. Internal priority setting and planning occurs at different times in sectors and organisations. This does not support opportunities for partnership and collaboration. Consequently, shared priority areas across different sectors are addressed in isolation, increasing the risk of duplication. This mismatch also increases the likelihood of gaps in service provision in areas of high need. This highlights the need for improved communication and integrated planning across the varying sectors and across local and state and national government departments.

Moving forward

It is still very early days and we anticipate that the 'walking school bus' program will nevertheless go ahead in a number of the local schools. Some positive dialogue has already occurred between ourselves and a couple of the departments within council. Furthermore, several schools have expressed interest in participating and we are currently in the process of sourcing funding to really move this program forward. Although it has been a difficult journey, it has been and continues to be a valuable learning opportunity. It has enabled us to 'rethink' how we plan community initiatives, and how we partner with other organisations. We have faced a challenging obstacle but are committed to achieve positive outcomes that everyone can live with, whilst also developing a base of trust and a spirit of cooperation that will help us to create new possibilities for the future. Our current conclusion is:

"When life hands you a lemon make lemonade."

The MIGs story

Jaime Timmerman

Jaime is an accredited practising dietitian and health promotion co-ordinator at the Western Region Health Centre.

Author's note: This narrative piece was written to give the reader a greater insight into the experiences of and changes made by the men who participate in the Western Men's Interest Group (MIGs). The narrative is based on information from interviews with five members and was composed for and approved by these men.

The MIGs formed as a spin-off of the Western Region Health Centre Men's cooking course, a six-week program for men to learn easy healthy cooking for one or two people. At weekly sessions the men prepare and consume a healthy meal. A nutritionist provides demonstrations and cooking support, and a dietitian provides nutritional education.

Participants who had finished the course didn't want to stop attending the group. Realising the importance of providing others with the opportunity to learn cooking, eight graduates formed a new group in July 2003, the MIGs. The MIGs, now with 15 members, provides a continued opportunity to meet socially and cook. The group is supported by Western Region Health Centre (WRHC) and other bodies, but functions quite independently. The group continues to grow from strength to strength and expand into new ventures.

A dietitian reflects...

In my house Mum always did the cooking, Dad's involvement was limited to carving the roast once mum had cooked it. Recently my parents' lives have changed and Dad has started to get more involved in the kitchen. I'm thankful for this because I believe it is important for men to know their way around the kitchen.

As a dietitian I often see men whose wives have passed away and they find themselves alone, having to contend with the unfamiliar territory of the kitchen. This is hardly the time to be learning new skills — while also dealing with grief and loss. Some men can end up eating basic, boring and nutritionally unbalanced meals, and wind up knocking on the dietitian's door due to poor health.

With the intention of introducing men to their kitchens and to simple healthy recipes, WRHC established a Men's Cooking Course. I recently had the pleasure of reviewing this program and meeting with five of its graduates. Graduates who with three other graduates, formed a group titled the Western Men's Interest Group, affectionately known as the 'MIGs' for short. The men formed this group to enable graduates of the Men's Cooking Course to continue to meet socially and further develop their cooking skills.

The first time I met the MIGs, I arrived at their meeting and was offered home-cooked muffins, proudly presented to me as an example of culinary achievement. After lining up individual interview times with the men for the review, I started busily preparing the questions I intended to ask. Second guessing, I expected the type of information I would gather would be of cooking skills learnt, tales of recipes made, and perhaps some changed eating habits. The reality turned out to be all of this and much more! I quickly learnt that the group meant much more to the men than simply food and nutrition; it also represented, for example, an opportunity for sharing a joke, bonding with others, and having plenty of fun. As stated by MIGs member Peter H:

"When we are in the cooking group we interact, bond with each other, talk with each other, have a bit of a stir up, joke with each other ..."

This sentiment was also reflected by Kevin who stated:

"we all joke about each other and pick on each other like and all that, but the picking part is only in jest ... there is nothing really about it and they are all good friends, a good bunch of fellas."

Although it might sound like a bit of schoolyard bullying Peter assures me that:

"that's the way we are, we just have a bit of fun with each other".

In addition to having fun I also found that being a part of the group had many social benefits for the men. Asked what he thought the most important thing about being in the group was, one man said:

"having the friendship with all the other guys and that, being able to bond with them." (Peter H)

When asked the same question, other men identified the social aspects also:

"It gets me out of the house'... its 'good company.'" (Peter C)

Workers often talk about 'decreasing social isolation' and 'improving social interaction', but from speaking with these men, I'm guessing that these terms don't mean much. In their terms it may mean:

"out of (being in) the class and being in the MIGs I've found I've got more, (I'm) getting out more, making more friends and meeting different people." (Peter H)

Peter acknowledged the increased community involvement he has experienced since joining the group:

"I'm getting to know a bit more about the community and about the people around the neighbourhood."

Peter's involvement with the group has seen him catering at the Braybrook Big Day Out Community Festival and regular 'Dance For Life' functions. These and other initiatives have also enabled Peter to be involved with local community residents and workers from a number of organisations such as WestNet, Neighbourhood Renewal, and the Quang Minh Temple. He commented:

"I'm getting to know a bit more about the community and about the people around the neighbourhood; I'm getting to meet different people from different backgrounds that I never thought existed." (Peter H)

It is obvious that the social interaction is an important part of Peter's life:

"the Christmas break is going to bugger me up a little bit' he confided, referring to the Christmas period when the program stops for four weeks. After stating this he continued very positively that, 'I'll be saving myself for a lot of fun next year!" (Peter H)

The relationships between participants were also obvious to me throughout the review. Perhaps these friendships explain why the men go out of their way to help one another. For example, one participant told me how he spent time outside the classes teaching another participant how to use a computer. He told me this while laughing about how his 'student' then proceeded to be late for the next meeting because he was preoccupied looking up recipes on the Internet!

This mateship even extends to new members of the group. During one of the cooking classes a new participant collapsed and was taken to hospital with a serious health condition. Although a stranger to the group, one of the MIGs visited him regularly in hospital. Due to his poor health he was unable to attend the rest of the cooking classes; despite this, however, the MIGs

member who visited him in hospital encouraged him to attend the cooking class Christmas party. Fortunately this man was able to attend and was even provided transport by another member. This man was welcomed by everyone at the Christmas party despite being relatively new. These kinds of critically-significant community support outcomes are often lost when we refer to them in terms such as 'social capital'.

During the interview I asked the men their background and what type of skills they had prior to the cooking classes, what they had learnt during the classes and how this had impacted on them. All but one of the men I spoke with had limited cooking skills before joining the cooking classes. Each of these men commented on changes to their life, particularly the increased variety of their diets. Peter C reflected that cooking is easier now and he is having more variety, while Peter H stated he is eating more fruit and vegetables. In particular, however, Kevin's story of change really stood out.

Before the program he noted:

"I was only into pies, pasties and fish and chips. I couldn't cook at all, nothing at all. I think the best thing is learning how to cook... I couldn't, I didn't do anything, the wife did it all, I did nothing. I didn't bank the money, anything like that. I didn't even open the side gates. I'd come home at night-time and I'd be lucky if I shut the gates at night. See, I didn't even do the dishes."

Then after Kevin's wife passed away, he could only cook:

"fried eggs, sausages... stuff like that which was non-nutritional. Now, I look after the cooking myself plus (the cooking for) me family and the grandchildren."

Kevin very proudly told me the list of dishes he could now prepare. Although during classes Kevin has learnt to cook nutritionally balanced meals with an emphasis on healthy ingredients, he has taught himself to cook a repertoire of sweets, including bread and butter pudding, custard, rice pudding, nut-loaves, cakes, biscuits and muffins.

His self-learning wasn't without mishap though, as I heard when he told me about his first attempt at making lemon meringue pie:

"My first one was a disaster. It was as black as the ace of spades. I heard the smoke alarm go off and I wondered what happened."

Fortunately for Kevin though the:

"lady down the road came up and showed me and bingo, there was my lemon meringue pie!"

Not surprisingly, Kevin said:

"I think the best thing is learning how to cook. Now that I've done the cooking I find it extremely useful, (extremely) helpful. I cook for myself plus I cook for my daughter and son, and when I go to their house or whatever, we have family night, and I cook the sweets. I wouldn't have been able to help out in the past. I wouldn't have had a clue. I would've bought a cake and opened tin fruit."

Now, *'We all chip in'*.

Many of the men indicated gratitude to the nutritionist Viola and to the program dietitian. One participant praised her for her ability to fit in and have fun with the men. One man commented how he joked with Viola:

"yes mum, no mum', he replies to her, 'just for a bit of a stir up."

He then told me, smiling, "she reckons I'm cheeky anyway".

As one participant put it:

"Me confidence has, yes, grown through Viola, and Dianne with the dietitian part of it. Viola says, 'You can do it, you can do it' well yeah, the confidence has come from Viola and she has done exceptionally well, not only for me but for the others also."

Another participant stated:

"with her confidence in us, we can do anything she shows us."

Although impressed by the increase in cooking skills, confidence and the social opportunities the program offered, I was desperate to find out how much change to health had occurred. Peter's story gave me some insight:

"I had to start eating healthy because I found out I was diabetic, once I found out that, bang, into the cooking group...to learn to cook healthy, eat proper food and eat healthy."

Prior to the group, Peter's diet consisted of junk food, particularly pies and garlic bread. He cooked what he considered a healthy meal only once a month. Now, as a result of being in the program and keeping appointments with WRHC staff, Peter's health has improved:

"it's a lot better, I feel a lot better eating healthy food."

Using his cooking skills and recipe ideas, Peter now prepares five 'healthy meals' per week. This is a 20-fold increase in consumption of healthy meals! He contributes this change to being part of the group:

"If I wasn't with the boys I'd probably stay on the way I'm going for a couple of months then I would have gone back to the old once-a-month sort of thing."

"I feel a lot better eating healthy food. To tell you the truth I feel a lot healthier and I've lost a fair bit of weight."

Peter has lost 20 kg:

"It's a lot to do with the cooking class, plus doing a bit of exercising."

Since being involved Peter has purchased a bike and is riding regularly, as I saw when he turned up for his interview in his MIG's shirt and bike helmet in hand.

Fred also agreed that he is eating more variety; he is now cooking stir-fries. He also told me about different cooking techniques and tips during the interview. He stated:

"It is very good like, you know, not just having the same old thing."

So I went from doing a review of a program about cooking skills and eating habits to meeting a great bunch of men who were happy to share their experiences of the program and personal experiences. It was also fun for me.

Oh, and before I finish, Peter wanted me to add:

"if there is any women that want to join it, I wouldn't say no, the more the merrier the more fun we can have!"

OK, Peter was only joking when he said this. I think it was a joke to stir me and aimed at me joining the group. Although a private joke I thought I would add it so its author could have a bit of a laugh to see it in print.

Less is more ('Throw away that stick!')

Michael Falloon

Seventeen years as a physiotherapist has seen Michael work across a broad range of areas and roles within the health sector and elsewhere. For the last 18 months he has been working in community health with ISIS Primary Care. Michael is a 2nd generation NEAR narrative action evaluation writer who learned from practitioners involved in NEAR Phase 1 and Trial 1 of NEAR Phase 2. The story he tells here follows a full cycle of health development, using a community perspective, and illuminating genuine change with evidence. It reports at catchment priority level (overweight and obesity).

The 'Moving On' Gym Program story

To be more active was the conundrum. Finding the answer was a daunting challenge. Surely it was simple: Teach people how to do it, and they will rush out into the community with inspiration and a new zest for life!

Diving in

The seed for this story was planted in April 2004. To me the notion of teaching people how to become more active innately made sense; while feedback from clients and cardiac rehabilitation participants indicated a need for some way of gaining the confidence to exercise more. With this in mind I devised the Moving On Gym Program with the prime aim of enabling people to become more active within their local community. Once the program was designed the following offer was presented to adults that have come through ISIS Primary Care's doors at our Hoppers Crossing campus. Ultimately it would be available to any adults living within Wyndham:

- an initial assessment with the physiotherapist at ISIS
- attend a weekly exercise class (supervised by the physiotherapist)
- after eight weeks each participant would be launched into the community, transformed into active, inspired individuals
- long term follow up and support upon completing the program.

An offer they could not refuse!

Time was to prove that the transformation did occur, however the method in which it transpired was very different to the approach I initially utilised.

The first enthusiastic group commenced with said physiotherapist carefully taking the group through a series of exercises. Each week the participants studiously filled in their exercise diaries, and dutifully followed my supervision during the gym sessions.

Yes all was well; this approach appeared to be working. Then the group came to their final session from which they were going to leap into the community, avidly maintaining their new active lifestyle. They were so used to being closely supervised that the thought of "moving on" was too difficult to consider. What had I done wrong? Everything was going according to plan; until the end! The participants wanted to continue attending the sessions at ISIS rather than moving on into the community, some even returned to their pre-group levels of activity. The classic relationship between service providers and their clients was being perpetuated. Then the realisation hit home; for this to truly succeed the participants would need to run the group with the physiotherapist hovering quietly in the background just in case they were needed. What a blow to my role as an expert – I was now reduced to a casual observer.

I can see a light

So grasping with this difficult notion, the second round of enthusiastic clients began their journey. The ability to stand back and let people do it was the opposite of what we had been trained to do. It was also the opposite of what some of the clients expected. Yes they still had their initial assessment, however when it came to the gym sessions it was basically up to them to determine how they completed their routine.

Why did you join the MOGP?

Arwen: "To keep my muscles working and to get fitter"

Sam: "To gain more confidence"

Frodo: "I want to get stronger and ease my pain"

For some this was a little daunting (they wanted to be led and directed through every step of the way, they couldn't do it themselves), while others thrived in this environment. This gradually spread across all the class participants until, low and behold, they had gained the confidence and self-belief to do it.

These statements were commonly heard during our sessions:

"I want to do more."

"Where can I go to when I finish here?"

"What is available in the community?"

"I am feeling so much more confident."

"Being active is fun."

Clients were independently modifying and adjusting their programs to suit their needs. Some were feeling confident enough to offer assistance to others in the group as well as to new members of the group. This indicated that individuals now had the confidence to help themselves and each other.

I was now used as a resource by participants rather than as a leader, which is exactly what I had wanted from the changes I had made.

It was initially frustrating, as I had to stop myself jumping in and solving some of their issues, but as time passed the ability to witness the transformation in the group members was immensely satisfying. The follow up sessions have demonstrated that the clients have continued with the changes in their lifestyle and are still reaping the benefits.

