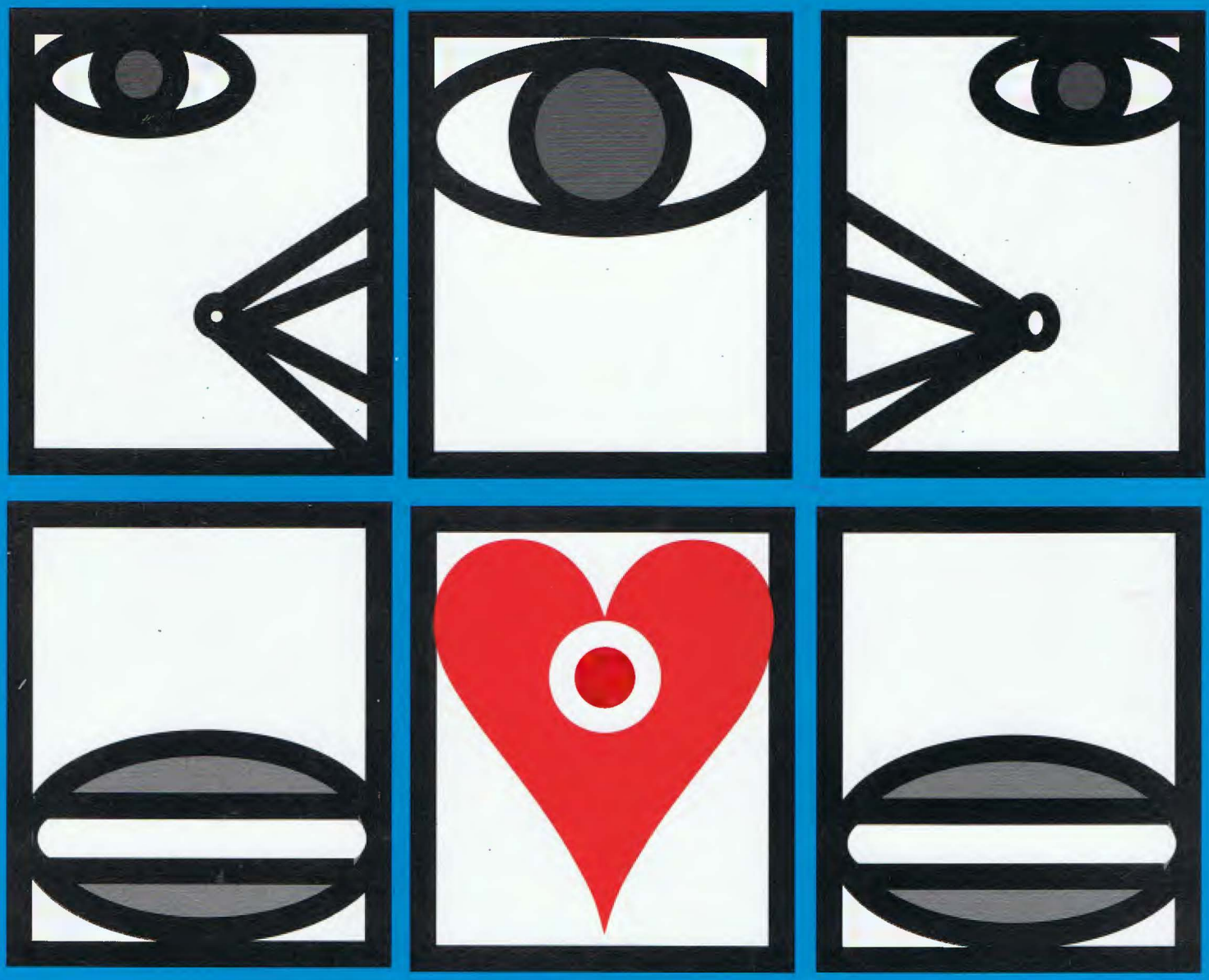
Talking better health



a resource for community action

the training manual

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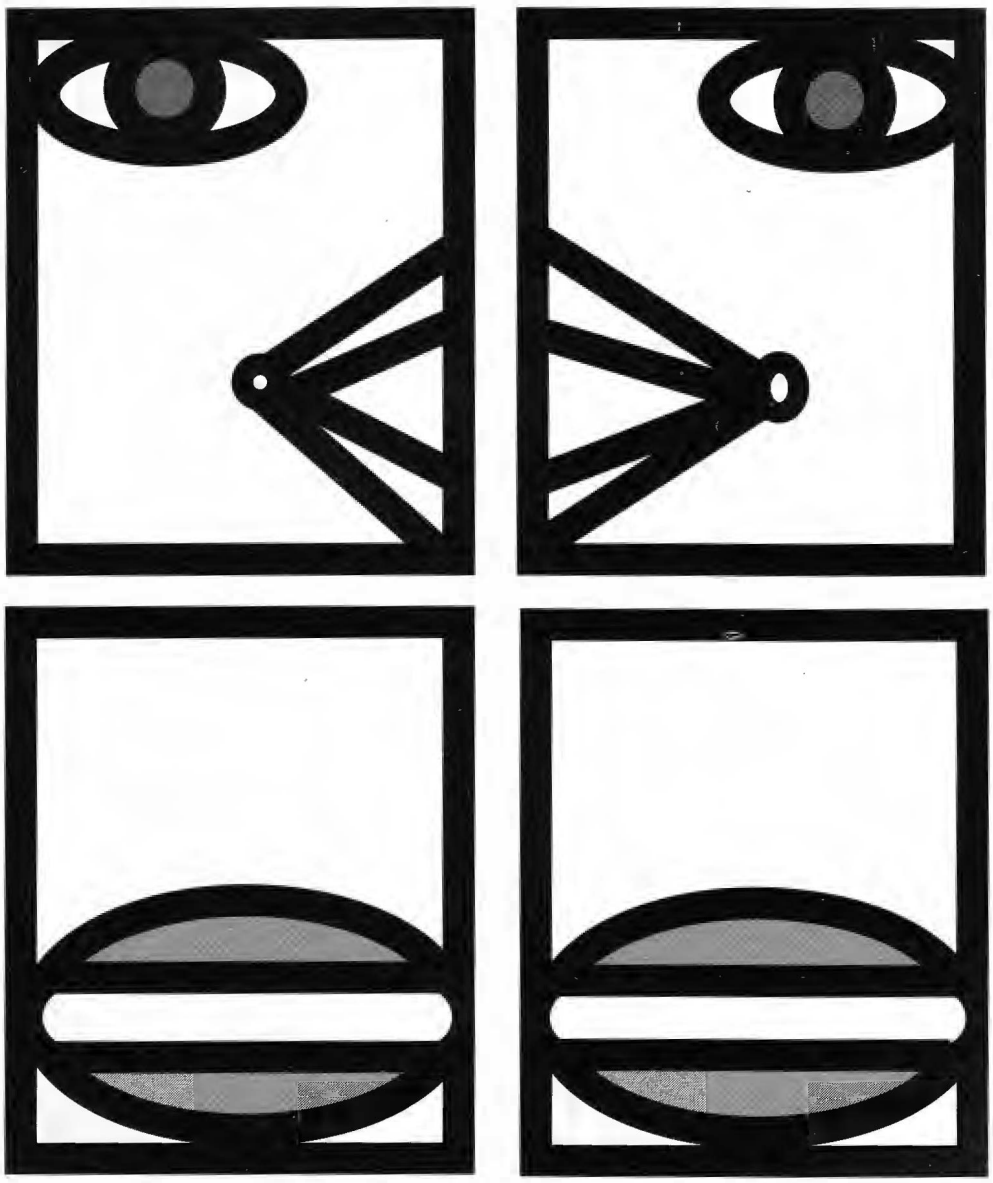

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Contents

Talking better health

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Introduction

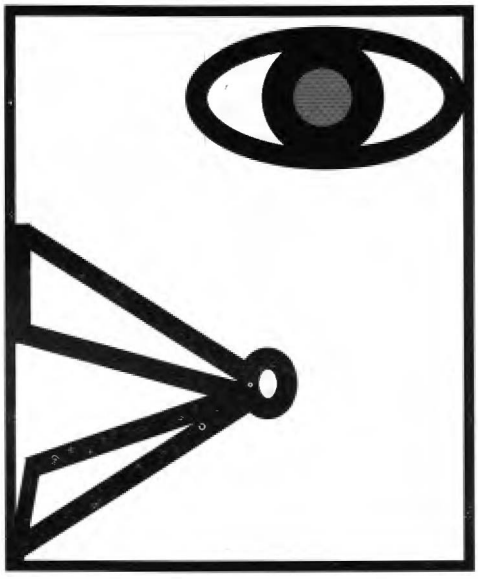
Health and the health care system

Health is an issue which affeds all people and communities and impinges on every aspect of our lives. The term health is used here to describe a state of physical, mental and social wellbeing. It is not merely the absence of disease or infirmity. Health is one of the preconditions and resources for living well. Health affeds and is affeded by many things in people's lives. Such things as the environment, employment, income security and economic development, education and housing can have a significant impact on the health of both individuals and groups.

Conventional understandings of health and approaches to health care are being found to be increasingly limited in the last decade of the twentieth century. Most of us think about health in terms of sickness. The health care system tends to focus our attention in this way too. Health is only addressed when something goes wrong or when a problem arises.

Another limitation of the health system is that people are often 'treated' as separate individuals and as a combination of body parts. A person tends to be seen as a 'body' and treated in a way which does not take into account the complex social and physical environments in which they live. Conventional health care tends to focus on small aspects of the person's physical condition rather than on the whole person. This leads us to rely on and expect expensive and complicated medical technologies as the best solution to all health problems.

The health system, more often than not, casts the person as a passive recipient of treatment rather than an active partner in the management and definition of their own health.



There are many barriers which people confront when trying to become more involved in the decisions which affect their own health. As a society, we tend to remove health from people's everyday experiences. There is the assumption that experts always know better. There are also barriers to people determining and changing the social and physical environments in which they live and which affect their health. For example, town planning is mostly done by town planners and not by communities of people. Conventional approaches to health often serve neither individuals nor communities well.

Talking better *health*

Talking better health is an approach to dealing with health and health-related issues. It begins with people's own experiences and can enable them to address the circumstances which are adversely affecting their health. Talking better health is part of broader developments in primary health care and is one aspect of the new 'public health movement'.

The Talking better health approach can be summarised as follows:

1. *Everybody has direct experiences of health and health issues. These experiences need to be valued when thinking about the 'big picture' of health.*

2. *People make sense of these experiences by talking about them. This is described in the manual as 'Telling a story'.*

3. *People telling their own stories in a group can lead them to discovering similar issues which can become a common story for that group. Common stories create a sense of community.*

4. *As a community, groups of people can plan for and take action to bring about change in the conditions which are adversely affecting their health.*

Talking better health employs various techniques and strategies to enable people to take action on issues which affect their health. People begin by talking about their own experiences. On this basis, they build an understanding of the bigger health picture. There is always a connection between the big picture and personal experience.

Just as one person's experiences and the big picture are interrelated, small changes can also have very big effects. Talking better health is designed to work from people's direct experience to bring about practical and worthwhile changes in the conditions affecting their health. Many of these changes may seem small but they can, and often do, alter the big picture.

The general aims of Talking better health

Talking better health aims to contribute to better health by:

- Supporting the new public health movement and community development in health.
- Enhancing the skills of primary health care practitioners, community development workers in health, and consumer health activists.

The approach and techniques of Talking better health are presented as part of a training course which fulfils the above aims by:

- Introducing the specific techniques and the general approach of Talking better health to health care practitioners, community development workers and community activists.
- Enhancing the participants' skjlls of working with groups, listening and questioning.

- Developing participants' confidence so that they can use story telling to reinterpret and enrich their knowledge about health issues, forge consensus and a shared commitment within diverse groups, and develop social actions which <;onsolidate and extend people's understanding of health.

- Assisting participants in applying the **Talkingbetter health** approach and the specific techniques to a variety of health issues within diverse settings.

The Talking better health training course

This manual is a record of the course. The techniques explored in the training course and described in the manual are designed to help communities reflect on their own health, look at these issues in some detail, and provide some practical suggestions to bring about change.

At the end of the course, participants in the training will be equipped to use the approach and strategies of **Talkingbetterhealth** as part of community development initiatives in which they are involved.

Some people will use the 'steps' and strategies of **Talking betterhealth** to work with members of their own community on a particular issue. Others will use the strategies to undertake community consultations or as a means of getting groups of people to assess their own health needs. **Talkingbetterhealth** could be used as a form of peer education on topics ranging from homelessness in young people to HIV and AIDS. The strategies can also be used less formally. The central ideas of storytelling and personal narratives as a way of clarifying and extending understanding about health and health-related issues can be applied in many different situations ranging from one to one to large groups.

Participants in the training course will tend to be either community-based primary health care workers who are involved in community development, or people who are interested in local health issues in their own community and want to take action to bring about change.

The **Talkingbetterhealth** training course normally runs for two and a half days.

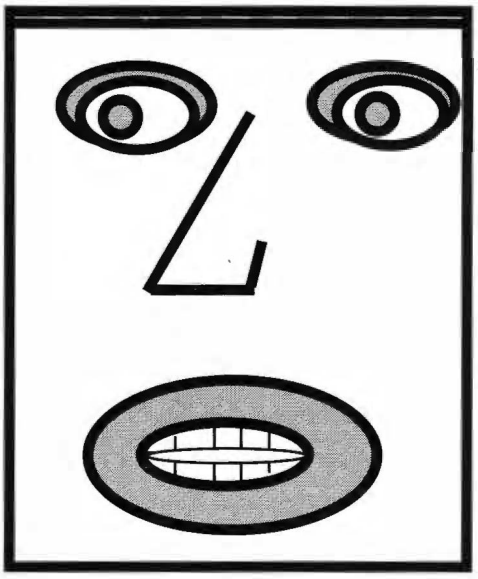
The first half day or evening session which is referred to as the 'pre-meeting' provides an overview of the.training course and the philosophy and practice of **Talkingbetter health.** The aim is to establish and explore some of the principles and key techniques upon which **Talkingbetter health** is based.

After the first session, normally two sequential days will be set aside for the bulk of the training. On the first of these two days, participants will undertake some of the activities of **Ta/kingbetterhealth** to get a first-hand experience of the various techniques involved.
The second day addresses the skills which participants need to take a leadership role so that **Talkingbetter health** can be incorporated into their work and community-based activities. Time will be provided to plan and organise their own use of the **Talkingbetter health** strategies.

There is the option of a follow-up meeting which is termed the 'third day' in the manual. The idea is that over the next couple of months participants will maintain contact with each other to share ideas of how they have used Ta/king better health. Sometimes the participants will decide to meet again. This may be for one evening per week each month, or another full day.

Participants in the training course may not presently be working within a group structure or be directly involved in community development activities. Groups form for specific reasons and cannot be arbitrarily organised. It will be useful for participants therefore to look for other opportunities to incorporate the broad approach and techniques of Talking better health into their current work and approaches to health issues.

The training course is summarised in the table on page 14. The general areas which will be covered are listed in each of the columns and these correspond to the sequence of the training. The information in the manual is organised in the same way.



The purpose of the manual

This manual:

- Describes the Talking better health approach to dealing with health issues.
- Details many of the techniques and strategies which can be used in this approach.
- Provides a record of the training course.

