

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 funders 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 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 are passed on for others' use and reference, not so much as 'The Truth' but as 'these

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

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.

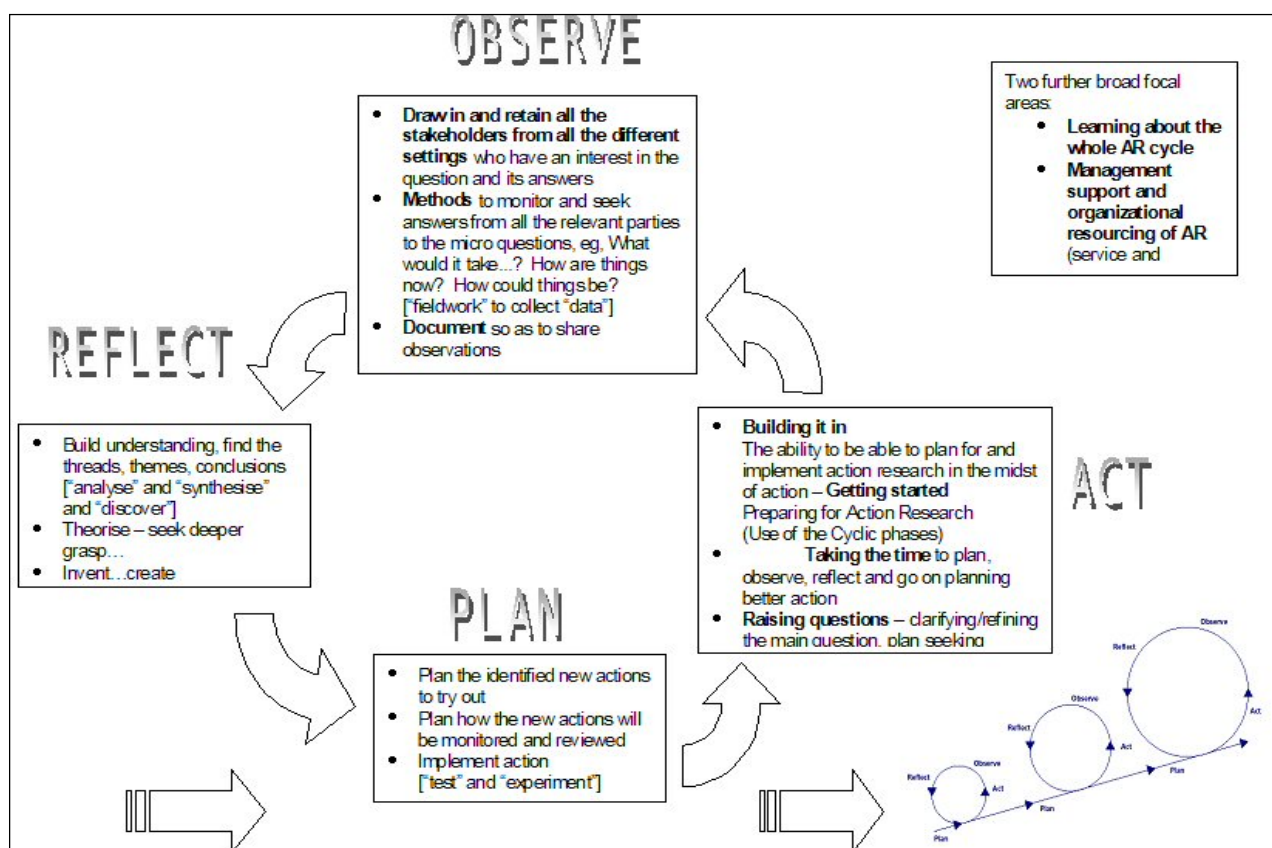
It draws on Fran Peavey's sequence of strategic questions (see **Resource D** Number 5). You may also like to use **Resource H** to do this, as this planner or checklist is the one we are using in all NEAR writing, as it incorporates Fran Peavey's strategic questions.

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.

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

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)
- 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:

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