Moving on

At the two three-month follow up sessions completed to date, all the clients were maintaining the level of activity that they were at upon finishing the sessions at ISIS. Overall 90 per cent had increased from only one to four sessions of activity to five to seven sessions of activity a week. They had all reported an improved quality of life and were keen to keep as active as possible. The majority had indicated that the main change they had gained from the program was an increase in their self-confidence. This now enabled them to be happier with themselves and to feel that they were able to be more active within the community.

What did you get out of the program?

Arwen: "I thought I was too fat to exercise, but I did things I haven't done before. It gave me confidence as well as social contact with others in the same boat. I am still exercising, still confident. It has shown me there is more to life than my own bed (I was so tired I wouldn't get out of bed), and it has made me a better person. It has got me out of a rut, I am now going to the gym and Weight Watchers."

Sam: "For three years I haven't been able to mow my lawn, now I mow my neighbour's lawn as well as my own. I am not dizzy any more, am walking more and doing weights. I have much less pain and know what activities I can do at home. At pension club outings I beat everybody! I now live the good life!"

Frodo: "I have more confidence because I know I can do it. I have not been tired any more and am able to cut my own firewood. I am more active and want to do more and am thinking of doing aerobics as well."

Hence the old saying of '*less is more*' could not have been more effectively illustrated than with this group.

One journey: K's Story

(K is 61 years old and was experiencing difficulties in dealing with Type 1 diabetes, hypertension, osteoarthritis in her lumbar spine, shortness of breath on exertion, a painful right hip, and fluid retention)

The following is a combination of an interview that I conducted with K and her own summary of the moving on gym program (MOGP) experience.

K started the gym group in May 2004, and then moved on to a local gymnasium in July. Upon first visiting the gym, there were two imposing flights of stairs to tackle. Rather than seeing this as a negative, K's reaction was to see the stairs as a challenge.

"I want to be able to run up those stairs."

She has been attending the gym since and has thrown away her walking stick (one of her main aims), and yes she is running up the two flights of stairs.

What led you to attend the MOGP?

"I was fed up with my current situation. I was having trouble breathing, walking and just doing day-to-day things."

"I had no energy at all. I felt I was going downhill fast and that it was only going to get harder."

"I really wanted to avoid being in a wheelchair" (As she has seen happen to her sister).

"I wanted to snap out of it."

"I wanted to throw away my walking stick."

What did you want to gain from the MOGP?

"I thought the MOGP was a starting point in my journey, and that it was a good way to become motivated."

"It would give me the impetus to keep me going once I got started."

Did it meet your expectations?

"Yes, I gained the motivation I needed. The exercise diary was the best incentive for me as I had to fill it out each day, and it required me to be honest about what I had done."

Upon finishing the MOGP, have your new circumstances continued?

"Yes, I now attend a gym three days a week (weights, light aerobics and water based exercises), and I walk 2 to 3 km three times a week."

"The stairs at the gym were a challenge, but I knew I would get there. Initially it took me 10 minutes to walk up the stairs to the first floor, now I run up them."

"The young people at the gym are fantastic as they are so helpful and encouraging."

"I have not used my stick for the last five months."

"I find the main motivating factors now are the enjoyment in being active and the friendships that have developed at the gym."

Some of K's reflections:

"I am sorry that I didn't start this years ago."

"This is now my time. Nobody dares to interrupt my Fridays!"

"I love the company."

"I just love it."

K's written summary of her MOGP experience

AIMS:

Desire to improve way of life and stop downhill slide.

To be able to walk without a stick.

To improve my breathing.

PROGRAM:

Exercises gentle to start. Keeping of diary made you do exercise at home. Being able to discuss any problems or difficulties that may occur. Being in a group of people with similar problems.

WHAT I GAINED FROM THE PROGRAM:

- 1) *Encouragement and support to keep trying to achieve my aims*
- 2) *More mobility*
- 3) *More energy*
- 4) *Breathing problems easier*
- 5) *Made new friends*
- 6) *Determination not to let myself slip back*

SINCE COMPLETING THE PROGRAM:

I now do 3 days a week gym under supervision. Monday and Wednesday 1.5 hours of general exercise and Friday 4 hours of cardio, aerobics and water exercise. Now able to walk without walking stick. Do 2 to 3 km walk 3 times a week. Still have some pain in knee and hip. Breathing is good. Diabetes better control.

As you can see the results literally speak for themselves. The outcomes have been achieved, but only through a different approach to what was first envisaged. I must admit that it has been a fantastic experience to observe clients realising their potential; but it only works if you stand back and let them.

As per the title of this narrative: "Less is more".

Beyond the light

From April to December 2004, 40 people have completed the initial sessions at ISIS. Over this period only a handful have dropped out of the sessions. One was due to a significant deterioration in his health, while the others we ascertained were not ready to personally make such a journey. It was important for each person to determine if they are ready or not, which often becomes clear after two to three sessions. Reassure them that when the time comes that they are ready, they can come back into the program.

The gender distribution has varied from group to group; overall it has been an equal number of men and women involved in the program. The youngest participant was 20 and the oldest 80 years old. Typically the majority have been 50 years and over.

Due to the demand we are now offering two group sessions a week, the second session filled with participants as soon as it started.

There are probably three main barriers to the future success of the groups and our ability to reach a greater population.

- The lack of resources (We are currently unable to offer more groups at Hoppers crossing)

- The procedures at ISIS (The delays created by long waiting lists, difficulties in accessing the physiotherapist for an initial assessment and the need for full client registrations result in many clients losing interest by the time they have been processed).
- The general lack of awareness within the community of what ISIS actually represents and thus the services it has to offer.

In terms of enablers, one of the obvious is the range of clients that currently are registered with ISIS. This provides a population that is ideal to market the program to. The expertise of ISIS staff combined with the current emphasis towards health promotion and chronic disease self-management results in ISIS having the means and capability to run this type of program. The existence of strong links/partnerships with community facilities and groups ensures there are ample opportunities for participants to move on to when they finish their sessions at ISIS.

My advice to service providers that are contemplating running this type of program:

- It is essential that participants are ready for this type of approach.
- The intent of the program must be made absolutely clear to each participant.
- Participants must also understand that the program involves long term follow up and support for them.
- Strong partnerships with community facilities and groups must be developed and maintained.
- Service providers must be able to step back and allow the participants to realise their own potential (let them run with it!).

Always remember less is more!

A story of survival – the Collingwood Community Gym

Kristine Olaris, Lina La Guardia and Melissa Bryan

Kristine Olaris works as Manager of Allied Health and Dental Services, Lina La Guardia as Dietitian and Melissa Bryan as Health Promotion Co-ordinator at North Yarra Community Health (NYCH), a multi-sited agency in the cities of Yarra and Melbourne. While 'Healthy weight' is the catchment-wide priority forming the focus of this narrative, it also illuminates multi-governance cooperation in responding more effectively to the expressed needs and lived realities of those in the community.

One significant change that took place in the redrafting of this narrative was the reframing of the story of the gym from being one of a 'hot potato' to one of 'sustainable survival'. The narrative is now being used for ongoing training of workers as well as for reporting purposes.

It is written at the interagency and service level and uses a fictionalising device of a single persona to capture the connections between the services and the community. This use of a fictionalising device was experimental in the second phase of the NEAR project.

From then to now

Residents of the Collingwood Public Housing Estate (the Estate) have, for a long time, given their whole-hearted support to the Collingwood Community Gym (known locally just as 'the Gym'). The Gym is located at the base of one of the high rise towers on busy Hoddle Street, and residents find it to be an affordable and welcoming place where they can exercise, have fun and make friends. For some it has also led to important employment opportunities.

Yet many issues have plagued the Gym over the years – including a lack of ongoing funding, inadequate resources, limited supervision and fluctuating utilisation. This has resulted many times in the Gym being closed temporarily for lengthy periods of time, and in 1999, DACHTA⁴ was left with no choice but to close the Gym, seemingly for good.

Fortunately in 2000 the Collingwood Neighbourhood House, which had close ties both to the Estate and the Gym, decided to seek short-term funds to reopen the Gym for two hours per day, Mondays to Fridays. The Neighbourhood House approached NYCH⁵ to assist with a submission to VicHealth and to become the financial auspice for the Gym, as they were concerned they were not big enough to take on the considerable financial and human resource management risks and accountabilities of running such a facility.

NYCH was certainly not in the business of running gyms but saw something unique and special about the Gym: an opportunity to provide a supportive health promoting environment and address social connectedness issues on the Estate. So in 2001, with the assistance of the VicHealth funding (which included employing a qualified gym instructor), NYCH took on the management. One of NYCH's first tasks was to commence securing future funding for the Gym. Between the years 2002–2005, NYCH applied for and received annual non recurrent funding from the Office of Housing (OoH) to enable the Gym to remain open.

A gym for the community

Mr Nguyen⁶ is a 55 year old Vietnamese resident recently diagnosed with Non Insulin Dependant Diabetes Mellitus. He had read about the Gym in *The Link* newsletter, a publication of the Estate, but thought he was too old and didn't have the confidence to ask about it or join

⁴ DACHTA – the Dight Street, Abbotsford & Clifton Hill Tenants Association – that had established the gym over 20 years earlier, with funding from the Departments of Human Services and Justice.

⁵ NYCH – North Yarra Community Health Service

⁶ 'Mr Nguyen' and other named residents are fictionalised characters whose stories are composites based on actual experiences of residents of the Collingwood Public Housing Estate.

in. Mr Nguyen first considered joining the Gym after attending North Yarra Community Health's (NYCH) 'Living with Diabetes Group' where he learned that regular physical activity could improve his blood glucose control. As NYCH was now running the Gym, the staff there knew all about it and gave him lots of information about the gym sessions. He had also heard the Gym mentioned on 'NYCH News' on his local radio station 3CR. It may have been speaking to others on the Estate that finally convinced him to attend the Gym. This circle of contacts included fellow residents and also workers at the Collingwood Information Centre run by Jesuit Social Services, and the Collingwood Neighbourhood House. These two local agencies, also located on the Estate, have close ties with NYCH, and are strong advocates of the Gym.

So eventually Mr Nguyen became a regular attendee and was interested in the Gym's story of survival. Although a newcomer, he was pleased to hear about what NYCH has achieved since taking over in 2001.

Mr Nguyen tells of his involvement with the Gym and the positive impact this has had on his social, physical and psychological health. He underwent a health assessment, and an individual exercise program was devised to suit his needs. He learned much about exercise benefits and technique. The opening hours of 5.00–7.00 pm suited him, as he spent his days looking after his grandchildren. And he found the \$2 fee affordable.

Mr Nguyen established a great rapport with the gym instructors and gym assistants and his confidence grew. He was very willing to help the instructors put up posters and written health information in a variety of languages around the Gym. He made suggestions about some improvements that he felt were needed at the Gym – such as repainting, the need for air-conditioning, and new pieces of equipment. He was impressed that these suggestions were followed up. Mr Nguyen spread the word of the benefits of the Gym to other residents. Mr Nguyen feels fitter and stronger; his blood glucose control has improved and he is grateful for the opportunity to make new friends and to contribute to his local community. Mr Nguyen is happier and feels a valued member of his neighbourhood.

As a frequent user of the Gym, Mr Nguyen has learned of the targeted group programs NYCH has established to facilitate access for specific resident groups, and which work to make the Gym an inclusive environment. These programs now run in addition to the evening sessions. Mr Nguyen has seen many of the attendees of these groups around the Estate, but had never really acknowledged them apart from a nod of the head. Now they had something more in common, all being members of the Gym. Together they bring to life the words 'social fabric' for the estate community.

For example, married couple Maria and Nick, who live on the floor below Mr Nguyen, attend **The Stronger Living Weights Group**. The main purpose of this group is to increase strength and mobility in participants such as older adults with conditions such as osteoporosis, arthritis and diabetes, and to assist them to better control their chronic conditions.

Or Jack, who Mr Nguyen has seen frequently at the bus stop, who attends **The Gym Program**. This provides a safe supportive environment for people who are homeless to access a gym facility. This program is run by Greg, one of NYCH's physiotherapists who works with homeless people. It has flourished after a partnership was formed with RecLink who assist by referring people into the group and facilitating their attendance.

The energetic teenagers he bumps into in the lift attend **The Youth Gym**. It is open to young people between 12–18 years of age. The success of this program can be attributed to the joint work of a NYCH youth worker and a NYCH physiotherapist. As a part of this program young people are encouraged to set individual targets for themselves, for example: 'Walk for 15 minutes on treadmill, 3 times a week'. NYCH has also implemented a Youth Card which gives young people on the Estate free access to the Gym at other times. "Young people need support," says Mr Nguyen.

Selamawit is a 30 year old Ethiopian woman who Mr Nguyen met recently when she was on her way to **The Women's Health Group**. As a recent arrival in Australia, her English is limited; however she managed to convey to Mr Nguyen how much she loves going to the Gym both for the exercise and for the free massage from volunteer masseurs. This program targets women who for religious, cultural or personal reasons require a women's only space in which to exercise. It has had a particular focus on newly arrived refugees and has developed links with Foundation House and the Asylum Seekers Resource Centre. NYCH physiotherapist, Jess, has noted that there are many women in this group who had never previously exercised:

"I will never forget an older Somali women's delight at riding an exercise bike for the first time. She laughed continuously for the whole ten minutes."

Whilst attending the Gym, Mr Nguyen has also got to know the gym assistants well. A review of staffing issues by NYCH in December 2003 had resulted in the development of paid gym assistant positions in addition to the existing gym instructors. The role of the gym assistants is to 'meet and greet', provide attendees with information about the Gym and about NYCH, collect attendance statistics, ensure the cleanliness of the Gym, and report and liaise regarding any faults. They also have an important role in being able to waive Gym fees for those who couldn't otherwise attend.

All of the gym assistants are public housing residents. Many of them had not been in paid employment for some time and most have health and welfare issues. The NYCH Health Promotion in Public Housing (HPPH) worker provided these workers with the support they've required. However support for these workers will be a future challenge, as the HPPH position has been a time limited one and recently came to an end.

In 2004 NYCH secured funding from the City of Yarra Community Grants program to allow the assistants to undertake a Certificate 3 course in Fitness Instructing. The assistants were keen about this because of the employment opportunities this will create for them. As these gym assistants become able to take on gym instructor roles, other residents will move into the assistant positions, thus providing a valuable employment pathway for Estate residents.