Most people who are reading the manual will be, or have been, participants in the training course. We have found it useful for participants to read the manual before attending the course. The manual, however, is a useful resource on its own, even if the training course has not been completed.

The manual is divided into chapters which parallel the format of the training course. Each chapter provides information on the substantive issues which are being explored. In addition to the activities undertaken as part of the training course, others are suggested as ways in which Talking better health might be incorporated into community development.

The substantive ideas and activities are often supplemented by case studies which show how other people have explored the ideas within community settings.

The training course models the techniques of Talking better health so that participants can get a first-hand experience of using personal narratives and story telling as an important way of exploring, re-forming and placing issues and concerns about health within the bigger social picture. For example, the case studies can be seen as one person's story.

The development of Talking better health

Ta/kingbetter health has been around in various forms for the last seventeen years or so. Health Feedback, as it was originally called, was primarily used with boards of management of community health centres in Victoria. Later, Healthwisewas developed in Victoria, South Australia and Tasmania. Within the Healthwiseprogram the ideas have been through a variety of transformations, each with a slightly different focus.

The dual commitments of community development and community participation have remained constant. Many people share these commitments, but we have sometimes found that they do not have the confidence or the skills to turn these commitments into practical strategies and ways of working. Ta/kingbetter health presents one approach which can be taken.

The material has been based on the initial work of Pauline Sanders who was at the then Health Department of Victoria. This current manual has relied extensively on the work of Alison Sinclair of the South Australian Health Commission. Supplementary material has been added by John Mcleod with the assistance of:

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PRE · MEETING

The central ideas of Talking better health

PRE meeting

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Talking better healtlt — train';,g timetable

PRE MEETING	DAY1	DAY2	DAY3
Introcluctio11 and overview of the traioing course + Group buildi$_{ng}$. !This will not be oddres.sed fully agoin on d$_{ay}$ 1) ● The philosopby ci Talking belier health + DiffeTe11t communities: dlffere11t meaning, ● Telli119 stories ● Smolli stori◆, big pictu◆s	The five 'steps' of the *Talking better health* approach: ● Building the group ● Sharing personal experiences and identifying common issues ● Reflecting on and analysing these issues ● Planning for action ● Taking action	Leadership redefined ● Listening and questioning ● Bringing groups of people together ● Planning to use *Talking better health*	Changing practice ● Evaluating the training course ● Future planning

Chapter 1

The-pre-meeting

Philosophy, as we are using it here, represents the patterns of insights which we have gleaned from our experience within the world. Every day we draw upon these insights in different and creative ways to determine, guide and understand our actions. A philosophy is not a blueprint for action; nor is it something which is static. A philosophy is always fluid and emerging, responding to and being determined by our experiences within changing circumstances. A philosophy embodies the ethical and theoretical resources which we can draw upon to act and make sense of our actions.

The philosophy of Talking better health

We may seem to be pushing our luck a little to include a section dealing with philosophy in a training manual. There is sometimes a tendency to gloss over philosophical ideas and get onto the more pradical (and seemingly more useful} section on strategies. However, it is worth persisting with this section because it provides the framework on which the rest of the ideas are built. We often assume that the world is the same for everyone and that we take similar insights from our experiences even though these may be diverse. This section tries to recognise that people's different experiences constitute different worlds.

The importan,e ol language in Talking better health

Describing and naming experiences and putting words to the patterns sheds a new light on everyday action. Experience is restructured through language. We become consci9us of something through naming it and talking about it. We see experience in terms of the language which is used to describe it. Without a name, some things seem almost not to exist.

The groups of people who control language also control the ways in which the rest of us see and act in the world. Dale Spender (Man Made Language. London, Routledge and Kegan Paul, 1980) argues that the language which is used to describe events constitutes a world view which is that of the most powerful group in society. In our society, that group is traditionally made up of men. Controlling language enables powerful people in society to control the debates which can occur.

Talking better health is about enabling people to describe their own experiences and to create their own understandings of health issues. The stories which each of us tell constitute our own reality; and this reality is valid from the perspective of our own experiences.

Sometimes language itself is inadequate to encapsulate the experiences and feelings we have. The words which we use can approximate our experience and knowledge, but often they are only an approximation. Language is a little like the tip of an iceberg. There is much more meaning than the bit which is seen. As the Hungarian scientist and philosopher Michael Polanyi put it: 'We *know more than* we *can* tell."

Often we need different forms of expression to try to understand and make sense of new experiences. The metaphorical language of poetry, knowledge which is expressed through action in role plays, or the iconographic expression of paintings, are all ways in which new and different experiences and understandings can be articulated, given a public face, and communicated to other people.

The central idea of *Talking* better *health* is that if people begin by talking about their own experiences and problems, they can analyse them and develop joint action to change their situation. By talking with others, we place the issues in the forefront of our minds and put them into a public forum which can be shared with and communicated to other people. Talking raises our consciousness about our own and other people's experiences.

Building on a tradition o l ideas

The approach which is taken in *Talking* better *health* draws on a number of sources which include some of the ideas on stories and the uses of narrative in the creation of personal identities and social action. Other ideas are derived from the pioneering work of Paulo Frei re who suggested that:

+ Education is always political, it is never neutral. Education either serves to bring about change or it maintains the status quo.

+ People will act on issues about which they feel strongly. Education programs begin by identifying those issues about which communities speak with excitement, fear, hope, anxiety or anger.

+ All people have the capacity to solve problems. Education is seen as a search for solutions to those problems. Leaders and workers should enable communities of people to identify their own problems. The people who define the problem control the range of solutions.

+ Everyone has different perspectives based on their own experiences. In order to solve problems, people need to engage in a dialogue to acknowledge the other person's perspective and find some common ground. Dialogue, rather than argument, accepts the validity of another point of view.

+ Action is more effective when people stop to reflect upon a problem, analyse it, and seek to identify what needs to be done to bring about change. It is even better if there is an ongoing cycle of reflection, planning and action, which in turn leads to further reflection, planning and action.

Principles as a starting point

The philosophy of Talking better health is expressed as a series of principles. These principles inform all of the activities and strategies which are included in the manual. The activities can, of course, be undertaken by themselves and without a strict adherence to the philosophy; but if this happens, the activities don't tend to make much sense. Talking better health is most successful when there is a strong interaction between the philosophy and the activities.

The principles are presented here under the headings of *Health and* community, Community *participation and active citizenship,* Community *education and action.* They are a way of setting the scene for the whole Talking better health approach. The term 'health' is used by different people to mean different things. Both the following principles and activities are designed to look at the range of those meanings.

Health and community

Health can be seen as a state of complete physical, mental and social wellbeing and not merely the absence of disease or disability.

The purpose of health can be seen as a resource for everyday living as it enables us to achieve our potential and respond positively to the challenges of the. environment in which we live.

Health policies and services often focus only on the presence or absence of disease and not on the purposes of health.

Many public and private organisations and institutions have an impact on the health of the community. Such organisations and institutions include transport, education, housing and agriculture.

Physical, socioeconomic and cultural aspects of the environment have an impact on the health of the community. The community needs to intervene to change those aspects of the environment which are promoting ill health rather than simply deal with illness after it appears.

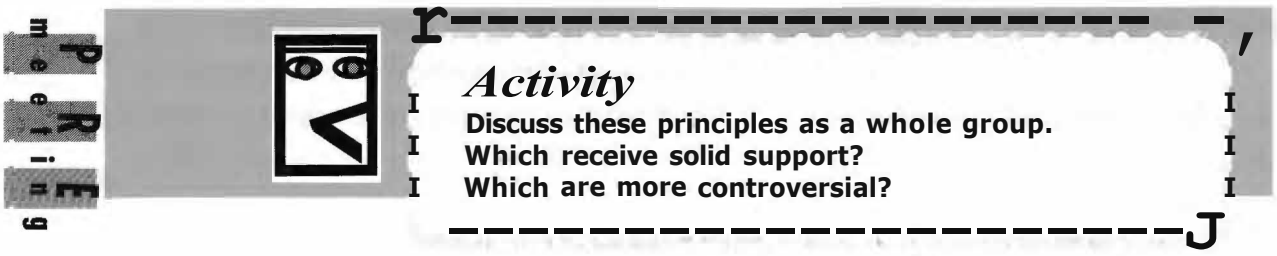
Adivi,,

How do you use the term health? Jot your ideas down on a piece of paper.

Share these with another person in the group. Try not to talk in the abstract. Use examples from your own experience to show how your concept of health is translated into action and everyday life.

Extension

Think about the social and physical environments in which you live. What contributes to your health in a positive way? What has a negative effect? Which of these things are personal? Do other people have similar experiences?



Activity

Discuss these principles as a whole group.
Which receive solid support?
Which are more controversial?

Community participation and active citizenship

Part of the balance between rights and responsibilities in a democracy is that people need to make informed decisions about issues which have an impact on their lives.

Social institutions and structures should serve the needs and wishes of the people on whom they have an impact, rather than the other way around.

Community participation in all aspects of health care and health decision making is beneficial to both individuals and health services, and in the long term, to the health of the community.

Health services should be accessible to the people who have need of them, acceptable in terms of their organisation, approach and orientation, and affordable.

An active and informed community is more healthy.

Community views and experience provide an extremely important perspective for planning and the delivery of services.

Sharing individual experiences is an important starting point for identifying issues and concerns which affect the broader community.

Community education and action

Leadership is shared.

People have different levels of expertise, but there are no experts who know all the answers.

Expertise can be embodied in action. People's actions are a valuable resource for the community.

Action for social change is an important outcome of community development.

Facilitators of community development are committed to action and will support the development of ideas and skills within the community for this to occur.

Community development activities focus on group, rather than individual, solutions to problems.

In open communication, everyone teaches and everyone learns.

Everyone participates and shares their ideas, experiences and knowledge.

The process aims to generate interdependence and cooperation, not dependence or competition.

Learning begins with the concrete experiences of the learner.

Different *communities: different meanings*

These principles are just a set of theoretical ideas until they are put into practice by real people in real situations. The communities in which people live and work have different features and pressures which mean that the above principles need to be interpreted in a variety of ways. For example, an active and informed community may be more healthy, but active may mean a variety of things in different situations.

A person's community can range from the personal to the public. The personal affects only a small number of people, whereas the public affects many. Communities can promote or hinder health. For example, one household may decide to have no smoking indoors. At a public level, the government's policy to ban smoking from all its buildings also contributes to this family's decision. Communities can facilitate change or can set up barriers to change.

People will also use the strategies of **Ta/kingbetterhealth** in different ways. The strategies which are being used must be responsive to the interests, skills and aspirations of each particular group or community. The activities described in Chapter 2 of this manual are a resource which present a number of possibilities from which to choose and from which your own work will be developed.

An understanding of your own particular community is crucial when incorporating **Ta/kingbetterhealth** into your practice. The who, how, where, when, why and what questions which are posed on page 66-67 are a good way of building a deeper understanding of your own situation and the effect it will have on what you do and how to proceed.

In using **Talkingbetterhealth,** there will always be choices available. Participants will make their own pathways through the material. This unpredictability may seem to present problems for the facilitator or leader. However it is really a question of style of facilitation. This will be addressed in Chapter 3.

In Chapter 2, each of the 'steps' of **Talkingbetterhealth** is discussed in relation to a series of questions. These questions represent the criteria which we can apply to the choice of activities to ensure that they are appropriate. You might think other criteria are more important or some of those listed may need more emphasis. When you are planning your own use of **Talkingbetterhealth** on Day 2, think about the criteria you are applying and make sure that the activities you choose fulfil the criteria which you have selected.

A tivity

Think of the features of your own community. What are the things which promote health and those things which hinder it?

As a follow-on, think about the barriers which exist to bringing about healthy changes? What are those things which facilitate change? List these a piece of paper. Do they exist for all problems which you are grappling with, or do they vary given the problem at hand? Discuss in small groups.

Pick one barrier which is easy to change and develop a plan to get rid of that barrier. Pick the barrier which seems most intransigent and immovable. Brainstorm ways of knocking it down or getting around it in some way.

PREPARING

Activity

It is useful to take five minutes at the end of each of the training days to review the activities which have been undertaken. This can be done as a whole group. The important thing is to reflect on what was done over the time, how the activities were done and why they were done in that particular way. This type of reflection on the activities of the training course will help in your role as future users and implementors of Talking better health. It is useful to keep asking: why are we doing this and what type of learning and outcomes do these activities afford?

The following chart is one way of organising the information:

Talking better health - thapter review
+ Complete for eath set ol attivities +

What adlvities were undertaken?	*How* **were the** *adivlties undertaken?*	*Why were tlJey undertaken in* **the** *way llJey were?*

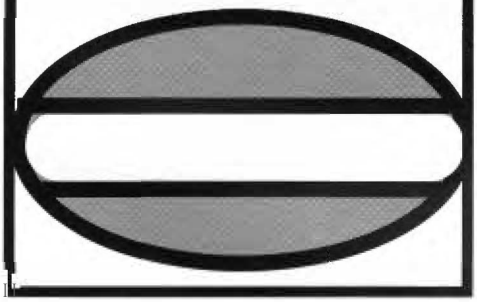
photocopy

Telling stories

Ta/kingbetterhealth is a group discussion and activity approach to health issues which begins with people sharing their own experiences about things which concern them. **Talkingbetterhealth** enables people to tell **their** own stories. **Personal** experiences and personal knowledge are the starting point for community development and social action.

We have called this section **Tellingstories** because people's stories are the foundation on which the rest of **Talkingbetterhealth** is built. Stories are used to represent or re-present experiences so that those experiences can be analysed, reflected upon, and shared with others. In the telling of the tale, the experience is crafted. Some features of the experience are selected as important while others may be played down.

"Tales ,an be told in **different** *ways, depending on who is doing the telling."*



Stories, more than any other form of communication, personify ideas. People are central to stories. Through stories, abstract and theoretical ideas are given a human dimension. We could talk, for example, about the 'consumer/professional interface' in the health care system. However, when a person talks about his or her experience of actually dealing with a specialist, a certain depth and texture is brought to the issue and *to* our understanding. Stories have veracity because they highlight the teller's commitments and values and we can test them against our own experiences and understanding.

Stories invite us to enter into a dialogue with the teller. **"This** is **my experience. How does** it **match with yours?"** Stories are part of building a shared view of the world. They tend not to be didactic in the sense of there being a definite right or wrong answer. They offer one person's interpretation of events. There are always other interpretations. Tales can be told in different ways, depending on who is doing the telling.

Stories are grounded in people's real lives. They draw attention to the details of that person's situation rather than looking at the person's health in an isolated way.

In Chapter 2, some story telling techniques are described under the heading: **Sharingpersonal experiencesand identifyingcommon issues.**

PRIE meeting

A,tivity

Draw a line on a piece of paper. At one end is O years. At the other end is your age now. Mark off those events which have been very significant to you in terms of your health. You might like to focus on times when you felt very healthy or on those times when you or someone close were ill.

With a partner, choose two events which have been separated by some years and describe their significance in terms of making sense of health, illness or the health system. Focus on what the event was and on its significance in relation to what else was going on in your life. How did you react to those events at the time? How do you see them now?

In groups of three or four, choose one event which is significant for a person and create three 'freeze frames' which present what happened in that incident. The frames are three points in time within that event. There will probably need to be a narrator to explain who the other people.are, but the frozen poses of the participants should show what is going on.

Discuss as a whole group. The focus is not on the presentation but the significant event. Did other people choose similar things? Have other people had similar experiences?

