

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.

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-fits-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 uniformed 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

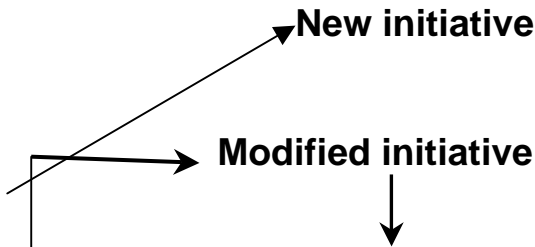
- How effective and realistic were your evaluation processes?
- Were there differences between planned and implemented evaluation processes?

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?

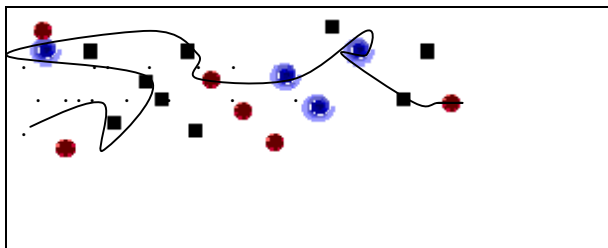
Think about who you are writing your story for and orient the story to *them*. Are they interested in this story do you think? Why? What interests them most and why? What drives them? What do they know and think right now about the 'evaluand' of your story? Do you have to bridge a gap between them and 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."¹

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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¹ <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?

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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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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.

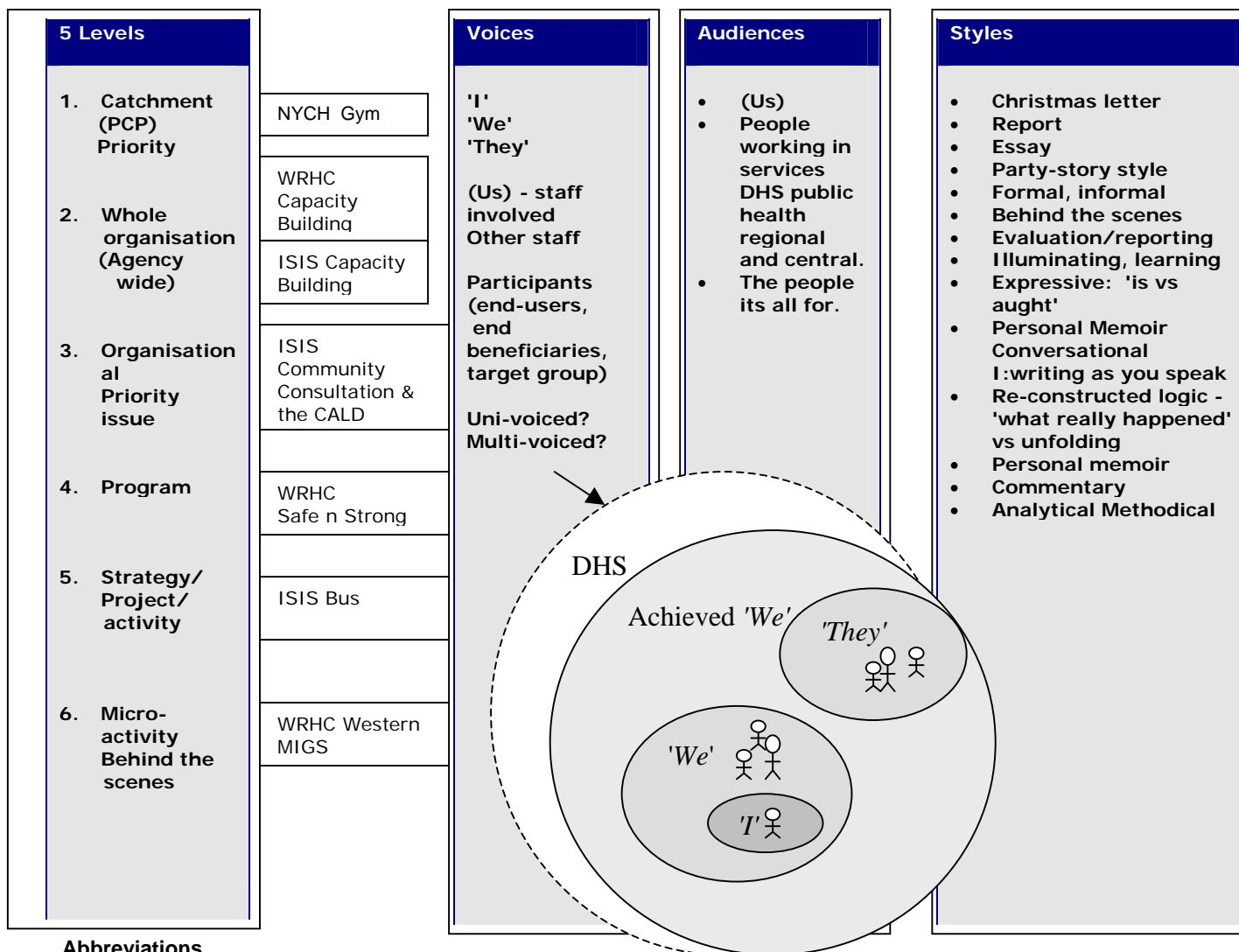
Vale Marjorie. We will never forget you.

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](#) 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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