Mr Nguyen also got to know Jacqui, NYCH's HPPH⁷ worker. It was Jacqui who invited (and encouraged) Mr Nguyen to attend the Health and Wellbeing Subcommittee (H&WS) of the Neighbourhood Advisory Team (NAT) on the Collingwood Estate. This committee, which developed out of the Neighbourhood Renewal strategy on the Estate, is made up of a mix of residents and agencies. The meetings provide a perfect forum for residents such as Mr Nguyen to have a say on what is happening on the Estate. Mr Nguyen not only has the opportunity to speak on his own behalf but also as a member of the Vietnamese Community. The Gym was a hot topic at many subcommittee meetings.

Aiming to sustain the Gym

It was at this forum that Mr Nguyen learnt what the Gym means to NYCH; the organisation he has been visiting since he arrived in Australia 10 years ago. The Gym works to implement concepts in the organisation's mission statement such as to provide responsive programs and services to all members of the community, to work with people to overcome their experiences of disadvantage and discrimination, to support people to make informed decisions to promote their health and wellbeing and to encourage active participation in the life of the community.

Mr Nguyen and other subcommittee members have also supported the objectives of the program. These include to address community health and wellbeing by increasing participation in physical activity on the Collingwood Estate, and to promote social cohesion and community connectedness.

⁷ HPPH - Health Promotion in Public Housing

At the H&WS⁸ meetings Mr Nguyen also learned how much the Gym meant to others on the Estate. Attendance figures that were presented showed that the Gym was now being regularly utilised by between five and seven people every evening session. Many of the NYCH targeted programs are running at optimal capacity, which is between ten and 12 people. The membership of the Gym includes residents from a broad array of backgrounds and ethnicities. There were also lots of young people now using the Gym, both the Youth Gym and also the general Gym sessions. Mr Nguyen knew that until the Youth Gym program was established there were no young people at all exercising there. Now they make up about 22 per cent of those using the evening sessions. Evaluation surveys results and comments from residents and workers also gave the committee a strong understanding of the importance of the Gym. Some of this useful feedback is illustrated.

In February 2005 the H&WS on the Estate identified the Gym as a whole-of-government priority issue. The Gym resonated as an issue for the residents who saw the many benefits that people gained from it. They were aware of the concerns regarding its ongoing funding and management and saw its prioritisation as a good way to ensure its survival. As a result of this a number of stakeholders including the City of Yarra, the OoH⁹ and NYCH started meeting to discuss the long term sustainability of the Gym.



⁸H&WS - Health and Wellbeing Subcommittee

⁹ OoH – Office of Housing

Cooperative pathways

This was a significant turning point in the story of survival of the Gym. The path to this point had been greatly assisted by the identification by NYCH of the Gym as an integral part of its response to its Yarra-wide Health Promotion priority of Healthy Weight for 2004–2005. As a result of this, NYCH put significant effort into the development of the many partnerships with residents, government and other agencies that had existing or potential interests in the Gym.

For example the Neighbourhood House, Jesuit Social Services and RecLink all actively supported and promoted the Gym. The relationship with the OoH has ensured the financial support for the Gym over the time that NYCH has managed it. The Neighbourhood Renewal Program of the OoH has enabled the residents of the Estate, and other local agencies to have an opportunity to express the importance of the Gym to the community on the Estate. The relationship with the City of Yarra has been more recent and was greatly strengthened by the identification of the Gym by the NAT as a whole-of-government priority. This illustrated to local council the need for leisure services to be provided differently to different groups within the community.

The development of strong partnerships with key stakeholders was fundamental to ensuring that the Gym was not seen just as a NYCH program, and to ensuring integration of the different elements of the program, and to consolidating a commitment to the ongoing viability of the Gym.

As a result of the discussions between NYCH, the City of Yarra, the OoH and the NAT¹⁰ it was agreed that for three years from 30 June 2005 the City of Yarra would take over the auspice of the Gym with their own funding, and that their management would be underpinned by a collaborative partnership between these stakeholders. A financial contribution from OoH and NYCH was also agreed upon. A steering committee consisting of the City of Yarra, the OoH, NYCH, and the NAT will ensure the Gym remains an accessible and responsive resource for public housing residents. There are plans to increase the self-sufficiency of the Gym over these three years to enable its continuation after this time.

Towards a viable new partnership

Mr Nguyen believes that the change of management of the Gym is likely to have positive outcomes. For example the City of Yarra has already committed to extending the opening hours of the Gym sessions from the previous ten hours per week to 15 hours. This will include two group exercise classes. NYCH will continue to run its targeted programs as well.

There are also plans, which are supported by the OoH, to try to expand the Gym into an adjacent space so that its capacity can be increased. The City of Yarra has also given a commitment to continue to offer employment and training opportunities for Estate residents. These opportunities may include employment within the Gym but also in the three other Leisure Centres that operate in Yarra.

At a recent launch of this new partnership, Mr Nguyen heard the Mayor of the City of Yarra, Kay Meadows, suggest that it might be possible in the future to consider extending the program to the Richmond and Atherton Gardens Housing Estates. Mr Nguyen was pleased to think that not only had he been involved in supporting the survival of the Gym, but also that he may have contributed to this unique program being replicated on other estates. He could see that one of the major challenges for the steering committee in the future will be to advocate strongly that this occurs.

The transition of the Gym from an underutilised public space to a space of community engagement and participation is an example of health promotion and multi-stakeholder collaboration at an inspiring level. Not only has the gym provided numerous sport and

¹⁰ NAT - Neighbourhood Advisory Team

recreational opportunities for individual members of the community such as Mr Nguyen and his fellow residents but it has demonstrated the valued meaning of 'community'.

When Mr Nguyen reflects on the Gym's historic journey of survival, he is happy that the Gym finally has an appropriate management structure and a likelihood of long-term sustainability. He notes however that the story of survival has not been without its challenges. Some of these challenges have been overcome, some it is hoped will be addressed by the new management structure, and some are likely to remain ongoing issues for the steering committee. And so the story will continue to unfold...

'So much more than tea and biscuits' – the MM Young, Pregnant and Parenting group

Katherine Goulliart

Katherine works at Djerriwarrh Health Services. Her story is at the service and micro level.

Go steadily amid the noise and haste
And pay attention
What direction there may be in the unspoken need
--Adapted from the *Desiderata*, 1692

"Hello, Katherine, remember me? It's Lauren from the antenatal classes..."

"Lauren? How are you? How is the baby?"

"We are fine, she lives at Mum's place now but I'm pregnant again"...

"Really?"

"Yes, I was just wondering about is there any young mums group in Melton? You know, I've gone to parents group after Emma was born but I don't feel comfortable, they sort of looked down on me because I was so young so I stopped going. Now, I like to meet other Mums of my age, you know..."

"Oh, Lauren, I'm sorry I know there isn't any such group in Melton and I do know it's a need but I just don't have the time to start anything now. But I tell you what, it's definitively on my list and will look at it ASAP..."

Three months later:

"Hello Katherine, anything new about a young Mum's group?"

"I'm so sorry Lauren, I'll call you back about it as soon as there is something new, I promise I haven't forgotten."

A year later:

"Hello Lauren, guess what? We've got funding to start a group, do you want to join?"

Lauren did come but only for a while, so did other young Mums until we listened carefully to their expressed and impressed needs and Melton Moorool Young Pregnant and Parenting (MMYPP) took a more defined form. However, while she might never realise it, Lauren had started a cascade of events that would somehow ease and change some lives...

It had been very clear to me that isolation of young mothers and parents in our community was interfering with their short and long term development and fulfillment as an individual and also a member of the community at large. International reports also point out that teenage pregnancies and parenting are risks for limited education and qualification, employment and social recognised worth, leading to varied poor health outcomes.

Having run antenatal classes, I was very aware of parents' expectation that once the baby was born, "everything would get back to normal". They often experienced back from the hospital, sometimes painfully, an acute need for further support and encouragement only to find a gap in the community resources. I had dreamed for a long time of a support group that would welcome Mums and Dads from pregnancy and would continue while they raise the children. I could read the statistics, hear the requests, the funding opportunity was there. I knew who would be good at running such a group, we had multiple allies in our local network: the schools, maternal and child health nurses, the shire family services, some doctors and our own Youth Health Service...

The time was ripe...

I contacted Maryvonne in early 2003 and she was interested to facilitate the group, a very modest funding was granted and DjHS was supportive of a pilot program.

The aim of the group at that time was to promote social connectedness and parenting skills especially to the very young local mothers. Right from the start, Maryvonne and I worked on community participation principles; we established that the participants would be the driving force: we wanted to hear what they needed to facilitate positive outcomes. We also wanted to welcome partners and integrated pregnant and already parenting participants to encourage peer support between the 15–25 years old. Healthy lunches would be offered, so we chose the weekly 12.30–2.30 time slot of the day.

The early participants were clear about wanting social time but we had also in mind skills development and trying to entice to further education, so we organised for guest speakers fortnightly, giving the topic choice to the participants, alternating with free talk meetings. We average only 2–3 participants and had quite a turnaround for more than six months. We also heard about workers having given our contact number without being contacted by the young Mums themselves. So we designed a referral fax form that allowed us to contact the young person and reduce the intimidating and costly first call to them.

The first contact was made easier but we still did not succeed in attracting the very young mothers. On reflection, it appeared that they actually had found support from their mothers and for some, even from their school. Instead of worrying about it, we re-evaluated our aims and focused on the group that was responding. The ones we attracted were slightly older (17+), not leaving with their mother and having lost their previous friends. Slowly, the group was taking shape and a core group of 10 met regularly from a year after the start of the project. Slowly too but surely, they were driving the boat in another direction...

In early 2004, a parenting course brought issues clearly to the surface. The participants complained that they had not enough time to talk to each other any more because of the time spent with the extra facilitator...What could have been seen as a failure was in fact a success of having young mothers standing for themselves and trying to get what they needed at that time: time to talk, be themselves, not be judged, have fun, express their fear, frustrations, being listened to and acknowledged by their peers and supportive workers in a self-directed environment...

So, we stopped having guest speakers, and they talked and talked and talked....They talked so much, five conversations could be going on at the same time across the room! Maryvonne and I keeping attentive to issues that needed follow up.

And the shy ones started to say things, and the talkative ones started to listen more, and they started to comfort each other, sympathising or cracking a joke, they started to invite each other to their home and exchange phone numbers, catch up when one would not come or ask us to follow up one them might be worried about. They encouraged each other to not feel sad when leaving their baby at child minding.

It was such a drive to apply for further funding, positive things were happening. We received two rounds of external funding and then DjHS integrated the group as core business. Another male community health nurse, and young Dad himself, had started working with us, it was such an opportunity to offer a positive male model to young women who often had difficulties with their partner and break down some myths! Jarrod was easily accepted and soon counted as "one of the girls".

As the background worker, it was important to keep interested in what could further help in developing the group. It came about hearing that Women's Health West (WHW) was about to start research on the health of women in the west. Gaining research back up about the impact of the group was most welcomed when immediate resources do not allow it.

The young mothers were more ready that time to share their time with the WHW staff, but it was still hard work to focus on outsiders' questions. They stuck to the commitment even when just talking would have been so much easier...six months later came the day when they could see for themselves that they do matter in this community that was often quite critical of them. WHW supported a day event at a local playground chosen by the young mothers, where younger parents of the community could come, enjoy and meet other parents – and them.

A crowd attended! The local newspapers reported the event and a brochure design by them was launched...16 names were collected for further groups. It was simply a fantastic success.

The event has certainly strengthened the bonds between them. We have now three second babies! The Mums visit each other at the hospital and return to the group the following week with the brand new baby, eager to not miss a session.

We are now at the stage when we wish to see this tightly knit group stretch its wings and develop into a playgroup of their own. They are strong, have come a long way and while perhaps a bit intimidated to take the plunge, they are open to trying a new model knowing we would still support, visit and be there when need be. Some talk about further study that was not possible until they felt stronger in themselves and are also interested to be used as peer person for the new Mums to come...

So, let's start another group?

'...there is never enough dancing'

Sally Camilleri

This is an account of a health promotion worker's experience with Bosnian Women. Sally works with Women's Health West with an inner-city (Footscray area) focus on both women's issues and multi cultural issues.

The Bosnian Women's Festival day arrives...

The crowd was really excited when the Behar Choir began their performance. Once women broke into traditional Bosnian dance it was almost impossible to pry them away from sunlight to go back inside for health information session. Musha, one of four of the hosts who were employed to keep the day flowing, danced, as she avoided making eye contact with me because she new I hoped women would begin to move inside, while Nermina, another host explained "everything will be ok, they really want one more dance". I must admit I really enjoyed that dance.

After pondering on what will the weather be like on 24 November since June, it turned out to be a beautiful sunny day, not a cloud in the sky; a perfect day to have lunch under the Gum trees. Fifty-five women came to Festival Zdravlja Zene (the Bosnian Women's Festival). It was a little scary when the coffee was slow to start up, as I had been clearly advised that "it is important to start the morning with coffee!". Once that was sorted, an exciting day was underway.

Melissa (the CEO of Women's Health West) kicked off the event with a welcome and was followed by one of the hosts: "My name is Musha and I have been involved with Women's Health West from when I went to a leadership course" I heard her say through an interpreter for the few of us who couldn't understand Bosnian. She talked about the work Women's Health West does and about what was going to happen throughout the day. Women joked and laughed together, asking heaps of questions of the Bosnian GP, Dr Nermana Gradisic, who answered women's health questions for over an hour, focusing on stress management, sleeplessness and nutrition.

One woman had explained to me at a picnic earlier in the year that she and many of her friends were struggling to manage their weight and fitness in Australia because of the change of weather and lifestyle.

"In Bosnia we work hard and walk everywhere. It's very cold and we eat heavy meals. Here we eat the same, but don't walk or work outside."

She agreed it would be a good to learn more about nutritious food and how our bodies use energy. Women also explained that they continued to have trouble sleeping, and experienced debilitating stress because of their experiences in the war.

"We learned what we can do to help ourselves to be healthy."

Women said that they appreciated the massages provided on the day and the self-massage session, which was offered as one of the three rotating health workshops in the afternoon. Women's Health nurses from ISIS Primary Care and the Western Regional Health Centre ran a session on women's health generally and Lisa, a dietician from ISIS Primary Care, covered nutrition and energy.