Small stories, big pi tures

In a complex society like ours, the stories which are normally given the most importance are the grand narratives which are far removed from our own experiences. Public information tends to be generalised, such as in the high cost or unavailability of hospital beds or concerned with the latest medical 'gee whizzery'. Little debate concerns people's actual experiences. Most of us feel powerless to bring about change at the level of what is conventionally defined as, the BIG picture. "That's simply the way things are." 'What can one person do against the system?"

Ta/king better health **takes a different approach. The small stories of people's experiences can provide insights into the big pictures of institutions, social structures and government. These insights can point to the types of actions we can take in relation to the big picture. The process is one of moving from the individual and particular perspective to one which is based on shared experiences and common goals and aspirations. As ntioned above, telling stories about one's own experiences is the first step towards a collective consciousness and group action.**

11 Telling stories abo
is the **first** *st*
consc,ousn•

Everybody's story has implications for much wider issues. This is not always apparent. Concerns are sometimes so immediate and pressing that they become ends in themselves. Sharing stories with others is a way of seeing that there are often many common threads.

This is a very important change in perspective and one which seems to go against the way society is presently organised. So much of our society is based upon the idea that we are individuals. We are physically separated in our houses, but we are conceptually separated also. We see problems in individual terms and having individual solutions. We see rewards occurring on the basis of individual effort. This is very central to our culture. The problem with individualism is that we often feel disempowered. We are so small in the face of a massive system.

Being part of a group and working collectively presents a different way of looking at the world. This is the experience of community. When people share experiences, hopes and aspirations they are part of a community. Community is often seen only in terms of location or ethnicity. However, our experience of community is much more pervasive. Community is like a web which connects us with many different people in different spheres of our lives.

Location and ethnicity are two ways in which we think about and experience community. What are some others? Brainstorm some ideas and write them on a white board. The list may be useful when planning your *Talking better health* program.

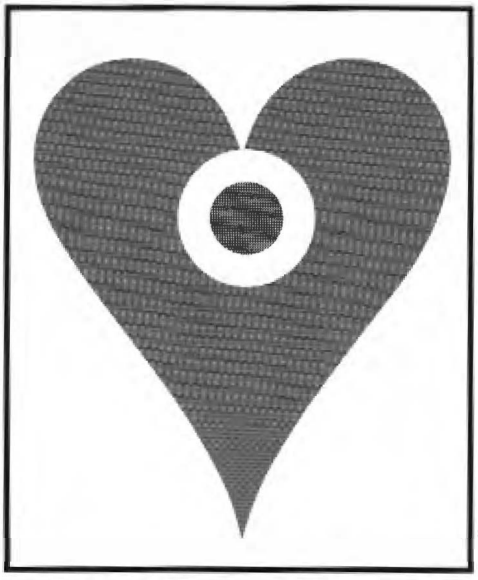
Sometimes it is hard to see the bigger picture. Community development processes are a useful way of thinking about immediate concerns in relation to the institutions and structures of society, and the even broader concept of social movements.

ioUlle's 01Nnexperien es ste,wards a olle tive ne,nd group a tion. [11]

A,tivity

In the following case study, what were the principles of community development which seemed to underpin ·Kathleen Millicer's work?

Patthwork-bushlire safety edu,ation



Kathleen Millicer describes the process of making bushfire education a community concern. Starting from her personal experience of the Ash Wednesday bushfires, she describes how a number of people in the local community joined together to create an awareness of bushfire education which affected the local community and also continues to generate much wider public interest.

case study

"Start from personal experience."

The project began after Kathleen Millicer's own house had been spared from the bushfires which ravaged the Victorian coastline in 1983. She read all that she could get her hands on regarding bushfires and bushfire prevention and protection. Safety precautions were installed in her own home. On a day of total fire ban some years later, she was concerned that many of the holiday houses in her street were unprotected and this prompted her to contact the owners to talk about simple prevention measures.

This concern for the unoccupied houses in the resort town of Anglesea led her to contact the local fire captain to investigate the feasibility of a bushfire safety education campaign which combined the resources of the townspeople with the local Country Fire Authority. The CFA provided multiple copies of bushfire safety pamphlets and these were distributed through the 'meals on wheels' network.

A small meeting was called to discuss the possibility of developing a bushfire safety education project as a joint initiative of residents and the CFA. The name 'Patchwork' was chosen to convey the idea of many individuals contributing to a joint effort. The CFA decided to become involved, a local artist designed a logo for the project, and a visual display was set up in the local community house and volunteers began signing up immediately.

Posters urging people to become volunteers were put up around the town and the community house magazine also carried information on the project. The town was divided into zones with coordinators, and fire prevention pamphlets were distributed to all households by volunteers. These people also informed the shire if there was any special feature in their area which would be a particular hazard in the event of a fire. They also noted any people who may have needed help and this information was kept on a central record.

Patchwork received official support from the central CFA with the hope that it would be picked up as a model by other communities. Information on the project was also disseminated through the network of community houses in Victoria.

Ref:Millicer, K. 1993. 'Patchwork-bushfire safety education.' In P. Butler & S. Coss (eds). *Case Studies* in *Community Development* in *Health.* Melbourne, Centre for Development and Innovation in Health. pp 19-25

Kathleen Millicer summarises how they made Patchwork work.

Step 1 *We realised we had a problem*
"Anglesea is a bushfire area."

Step 2 *We defined our objective*
"Ta make Anglesea as sale as possible."

Step 3 *We planned a course of action*
"We invented our Patchwork project."

Step 4 *We communicated effectively*
"We used local press and a community newsletter."

Step 5 *We found others who agreed*
"We put up posters and lists asking far volunteers."

Step 6 *We were tolerant of opposition*
"It was a new idea; same people were sceptical."

Step 7 *We encouraged others to join*
"We made a visual display at the community house."

Step 8 *We achieved our objective*
"Bushfire safety is now a township concern."

Step 9 *We are spreading the idea*
"Articles have appeared in community publications."

PRE meeting

A,tivity

Think of a process of community development in which you have been involved where a personal concern took on a much wider focus. Use an example which deals with health if this is possible. In small groups, discuss steps which you went through.

photocopy

Talking better health - ,hapter review

• Complete lor ea,h a,tivity +

What adivities were undertaken?	How were the adivities undertaken?	Why were they under· taken in the way they were?

DAY 1

The live •steps• of the Talking better health approa,h

Taliting ,,etter health · training timetable +

PRE MEETING	DAY1	DAY2	DAY3
Introduction and overview of the training course ● Group building (This will not be treated as part of the program on d$_{a\ y}$ l) ● The philosophy of Ta/lci$_{n\ g}$ better health ● Different communities: different meanings ● Telling stories ● Small stories, big p◆dures	lihe five "steps' of the Ta/lcing better health approach: ● Building the group ● Sharing personal e,cpe,ienc:es tJ◆ idM1fifyi$_{n\ g}$ commmi issues ● Reflecti$_{n\ g}$ on and analysi$_{n\ g}$ these issues ♦ Planning for action ● Taki$_{n\ g}$ cidi>n..	Leadership redefined ● Listening and questioning ● Bringing groups of people-together ● Planning to use Ta/lcing better health	Changing practice ● Evaluating the training course ● Future planning

Chapter 2

Day 1

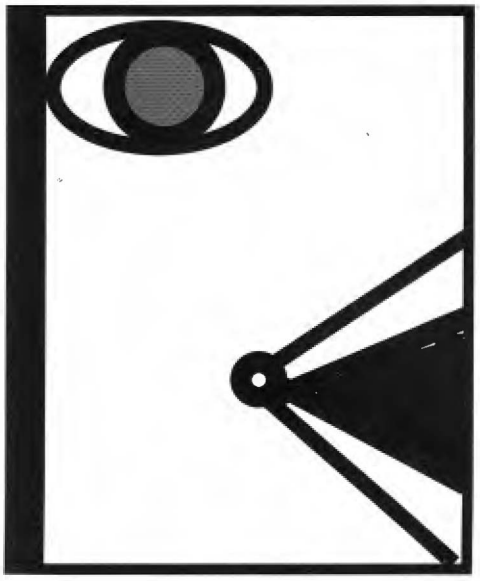
Instead of a linear process, the five 'steps' tend to build on each other more organically. For example, the first 'step' which is listed below as **Buildingthe group,** emphasises people feeling confident enough of each other to work as a group and ensures that everyone is involved. This emphasis permeates the whole approach and should be a part, and a consequence, of any activity which is pursued.

***The live* 'steps' *of Talking better health* are:**

1. *Building the group*
2. *Sharin11. personal experiences & 1'dentifying common* **issues:**
3. *Reflecting on and analysing these issues*
4. *Planning for action*
5. *Taking action*

Strategies to use

The techniques of Talking better health are described here in a fairly linear way with each separate 'step' leading neatly onto the next. This is really for the convenience of the description and to provide an easy way of conceptualising the whole orientation to practice which Talking better health represents.



Each 'step' contains a number of specific strategies and activities. These are provided as examples of things you might do within a group. Some of the activities are going to be more appropriate than others. You will also think of other activities. The choice of the most appropriate activity needs to be made in light of the people within the group, their concerns, and the type of activities with which they feel comfortable.

To help you make the choice, a number of criteria have been included to help you decide which of the listed activities are most appropriate and to help you think of other activities which suit your needs better.

The activities and strategies tend to overlap and flow into each other when the program is undertaken. For example, planning for action simultaneously builds group cohesion; and sharing personal experiences is the beginning of analysis of these health issues.

Building the group 1

The amount of time spent on this omponent (if indeed it is included at all) will depend on how well the various people know each other or how clear the common purpose of the group is. When people know each other well, or they have a very clear sense of what they are about, it may be more appropriate to move on to the more substantive issues of Talking better health.

The object of this component is to make people feel a little more comfortable in the group and to build some trust and common ground between people.

Criteria

Criteria to apply in thoosing adivities at this stage ,ould indude:

+ ***Does the adivlty involve everybody in the group?***
+ ***Does the adivlty help eath person feel relaxed in the group?***
+ ***Does the attlvity allow people to reveal a little of themselves and help them get to know other people In the group?***

Interviews

Activities in this component could include:

+ In pairs, people interview each other, talking about the reasons they have joined the group and their expectations of it and what they want to achieve. Each person in the pair then introduces the other person to the whole group.

+ The facilitator asks the whole group to find someone else who...
  - ...has children.
  - ...lives in the same suburb where they lived as a child.
  - ...gets paid for the work they do.
  - ... has been to the doctor in the last month etc.

The categories can either be serious or trivial. They can deal with health issues or be about life in general.

Revelation

Participants individually write down on a piece of paper the three thing which are most important about themselves and the three things which are least important. The whole group is then asked to share one or two of the things which they have written.

Being healthy

The group imagines there is a healthy environment continuum running down the centre of the room. At one end their living environment is very healthy, at the other it is very unhealthy. People have to place themselves on the continuum and negotiate their relative position in relation to others in the group.

Jigsaw

This is a strategy to combine people into different groups and is a way of getting people to talk with each other. A number of large pictures are cut into irregular shapes. Each person is randomly given one of the shapes and the whole group is asked to rebuild the pictures.

Time *management*

This activity may be undertaken at various times in the life of the group. It is a group building exercise because it encourages a greater appreciation of the time constraints which are placed on individuals. It is also useful as a part of planning for action because the activity gives an indication of how much time is realistically available for people to devote to the ideas for action which might have been suggested.

Each participant is given a a piece of paper on which a circle is drawn. This is used as a pie chart. The person is asked to think about the things or pressures in their life which compete for their time. The circle represents 100% of their time.

The person allocates a proportion of their time to the various areas in their life. For example, 20% may go on cleaning the house, another 12% on cooking, and 15% on spending time with the children, and so on. For another person, 60% of their available time may be spent on paid work. This activity gives an indication of the amount of time which can be spent on community action. This exercise also provides an understanding of the complexity and pressures of other people's lives and can avoid the perception that 'work is always left to the committed few' or that 'some people are not pulling their weight'.

One interesting outcome of this activity is that many people never allocate any time for themselves. This could well be an issue which *Talking* better *health* addresses.

Establishing rules for the group

Every group has 'rules of conduct' of which the participants are consciously or unconsciously aware. These rules govern what is acceptable or unacceptable behaviour by members. It is useful when working with groups to develop a set of rules which are applicable to that group.

These can be devised by the group for their own use and it is a useful way of setting the ground rules and building a commitment to the group structure. Ask the members of the group how they think the group should operate. Consensus at this point is very important.

One group, for example, came up with the following list. Members of the group should be able to:

- Accept individual differences.
- Speak in confidence and have that confidence respected.
- Ask for and give reassurance.
- Ask for clarification.
- Be open and honest in personal communication.

The group found that they revisited their list on a number of occasions to modify and change some of their rules. At various times they also appealed to these rules when someone was not completely comfortable with what was happening in the group.

Sharing personal exper,entes ·and identifying tommon issues

2

This is the core of *Talking* betterhealth and represents the basic and most important strategy of the approach. Through sharing stories and experience, people develop a more comprehensive understanding of the problems and concerns which face the community. Common issues can emerge and form the basis of action in the later stages of the program.

This 'step' enables people to tell their own stories about health-related issues which concern them rather than talking in a theoretical or generalised way about 'the health system'. Moving into generalised statements at this point tends to leave people feeling a bit overwhelmed and powerless.

Criteria

Criteria to apply in ,hoosIng adivities at this stage ,auld indude:

- **Does the adivity work from people's personal experien,es?**
- **Does the adivity en,ourage people to avoid think,ing about the issue in vague and abstrad ways?**
- **Does tire adivlty enable people to ,antrlbute tlteir own experien,es and build on the perspedive al others?**

The following strategies are given as examples of things which you might do to enable people to tell their stories. The strategies are not ends in themselves. They are the means by which people can place their personal experiences in a more public domain. Common threads are woven together to achieve a common understanding. It is important to use one person's story as a springboard into further discussion. For example, "This is one person'sexperience. Do others have similarexperiences?"

The bas

2.
Break inti small grou1

3.
Ask for a volunteer i sltare a sto, experien,i

4.
Instrud th• group In tit role of adl1 listeners and get tltem t, tltink abou bow one person's stc either ,anlir their own experien,e adds anotlt dimension tlteir storie

Shaje personal experien,es and show how they relate to wider issues. Personal ane,dotes from the ladlitator are useful ltere be,ause tltey Introdu,e tire ,an,epts by demonstration and reveal a personal ,ammitment. Tltis opens up tire pro,ess of dialogue.

Other strategies

Existing stories

Instead of asking people to tell their own stories first up, it might be useful to find other people's stories which appear in newspapers or magazines. For example, many magazines have columns in which readers ask for advice.

"Has anybodyhad a similarproblem? Whatwere the circumstances?How did you solve it? Was it effective?"

Nursery rhymes and fairy tales

Nursery rhymes and fairy tales can be seen as allegories for human experiences and they can be used as vehicles to reinterpret contemporary experiences. Small groups could be asked to pick the basic story of a nursery rhyme or fairy tale which has contemporary relevance and to tell it to the rest of the group.

For example, the story of Mother Hubbard could could be a way of exploring the issue of running out of money in our society.

The stories could also be acted out.

Ma hines

Each person becomes part of a machine reminiscent of a Bruce Petty cartoon or a Heath Robinson drawing. The machine deals with one person's experience with the healthcare system. Each person has a phrase and an action which is repeated and which connects to what the other people are doing.

This could be worked out in small groups and then presented to the whole group.
Alternatively, one person could start and others just add on when they see an appropriate opening.

sistrategy

5.

Use a reflection tecltnique to try to ,;,111 tlte ltealtlt issue from tlte story. rite issue can tlten be separated from tlle context in wltlclt ,t ,s embedded. We will look at various reflection te,ltniques tltrougltout tltis section, but a simple idea Is to ltave one person In tlte group relate tlte major points of tlte story back to them or have eaclt member of tlte group state wltat tltey tltinlc was tlte •ajar tlteme of tlte story.

6.

Isolate issues, problems or concerns wltiClt ltave been expressed by individuals and present tltese to tlte wltole group.

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Role play

Instead of people describing their story, they act it out. The person who is telling the story can either play themselves in the role play or they can be the director while other members of the group act it out. Roles often turn into stereotypes which can be useful in clarifying issues. However, stereotypes tend to polarise people's positions. The challenge of making each role believable and reasonable often adds more depth to the whole role play.

Photographs

These are basically static role plays. The group takes up the poses in three or four static 'tableaux' just like photographs in an album to tell a story.

Photo-,ollage

People create posters which, instead of carrying a health message or advertising a particular product, distil their particular stories into a single image. Creating newspaper headlines is a variation on this idea.

Ane,dote list

Individual anecdotes are recorded on a sheet of paper to ensure that issues are not lost over the time when the group meets. A simple three column schema can be used which includes the name of the person who tells the story, a two sentence account of the event or situation, and the larger health issue which is implied by the story. The last column may not be filled in at the time when the story was told, but later after some discussion.

For example:

Ane,dote list

Name of aerson	Two sentence account of anecdote	Brooder health issue
Anna	Requested a tubal ligation from the male specialist but was told that her husband should also be involved in the decision.	1. Power relationships between doctors and patients. 2. Women's control over their own bodies. 3. Who makes decisions in health?

Con,lusion

No matter which of the strategies are chosen, it is important that people tell their own stories and the veracity and integrity which goes with this is not lost.

Timing is also crucial. The pace of the activities must suit the participants so that they are neither rushed nor become bored.

Reflecting on and analysing these issues 3

Reflection upon and analysis of issues is designed to bring a greater depth to the immediate concerns of the people involved.

Criteria

Criteria to apply In ,hoosing activities at this stage tould indude:

- **Does the activity build on people's experien,es by darifying the iHue at hand?**
- **Does the activity enable the partidpants to go beyond their own perspective and see the issue from a number of points of view?**
- **Does the activity link various people's ,on,erns?**

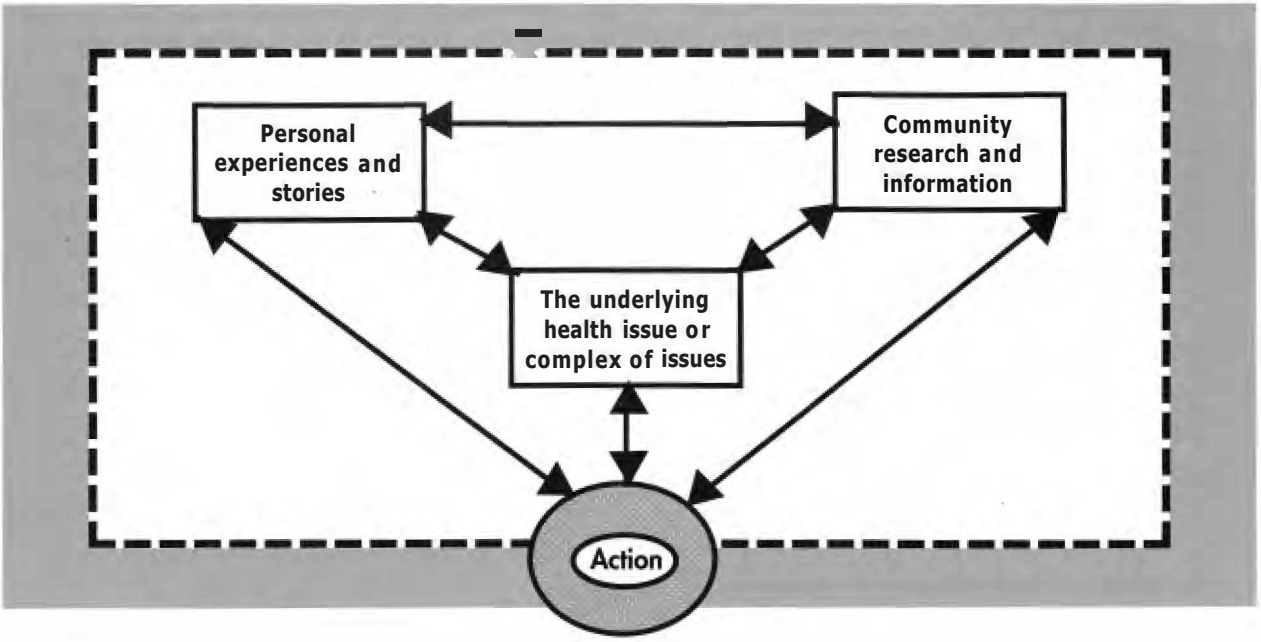
This 'step' looks at ways of seeing the broader issue or complex of issues which are meshed together within the personal stories of the participants. It also offers an opportunity to tease out the various details and different perspectives involved in a particular issue.

Participants can undertake some community-based research which can add to and extend the understanding of the issues being explored. This can include discussing issues of concern with a range of friends, seeking out information from service providers, and making contact with sections of the community not represented in the group to ascertain their views.

Personal experiences, research, the broader health issue or set of issues and social action by the participants are very interactive with each component informing the other. This can be shown diagrammatically :

Themes and issues

This is a technique which enables participants to address the underlying health issues which are embedded in people's individual experiences and stories. As a person (or group) tells their story either verbally or through a role play or photographs etc. two or three other people are asked to stand back and extract the major themes or health issues. These people then report to the whole group and lead a discussion on what they perceived as the major health issues implicit in the story.



The observers may pick up on different things in the story. This is OK. Most stories have implications for a number of health issues. Different emphases and different perspectives are useful.

That reminds me...

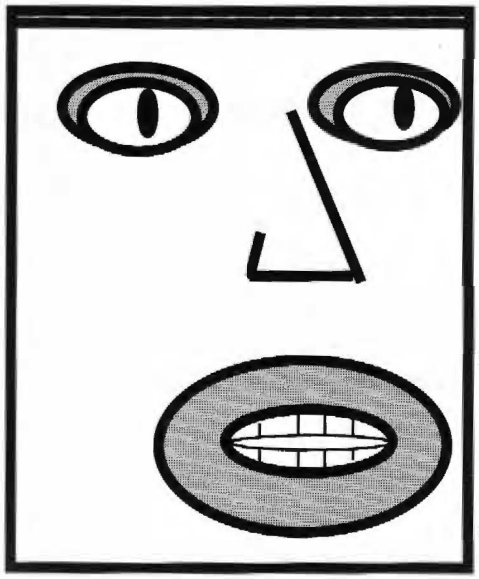
After people have told their story, others in the group respond with "That reminds me of a situation which happened to me (or to a friend)..." This gets people thinking along the same lines and demonstrates that issues and concerns are shared even though the experience may be slighdy different.

Another person, another story

Having heard one person's or group's story, the same experience is retold by another group from the perspective of another character from within the story or from the perspective of a 'professional' such as a bureaucrat or doctor.

For example, an elderly man spoke of the frustration he had experienced when trying to convince the home nursing service that his wife needed to be placed in a nursing home. He was not coping with running the house and caring for his wife. The visiting nurse had a slightly different perspective given the assessments she had made of the home environment and the skills of the woman. The woman herself was very resistant to the idea of being moved from the family home.

The retelling of the story from a different perspective requires people to extract the salient points and place them in a different context. This will tend to emphasise the issue rather than the individual experience. It is also a process of problematising a particular experience or set of experiences. Just retelling the story doesn't get us very far. However, seeing it as a *problem* which needs solving moves us towards thinking about appropriate social action.



Having generated a number of issues, the group needs to make a selection for further work and analysis. A good technique for this is...

Dotmo,ra,y

The health issues which the group has isolated are listed on a white board or piece of butcher's paper. Each participant is aHocated three 'dots' which they can place beside the issues of their choice as a vote. They could, for example, place three dots against one issue or place one dot against three different issues. The issues with the most dots are the ones which the group will explore in more detail. There is also the possibility of adding extra issues to the list.

Before placing the dots, it is sometimes useful to discuss the criteria to be applied to help participants decide which issues get their votes. For example, the criteria could include:

- Potential impact of community action.
- Likelihood of effecting change.
- Personal interest.
- Numbers of people affected by the issue.

Having isolated which issues the group wish to address in more detail, there needs to be a way of bringing a greater depth of understanding to the problem. This can be achieved in a number of ways which use the full resources of the group and also supplement those resources by undertaking research.

So iodrama

Sociodrama is a dramatic presentation, prepared by participants, demonstrating their analysis and understanding of a particular issue or problem. Dramatic action is a different way of knowing and expressing issues. Moving outside the use of language often enables participants to see the issues in new light. The emphasis is not on 'good acting' but rather everyone joining in and having a go.

Sociodramas place complex health problems in a human context. From a general introduction, it is often useful to divide the group into smaller groups of five or six participants who work together to devise a scenario which explores and illustrates the health problem. This scenario is then acted out.

It is sometimes useful to introduce the concept of 'style of presentation'. Sociodramas can be presented in a style which fits somewhere along the continuum of:

Realism. ◆ Stylisation

In realism, the participants are trying to make the scene as real as possible. Even characters who may seem unsympathetic need to have a realistic point of view because in real life most people believe that they act with integrity and good faith. In realistic sociodramas, it is important to know where it is set, who is involved, and under what circumstances they are involved.

In stylisation, though, the presentation does not have to be realistic. For example, big business could be symbolised by a cigar smoking character who sits high on a chair and whose only comments are: Buy!! or Sell!!

Props such as old hats, clothes or cheaply made masks are often useful in supporting people in the scenario they are presenting. Simple lengths of material have many uses such as symbols of power. a division of the space between the past or the present, or as the trappings of wealth.

It is useful to have a discussion afterwards and talk about people's reactions both in role and out of role. This provides a dual perspective on the issues and the situations being explored. If there is an audience, they too can make comments about their reactions to the issues as they were presented. The sociodrama can be analysed from different standpoints. Each standpoint has the potential to provide another perspective on the issue. It is important to focus on the issues which were presented rather than on the ways in which they were presented.

Sociodramas and role plays can often deal with personal issues in a very emotionally charged way. This is the strength of the activity. However, it is important to acknowledge the emotions which may come up. and also refocus the activity on the health issues being explored. Discussions are a good tool to build on the insights gained from the activity and 'debrief the participants at the same time.

s,ulpturing

This strategy involves all the people in the group forming a human sculpture and positioning themselves in ways which express the power relationships in a particular situation. The outcome is a visual representation of the group's understanding and knowledge of a specific issue or theme. Also, by stressing the power relationships, it is a particularly useful technique to help people start to think about the likely outcomes of actions they might take.

There is a real need for cooperation and negotiation because the whole group is involved. This, of course, is sculpturing's strength and weakness. There is the potential to explore quite complex interrelationships. There is also the potential for chaos. It is wise therefore to demonstrate the general idea with three or four people or to have undertaken the machine exercise described above. The facilitator or another member of the group may take the role of a director.

It is also useful to 'brainstorm' (when people throw in as many suggestions as they can without discussing or judging them at this stage) the various players in a situation. The power relationships between these individuals and groups need to be discussed. Roles are allocated and stick-on name tags can be used to identify the various players. The power relationship between these players then has to be expressed in some way. This can be done through physical placement, movements or dialogue.

The task is to use all the people in the group and to get as much complexity into the sculpture as possible.

If the sculpture looks at things as they presently are, it is useful to do a second sculpture which looks at things as they might be if improvements could be made to the health system. This begins to generate new solutions and suggests changes which can be made.

In addition to the director, it can be useful to have a roving 'reporter' to 'interview' the various people or groups of people to gauge their feelings and responses to other people and groups. For example, in one group, the patient who felt they should have been the centre of attention also felt that they had been forgotten and marginalised by all the concentration on the technical wizardry of the operating theatre.

The web

The web is a process which enables a group to look at the various causes of a health problem. The web is useful for looking at the various levels of causes and the ways in which problems, causes and solutions can be linked together.

The web normally takes an hour and a half to complete and it is best to do it in groups of no more than ten people. A worked example is provided on the next few pages.

Web onstrudlon

+ The selected health issue is written in the centre of a piece of butcher's paper: e.g. poverty among single parents.

+ The group then lists the immediate causes of the problem. This process is a combination of brainstorming and reflective discussion: e.g. no paid work. [Stage I in the diagram on the following page.]

+ The group then lists second level causes for those causes which have already been listed; and the two levels of causes are linked by lines to show the various connections. The facilitator has to keep the group addressing the whole picture and not simply focusing on one aspect such as in the example, the structure of pensions. [Stage 2.]

+ The group proceeds to a third or even fourth level of causes: e.g. Government policies on maintenance. [Stage 3.]

Web analysis

This part of the process helps to decide where change can best occur and who should be responsible for it.

+ The facilitator introduces this part of the process. e.g. the web has now established a pattern of causes. In this part we will brainstorm strategies that will reverse the cause; that is, strategies to eliminate or alter them in such a way that they no longer lead to the problem.

At this stage, people should feel unconstrained about how these causes will be eliminated.

The objectives are to understand better the relations that exist in the web and to develop strategies at a local and immediate level that also lead to larger (macro) level change.

+ Use the causes chart, but use a different coloured pen to draw in strategies with arrows pointing inwards.

+ Have an unrestrained brainstorm for a few minutes and list ideas of possible strategies, placing them on the chart at an appropriate level.