Mersija Islamovic and her family were recommended by a group of Bosnian women to do the catering. Sitting in her lounge room sampling the chevapi, a cheese filled pastry, Mersija planned to serve on the day, she explains to me that the food is very important:

"there must be enough food for everyone and it will be authentic Bosnian food."

Her daughter speaks of the respect she has for her family and of the challenge of making a new life in Australia.

"We must study hard and make the most of the opportunities in this our new country, but we all miss Bosnia very much. Before the war we could go out and be with our friend. Here my parents worry about drugs and things like that."

Mersija and her family surpassed all our expectations, providing an ample yummy spread for lunch outside. We had Burek, Chevapi, and salad. This was followed by fruit salad and a sugarless traditional apple dessert (it's traditionally made with heaps of sugar, but this is a health day after all).

Women had some lovely things to say about the day, but of most interest to me was the comment that everyone was surprised that it felt so "Bosnian", "Sally you are not from Bosnia". I was really pleased about that, but if we could do it all again I would definitely make sure the coffee was prepared earlier and that we had more time for dancing...

My reflection on the festival project in wider contexts

When I started at Women's Health West, as a health promotion worker 15 months ago, the concept of health promotion was very new to me, I thought, however, that I was pretty good at working with people from diverse communities. I came to Women's Health West after running an education unit dedicated to the subject. Through this project I was honoured with insights into the uniqueness of the Bosnian community, more specifically Bosnian women. For example, through spending time with Bosnian women, I came to understand how important it was to women to have fun and forget about their problems, about enjoying good traditional food and coffee together. This reinforced, for me, how important it is to take time, build relationships, encourage participation and then do real consultation. I use the term 'real' to highlight the need to be flexible in order to respond to what women identify as important and to respond to barriers as they are revealed.

In my role as a health promotion worker I had one day per week within the family planning project, to build links with Bosnian women, to organise an event where Bosnia women could be told services and resources were available to them that will optimise their health and wellbeing, and specifically to provide the relevant information around sexual and reproductive health. When I joined the project, consultations had already started, and the plan was to run a festival that would incorporate a celebration and the provision of health information.

What happened next?

A group of Bosnian women meet every week in St Albans. Having originally met through the Foundation for Survivors of Torture, the women wanted to continue to meet regularly. Supported by the North Western Migrant Resource Centre, ISIS Primary Care and Merhamet-Bosnian Welfare, the group named themselves 'Ostanimo Zajedno' (Let's Stay Together). Mersada took the lead and worked tirelessly to organise the groups weekly get togethers. Ostanimo Zajedno agreed that I would attend their meetings regularly, and they would assist to organise the festival.

After the Festival Zdravlja Zene, the women said that their friends who didn't attend the festival regretted not coming, but that "no one believed it was going to be so good and so organised". Women who were there were very surprised:

"We were very happy. Great organisation, nice people, nice food and dancing; but we were very surprised."

I was confused by this:

"It all came from you, I said, you told me about the family who could do the catering; you

told me about the Behar Choir. You talked about the stress and problems you have sleeping after all that you have been through; you talked about how hard to it is to keep your weight down and to stay healthy after you moved from a cold climate where you physically worked hard and walk everywhere, to living in Melbourne where you eat the same food and don't walk so much. It all came from you."

One very outspoken woman in the group explained:

'We were very happy; we did tell you everything, but you don't know our culture so we didn't know that it would be so good'.

For much of the 'planning phase' while I was meeting with Bosnian women, it felt that they thought of me as a nice girl who was spending time with their group; who organised funny games, the occasional shiatsu massage, lots of laughs and some tears. For a few, I was a nice single girl for whom it would be fun to find a mate. All the while I was engaging women to look at venues, plan catering and entertainment and to discuss health issues in preparation for the festival.

It seems the concept of community development, which we know is not universal, just didn't make sense; women didn't see what was happening in the community development context. Regardless of my many attempts to explain my role, and regardless of the fact that I was advised the idea for a festival came from the community, it seems that while I thought we were working together, this group of women did not think the festival was theirs to have ownership over.

I am not in a position to make connections between their experience of war and trauma, or to really understand the Bosnian experience in terms of history and culture. But I often wonder about the connections... for example I wonder how women could claim ownership over events in a new place when they have been forced to leave everything they had ever known.

Service providers, including myself, have found engaging the Bosnian community in community development difficult because community development activities, like organising a health festival, did not appear to fit into the Bosnian field of experience. It's not how things usually happen for this community. Women, in particular, are busy keeping their families and their own lives together, rather than putting energy outside the family in to the broader community.

Yet a great time was had by all at the Festival Zdravlja Zene. Information about relevant health issues and services was provided. And women were impressed that health organisations would go to such lengths to organise an event that was true to Bosnian culture. The new challenge is to engage women so they feel ownership of their group, their community and that it is indeed what they want to do.

Later...

I went back to the group a few weeks after the festival to find that Mirsada, who the group relies on, had decided to stop organising the group. Other women were concerned about losing their opportunity to get together each week, but seemed to be at a loss as to how they might organise things themselves. This was my opportunity to encourage the women to take ownership, perhaps to become more active developers of their own community, and in turn their own health and wellbeing.

Although each of the eight women at this meeting felt unable to take up a leadership role:

"I can't speak English' 'I don't understand how systems worked in Australia' , 'I can't be a leader"

they all agreed that they would like to take responsibility for some small aspect of maintaining or running the group, that was within their capabilities. So now we have embarked on the next stage of this project,

to support this group of Bosnian women to see that they made the Festival Zdravlja Zene happen, and that they can keep their group alive if that is what they really want.

In the meantime I am advised by a worker from Merhamet Bosnian Welfare that women across Melbourne have asked for another health festival each year. Hopefully next year they will give themselves credit for organising the festival themselves.

One thing we can be certain, there is sure to be lots of dancing.

Young mums rock!

Joy Free

Joy works at Women's Health West as a researcher. Her account of this work focuses on younger women at the community-based service level.

"We're not just a bunch of tarts you know."

"If you can push one of these things out, you can do anything!"

Peals of laughter fill the room.

"But they think that you can't do anything, the doctor said to me; 'how can you manage a baby, you don't even have a job.' I did have a job but he just assumed I didn't."

"You feel so alone, there could be 20 people in the hospital delivery room and you feel alone."

Young mothers share their experiences and feelings amidst chaos. Babies gurgle on the floor or are passed from mother to mother. The conversation tends to break up into small groups until someone says something outrageous which unites the group once again in laughter. Discrimination, social isolation, tears, fear and always an overwhelming sense of joy.

This was one of six workshops with a young mothers support group as part of an action research project to promote the mental health of young mothers living in Melton, an outer western suburb of Melbourne.

The young mothers group was established and thriving. Service providers were curious and intrigued:

"We've been trying everything to engage young mothers, they're just not interested, how did you do it?"

They asked the group facilitator:

"It's been a long and hard journey, the facilitator replied, It's taken eight months. I think the main thing was that we did what they wanted."

Doing what people want. Not rocket science. Instead, a cornerstone of health promotion and the Ottawa Charter. People as experts of their own health. Not so simple in practice.

To me this project felt like riding the New York subway. Every train line has a complicated identification of a letter, numbers and colour like 'A119 red line'. You may have an idea of which direction you are going in but you're never quite sure where you will get out. Not that it really matters, because you know that the journey and destination will always be valuable and interesting. You're bound to learn something along the way!

Initially, we wanted to hire one young mother to be a co-researcher on this project. But then we realised that this could create problems within the support group by creating a sense of inequity. We then adopted an action research approach, which enabled the young mothers as a group to identify what action they would like to undertake to promote the mental health of young mothers. We went in with a very open ended task. The project had a timeframe of 12 months and a budget of \$10,000. They could decide what actions they wanted to undertake.

At the same time, we were working very closely with workers attached to the support group including the facilitator and two community health nurses, one a male nurse to provide the women with a positive male model and support partners who were also invited to participate in

the support group. We also liaised with a wide range of service providers via existing service provider networks.

Our initial aim was to observe and learn about the context within which these young mothers live and their experiences and feelings. What is it like to be a young mother living in Melton? How does it feel? What are the good things? What are the not so good things? What might help to make it better or easier?

Young mothers told us about feeling very isolated and scared. They felt there weren't enough services to support young mothers and that they didn't have enough information about the support services that existed or the confidence to access services each step of the way. They told us about the shocking discrimination they face walking down the street and by service providers. What did they want? To be valued, respected and appreciated by their community, to know what help was available and how they could access this help. More chances for young mothers to meet and share their experiences. To have more child and mother friendly community activities for themselves and their children. To have better transport services. More doctors. Free dental services. Opportunities for education and work training.

We were also very interested in the context and experiences of service providers. How did they work with young mothers? What things worked? What didn't work? What are the service gaps? What might help service providers to deliver quality services to young mothers living in Melton?

Interest in young mothers by service providers was high. Young mothers were felt to slip between the gaps of youth and adulthood services. Service providers told us that many young mothers didn't feel they fitted with older mothers. Their experience was that a lot of young mothers weren't interested in support groups, that trying to get support groups established and sustainable was too hard. That many young mothers didn't like the traditional style of health education. Some service providers were looking for new ways to engage with young mothers. To build relationships and share information. Some felt like introductory agencies where they would introduce like minded young mothers to each other. Others had tried to get groups of young mothers together but these had collapsed without worker support.

Initial reactions to the project were reserved. What is it all about? What does it hope to achieve? There was a sense of scepticism. Is it worth the effort? The young mothers were generally more enthusiastic:

"If we can help to make it better for other young mothers that would be great."

Their sense of how their experiences could help others in the community strengthened throughout the project.

It seemed like a juggling process to keep up the motivation of the project with service providers while at the same time giving the young mothers control over what action would be done. People kept asking 'but what are you actually going to do?' I didn't know. It was up to the young mothers. And that took three months to work out. We understood that whatever the action, it needed to be realistic and achievable to build and maintain the trust of both young mothers and service providers.

The first couple of workshops focused on their experiences as young mothers. We sat and mainly observed; watching women share and learn from each other amid the noise and seeming chaos. The third and fourth workshops included some brainstorming tasks to further explore wellbeing within the community. The project task did not prescribe that the action directly impact on young mothers (on the assumption that actions could occur in the broader community and impact positively on young mothers indirectly). But these young mothers wanted to focus on young mothers specifically, and so we ran with it.

It was a delicate balance between keeping the project moving towards identifying an action and respecting the wants and needs of women in the support group to share their experiences.

At times the young mothers resented the time taken up on the project, every second week of their support group time. We considered having the project outside of group time but everyone was sceptical that the women would turn up. This was the established time and place they were used to attending. Many of the women had very complex lives and this group had become a routine.

The women were generally enthusiastic; some were even excited to be involved in the project. Their main motivation was to make it easier or better for other young mothers. But their motivation did wax and wane according to other things happening in their lives, and if they missed a session. We tried to make the sessions fun. One of the things we did was to bring little gifts each week. We would put them on the table: strawberries, essential oils, stress balls, chocolates, flowers. Something new each week to look forward to, little gifts to pamper and nurture. That's what they identified as important to their wellbeing – having a sense that they were appreciated.

It was very challenging to identify a common goal for all the women. Why did we feel so pressured to have a common goal? We had to achieve something and it seemed if we could find something that all the young mothers wanted to do then we could pool their motivation. But this was a diverse group in terms of age, life experience and personality. Some mothers resented being identified as young mothers. Others appreciated recognition that young women who have babies may have specific needs. It was important but tricky not to let the leaders of the group overwhelm the quieter women. Even service providers differed according to the value of separating motherhood according to age. How old is a young mother today? Under 20? A generation ago most women had babies under 20. Under 25? What about older mothers? There were no clear cut answers and no one answer suited everyone. As the project progressed one thing became very clear. We needed an action that was realistic and achievable for the young mums. And we needed to ensure the action was implemented. These women were used to being let down. We had made a commitment and we needed to follow it through.

I became quite anxious. I talked with the young mums. I talked with key workers and the project reference group. I talked with other workers with expertise in working with young mums. Ideas for what we could do, what would be realistic and achievable? What would really help young mothers? We talked about poor public transport and child facilities in the local shopping centre. Was there something we could do about this? I didn't want to be tokenistic. It seemed like trying to fix the titanic with a life boy. But we had limited resources.

Two issues kept coming up in the young mother's experiences: feeling socially isolated and not knowing about what services were available. One idea from the young mothers group was to have an event for young mums at an indoor playground called Mumbo Jumbo, which was a well-known treading ground for young mothers in the region. Women had noticed a lot of young mums went here but they didn't seem to interact with each other. Here was a chance for young mums to meet other young mums in a fun and informal atmosphere. The young mums seemed excited about having an event.

The women were motivated to help other young mothers going through what they had been through: they wanted to tell them that you didn't have to go through the hard parts of being a young mum – that there are other women who are going through it too and you can get help and support. I introduced the idea of producing a brochure, which would be designed by young mums for young mums and could be given out at hospitals, maternal and child health centres and community health centres targeting isolated young mothers. We could launch this on the Young Mum's Rock Event day. The women were excited. Together the young women, service providers and researchers decided on two achievable actions: to hold an event day and to produce a brochure. And we had two months to do it.

Workshops with the young mums identified the brochure would talk about the good and bad stuff of being a young mum, that reaching out for help can be hard to do, tips on getting the support you deserve, "you've got rights" and where to start. The young mothers were

interested in using cartoons and we were able to use the great talent of a worker to design the cartoons based on what the young mums wanted the pictures to portray – real looking young mums not Barbie dolls; cultural diversity using a woman wearing a hijab with a baby approaching; mum and two kids crying their hearts out; mum and child in loving cuddle and a group of young mums talking at the table. The brochure would be launched on the Young Mum's Rock Day. The young mums worked really hard on the brochure. They were able to recognise and use their experience and wisdom to help other young mothers. They were very excited to see the final design of the brochure with their words printed and the bright and colourful cartoons.

It wasn't perfect. It wasn't going to change the world. But it was something we could really achieve. We talked about a title for the project. Young Mum's Rock was most popular. It promoted a strong, resilient and positive image of young mothers. It challenged the discrimination of young mothers in the community. We had some stickers and balloons made up. These could be used at other council events to help promote more positive images of young mothers.