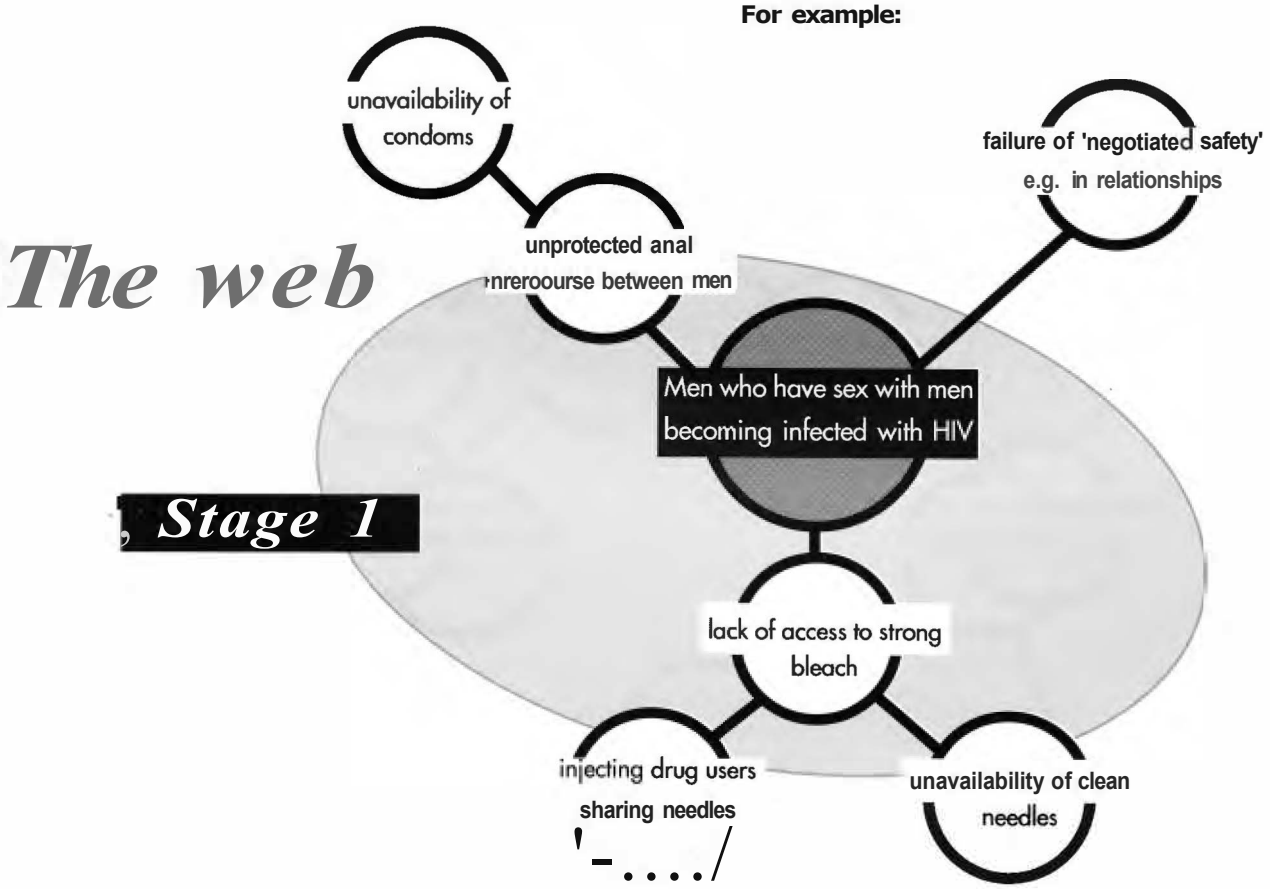
+ Focus on the level of causes which are more direct, personal and immediate. Use the other levels as reference points for discussion about more far-reaching strategies.

+ Work on one line connection at any given time.

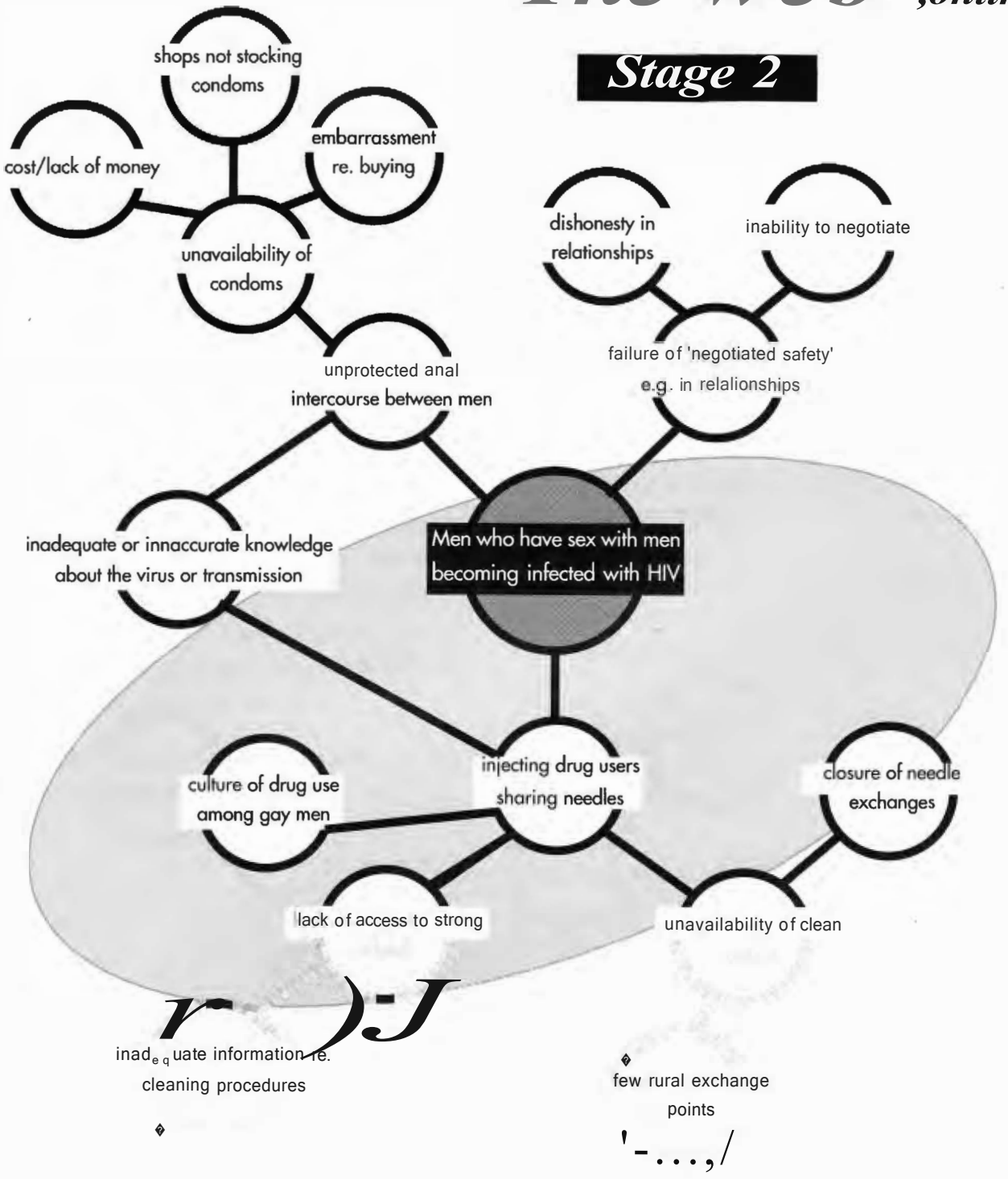
+ Consider the interrelationships between and among the different levels and see whether an all encompassing strategy at a particular level would work.

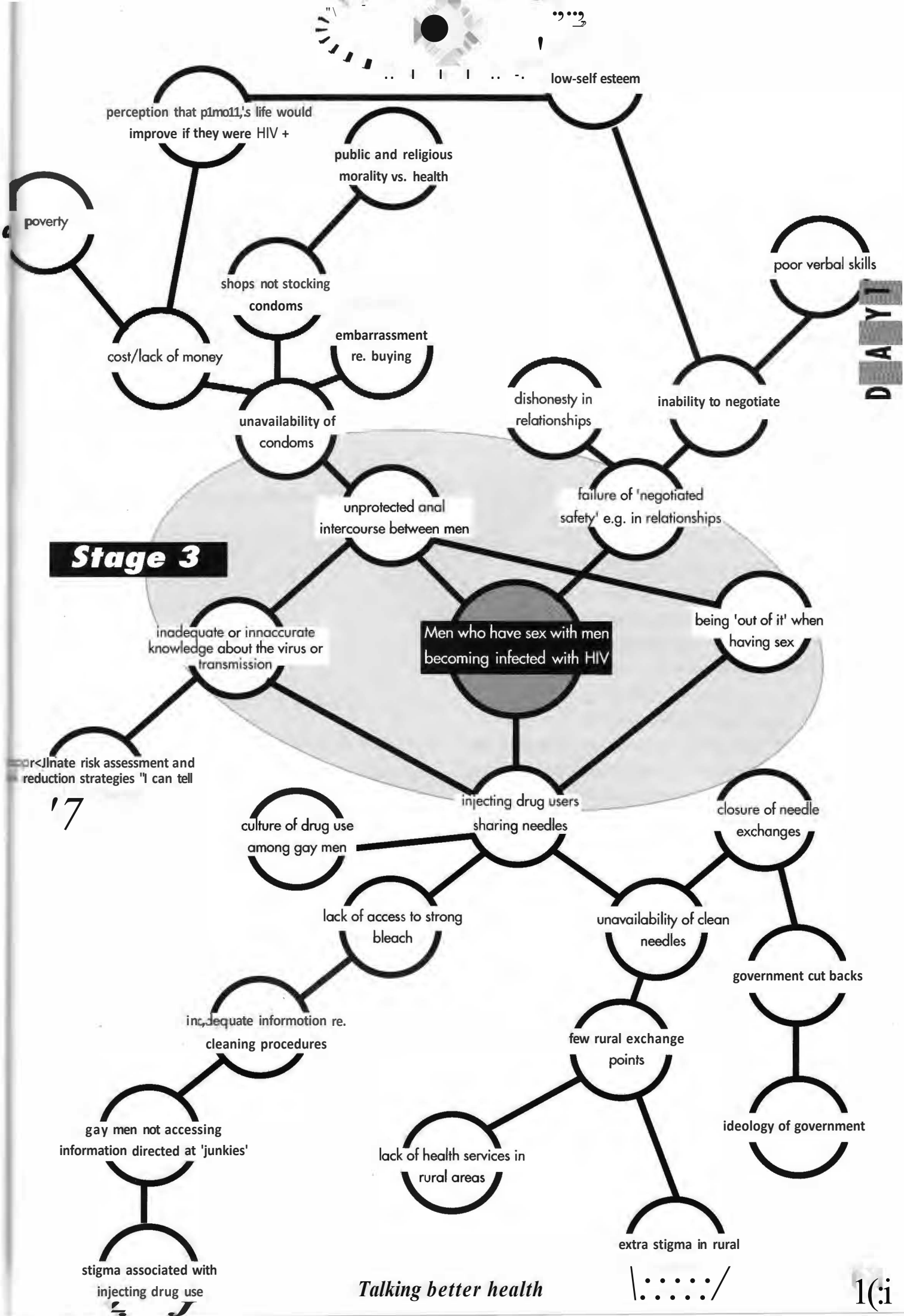
It is useful to make the web chart as large as possible with quite a lot of space between the various levels so that people can write their ideas and draw out as much complexity as they can.

For example:



The web ,ontinue




low-self esteem
perception that p1mo11,'s life would improve if they were HIV +
public and religious morality vs. health
poverty
shops not stocking condoms
poor verbal skills
cost/lack of money
embarrassment re. buying
dishonesty in relationships
inability to negotiate
unavailability of condoms
unprotected anal intercourse between men
failure of 'negotiated safety' e.g. in relationships
Stage 3
inadequate or innaccurate knowledge about the virus or transmission
Men who have sex with men becoming infected with HIV
being 'out of it' when having sex
injecting drug users sharing needles
culture of drug use among gay men
closure of needle exchanges
lack of access to strong bleach
unavailability of clean needles
government cut backs
inadequate information re. cleaning procedures
few rural exchange points
ideology of government
gay men not accessing information directed at 'junkies'
lack of health services in rural areas
extra stigma in rural
stigma associated with injecting drug use

llesear,h

Research is simply going to particular sources to find out information, collecting data, and documenting your findings. It is not just the province of academics or experts. Brainstorming is a useful technique to list the type of information you need to find out. A list of key questions can be generated on a white board, and these can then be grouped under thematic sub-headings. Sources of information to answer the questions need to be listed. These may include such things as government departments, or other people who have confronted the same issues.

There are ways of going beyond the individual perspective and seeing the bigger picture. Finding out how other groups have addressed or solved the same problem, or looking at government policies or regulations which may impinge on the possible solutions can be useful approaches.

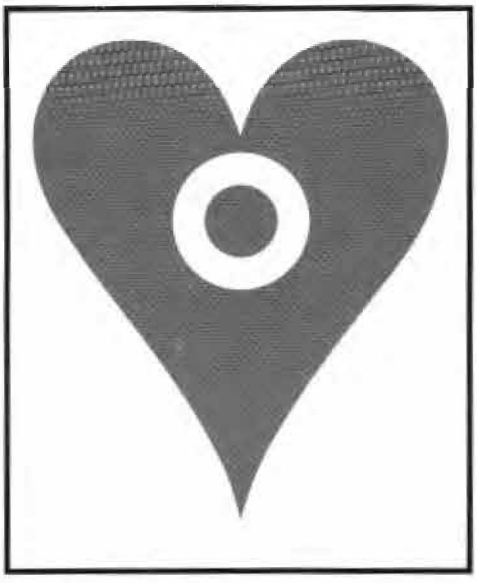
The question of how the information is going to be collected also needs to be addressed. Sometimes this will mean getting hold of policy documents, looking up regulations or interviewing relevant people.

The strategy is very amenable to setting individual people tasks and this builds a sense of purpose and achievement when the information has been gathered. Pairs of people are sometimes better than individuals because of the mutual support which is provided.

A,tivlty

In the following case study, what information was needed? What were the ◆ources ◆f the information? How did the group go about getting the mformat1on?

Community ,hild,are



Gayno r Hartvigse n Chro nicle s one aspect o f a shift in the Strath albyn and Distr ict Neighbo urho od Aid fro m Se rvice pro vide r to Co mmunity d eve lopment age ncy. Th is Sh ift signifie d a to tally d iffere nt o rie ntatio n to pro ble ms in so cial e nv iro nments and challe nge d th e pictu re of re sid ents as me re o bse rve rs and Co nsume rs o f Se rvice s.

As part o f a wome n's h ealth pro je ct a gr o up was form e d o f wo me n Who we re hav ing the ir first babie s, and the d iscussio n mo ve d fro m birthing to Child care. A lo t o f the wo me n we re new to the to wn so the y d id n't hav e a suppo rt ne two rk o f family and re lat ives. Pe o ple in the gro up fe lt th at the re was a ne ed for a cre che and o c<asio nal child care.

Backgro und re Se arch was und e rtake n by making co ntact with e stablls he d ch lld care ce ntre s to lea rn about the ir po licie s o n h ealth and safety and abo ut guid elines for setting up a cre che and the re quire d ratio o f ad ults to Child re n. They we re Co ncerne d about e stablish ing the cre che pro pe rly and to make it a re putable Se rvice. Ne igh bo urho o d Aid pro vide d the initial $400 for the first insurance po licy and pro vide d a legal auspice for the cre che Co mmitte e.

It was clear that vo lunte e rs wo uld run the cre che, but the re was also Co ncern about e nsuring some co ntinuity so efforts we re made to hav e a Co mmittee me mbe r the re for e ach Se ssio n.

Go ve rnme nt regulatio ns pre vente d the gro up fro m Charging a fe e for the Se rvice which was pro vide d; a small do natio n was re que ste d fro m pare nts. By way o f ince ntive, vo lunte e rs we re allo we d to accumulate child care ho urs in lie u o f this do natio n.

case study

totally diffierent orientation to problems. *II*

ef: Ainsworth, **C.**, H';)rlvigsen, **&** Buddle, B. (**1993**) Strathalbyn and d1stnct o en s healt project.' In P. Butler & **S.** Cass (eds). *Case Studies m Community Developmenf in Health.* Melbourne, Centre for Development and Innovation in Health. pp 75-88

Planning for a,t,on 4

Although Planning for action is described here as the fourth 'step' of Talking better health, planning for and implementing action permeates the whole approach. For example, the research part of the previous component is an important action outcome. The consciousness raising and commitment to change which are part of all the activities are valuable actions in themselves.

The last two 'steps' of Talking better health formalise action and address the concept of social change direcdy. As mentioned previously, Talking better health is designed to challenge and change those factors which are adversely affecting health and wellbeing. Implicit within Talking better health is the idea that many health problems may be caused by social and community factors rather than those which are based totally within the individual. An individual's ability to change their personal situation is heavily influenced by institutional structures. These two action stages of the program may help individuals to change their personal situations as well as challenge the structural barriers in their environment.

Planning for action can be looked at in a couple of ways. The way we normally think about planning is that, as a process, it clarifies the actions we are going to take to bring about certain predetermined changes. This type of planning is important and will be discussed in some detail below.

The other type, though, is equally important. This is planning for our own development so that we are better prepared to meet unexpected challenges and bring about changes in ways which we couldn't even think about in advance. In this type of planning, we don't know the outcomes of ours or other people's actions. We plan to sure that we can respond effectively and make better decisions.

For the first type of planning, there are a couple of broad models which might be useful as a framework in which to use some of the activities which come later in this section.

The Journey

Model 1: The journey

The first uses the metaphor of a journey and asks a series of questions which can guide people's thinking. Depending on the size of the group, the questions can be addressed all together, or smaller sub-groups can be formed. The advantage of the whole group is that a consensus can be developed and maintained throughout the whole process. The advantage of smaller groups is that more diverse solutions can be found.

Questions to onslder:

Where are we now?

Where do we want to get to?

How are we going to get there?

What resources do we need?

What resources do we already have and is there anything else which helps us?

How do we know when we have arrived?

Model2: An action plan

An a,tion plan

The second model covers much of the same area but in a slightly different way. It is more complex, but it tries to cover issues and contingencies from a variety of perspectives. This model asks for more information from the group and can provide more support.

An example of an approach which was pursued by a group of senior students in a school is given in italics under each of the headings. Prior to developing an action plan, the students had spent a considerable amount of time talking about concerns which they had about the structure and curriculum of their school. They had isolated a number of issues. The one used in the following example was felt to be the most pressing.

The issue

The number of student pregnancies in their school.

The current consequences of the Issue

[This highlights the implicit aims which are trying to be achieved.]

A number of girls leaving school early.
Girls being kicked out of home.
Increase in abortions.

Range of solutions

[It is useful to brainstorm this part because some of the seemingly oddest solutions may have merit on further examination.]

Develop a peer education program so that young people can come into direct contact with the consequences of student pregnancy.

Initiate a comprehensive sex education program with adequate contraceptive advice as part of the normal school program to both males and females.

Provide the means for contraception within the school environment

Keep the boys and girls apart as much as possible.

Increase the amount of sport in the school curriculum.

Make all parents aware of the issue and the number of pregnancies so that they will supervise their children more dosely.

Preferred solution

Initiate a comprehensive sex education program with adequate contraceptive advice as part of the normal school program to both males and females.

What will hinder the solution?

Some parents object to sex education on the grounds that it encourages young people to become sexually active.

Statewide curriculum policy mentions the importance of health education but draws back from compulsory sex education and does not mention contraception at all.

The school principal has expelled every girl who has become pregnant or at least has counselled them to leave.

There is an attitude among some of the school that it's not needed because they 'know it all anyway'.

Stakeholders involved

Students
Parents
Health teachers
Curriculum committee
Principal
School council

Steps to take

[Each of the stakeholders may need a different strategy* or set of *strategies.]

Put up a briefing paper to the curriculum committee outlining the general proposal and approach to be taken. Get one of the sympathetic teachers to speak with the chairperson prior to the meeting.

Float the idea with the student population through taking up one of the weekly homeroom sessions.

Raise the general issue of health education at the school council meeting. Talk about a number of issues, not simply the sex education program.

Research the requirements regarding who could take the program. Does the person need to be specifically qualified?

Find out from other schools how they address this problem.
[These steps were the initial ones which were planned.]

Timeframe

The above strategies were planned for the first two terms of the year.

Resources required

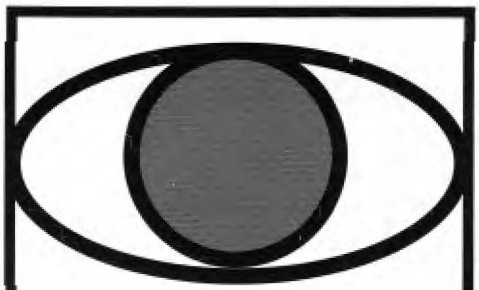
The major resource was time. The students working on the project were able to build it into to their formal school program which required them to undertake a research project of their own design.

Review and evaluation of the success of the action

The students set a number of goals which include to:

- Reduce the number of pregnancies in the school.
- Get a sex education program into the school.
- Increase the awareness a fthe issue in the school population.

The first two were tangible indicators of the success of the students' efforts. However, there were other results which were less obvious but were nevertheless successful outcomes. The group of students leamt an enormous amount about the ways in which decisions were made in their school and the avenues which were available to them to influence some of these.



"Feel more positive and be able to deal with the unexpected."

Planning for action is often seen just as discussions. There are, however, a number of planning strategies which do not rely solely on group discussions. Many of the following activities use action and other means as part of the planning process. Discussion tends to provide one s.ort of solution. Action methods such as role plays and sculpturing, for example, tend to provide different types of solutions.

Criteria

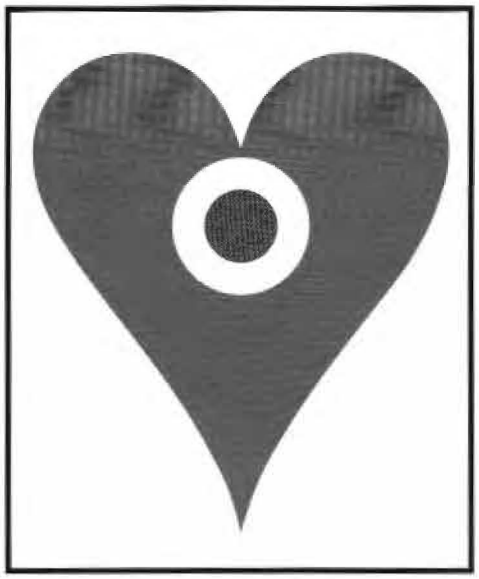
Criteria to apply in dtoosing adivities at this stage ,ould indude:

- *Does the adivity darily the ,hanges whi,h people want to see happen?*
- *Does the adivity lo,us partidpants' attention on pradi,al things whi,h ,an be done?*
- *Does the adivlty leave partidpants luling more positive, powerful and able to deal with the unexpeded?*
- *Does the adivity help people be more relledive about their ,urrent skills and needs as a group?*

Activity

In the following case study, how did the group plan? What were the unexpected results? How did the planning help them deal with these?

A country women's health project



The project started with a small group of women on the Health and Social Welfare Council executive feeling the need to do something about the vast range of women's health issues in the country. A questionnaire was developed which addressed women's health problems, frequency of pap smears and breast examinations, health services most used, and general concerns and comments.

While the results of the survey were being collated, further consultation was undertaken. One way of complementing the results of the survey was to run a series of workshops with a smaller number of women. Here, they could discuss in more depth the issues and their hopes for the future.

Two workshops were held when the question of women's health needs was looked at in greater depth and issues were placed in priority order. Although reproductive health issues were raised, the role and powerlessness of women, issues of access to health services, transport, and socioeconomic factors were identified as major concerns.

It was important to talk with service providers such as GPs and nursing staff who worked with women as well as targeting some groups of women who had not completed the survey. The team went to Neighbourhood Houses, a disability group, groups of older women and Aboriginal women and received a wide range of comments from all of them.

The participants in the second workshop were also given a draft report containing a summary of the information which had been gathered and were asked to confirm the results. Feedback was important to ensure that the process was on the right track.

case study

"Maintain the momentum for change."

One of the strategies decided at the second workshop was to establish a Women's Health Advisory Committee to maintain the momentum for change and ensure the implementation of the recommendations within the report. The committee also had a role in continuing to involve women in the planning and delivery of women's health services.

One of the lessons learned from the project was that women's collective voice carried a lot of weight in the planning of health services. The collective voice of many women also showed local service providers that change was required.

Reference: Worth, C., Hartvigsen, G. & Buddle, B. (**1993**) 'Strathalbyn and District women's health project.' In P. Butler & S. Cass (eds). *Case Studies in Community Development in Health.* Melbourne, Centre for Development and Innovation in Health. p 37

The following are some strategies to help people to develop a plan for action.

Telegram

On a piece of paper each participant writes a message in 20 words or less which begins"/ **stronglyurge_ ".** The telegram addresses the desired change and should be directed at a person or body who has responsibility for or **who** can bring about that change. **This** strategy **is good for thinkingsuccinctly**about **changeswhichare** necessary and the people who hold power in this situation.

Discuss a number of the telegrams as a whole group and look at whether the suggested action would solve the problem. As a whole group, generate alternative action strategies which might solve the problem (or parts of it) equally well. As part of the discussion, look to see whether there are other people who have power in the situation and who may be enlisted to bring about change.

Just suppose•••

The group imagines that it has been appointed as a 'local consumer voice' for the broad health issue which is being addressed. A grant of $30,000 is to be made available to the group to address the concerns which they and similar people within their community may have. The group has to decide how the money should best be spent.

First of all, the group should brainstorm ideas and generate a range of possible projects. At this stage it is best not to judge the ideas, but to work on generating further ideas. Having thought of a range of projects, questions such as the following could be asked:

How does the projed take into auount lo,al sodal, eionomi,, politi,al and ,ultural realities of those people it will affed?
How does the pro/ed adively involve all the people and groups whi,h will be affeded by it?
How does the pro/ed address Inequalities whi,h may presently exist?
Does the projed deal with the ,auses of problems as well as the symptoms?

These questions help people judge good ideas from those which are less useful. The group might like to develop further questions as a way of sorting through the proposals. Dotmocracy which was described previously is also a useful technique.

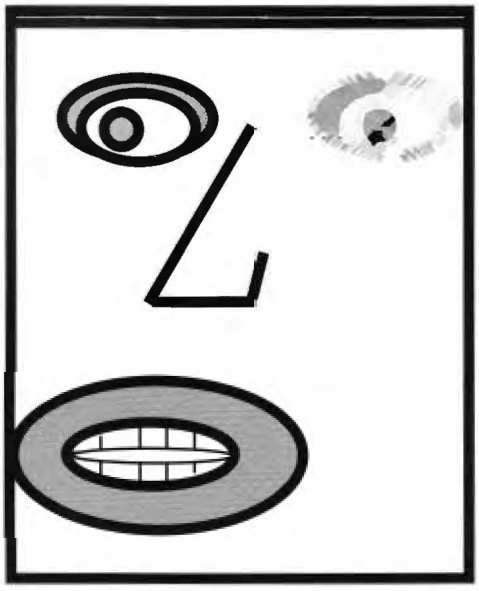
PO

Edward De **Bono (Lateralthinking: a textbooko fcreativity. London, Ward Lock Educational. 1970) coinsthe word** P O as a device to juxtapose two seemingly unrelated ideas to see what creative solutions can be generated to solve a particular problem. The idea is to look at the qualities of the unrelated thing or concept and see whether these qualities can be applied to the problem to suggest creative solutions.

For example, the problem may be the lack of services for young people with psychiatric disabilities ***PO*** verandahs.

Verandahshave the qualityo fprovidingshelterwithina home environment It mightbe worth exploringthe possibilityo fdifferenthome-basedservice options.

Verandahsare adjacentto homes. Psychiatricservicescould be community-basedbut not withinthe young person's home, possiblyadjacentto it



Verandahs provide shelter from climatic extremes but don't provide a hermetically sealed or coddled environment Services could place normal community living demands on the clients but alleviate some of the major stressors such as finding accommodation and earning money.

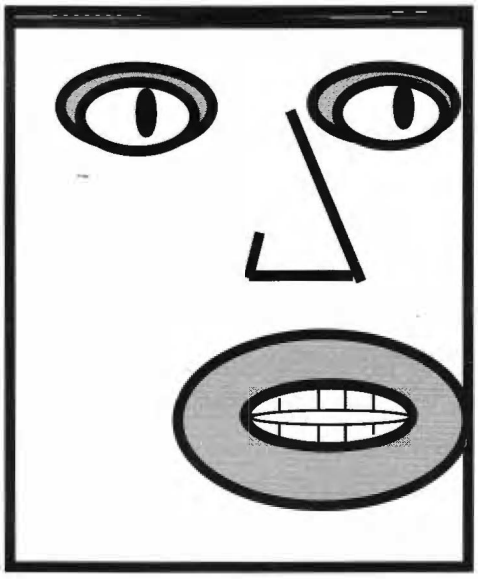
The artificiality of the juxtaposition is a useful way of jolting us out of the normal and well-worn paths we normally follow. Any word or concept can be used for the juxtaposition and one can be suggested from the group or by the facilitator.

Skills audit

The group looks at the ideas for action which they have devised and asks what skills are necessary to implement the ideas successfully. For example, sending letters to the editor of the local paper requires someone to be able to put together arguments in a written form which are expressed in a concise and pointed way. Similarly, getting together a public meeting needs people who can organise venues, refreshments, and some people who are not fazed by speaking in front of a group of people.

Having broken down the tasks in terms of the skills required, it may be that some of the skills are not covered by the people in the group. The group may need to approach others who do have the skills they need to join the group. Alternatively, some of the tasks can be changed to accommodate the skills which are available in the group.

Another way of doing a skills audit is to start with the participants rather than with the plan. Participants can list their own particular skills on a sheet of paper, or if people know each other well in the group, one person could state the skills which they perceive another person has. Many people are modest about the skills they have or often do not see their abilities as skills at all. Women, for example, who regularly shop, cook and manage a household have highly developed organisational skills. However, they sometimes see themselves as unskilled outside that context. Most people's skills are transferable and are assets to be used in Talking better health.



A small warning on planning for a,tion and setting goals

Working out exactly what you want to achieve is !osier said than done. Olten you have a broad goal in mind which is formed in general terms and this goal addresses the health issues or problems as you see them. In this case, you need to think of smaller strategies which contribute to achieving the broader goal.

Sometimes, though, you don't quite know where it is you want to end up. You want to solve specific problems and you do not have a clear sense of what impact small changes will have on the bigger picture.

There is always an interaction between the actions in which·you are involved·at.a local' level and those commitments you have and the changes you wish to see occur on a much broader level. The maxim 'Think globally; act locally' is an important idea to keep in mind.

There is also· a dynamic relationship between the goals, which you might set and the strategiesiv.ihich you pursue to achieve the goal. Sometimes the strategies may suggest other goals which are more appropriate to the problem or more achievable. At other times, the actions·which are taken change the people who are involv d o that they see the problem in quite dillerent terms.

Just having a focus on a predetermined outcome tends to miss opportunities for excursions into other areas and to miss the changes in perceptions and skills whic/i,occur in the people involved. As somebody once put it: "If you know exactly where you're going, you've already gone." The process of setting goals is a little like placing a few signposts as a guide on the journey. They are not the journey itself, nor the destination.

Reviewing the group

This whole process is more cyclic than linear. It is useful at various times to review the processes you have gone through and the way in which the group has developed. The process of review is, in itself, a group building exercise and it can provide a sense of achievement of where you have been and where you want to go. There is a group story to tell of the processes you have gone through and there is value in celebrating this.