We thought about how we could make the most of the Young Mum's Rock Day. We decided to make the day a fabulous celebration of young mothers. To let them know that they were special and appreciated. We had a range of activities to pamper the body and soul including make-up, nails, massage, jewellery making, music and dance – where possible run by other mothers from the region. We invited workers from the Council including family services, youth services, housing, community development workers, Centrelink, maternal and child health nurses, family violence workers. The local workers could bring information and chat informally with women and be involved in the pampering activities. Information was available on tables away from the crowd. Young mothers could choose if and when they wanted to get information and could do so privately especially information which they may want to access privately like sexual health and family violence. This was young mother's turf. This was a way to help make services more friendly and accessible. We provided child care and transport.

The young mothers worked hard to promote the Young Mum's Rock Day. We had over 100 enquires. All of a sudden the Event Day at Mumbo Jumbo Indoor Playground was happening and it was a fantastic success! Over 90 mothers and 60 children attended. Women loved the friendly and fun atmosphere. They were able to meet with each other and get information on local services. They want more events like this.

One woman told me that she hadn't been out since the birth of her baby six months ago. A day like this gets you out of the house.

Over 15 local service providers came to the event. They told us it was a great way to engage with young mothers. They told us they would be willing to support more events like this. We are now looking to see if we could have regular Young Mum's Rock Days at Mumbo Jumbo Indoor Playground.

Both the mothers and service providers felt the brochure was fun and informative and shared the real life experiences of young mothers. We are exploring other ways of giving information to women about local services, particularly family violence, in a second phase of the project.

Thinking back over the project we know that it hasn't been perfect and there are many things to be learnt. Questions beg to be asked: How can we better work with young mothers to hear their stories and service needs? How can we include a diversity of young mothers in our work, especially very young mothers? How can we identify and implement actions, which can have a real and long lasting effect on the community? How can we better involve service providers? Learnings will feed into the second phase of the project. And so the story and the learnings go on...

Young Mums Rock! continues to be a wonderful, challenging and in many ways inspirational adventure. The strength and resilience of these young mothers is a privilege to witness. To see their real life experience and wisdom shared amongst each other and with workers has been

the most valuable outcome to date. To see their pride and sense of achievement:

"I'd like to help people in similar situations"

"I contributed something to the community."

Young Mum's Rock – you bet they do!

The Children's Art Space at Panch Health Service

Marianne Mahony

Marianne was Community Liaison Coordinator at the Panch Health Service in Preston. This multi-voiced narrative is at the Project Level of a Program and was written as part of the self-study (DIY) Trial 3.

"Those walls, those long walls, those long bare walls
--- I wonder what could be done with them?"

Walking down that long, long corridor in this brand new facility, I found myself overwhelmed by the empty spaces and daunted by the sheer size of the building. In August 2003, I had commenced in my new position as Community Liaison Coordinator in this shiny new integrated health care centre, Panch Health Service.

The centre had risen like a Phoenix on the site of the nurses' car park of the former PANCH Hospital. It was a political compromise, and as such did not quite meet the expectations of its community. But it existed, and with its six partner organisations and more than 40 services, it was operational and ready for the surrounding communities to use.

As the days passed, I quickly became involved in the life of the centre, meeting people and learning about their work, preparing brochures, organising tours for interested community groups and starting a staff newsletter. Put simply, helping to put in place all those things which make organisations hum. And I began to receive feedback about the building, how staff and community members liked its newness but found it sterile and boring. I began to ponder if I could do anything to bring people into the centre and make it a welcoming place.

The idea of turning the foyer into an Arts precinct came from my previous experience of visual art and its importance in helping to build community connectedness. So, with the approval of the General Manager, off I went on the quest to establish the Foyer Arts Project at Panch Health Service. The Children's Art Space was one part of the Foyer Project. This quest carried me in many different directions, and engaged me in many debates — such as whether to award a prize for 'best work' or give prizes to all — and with many people and organisations with whom I had had little or no previous contact. The project moved very fast. Within six months, I had secured funding and patronage from the local member (and Minister for the Arts), sourced and erected a professional art hanging system, employed the Art Curator and negotiated involvement from three primary schools. The Inaugural Exhibition, 'Summer and Autumn in Melbourne' was launched by Mary Delahunty in May 2004, and since then we have had five more.

The quantitative data tells a 'bare bones' story of The Children's Art Space having had six exhibitions involving 15 primary schools (one is a special school) with 150 art works from 175 students. There have been approximately 80 people attending every exhibition; so more than 480 people have seen Panch Health Service through this creative and child-friendly 'lens'.

Upon reflection, I think that it is the positive engagement of so many diverse people and organisations in this project, which most excites me. It has been a community project and one which doesn't cost much but has engaged many people in its development and operation. For us at Panch Health Service, we are now more part of the community, celebrating our children and professionally displaying their art at our centre. We are seen more as an integrated health care facility, which publicly acknowledges and demonstrates the link between visual arts and wellbeing. For me, personally, it has been great to create something from scratch and to be innovative and to work with so many positive and creative people.

How can I tell you about its participants, how it was shaped and what its effects have been? I think it would be best if they tell you themselves. So here are the stories of the five key players— how they became involved, what they gained from their experience and how it has affected and changed them.

'The cast'¹¹ in order of appearance:

- Marianne: the Community Liaison Coordinator,
- Mark: the Arts and Cultural Development Manager from the City of Darebin,
- John: a Director of the Northcote Lions Club,
- Dawn: the Children's Art Curator
- Judith and Kathleen: Principals of local primary schools.

I've envisaged the story as a hoop which gets bowled along from person to person as the development of the Children's Art Space evolves over a period of about 12 months. And I've reported the story in their own words, putting their voices in a sequence so you can hear all the different people and their contributions to the hoop's journey.

Shaping a children's art exhibition space—is it possible?

Mark is Arts and Cultural Development Manager at the City of Darebin

"There is an artist in everyone and being involved in the arts is good for health and wellbeing."

He takes up the story this way:

I became involved in the project towards the end of 2003, when I was approached by Marianne to provide advice to determine if such an art space could be established, and how this could be achieved. I'd been aware of the Centre being built, but hadn't been inside the building previously, and, like Marianne, was struck by the long walls and high ceilings of the Foyer area. The decision to locate the Children's Art Space at the far end of the Foyer was relatively easy. First, it had good natural light and second, behind the wall were the dental services, including the Pre School and School Dental Services, and so it was an area to which children and parents naturally gravitate whilst awaiting their appointment.

My engagement with the project was based on my role of promoting arts and culture across the City of Darebin and in developing strategic relationships between organisations and agencies. Such relationships seemed to me would help to show the connection between art and individual wellbeing and art and economic development. However, it was important for me because of my particular interest in art and wellbeing; I thought this was a good idea and I liked the concept of using a health service to display local children's art. And finally, I thought that it would be relatively simple to achieve. Establishment costs could be obtained from local service clubs, and because there are few outlets for displaying children's art except schools, there would always be a ready market of material from schools for the space.

Looking back, I think that the Children's Art Space has reaffirmed a number of things I knew, and dramatically highlighted the connection between the visual arts and health and wellbeing.

First that with small effort and few resources it is possible to achieve something which is of an ongoing nature. Many of the health promotion community arts projects I see don't last because they are dependent upon a particular staff person or a particular group, whereas this project can continue irrespective of either. Second, it makes my job easier because it is a model for how community arts projects can operate. It is about every child being an artist, and displaying the creative efforts of all. And, related to this, the project illustrates that good health is influenced by determinants such as wellbeing which lie outside the health arena, but can be accessed through the medium of the visual arts. And thirdly, it is a good location partly

¹¹ Permission granted from each to use their names and words in this story

because of the actual fabric of the building, which needs art to take away the blank feeling but also, because it is a place where families with young children visit regularly.

It's no surprise that the Children's Art Space has been successful; everyone gains – the school, the students, the families, and Panch Health Service and its community. However, what is relevant in health promotion terms is the approach. It's a move away from the individual one-off project to a proactive model of supporting every child to engage in the visual arts.

Selling the dream—but who will pay for it?

John (Director, Northcote Lions Club) enters the stage.

“I bought my first painting when I was 14 and I've always been involved in arts, partly because I admire artists and partly because art is crucial to people.”

I first learnt about this project when the Lions Club received a letter from Marianne telling us about the proposed project and asking if we would like to make a contribution towards its establishment. So I arranged for myself and another Lions' Director who is not interested in art to visit Panch Health Service and discuss the proposal. We saw the new centre being built, but didn't have any connection to it. Previously, the Lions Club had supported projects at the former PANCH hospital but we hadn't had any contact with the new service. Our Lions Club has a long history of involvement in the arts, and we had been a big supporter of both the Preston and the Northcote Art Shows.

Normally this isn't something that we would support, because arts projects are pretty low on our list of priorities. But after our visit to the new Panch Health Service, and seeing the number of services available to families and young children, and the bare walls, we could see the value of such a project. The Club decided to make a financial contribution to the project for a number of reasons. First, we could see that it would be great for local children and secondly, that it was proposed to do it properly—we liked the 'professional approach' with proper frames for the art work and a real hanging system, as well as the 'no judging' system, but instead celebrating the work of every child. We supported the concept of having art in such centres where lots of people would see it and finally, we knew that people could derive pleasure and solace from visual arts.

For us, supporting the Children's Art Space has proved to be very worthwhile. For our Club, we are pleased that our contribution is publicly acknowledged by both signage and invitations to be part of each exhibition. We see ourselves as a partner in this project, and not just the banker. But it is the excitement of the children and the pleasure they receive from being part of the event that is really fantastic. A lot of people never have an opportunity to be creative and to have their creativity recognised and applauded; this is one project which supports this opportunity, and I think it will have long term benefits for the children involved. And, as a local resident, I know that many people in this community never have the opportunity to engage with the arts. Perhaps for some, seeing art professionally displayed may mean they visit a gallery or buy an individual work. Who can tell?

I know that many hospitals have art on their walls, and that they have many fine works by famous painters. Panch Health Service could not afford this approach, nor do I believe should it. The Children's Art Space is a more dynamic and community-orientated approach, and one which makes the children and their schools and communities extremely happy. I have, and I know other Lions representatives have, enjoyed being part of such a project.

Making the project work—how can it operate?

Dawn (Children's Art Curator), continues the story...

“You don't have to know the child to enjoy the art.”

I had recently retired from my position as Art Teacher at a Westgarth primary school when Marianne (the Community Liaison Coordinator) contacted me to ask if I would be interested in the position, if funding became available. The position as Children's Art Curator would be to organise 4–6 exhibitions from different primary schools annually in the space, which would include locating the work, hanging it and organising the openings. I'd loved working with children and it seemed to me that this would be a nice way of keeping involved with the community and the arts generally. So I agreed, and this is my story.

From my experience, it seems that our professional approach of hanging the work in proper frames and arranging exhibitions has been key to our success. Schools appreciate the respect this shows, and the value we place on all children's art. I know from personal experience how busy schools are and how hard it is to get them enthusiastic about new projects, so everything we can do to make things simpler, such as selecting appropriate themes or collecting and framing the work makes a big difference. Initially it was difficult to engage schools and we relied on individual contacts, but as we become better known, it becomes easier. Each exhibition is different but the focus is always on celebration and achievement, and we have a review so that we can improve by being more responsive to the children.

One change is to ask the child when he/she is being presented with a certificate and prize, if they would like to talk to us (the audience) about the paintings. Some children don't want to speak, but many relish the opportunity to tell us about it, and so do their families and schools!

Probably what I think is most exciting about the project is the opening up of new spaces for children's art. From my discussions with teachers, I hear that art is increasingly on schools' agendas and that the Children's Art Space can support schools and teachers who promote art as a valuable activity. The range and depth of the work in our exhibitions has been amazing, and demonstrates that every child can engage with the arts and that we can celebrate and enjoy the work of all students. We have had reports of students whose behaviour has changed because of inclusion in an exhibition, but I think the pleasure and pride on each child's face, as his/her painting is acknowledged is also a meaningful sign.

The project has given me an opportunity to use my knowledge and skills to step outside the school setting, and see how visual art can contribute generally to peoples' health and well being. Organising an exhibition can be quite difficult because it depends on pulling a whole 'range of strains' together, but the buzz of an opening makes it all worthwhile. It is great to be involved in such a project, which is appropriately professional and, at the same time, so positive and reaffirming of children and the visual arts.

But how will the schools react? Will they engage with the project? What will be their experiences?

Two principals tell their stories...

"Our parents looked in through the windows." Kathleen (Principal of Thornbury Primary School)

This school has approximately 400 students, with 50 per cent of students from Aboriginal backgrounds, and a history of exhibiting student art in such spaces as the Ian Potter Gallery and the Children's Garden at the Botanical Gardens.

Dawn (Children's Art Curator) approached our school to celebrate NAIDOC week at PANCH Health Service with the theme 'Our Land'. We were delighted to be part of the program, especially as the theme reflected what we were studying in our Cultural Program, and would allow students to express themselves on a subject which was important to them. All our senior students engaged with the program so that the work on display was from Aboriginal and other children, and representative of all our students.

We are often approached to display our children's art. But this Panch Art Space experience was different. First, it highlighted that schools are part of their community, and one of the services that local people use. The 'Our Land' exhibition was one that local people who knew our school would see and relate to, as different from other exhibitions, which attracted people from all over Melbourne and beyond. For our parents, it demonstrated that our children are talented and have a contribution to make, which is valued by their local community. Our parents are proud of their children, and we know that many visited the service to view the art – and even looked through the windows to see the children's work. (One unintended [but delightful] outcome was the Children's Art Space is located opposite windows, so that people passing can [also] view the art). As teachers, we are encouraged because we see what we are doing as being respected by adults and that visual art is taken seriously by a health service. And for our children, they were excited and loved being part of the program. We see this as one small thing in a number of things, which will lead to change in behaviour. It did increase the self-esteem of the children by providing an opportunity where visual arts were celebrated and applauded. Our school community was delighted.

And what was especially wonderful was the respectful way the children were treated. The children were thrilled to be invited to the Opening of the Exhibition and to be individually acknowledged at the Opening. They enjoyed the afternoon tea and receiving a small gift. But it was the professional display of their work which was of special importance because it added weight to the importance of the visual art experience. In summing up, I would say that it was a positive experience and should the opportunity arise again, we would be delighted to be part of the program.

Finally: Judith (Principal of Our Lady of the Way, Kingsbury) concurs:

"Making art mainstream makes people feel better."