[Throughout the training course, a number of opportunities have been built in to enable participants to review the activities, look at what has been learnt, the methods which have been used, and to reflect on themselves as learners. This is very important in developing and refining your leadership skills.]

As part of the review process, it is good to ask what skills the group has acquired over the time of being together. This is also a way of thinking about the skills which need to be developed in the future. In this way, people start to get a sense of themselves as agents of their own change. This is a major step in enabling groups to be self-sustaining and not reliant on the input of outsiders.

It is useful to match the achievements with the original aims and objectives which the group had. This does not mean that the aims and outcomes necessarily have to match up, but it does enable the group to keep an overview of the journey it has made.

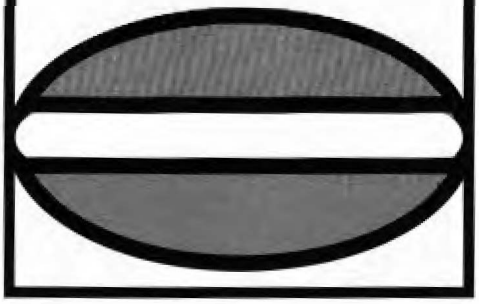
Taking action 5

Talkingbetter health is concerned with bringing about changes in the health and circumstances of the people involved. Sharing experiences, isolating common health issues and planning for change are important. However, Talkingbetterhealth is directed towards action.

The type of action will, of course, be dependent upon the plan which the group has developed. However, even with the best laid plans things have a habit of taking their own course. New issues crop up and circumstances change. Planning is one thing, but confronting reality can be a different thing entirely.

This section is primarily made up of a number of case studies. The first case study provides an interesting example of a situation where the desired outcome was not achieved in spite of the enormous planning which had been undertaken. This does mean that the work was not valuable. The outcomes, though, were not the ones which had been planned.

"Things have a habit of taking their own course."



Criteria

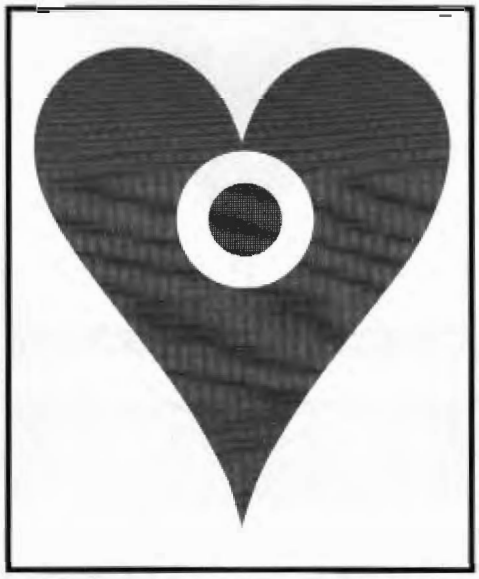
Criteria to apply In d,oosing adlon at t•is stage ,ould indude:

- **Does t•e adlon use t•e. strengt"s and skills of t•e people Involved?**
- **Does t•e adion require people to ,ommlt a reasonable (In t"eir own terms} amount of time and effort?**
- **Will t"e adion •ave positive out,omes for t"e people involved?**

A,tivity

In the following three case studies, look at the processes which the groups went through. Were there key events or approaches used? What made them so important? What are some of the other outcomes which might have occurred? What processes have you tried to bring about

SWEEP



A group of women were worried about the development of a large regional tip which was being situated on the periphery of the area in which they lived. They looked for ways of extending the life of their smaller local tip.

For six months a group of eight women met to develop a recycling strategy centred on the tip which they could run. The project was called SWEEP (the Strathalbyn Women's Educational and Environmental Project). A plan was developed which included a community education program, a landscaping plan for *the* tip, a recycling scheme and a business plan. This was formed into a tender to run the tip which was presented to the local council.

At this stage, the council rejected the tender because they were skeptical about a group of women running a tip and because SWEEP could not provide its own machinery and equipment. The person who had been running the tip in the past was the successful tenderer. The council at this stage began to demand a recycling strategy from the successful tenderer, and under this pressure he resigned from his position.

SWEEP's proposal had generated quite a lot of community interest, and when tenders were again called for, SWEEP was encouraged to apply. However, the council's offer to run the tip was inadequate and SWEEP turned it down. The council now runs the tip.

Although SWEEP was not running the tip as originally planned, other action resulted. They continued to pressure the council to adopt a policy on recycling. One way of achieving this was to co-sponsor a public meeting on recycling and this acted as a means of making more members of the community aware of the issues. SWEEP continues to act as a watchdog regarding the council's approach to recycling. The council has responded in a variety of ways including the development of a recycling depot at the tip.

case study

"Generate community interest."

Ref: Ainsworth, C., Hartvigsen, G. & Buddle, B. (1993) 'Strathalbyn and District Women's Health project.' In P. Buder & S. Cass (eds). Case *Studies in Community Develop;nen_f in Health.* Melbourne, Centre for Development and Innovation in Health. pp 75-88

B;rthwise: an antenatal and postnatal support group

The western suburbs were seen to have high numbers of women who had difficult pregnancies. Many of them had fewer than the recommended number of antenatal visits. Workers in the local women's health centre believed that strong social support was vital for women undergoing pregnancy or childbirth. The absence of support was felt to be as important as the absence of accessible or appropriate antenatal care. The existence of social support among pregnant and postnatal women was important in the prevention of so-called 'postnatal depressio'.

The pro/ed

Workers decided to pilot a program to explore women's antenatal and postnatal needs by working in a consultative and empowering way. The goals of the program were to:

- Create a feminist model of birthing care which empowered women.
- Use language which normalised the processes of birth.
- Challenge the view that postnatal depressio is a mental illness, rather than an outcome of oppressive and social forces.

The program was an antenatal support group which continued postnatally. It was held on a weekly drop im basis, which allowed women to come and go according to interest and need.

At each session, the women discussed their pregnancy care, their birth experiences and postnatal issues. In this way, the main issues affecting each woman's health were canvassed. The staff involved had some obstetric knowledge and the ability to follow up other resources or information, but essentially the women involved educated and informed each other.

As issues came up, women were encouraged to ask for what they wanted and needed in their antenatal care and to support each other. This helped the women to develop their personal skills in dealing with health care workers and lead to action on several levels. For example:

- Some women devised a birth plan and took it with them to the hospital.
- A group took collective action to complain about what they considered to be inappropriate or inadequate care provided by agencies during pregnancy; and were thus involved in public policy change.

The first group of women who met, continued to meet independently in addition to the weekly drop-in sessions. Also, most of the women who attended the sessions antenatally have been keen to continue to attend postnatally which has been some feat considering the extra work taken to transport a new baby to meetings. Women in the group actively sought other members for the group fram among their friends. Other outcomes were less tangible, but also important. These included the woman who felt she was better able to attempt a vaginal birth for her second child after a Caesarean section for her first child. Overcoming social isolation and gaining strength through creating social networks and a supportive environment helped create positive outcomes for the women.

Ref: South Australian Health Commission & the South Australian Community Health Association. **(1992)** ***The Chqngmg*** Fathce *of Health: a primary h♦lt♦ care case book.* Adelmde, Sou Australian Health Commission. p-3

A community program for Aboriginal women

"There can be too many problems in an Aboriginal community to know where to start Unemployment, poverty, boredom, alcohol all go towards the destruction of the community. Child health problems, diabetes, poor nutrition, and lack of medical services compound these problems." That is how the situation seemed to a community health nurse until she was invited to work with the community.

case study

"There can be too many problems."

In 1987, the Aboriginal Council formally invited some health care workers into the community. The team was expanded to include two Aboriginal enrolled nurses. These nurses set up a women's group which 'lurched from week to week'. The idea was to start with advice and education on nutrition but the women were more interested in learning how to make quilts and curtains, and upholster chairs. The program started with what the women wanted which meant that the women did some beautiful needlework and their children were warm at night. This approach gave them plenty of time for talking and learning how to be more assertive. It was a catalyst for:

- The women learning to speak for themselves and others, resulting in four of them gaining places on the council.
- Making plans for a childcare centre.
- Starting to use the library.

As the group progressed, the workers noticed that the women were not eating regularly or well. The community health nurse offered to cook lunch next week, which they all enjoyed. Many of the women wanted to know how to make it, so cooking and sharing food became a regular feature of the group. The spin offs were:

- One 10 year-old-boy started skipping school to get a free feed every Tuesday. However, the women told him in no uncertain terms to get back to school, so that he could be educated to get a better job later on.
- "I stopped drinking so I could come today" was how one woman with an alcohol problem explained her presence to the group. "I wanted to see what we were going to cook today."
- Using the recipe leaflets they were given, the women began cooking good, nutritious dishes, and even asked the supermarket to order such food as lima beans.

There have been other changes in the community:

- A number of people have applied for houses and received them.
- Several people have gone to TAFE and studied accounting among other subjects.
- A young woman was planning for i'he future of her young child and had moved out to the wider community.

Ref: South Australian Health Commission & the South Australian Community Health Association. (1992.) The **Changing** *Face of Health: a* **primary** *health care* case **book.** Adelaide, South Australian Health Commission. **p** *49*

Activity

DAY 1

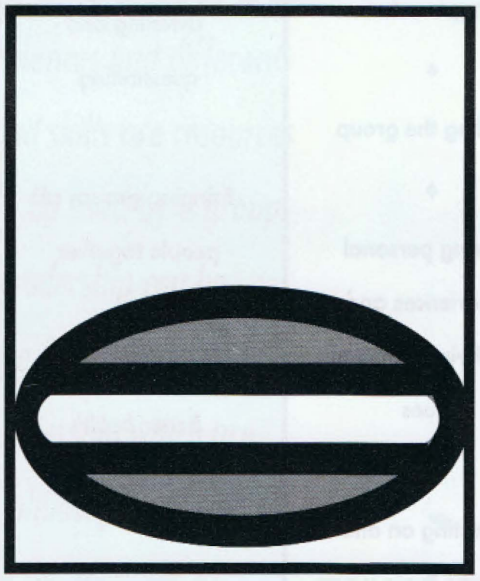
Talking better health - ,hapter review

♦ **Com;piete for ea,h** set **of a,tivities** +

What adivlties were undertaken?	*How were tlte adivifles undertaken?*	*Wby were lbey under-takn In tlte way tltey were?*

photocopy

DAY 2



Using Talking belt.er health

+ *Talking better health* · *Training Tim table* +

M,,rNGDAY1	DAY2	DAY3	
Introduction and overview of the training course I Group building (This will not be treated as port of the program on day I) I The philosophy of *Talking better health* I Different communities: different meanings I Telling stories I Small stories, big ,pictures.	The five 'steps' of the *Talking better health* approach: I Building the group I Sharing personal experiences and identifying common issues I Reffectifig on and analysing these issues I Planning for action I Taking action	Leadership redefined ● Listening and questioning I Bringing groups of people together I Planning lo use *Talking better health*	Changing practice I Evaluating the training course I Future planning

photocopy

Chapter 3
Day 2

Leadership redefined

People have different experiences and different skills. These experiences and skills are resources which are available and can be used by a group. In this way, expertise and leadership can be shared within a collaborative framework. We need to address styles of leadership which are appropriate to the general philosophy of Talking better health to ensure that the methods of working actively involve and empower participants.

Although there are lots of styles of leadership, it is important that each person's style builds upon their own personality. It seems obvious, but people sometimes feel that there is a facilitator style which they somehow have to emulate. A person who is naturally quiet and thoughtful should build upon this, just as a person who is more demonstrably enthusiastic should see this as something positive.

Activity

List the strengths which you have as a facilitator and leader. These could be commitments you have, personality traits, interests and abilities. These are the things which contribute positively to being part of a group particularly if you are in the role of a facilitator. Think of the ways in which these strengths can be maximised when being part of a group. Make your strengths work for you.

Having listed all the positive things and worked out how they can be incorporated into facilitating groups, try to think of those things which work against successful group work. Devise strategies which minimise the effects of these negative aspects.

As a follow-on, each person has three cards and writes down three possible characteristics of leadership: one on each card. All the cards are then placed in the centre and people have to pick the three cards which best describe their personal style. Discuss as a whole group.

Working with and facilitating groups is a complex activity. On the one hand, facilitation is about enabling participants to pursue their own interests and concerns. The facilitator ensures that the group works effectively, that the participants set their own agendas and come to conclusions which are right for them. This perspective is important because *Talking better health* builds social action on the basis of people's individual and shared experiences of health issues.

Facilitators need to work to engage the other participants to enable them to make real decisions about where the group goes, the issues which are explored and the conclusions which are reached. Facilitators work with people rather than on them. An overarching goal for group work is that responsibility for the processes of the group should be shared among all participants including the facilitator. As was mentioned in the previous chapter, it is important that groups decide on their own rules of operation and procedures.

Facilitators have an active role. They, too, have their own stories, experiences and perspectives. These are valuable as a resource to the whole group and also an important reason why the facilitator gets involved in the first place.

Facilitators can sometimes dominate other people, particularly if those people are not as experienced as the facilitator in being part of a group or operating in public or semi-public forums.

DAY 2

A tivity

Map the group or meeting in which you are involved. Sketch a picture of the room, indicating where everyone is sitting and put a tick beside the person every time they make a substantial contribution. If people seem to be directing their remarks to particular people, indicate this on the diagram. You should also graph the energy level for the same period. At the end of the meeting the sheets are pooled to discuss who does most of the talking and the effects of that talking in terms of the energy of the whole group.

This task could be shared among members of the group with a new person mapping each 15 minutes.

s enario 1

A worker was acting as a resource and focus for a group of women which had formed because each person had experienced postnatal depression. They had shared personal experiences and isolated issues which were common to each member of the group. As part of sharing information, talking to other people and undertaking some research into the topic, the participants concluded that the depression was caused by an hormonal imbalance and consequently best handled through medication.

The worker, though, was more interested in the social construction of the experience and the consequent labelling of it as a 'medical condition'. The worker was torn between her own commitments to playing down the medical interpretation of peoples' experiences and an equally strong commitment to valuing the experiences and interpretations of the people with whom she was working.

Scenario 2

Within a group there was a man who had a particular story to tell. When this story was not the focus of attention, he would try to bring the group back to his particular issue. He was particularly skilled at being able to draw a link between any story and his preoccupying concern. The difficulty was that the person was extremely vulnerable to criticism.

When the nominal facilitator tried to say that there were other issues, the person became hurt and withdrawn from the group which had the effect of other group members compensating to reinclude the person in activities.

Concerns which may initially seem poles apart, or at completely different levels of generality or sophistication normally can be addressed in a way which links them together.

It is important for facilitators to use their experiences and concerns within the group. They can tell their own stories to disclose their agendas. Information on such things as their background, experiences and commitments may be included if this is helpful for other people in the group to reflect on their own experiences. In this way, facilitators become collaborators with other participants in the group. Working collaboratively means that the skills and experiences of all participants are acknowledged and valued and are seen as contributing to the total functioning and good of the group.

Activity

The group is presented with a number of scenarios such as the ones above which represent a challenge to the leader and asked how they would respond as the facilitator.