This is a small school of approximately 170 students who come from a diverse range of cultural and socio-economic backgrounds. The school is located between La Trobe University and Reservoir, and in an area which has remained relatively unchanged for 30 years, similar to a quiet country town.

One of our parents, Kim, works at Panch Health Service and told us about the Children's Art Space. She mentioned it to me as she thought we might be interested. I said that we would and raised the matter at a staff meeting. Our Grade 2 Teacher volunteered, and Dawn worked with her to organise the paintings. Our school hasn't been involved in projects like this, and so it was important that teachers didn't feel overburdened or stressed. So the enthusiasm and commitment of our teacher was very important to the project's success.

What was the experience like? For our school, the opportunity to take the children's' art out of the school into their broader community was exciting. The parents were thrilled, and came along with cameras and extended family members to celebrate with their children. It has been written up in school newsletters and widely discussed in the parent community. For the children, the launch and the afternoon tea were very special, but their feelings of being valued, of being famous and of experiencing the relevance and power of the arts were even more so. They loved being part of it. For the Grade 2 teacher, it was also positive – the topic 'All Things Bright and Beautiful' was both appropriate and appealing and working with Dawn (Children's Art Curator) was easy and smooth.

And it has contributed to changes in our curriculum – from 2005, we are employing a visual arts teacher as our specialist teacher. This was to some degree influenced by our exhibition in the Children's Art Space and our increased understanding of the powerful contribution that visual arts education can make to children's' development.

We thought that we were also offering something to the staff and clients of Panch Health Service. Instead of walking into a building with blank white walls, they could view art, produced by local children, which would take away some of the stress associated with visiting

a health service. Many of our parents assumed that PANCH was long gone, and so the invitation to visit the centre and learn about the range of services available was invaluable. So it has been a positive experience for everyone— our school community and Panch Health Service, which, for local people associated with our school, is now well known as a local centre for health services. If the opportunity arose again, we would be very pleased to be part of another exhibition, and would recommend any school to be part of this project.

Marianne reflects on learnings so far...

Upon reflection, there was much to be learnt from this project. The reader will find their own conclusions, but mine, as Community Liaison Co-ordinator, include the following:

First, that if you want to work with the community, you have to go out of your agency and into the community. And, once in the community, you have to be prepared to work with and not for or to that community.

Second, it is valuable to give community members a voice and hear what they think is valuable and what they learnt from their engagement. This may be different from your experience, and may assist in project evaluation and future project design.

Third, this was a valuable project partly because it brought people into our centre but perhaps more importantly it brought Panch Health Service into a number of sectors or organisations which don't normally deal with health centres. Mental health isn't just the prerogative of health centres, but if such centres can build partnerships with other community stakeholders, it is possible to promote health and wellbeing across very diverse community sectors.

And finally, and perhaps most importantly, it reinforces the position that much of the business of creating health and wellbeing happens in places other than health care environments, and our work in health promotion needs to span the community and create effective partnerships to promote this.

4 QuickGuide

This QuickGuide is a summary of the 'key essentials' and resources from the NEAR Manual that may be downloaded and printed off back-to-back as a stand-alone handy reference document.

Extract from

Writing narrative action evaluation reports in health promotion – manual of guidelines, resources, case studies and QuickGuide

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Writing narrative action evaluation reports in health promotion – manual of guidelines, resources, case studies and QuickGuide, State of Victoria, Department of Human Services and the University of Melbourne, Australia.

Introduction – why narrative action evaluation?

‘What’s the story?’ we ask.

It seems a near-universal question – asked in order to weave together the threads that link otherwise separate aspects of human experience.

Then we ask ‘And what’s the moral of the story?’ to understand and learn the evaluative meanings encapsulated in it, which carry the all-important implications for what we do next: what new actions we might plan on the basis of these observations and reflections.

Narrative-writing and story-telling have ‘taken off’ around the world not only in health promotion – such as here in the Victorian Government Department of Human Services’ North & West Region Health Promotion NEAR project – or in human and community services more generally. This surge of interest is being experienced throughout industry, business and management. In the heartland of one of the USA’s largest companies – 3M, the makers of post-its – there is a particularly clear statement of their value in an article titled ‘Strategic stories: how 3M is rewriting business planning’. Shaw et al write (condensed quote):

We tell stories. We tell stories about the programs and people to explain what happened and why it’s significant. Our story-intensive culture is *central to our identity* – part of the way we see and explain ourselves to one another. Stories are a habit of mind and it’s through the way they make us see ourselves and our business operations in complex, multidimensional forms – that we’re able to *discover opportunities for strategic change*...[and] reflect deep thought or inspire commitment. [Our emphasis]

Writing is thinking. Bullet (points) allow us to skip the thinking step...(and) leave critical relationships unspecified...(They) can’t demonstrate that we really know what we’re doing or where we are going. We can’t see the whole picture.

...a narrative logic forces to the surface the writer’s buried assumptions about cause and effect. The act of writing a full, logical statement encourages clear thinking and brings out the subtlety and complexity of ideas. When assumptions are made explicit, they can be discussed...

A well-written narrative strategy that shows a difficult situation and an innovative solution can be galvanizing. When people can locate themselves in the story, their sense of commitment and involvement is enhanced...

Stories are central to human intelligence and memory. A good story (and strategic plan) defines relationships, a sequence of events, cause and effect, and a priority among items – and these elements are likely to be remembered as a complex whole.

Harvard Business Review (May-June 1998 v76 p41-8)

It would be hard to find a clearer statement of the value of narrative evaluation as a critical part of the quality improvement cycle, and these same purposes have inspired the 52 participants in the NEAR project’s Phases 1 and 2 (2003 and 2006) not only to ‘tell their stories’ but to tell them and re-tell them in a way so as to better ‘real’-ise the goals, purposes, impacts and outcomes of integrated health promotion.



Step 1 – Before you start writing

1.1 Think and talk...

You will need to have done some preparation. Firstly check you have everything you need:

- Strong interest, energy and enthusiasm – both your own, as well as that of your relevant clients, communities, co-workers and managers.
- All parties looking forward to exploring the value of narrative action evaluation as:
 - an integrative research and development methodology that matches, complements and helps achieve integrated health promotion
 - complementary to, and an essential component alongside, existing evaluation techniques including planning tools, quality assurance audits and reporting statistics that describe outputs and outcomes in quantitative terms
 - a way of 'keeping the plot' (holding the program logic) on complex process interventions and community, group and individual engagements
 - a way of identifying how the 'story can change' where feedback response data indicates a new approach is needed.
- This commitment and knowledge needs to translate into a managerially-supported allocation of work time: particularly being built into annual work plans.

1.2 Meet and decide

Secondly, bring together those interested in action evaluation writing – for example 2-6 people – to discuss the points at 1.1 and plan a 'start-up' orientation workshop. Also draft a timeline (see **Appendix 1 Timeline**).

1.3 Have a start-up workshop

Thirdly, meet for half to a full day to work through the four orientation exercises (see **Appendix 2 Exercises** and **Appendix 3 What makes a good narrative**).



Step 2 – Getting started (putting pen to paper)

2.1 Re-meet and tell each other stories

Soon after the orienting workshop – we suggest within one to three days (or at the workshop if you can take a full day) – re-meet in pairs or as a small group and settle on your storyline/s, titles, their relationships to levels of health promotion practice and priorities, and writing style/s. Take turn about to each tell verbally what the narrative seems to you to be at this early stage. Begin to shape and re-shape it (see **Appendix 4 Map of levels, voices and styles**).

2.2 Go away and get down a first draft

(...any first draft if it still seems hard to do)

Keep asking 'what's my story?', 'How would I tell this to someone else – or to my mum?', 'Where did it start, how did it unfold, where is it at now?'

It may help to encapsulate it in a title or heading, or to write it as a paragraph or half a page (it's much harder to cut back if very long at first). You might find it helpful to use a set of strategic

questions – either before (as a planner) – or after (as a checklist) (see **Appendix 5 A planner or checklist of questions**).

2.3 Exchange narratives and re-meet

Again, either in pairs or small groups, email narratives to each other or circulate hard copies. You may want to circulate to a wider reference group at this stage (for example, people you may have interviewed or discussed it with, clients, community members).

Consult your **Timeline** for the date to re-meet and **stick to it!**

When you re-meet, practise the art of responding by asking questions that help the narrator rewrite so they are able to tell the best story they can. You are not being a literary critic – you are helping the other person (or people) craft their stories just as they are helping you craft *your* story.



Step 3 – Keeping going!

3.1 Redraft

Again sticking to the **Timeline**, make the time to re-write your draft (we'd advise doing it soon after the peer writer support meeting). You may want to re-draft a couple of times.

3.2 Recirculate and/or re-meet...

You may find the need to re-meet more than once, or you may find the need to do additional research, interviewing, discussing with relevant stakeholders. You may also want to call on **a consultant** with more experience of writing narrative action evaluations. The meetings with peer supporters may become less formal, even just quickly snatched times for brief clarifying exchanges.



Step 4 – Finalising...and revising

Now is the time to circulate the almost-finished narrative further afield.

Discuss possible usage with other stakeholders, and begin to finalise, possibly in different forms for different destinations, for example, a committee of management, a centre newsletter, an annual report, the local newspaper, a community group's own use, a speech or presentation by a client, a professional conference, seminar or journal, other health promotion colleagues or programs, the Department of Human Services.



Step 5 – Winding up... then returning again later

Celebrate!

And think about what you might like to make a narrative action evaluation about, next year...



Appendix 1 Timeline example

Task	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep - Dec
Meet, discuss ideas for narratives, set date for first training workshop	Date ➔								
Plan/check/ or revise this timeline	➔	➔	➔	➔	➔	➔	➔		
Preparation for workshop – individually or in pairs		➔							
Workshop (work through all four exercises), arrange to meet to verbalise stories			Date? ➔						
Meet in group, or small groups or pairs to verbally tell each other/ clarify/shape the stories			Date? ➔						
Write first drafts and circulate them				➔ Date by which circulated					
Read and make notes/responses as questions (to clarify/explore meanings), set date to meet					➔ Dates by which read, and to meet?	➔ Date by which to finalise?			
Meet to ask each other questions about the drafts, set date by which to finalise									
Further revision and/or arrange wider circulation of narratives							➔	➔	➔
Other...									

Appendix 2 Exercises

Figure 1 summarises some key points about the three methodologies

Figure 1 The three methodologies – narrative, action research and evaluation

Narrative

At its simplest a 'narrative' is a structured story. Story-telling has a long human history as people have worked to understand and order our human experience in manageable 'chunks'. These 'chunks' are built from the endless flow of empirical sensations and the connections we see between them, as well as our thinking and feeling about them. 'Tellers, writers and actors' do this in order to pass on these experiences and learnings, by word of mouth, by pictures or by written or multi-media forms, for the benefit of 'listeners, readers and watchers'. Then the roles may be swapped as we tell these stories to each other and then hear new stories in response. In turn we may go on and tell different stories or the old stories in new ways.

It is possible to draw from both literary and social science traditions of narrative to better understand the structure and content of good narrative. Narrative's typical character of conveying a progression from a past to a present and possibly a future, meshes well with a process or continuous-cycle model of (action) research.

Action research

Social science also 'chunks' human experience in stories that have 'beginnings, middles and ends'. 'Aim, apparatus, method, results' is essentially a narrative structure of conventional laboratory science just as 'Hypothesis, test, conclusions' is for experimental science. Science also is 'telling its stories' and passing on its knowledge and learning to a 'community of scientists'.

New paradigms of understanding the social world as both continuous and socially-constructed by all participants (kind of analogous to the movie 'The Never-ending Story'!) have yielded a new way of doing social research. A typical way of describing this underlying methodology is in terms of continuous cycles of ACTION – QUESTION – OBSERVATION – REFLECTION – CONCLUSION – PLAN/CREATION – TAKE NEW ACTION and so on. Again, these experiences, conclusions and results of observed new actions are passed on for others' use and reference, not so much as 'The Truth' but as 'these truths' for these purposes, at this time, in this place, among these people ('community of scientists' – but now more broadly conceptualised as a 'community of practice of interested knowers and learners').

Evaluation

Evaluation has been seen as a retrospective process of observation and reflection involving judgements about 'value, merit, worth or significance' (Michael Scriven 1991 *Evaluation thesaurus* 4th ed. Beverly Hills, CA: Sage). In practice, evaluative judgements characterise both retrospective moments (both *formative* – 'how are we going?', and *summative* – 'how did we go?') and prospective moments (both *visionary* – 'how do we want to go?', and impact assessment – 'how do we think this will go?').

In doing so, evaluation can be seen as following the same logical and chronological sequence of all social science-in-action. Indeed evaluation is an inevitable aspect of action research and social science per se whenever decision points are exercised regarding what is of value (which are the best questions? best observations? best theories? best conclusions? best ways of understanding where to go next? etc.). Research and evaluation (and the relative truths they arrive at) in this way are all relative to context and purposes. Far from being 'value-laden', all inquiry, like the worlds it observes and understands, is necessarily in a sense 'value-driven' or displays a values-saturated 'logic'.

© Y Wadsworth (2004) 'Building it in...'

Exercise 1

Getting started from where you are at – what makes a good narrative?

This exercise has two parts: one preparatory, one in a workshop. It can be done in parts or small groups (3-8).

■ *Preparation before the workshop*

What makes a good narrative?

- Select narratives you have already written (or look at those prepared by others in the group), for example, for a previous health promotion reporting cycle.
- Identify one or two stories or draw out aspects from all that make them good stories or exemplary storytelling.
- Think about and record the criteria for a 'good narrative', such as most interesting, well-written, informative and illuminating.

What are good guidelines for writing?

- Now look again at the guidelines for writing narratives. These are in **Resource A**, p. 17, Part 1 Appendix 3 Reporting Pro Forma in the document *Health promotion reporting 02-03 and planning and reporting 03-04*, March 2003. Although these guidelines consist of only seven dot point prompts, they contain some important features of the narrative evaluation framework that will be developed further in this project.
- Rewrite those guidelines in the light of what you learned from your 'first go' at using them
- (see **Resources E and F** for NEAR agencies' examples of doing this).

Reflect on the reading

- Read through the annotated bibliography of 10 narrative evaluation materials (**Resource D**).
- Identify which ideas seem useful to you.

■ *When you meet...*

Talk about what makes a good narrative

- Review together your experiences of writing narratives in the last reporting cycle.
or Each tell a quick story about something that has happened that day (in the tearoom, on the weekend, at home, etc.)
- Pool all the features that made some stories or some aspects of the stories stand out. (**Resources E and G** address this question)
- Can people say how they would now rewrite or retell their stories differently?

Talk about what makes good guidelines for writing

- Examine how you'd rewrite the initial pro forma guidelines in the light of that experience.
- Draw conclusions about what that might mean for each person's preferred writing style.
- **Resource H** was produced in the NEAR project to guide writing, or for writers to check back against. It was found to be very helpful.

Talk about the reading

- Reflect on what you each liked among the ideas in the annotated bibliography of narrative evaluation materials.

These three little tasks comprising **Exercise 1** gave the NEAR writers a good start.

Exercise 2

Focusing on health promotion and 'who it's all for' (communities/populations)

This exercise has three parts. It helps orient towards the underlying purposes of the narrative writing: to strengthen integrated health promotion. It is best done in small groups (3-8).

Shifting the terrain to health promotion

i. Generate (quickly, brainstorm-style) as many alternate images, descriptive words or adjectives for health or healthy as you can in five minutes. Turn negative ones (e.g. 'not x' into positive states). Use direct colloquial language if that helps. These are descriptions of **your** health. e.g. sunshine, strong, glowing, fresh food, alive, vigor

ii. Now generate a list of what activities, events, practices or states in your own personal life make you feel like that. Idiosyncratic as you like. Find ways of listing ways that might be surprising or embarrassing! (pool these to ensure anonymity). e.g. morning run, a barbeque with friends, native bush hikes, white linen, sleep, going dancing, leaving a difficult workplace.

iii. Finally, imagine what kinds of activities, events, practices or states would make you feel like this – and that could be achieved if there was someone there to help you realise or organise them (to resource, support, assist you)... like a friendly community health promotion worker, for example! You should not have any preconceptions about this person's role except that they are there to help you do whatever you deem valuable to make you feel in a state or states of health. e.g. door knock to organise Tai Chi in local park at 7.00am, small local dance for all ages (no alcohol/smoking), quilting circle, local 'field days' (to learn bike maintenance, rose pruning), establish a self help group against bullying.....

© Y Wadsworth & Gai Wilson (1992) , 'Shifting the terrain to positive health promotion'
Issues in Victorian Community Health ARIA Inc., pp. 17-21

Exercise 3 Focusing on evaluation

This exercise uses the 'mug evaluation' to evaluate something simple (nothing to do with health promotion!) in order to observe the steps in evaluation and the two major 'moments' of evaluation:

- i. Prospective or developmental** 'open inquiry' evaluation 'what is of value, merit, worth or significance?; to draw out the indicators to establish that are implicit
- ii. Retrospective** or 'audit review' evaluation which checks whether previously identified valued states have been reached or achieved.

It also usefully indicates:

- i. the ease** with which we evaluate
- ii. the everyday** nature of evaluative thinking
- iii. how we can inductively generate** or identify evaluation criteria or indicator
- iv. how we can then use these** to deductively evaluate against.

In terms of writing evaluative narratives, it also alerts us to the first step of observing the reasons or logic for identifying the all-important comparisons or discrepancies between an 'is' and an 'ought' (or 'ought not'), between valued and not-valued states. ("It did or didn't work" – "why?")

The mug evaluation

[*Preparation:* Bring an ordinary unremarkable ceramic drinking mug for use in the exercise (at the beginning). Bring a second mug that is quite different (e.g. plastic) for use in the last step of the exercise.]

In a small group, ask each person in turn to say whether they would choose to use this mug (yes or no) if it was in the kitchen cupboard at work and 3 reasons why (or why not). Write these on butchers' paper. **(Fieldwork)**

Reflect on how easy that 'fieldwork' was to do; how asking 'why?' and then 'why' again gets more but is also hard to do; the importance of context (e.g. if 'for a picnic' imagine how different the values assigned would be); how it also rested on people already having stored the 'evaluative

comparative criteria' in their minds; the diversity of views; and how these differing perceptions (values) impact on any idea of its 'real objective value'; note impact of any group dynamics, etc.

Now go through people's answers on the butchers paper and ask people to draw out the evaluative criteria or categories (e.g. size, weight, colour, aesthetics, design, place of manufacture, etc.) and if there's time, indicators of what makes a good mug. (**Analyse**)

Reflect on what the difference was between these summary concepts and the initial responses (e.g. the categories come from the data and are socially-constructed best by respondents themselves to express what **they** meant i.e. is it 'design' or 'shape' or 'aesthetics'?; it is helpful to clarify, makes it easy to use as a checklist, **but on the other hand** reduces richness, seems more rigid and fixed)

Finally, now use the list of evaluative criteria to evaluate the second drinking mug. Reflect on doing that. E.g. quick and easy but unable to suggest change or improvement. (Use a polystyrene cup to illuminate the latter re. how the criteria are fixed by and dependent on the extent or limitations of the **previous** 'fieldwork' and who took part in it - and thus the list may not have a criterion regarding 'environmental sustainability'.) (**Plan and take new action**)

Summarise the steps by drawing a cycle diagram with the 4 steps round the circle: fieldwork, analysis, plan and take new action. (See also Exercise 4 diagrams)

Summarise by reference to the text [Y. Wadsworth (1997) *Everyday Evaluation on the Run*, Allen & Unwin, Sydney]

The comparative table (page 45) and distribute a copy of the wall map at back of the book, or use the action research cycle that accompanies Exercise 4.

© Y. Wadsworth and J. Wexler (1991) *Manual of notes for convening an introductory workshop on evaluation* ARIA Inc.

Exercise 4

Focusing on action research – using strategic questions

This exercise orients to the steps in action research; action research **as** research; the cyclic and change-orientation of action research, and the sequential nature of action research that lends itself to the narrative method.

It draws on Fran Peavey's sequence of strategic questions (see **Resource D** Number 5). You may also like to use Resource H to do this as this planner or checklist is the one we are using in all NEAR writing, which incorporates Fran Peavey's strategic questions.

i. The group chooses an example of a minor topic that is mildly interesting or problematic and also fun. Ideally this should have nothing to do with health promotion as the focus is on the *questions* and what they yield, not on the answers. For example, consider evaluating things like: mobile phone rings, shopping trolleys, conference dinners or the room heating! The mundane. The small scale. Something that can be worked on readily by **everyone** in the group.

ii. Work through applying the string of strategic questions in **Resource D** to the issue chosen.

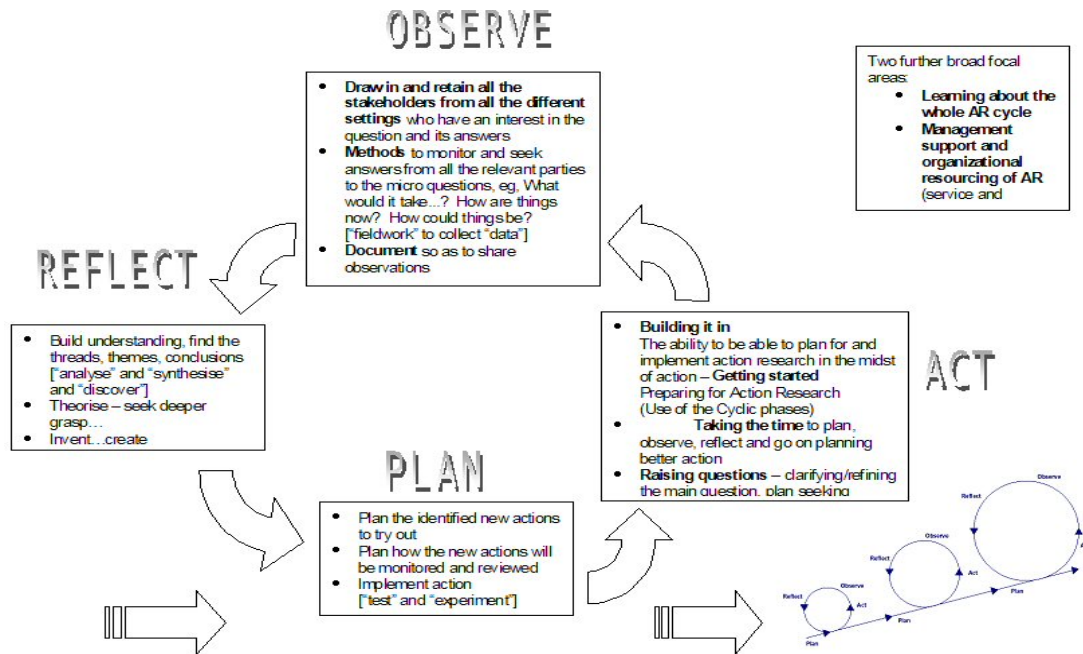
Spend no more than 5–8 minutes on the task, but try and get a response to each question from each person in the group.

Have a timekeeper who can keep saying 'don't spend too much time answering the question – only on whether you see what kind of answers you'd get if you asked it'. Try and move through each question, one after the other. At times you may need to double back, but the important thing is to keep going!

iii. Reflect on the value of the exercise. E.g. It can get you from 'what is' to 'what could be'; it doesn't just plan visions without a good grounding in both observing and asking 'why' regarding prior experience; it prevents anyone recommending actions others should take and instead

supports only self-reliant change that people can make; it gets more alternatives on the table, and it is a systematic way of tapping everyone's views.

Summarise by reference to the wall map at the back of Y. Wadsworth (1997) *Everyday Evaluation on the Run*, Allen & Unwin, Sydney, or the Diagram reproduced below, drawn from



'What is Action Research in Reconnect?', ALAR journal Vol 7 No 2, October 2002, page 69

Appendix 3 What makes a good narrative

(Note: This is **Resource G** in the Resource Kit)

Resource G

What makes a good narrative?

At its simplest a narrative is a story; a spoken or written account of connected events in order of their happening. The art and practice of narrating is about telling a story that *communicates* this (the events, the connections, and the order of happening). Both spoken and written narratives can draw on each other's devices – the 'dramaturgical' (the stage, the movie, the schoolhouse) for the spoken; the 'literary' (the book, the paper, the letter) for the written.

Without time to delve deeply into textual theories and approaches (for example, rhetoric, formalism, structuralism and semiotics, critical discourse analysis, narratology, genre and post modernist discourse theory :-) or even generative approaches (techniques for writing, heuristics), analytical approaches and the synergies between these, this short practical brief conveys the basics of writing a narrative evaluation using an action research approach to change and improvement.

What's the story?

Choose what type of story to write – is it a health promotion mystery? A thriller? Comedy? Redemption story? Are you Jeremiah thundering forth with a message of doom to shock the folks out of their myopic complacency? Or are you Mills and Boon with a romantic and heart-warming love story of silly human misunderstanding leading to loss of Eden climaxed by reunity and hope? Or do you want to tell several of these stories? What exactly is your story going to illuminate about the project or program? Encapsulate the basic story in an inviting title. Now tell it in one sentence as if to a curious person you meet at a party – 'what's the story?' Write it in a paragraph or two as an abstract. What is it about? What's it really all about?

Who are you telling this story to?

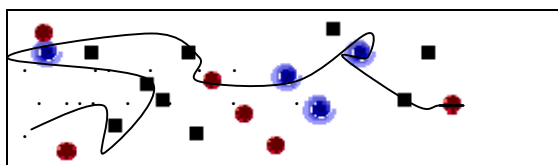
Think about who you are writing your story for and orient the story to *them*. Are they interested in this story do you think? Why? What interests them most and why? What drives them? What do they know and think right now about the 'evaluand' of your story? Do you have to bridge a gap between them and their world – 'where they're at' – and your story? What is the nature of that gap? Use the story, genre, language, examples, terminology and style appropriate for them to best *'get it'*.

Who's telling the story?

Whose story is it? Decide on the way you want to tell your story – is it your personal voice? A warm collegial voice? A cool professional voice? A disembodied scientific voice? A bit of each? Is it 'I' or 'we' or 'them' or a combination? Is it your story to tell? Which is the best story for *you* to tell? Do you want others to tell parts of the story with you? Is it multivoiced? What feels like the 'right' voice to tell it in?

Give the story a basic structure

What is the storyline? Of all the possible things you could say, which stand out for you as the highpoints or features that are **connected** in this story? Is it a straight logical line? Or is it more like a circle. Or does it go round in circles? Was it a circuitous story with false starts and dead-ends? Hold on to the main plot as you go up all those sidelines. There may be a lot of data, detail, and numerous things you could say – the 'dots'. You are finding the 'story' between them that you want to tell – identifying the lines or **threads** of the story', and the dots or **features** of the story.



A start...

What was 'the start'? Capture your listener's attention. State the problem. Even dramatise the beginning a little (even if it's to say how unremarkable it seemed at first). It will often involve a contrast between things. Orient your reader. You want them to ask 'what happened next?' ©Yoland Wadsworth 2004 S&H/NCEPH & NEAR/ARP

Who are the players? The characters. These may include disease states or physical environments, abstract populations or real communities! Characterise them. Give them a 'voice'. Make them 'speak' to the reader. Check the cast of players are each introduced at the right time in the story. Who (or what) was there at the start? Who or what came later...And what were their roles? What parts did they play? Were there unexpected changes to the lead characters? Do they speak to us? Can we see ourselves in them? Can you personalise to achieve this?

Now **the setting** (or settings). Characterise them too. What is in the background? Can we see, hear, smell, and feel the stage, the backdrop or environment? Does it touch us? Is there anything interesting going on 'behind the scenes', 'off stage', in the audience, outside the 'theatre'?

...a middle...

Having jumped into the action, what is the unfolding story? (Make the 'middle' as absorbing as possible)* What exactly has happened or is happening?

Identify progress or lack of it. There may well be complication. Were there stops and starts or stages? Events, highlights, surprises, barriers? Foreshadow or refer back to them. Show how the evaluative thinking unfolded and the data, evidence, observations, explanations and how theory/theories developed. It can help sometimes to give a heading to each paragraph to work out whether it would read better if their order was rearranged (to prevent the story being literally 'all over the place'). Maybe some paragraphs are about the same thing and it's better to combine them (or even reduce them if one or two can tell it best). Maybe you want a little bit of repetition to heighten the telling of the story...

...an end

What was the end of the story you are telling? (Even if the end is only provisional – a 'current' end. It might even be a never-ending story... :-) Work out what is the degree of certainty and closure or/and emergence and change still going on around the conclusion/s. Make the end as satisfying as possible, whether it is conclusive or not...the story needs resolution. Have people got the 'take-home' message/s in how you've conveyed the story (without rather woodenly announcing them)? Indicate any possible futures that might follow... What *could* come next? ('Stay tuned for the next exciting episode...!')

***Create credibility by evidence and rich 'thick' description**

Throughout your story use rich complex detail, nice turns of phrase, a bit of colour, crisp vignettes and illuminating direct quotes and graphical presentation. Build the evaluative story with the necessary data and attention to rigour, thoroughness, etc. Don't lose important detail that the reader needs in order to 'get it' re: the points you are making. And don't give so much extraneous detail they get lost. Reduce superfluity. Simple sentences. Precision. Show, don't tell. You are aiming to deepen the reader's understanding. Take them along with you on the research journey of 'discovery'. Give surrounding contextual information that helps them make this deeper sense of it all. Ask: What is going on? – What is *really* going on? This is a gestalt or hermeneutical approach to illuminate the figure by the ground and vice versa. The power of narrative rests in the sequencing of reasons, reasoning and explanation.

Find ways to surface the undiscussibles. Be as transparent as possible. Is this the whole story? Or are there other truths, other perspectives, controversies, paradoxes, contradictions, or 'stuck spots' in this story? Would it be useful to show them – even feature the conflict as well as the false starts, your original hunches and how they got transformed? Dramatic contrast may help ('On the one hand we/or others thought such

and such... but on the other hand we knew/found/noticed such and such...'). If your reader knows about these and doesn't see that you do too, or how you have responded to them, will your story be less plausible, less evidenced, less credible? Modest statements of obviously overwhelming conclusions will convince better than overstated weak conclusions.

Research shares with both literature and theatre an important potential characteristic of narrative:
"It can show you things you have never seen before and will never forget."¹²

References

Scan down to Narrative Paradigm and open Ch 23: <http://www.afirstlook.com/main.htm>

'What is narrative?' Jenny Rankin, Swinburne University

http://www.alfred.north.whitehead.com/AJPT/ajpt_papers/vol03/03_rankin.doc

An appreciation and critique of Foucault, Damien Broderick, Melbourne University

<http://www.lib.latrobe.edu.au/AHR/archive/Issue-February-1998/broderick.html>

See an exemplar: **Resource J** 'Marjorie Oke and the Hydrotherapy story (Vale)' as an example of an engagingly-written narrative.

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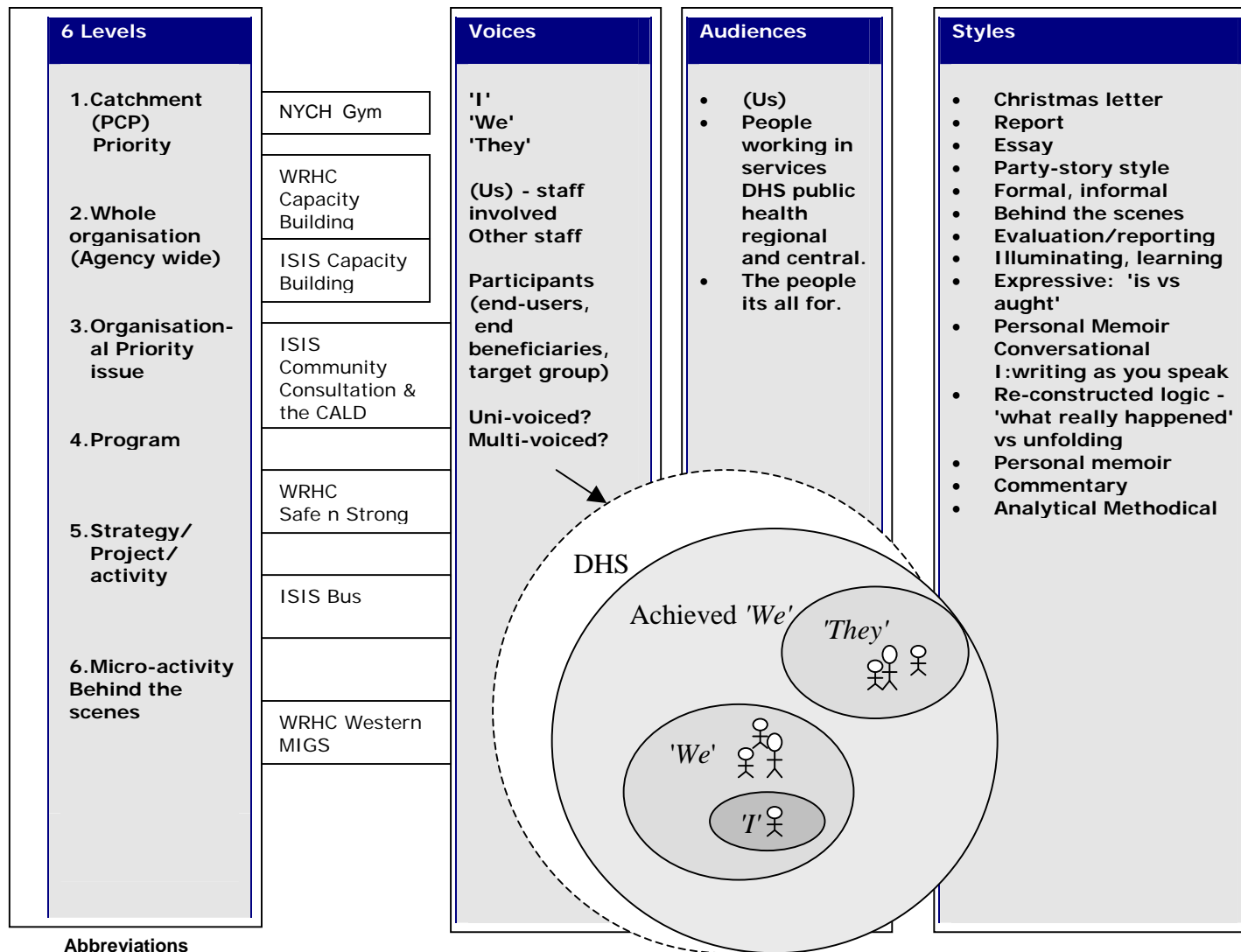
¹² <http://www.learner.org/exhibits/literature/index.html> [do not under any circumstances click on the door!]

Appendix 4 Map of levels, voices and styles

(Note: This is **Resource K** in the Resource Kit)

Resource K A NEAR working document: a map (locating the different narratives)

The 12 case study narratives (**Section 4**) are pitched at a range of levels, drawing upon different voices, and written in different styles. Each narrative also speaks to several audiences/stakeholders. This map may assist other narrative writers locate their story, their voice and their own audience/s. The examples given are mostly from NEAR Phase 1.



Abbreviations

- CALD – culturally and linguistically diverse
- ISIS – ISIS Primary Care
- NYCH – North Yarra Community Health
- PCP – Primary care Partnership

Appendix 5 A planner or checklist of questions

(Note: This is **Resource H** in the Resource kit)

Resource H

A planner or checklist of questions for narrative action evaluation writers

To bring together the elements of narrative, evaluation and action research

Firstly... two design issues:

Who were the stakeholders?

Who are the interested people/stakeholders/or participants? Who is involved already? Who should be? Who could or should also give their views as part of this story? Or who else should be here telling this story with you?

What were the practicalities?

Together with those others/stakeholders/participants, consider where, when and how would be the best way to capture and share these observations and experiences.

Retrospective evaluation

Firstly, looking back to see how things have gone so far...

What was being evaluated?

Name the area of activity, interest, issue, 'claim, concern or issue', practice or project...

What did we observe?

Looking at the whole... and

Looking at the parts...(for example, a range of activities that make up a program; or different parts of a work area; or different aspects of a project). Describe for each what you have – so far – seen, observed, noticed or heard about it... Why are these things being done? Why like this? Who identified the need (the participants, you, or the organisation)? What were the hopes?

What was its value? – 'Open inquiry evaluation'

Evaluate value, merit, worth or significance so far...

Overall, how is it going? Is it working well? (or not) What makes you say that? Describe what you've seen, observed, noticed, learned etc. (...and what others have seen, learned etc. too)

Try answering using a three-column matrix format: [1] Good or not so good? [2] I know because before (we observed) [3] Now its changed in the following ways.....

Did we achieve our objectives? – 'Audit review evaluation'

You may have set out to achieve certain goals or objectives in relation to this activity, interest, project. What were they? What were your planned indicators and targets or signs of achieving them? Were they met/achieved do you think? What happened? What were the actual outputs and outcomes? Try answering using a three-column matrix format: [1] We set out to... (goals, etc) [2] Our indicators/targets were... [3] Achieved or not achieved?

You might refer explicitly here to the statistical reporting accompanying the narrative report.

Why was it like this? – Analyse/Think/Reflect

Stop and reflect on (or analyse) what you think you are seeing. What do you think was going on here if you saw that sign? Why you think those signs or reasons actually made it good or not? What do you think was really going on here? What is your reasoning or logic about this? How do you explain successes or problems?

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How did we feel about it?

Now stop and reflect on how you feel about it. What made you feel like that was a good (or bad) sign? Why did it seem like it was right (or wrong)? Good or bad?

A threshold or liminal question..... Did you want change or not to change?

Looking back, did you want to change or improve the activity, project, etc.?
What did you learn?

Prospective evaluation

Now looking forward from 'what was then' to 'what could be'...

What was the vision?

How did you clarify your vision about what you either had hoped for then (and still hope for now) or, with hindsight, what you thought you would do differently or what would be better (or even better)?

What needed to change?

What change or changes did you decide would be needed to bring the situation towards the desired/ideal/something better? What did it take to make that happen? What actions, steps, pathways...? Who else needed to be involved?

What alternatives were there?

Were their alternatives you considered? Even seemingly 'way out' ones or suggestions that seemed at first impracticable or unworkable. This was the creative 'out of the square' moment. Did you listen to soft voices, different-from-us voices, and community voices belonging to the least powerful or most stigmatised, and possibly ones you disagreed with?

What were the consequences that led to your choice/s?

What were the consequences of going down these different tracks? What was the affect of taking up the idea? How did you feel about doing this? What were the responses to it by all the stakeholders? What were its strengths, weaknesses, opportunities, threats? Which had the most energy attached to it?

What actions came next?

When you settled on a course or courses of action, who did what personally? How did people collaborate? What were the actions that you or they could see could be taken next? ...And which you or they **really wanted** to take?

What support did you need?

When you identified your part in it, what did you personally, or each other person or collaboratively, need in order to actually **do** it? What did it take – what support, assistance, information, resources, people and etc. was needed?

Monitor... and...

What are you seeing now?

Now you were giving it a go... Did you monitor – observe, describe and evaluate it? What changed as a result of your work?

And what have you decided to do next?

Yes! ...It's an action evaluation research story! An ongoing story!.....

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Appendix 6 An example of a health promotion narrative

(Note: This is Resource J 'Marjorie Oke's hydrotherapy story' in the Resource kit)

Resource J

Marjorie Oke and the hydrotherapy story (Vale)

Marjorie Oke was a significant figure in the community, health and self help health scene for many years from the 1980s. She was a member of the Health Issues Centre Committee of Management and an Ambassador for Health for the Victorian Health Promotion Foundation's 'Active At Any Age' program. Through these – and many other areas of activity, Marjorie's sense of responsibility and desire to take the message of self-determination and holistic health and the part that could be played by supportive professionals, meant she seized the opportunities to contribute wherever and whenever they appeared. She was also a great teacher via the telling of stories.

We have reproduced at **Resource L**. her group's contribution to the first CDIH collection of case studies. The following is an extract from a Vale after Marjorie's death soon after the NEAR project had commenced, which was contributed by Yoland Wadsworth to a Memorial Service at the YWCA on 29 August 2003.

It was circulated as a narrative format example for the NEAR project training workshops' purposes.

The Northcote Hydrotherapy Group. Such an incredibly ordinary name for something that became – with Marjorie Oke's vision, drive and the energies of more than 20 people – so truly remarkable. Northcote: yes. Hydrotherapy: yes. And yes, a group.

But in reality so so much more:

- more like a wholistic life support system
- a comprehensive vitality-enhancing system
- an exemplar of health development or health promotion practice

First up, swimming skills were relearned (or learned from Marjorie for the first time by women and some men in their 70s, 80s, and 90s).

Massage and physiotherapy exercises were initially received from the professionals – but small grants were then sought to enable the skills to be taught to and then shared among group members using a trainer-the-trainer approach (before we knew that term so well either).

Friendships were formed, everyone had a place.

More small grants were applied for – for bus trips not just to the pool but also to interesting places otherwise inaccessible.

As soon as funds were found, no time was wasted and off people went to the Ballarat Begonia Festival, to Phillip Island, Lorne, and Hanging Rock.

Disabilities were overcome, crutches and walkers and even wheelchairs were dispensed with ...and another job was created for a group member, as tour organiser.

Diets changed (effortlessly) as recipes and food were shared on picnics, bush walks, at meals together and birthday celebrations.

Over food, stories were told, emotions shared, memories and current realities of love and violence, work and marriages, childbirth and death.

The group became a survival system.

Poetry was written.

Cheap tickets discovered for arts and entertainment events... a play could be attended.

More modest sums were hunted down by Marjorie – this time for a newsletter, and a journalist job created for a group member for whom this had once been their career.

Then the group started to become its own formal education system. Seminars were attended. Information exchanged. Interesting people met and listened to. Members began giving guest lectures to public health university students on the benefits of this kind of holistic self-help effort which was supported at critical moments by helpful health professionals who worked 'with and for' not doing 'to and at'...

A group secretary role emerged and morphed – when a letter arrived from a funder addressed to 'the Administrative Officer' – because that sounded a bit flash and a bit of fun! People enjoyed themselves. Mutual respect multiplied.

Health bloomed...

It was their group.

And then one day at the pool a younger woman with a camera was welcomed.

A small grant submission for precisely \$673 was written in 'spidery old lady's writing' (in Marjorie's words) to fund Meme McDonald's photography and taped stories,

...and a professionally published Penguin book of oral history with exquisite photos of the honest beauty of ageing ensued.

And then a calendar...

And the possibilities went on... and on...

... unfolding... unfolding... unfolding

This was not a group – it was a complete organisation.

A virtual village! A true community.

Marjorie practiced her 'whole systems research on-the-run for whole health' for more than a decade.

Not even a bus could stop her – though there was one that damaged her savagely.

Vale Marjorie. We will never forget you.