Sometimes when the facilitator is not normally a member of the group his or her experiences and agenda may be different from the rest of the group. This can sometimes happen when the facilitator is a paid worker who is involved with community development activities but who does not belong directly to that community. This is less of a problem than it really seems. The process of linking small stories to bigger pictures which we explored in an early chapter can be applied here too. The important questions to ask are:

'What is the **commonground between** the **various perspectives including that of the facilitator?"**
'What concerns are experienced by all people r'
"How can these **concerns be expressed in a way which emphasises the similarities between the concerns rather than highlighting their differences?"**

The philosopher Martin Buber talks of an Iffhou relationship when a person enters a dialogue with someone else. An Iffhou relationship is based on a mutual giving and taking. One's own perspective is challenged in the light of another. The 'I' gives up the primacy of their own perspective and tries to understand events from a different perspective. In contrast to the I/ Thou relationship is an I/It relationship which views the other person or viewpoint as separate, objective and not impinging on our own personal perspective and position in the world.

Facilitators of **Talkingbetterhealth** enter into a dialogue with the other participants to find a common understanding from which to explore issues and concerns related to health.

Two important skills which are needed by facilitators to encourage dialogue are:

+ Listening and Questioning

Listening

Listening seems easy because we think we do it all the time. Really effective, or what is often called 'active' listening, is a little harder.

People need to find their own voices and they need to be supported in this. This support can occur by being an effective listener. Some techniques include nodding, mumbling approval, or adding examples from your own experience which show that you have understood the point being made. Your own experiences do not have to be identical; in fact, this often stifles the dialogue. Extra anecdotes tend to function as analogies for the main story being told; and analogies are useful because they give the story a slightly different twist.

A number of the issues which people will discuss will be highly sensitive and on the raw edge of their experience. The facilitator needs to be aware of this and deal with both the issue and any discomfort which anyone in the group may feel in a tactful manner. Naming and describing experiences tends to put ideas into a public forum and enables them to be shared by the group.

r A,ri;ity _, - -

In two groups, develop a series of questions. Think about the type of question you are asking and what sort of information you are looking for. A 'facilitator' from one group then asks the other group the questions to see how effective they are.

As a whole group list those things which make a good questions ('good' questions may be different for different people). As each idea is listed, other people should think of two or three examples.

Questioning

One way of positioning yourself to be able to observe and listen is to ask questions rather than make statements. Questions invite responses, get people talking and change the focus from the facilitator to other participants. Questions are a first step in engaging participants in a dialogue.

Questions can either be open or closed. Open questions require opinions, encourage people to speculate on experience and build a personal commitment to the task. In contrast, closed questions ask participants to recall known facts, emphasise right and wrong answers and reinforce the power of the facilitator because the person asking the question normally knows the answer. Open questions tend to give more power to the participants.

Questions seem to imply that the person or people being asked already have the answers. This may not be the case. People will sometimes talk themselves into understanding. It is a little like Alice in Wonderland when she says: **"How do I know what I'm going to *say*, until I've actually said it?"** We use language to clarify our ideas and give a form to feelings of which we are only half aware.

New experiences also need new words. Often the words which we do have available only approximate our experiences. There is a need for metaphors which are less precise than other forms of language, but which can capture the essence of what we are trying to express.

Open questions

In general, it is better to phrase your questions in such a way that they require more than a simple 'yes' or 'no' answer. 'Yes' or 'no' questions sometimes fall flat and don't take the discussion anywhere. If a group merely nods, or if someone makes only a brief comment, the facilitator can encourage them to go on:

'Won'tyou carry that idea a little further?"

"Explaina little more **whatyou mean."**

"You don't seem **to** agree. **How wouldyou put it?"**

"You seem **to think that is a good idea. Can you tell** us **why?"**

It may take several questions to help a person express him or herself clearly enough for the group to understand. This may be done by seeking clarification: **"Are you saying. ?"** or restating the comment in your own words.

Restatement

This technique is useful as a way of valuing the comments which people are making, and affirming their contribution. At a practical level, restatement ensures that everybody in the group has heard the com ent. It emphasises the idea for a moment to make sure that it doesn't get lost. By restating, the facilitator is modelling active listening.

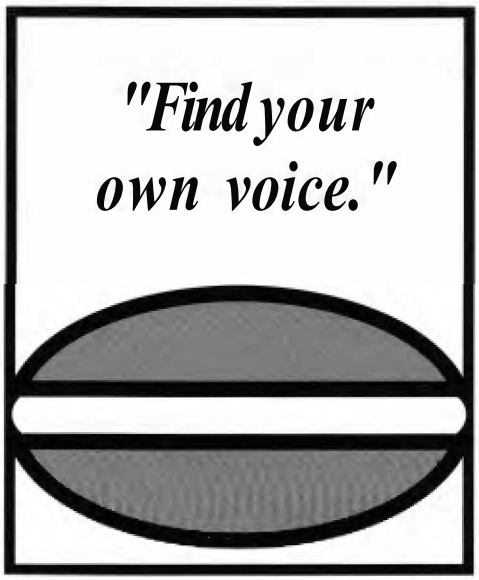
It may be useful to paraphrase the comment either to make it clearer or to give it a richer meaning. It is helpful though to check back with the speaker:

"Is this whatyou had in mind?"

"Am I saying it correctly?"

"It seems **to** me **that** you're **saying. or am I missing** the **point?"**

Sometimes restatement is neither possible nor desirable. The discussion is sometimes not moved forward by simply restating the idea. Sometimes, too, stories are not amenable to paraphrasing. They come out as glib truisms. Another story, or a more metaphorical approach such as a quote from a poem, can often be a more effective way of valuing the person's comment and capturing its essence.



Questions lor encouraging comments

'What do other people think about that?"

"Would anybody like to make a comment on that?"

"Does **anybody think differently?"**

These questions throw the ideas back to the group for their comments and opinions. This is an important technique because the focus is taken off the facilitator and placed within the group as a whole. It also encourages different people to give their opinions on an issue. Diversity is useful in discussions.

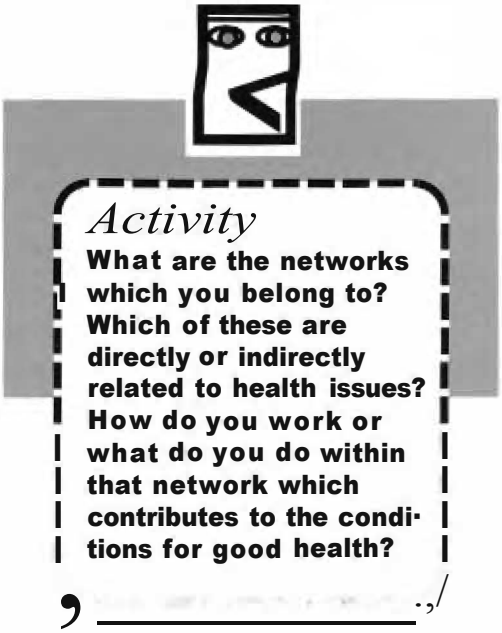
There is a big difference between a comment or an opinion, and an answer. Answers tend to stop a discussion, rather than lead it on. If a member of a group replies in such a way that it sounds like a final answer, you can always throw it to the group again for further opinion, just to keep things open.

As a facilitator, it is sometimes better to avoid answering questions because this can give the message you know most of the answers and that the other participants' views are not relevant. It is always a matter of balance between contributing to the discussion and dominating it.

Bringing groups of people together

To reiterate, *Talking better health* **is is based** *on:*

1. **Forging common or complementary interests and purposes among diverse people.**
2. **Developing a shared understanding through storytelling of the health issues being addressed.**
3. **Working towards cooperative and group action.**



Activity

What are the networks which you belong to? Which of these are directly or indirectly related to health issues? How do you work or what do you do within that network which contributes to the conditions for good health?

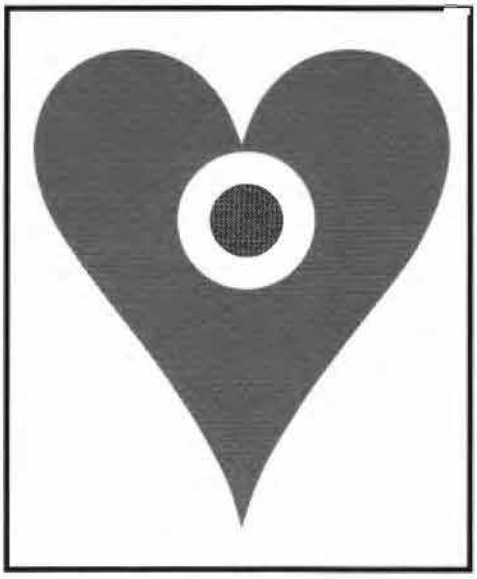
Groups can form around many issues. The case studies which appear in this manual give an indication of the range of possibilities.

Sometimes people see their health concerns and experiences purely in individual terms. They don't see them as linked to other people's experiences. This can make it difficult to forge the links between people so that diverse stories and experiences can be seen as having common elements.

The processes of story telling which have been described previously address this issue, but sometimes it is difficult getting people together in the first place.

The following case study shows how groups often start informally, or through social or work networks.

Work,over - life's easier on the dole



case study

"They swapped stories an same of their pro·blems."

This case study is about a number of people who were recipients of Workcover in South Australia in the early 1990s.

A number of Workcover recipients got to know each other while attending the local gymnasium as part of a rehabilitation process. They swapped stories about some of the problems they were experiencing with Workcover. This was informal and just occurred by way of making conversation while undertaking the exercise program.

Jim Boyle describes the major problems long term Workcover recipients seemed to experience. These were:

- Lack of support for people and their families.
- Weekly payments which were less than unemployment benefits.
- Weekly payments arriving up to six days late.
- Reimbursement for medication/treatment costs taking up to three months.
- People not having their rights and entitlements explained.

There were many other smaller problems experienced by the Workcover recipients that collectively caused undue stress, and added to the original injury.

Some of the people had sent letters and approached various government ministers about these problems. They felt that the people they had approached had thought that they were a minority and would go away if they were ignored.

A more formal approach was made to the local Health and Social Welfare Council's executive officer. A small action group was formed to investigate how widespread the problems really were. The group was expanded fairly tentatively because of fears of official repercussions: some posters were put up in the waiting rooms of local physiotherapy and advertising.

Ten people turned up to the meeting and a group formed with the aims of:

- Getting some changes made within the Workcover system.
- Starting a support group to help Workcover recipients.
- Changing the public's attitude towards people on Workcover.

Healthwise (a previous version of *Talking better health)* was then used to isolate common issues and to develop priorities for these issues. A vision of a better Workcover was developed and strategies to achieve this vision were formed.

Ref: Boyle, J. Workcover - life's easier on the dole. (1993) In P. Butler & ?· Cass (eds). Case *Studies in Community Development ,n Health* Melbourne, Centre for Development and Innovation in Health. pp 145-152

The strategies for contacting other people and developing a sense of common interest and common purpose will tend to be different given the situation in which you find yourself. This includes the particular health problem, the experiences of the people who share that problem, and the level of confidence everyone has about their ability to change things and get things done.

If you are in the role of the initiator, you will probably get other people involved by persuasion, exhortation and by the example of your own efforts. Getting people together to discuss a common issue is a bit like throwing a rock into a pool of water. Near the impact of the rock the ripples are strong but small; further out the ripples are much wider but also weaker. Closer to the centre, there tends to be a smaller number of people but their commitment is strong, whereas further away, more people may be involved, but their involvement may be less.

If you are a worker, it is useful to encourage members of the group to take a leadership role. This enables the group to become more self-sufficient and not reliant on the input from you.

Talking better health is about developing a shared understanding of the health issues being addressed, and working towards cooperative and group action.

A tivity

What are some of the possibilities which exist in your current situation for you to use *Talking better health?* Discuss this in small groups. What would you need to change in your situation to incorporate more of the ideas of *Talking better health?* What is possible in the short, medium and long term? Develop an action plan in small groups.

Planning to use *Talking better health*

When thinking about using Talking better health, and bringing this approach to health issues into your own practice, you need to address a number of issues. These are really to do with the situation in which you are operating. Your situation will go a long way in determining what you actually do. The big question is whether the activities which you plan and the strategies you use are appropriate to the issues being addressed and the people with whom you are working.

To get an understanding of your own situation, we find it worthwhile to address the following questions:

Who?

Who are the people you intend to work with using the Talking better health approach?
Do you know them?
Do they know each other?
Are there more people who might be interested?
How can you let these_people know?

How?

What structure is going to be used?
Are people going to meet as a formal group?
Will it be less formal with the techniques of Talking better health being used as a way of exploring and dealing with issues as they arise?

Where?

If there is a group, where will it meet?
Is the place comfortable and accessible to the people with whom you are working?

When?

When are you going to use Ta/king better health?
Is it a convenient time for the people with whom you are working?
If you are meeting formally, have you planned how many times and when you will meet?
Does the time mean that you have to do anything special such as provide childcare?

Why?

Why are you using Talkingbetterhealth at this time?

Do the people involved already have similar concerns?

Answering these questions tends to limit the options of *what* you are going to do.

What?

What are you going to do when you meet?

What are the sequences or steps you are going to take?

Which parts will you initiate?

Which are left open to other people?

DIARY

Activity

People are divided into five smaller groups. Each takes one of the five components of Talking better health:

1. **Building the group.**
2. **Sharing personal experiences and identifying common issues.**
3. **Reflecting on and analysing these issues.**
4. **Planning for action.**
5. **Implementing the plan.**

What are the criteria you would use for developing and choosing appropriate activities? Do they differ from those which are provided in the manual?

Think of some activities which you would do in that stage. What are the advantages and disadvantages of each of the activities you thought of? Keeping in mind the people with whom you are likely to be working, which activities are most suitable?

As a whole group, share the activities you have thought of. This will give each person a large pool of activities from which to choose when you are incorporating Talking better health into your work.

Adivity

Talking better health - thapter review

+ t mpl4e te for ea,h set of a,tivities +

Whal adlvllles were undertaken?	*How were the adivltles undertaken?*	*Wiiy were Ibey under· tafcen in the way they were?*

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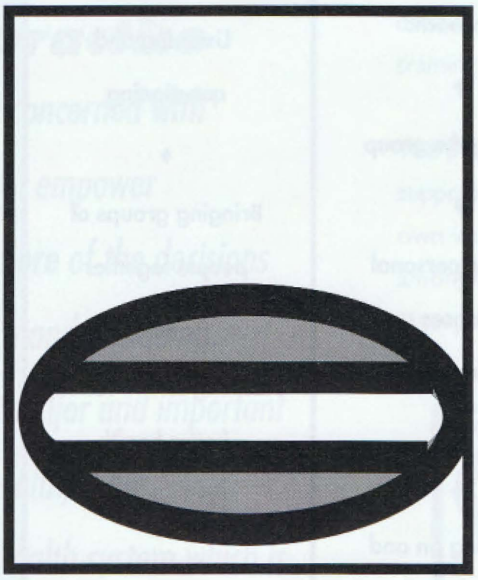
DAY 3



Changing pra,t,,e and evaluating the tra1n1ng

• *Talking better health* · Training Timetable •

MiE1fNG DAY 1	DAY 2	DAY 3
Introduction and overview of the training course • Group building. (This will not be treated as part of the program on day 1) • The philosophy of *Ta/lcing better health* • Different situations: different meanings • Telling stories • Small stories, big i;,ictures	The five 'steps' of the *Ta/lcing better health* approach: • Building the group • Sharing personal experiences and identifying common issues • Reffecting on and analysing these issues • Planning for action • Taking action	Leadership redefined • Listening and questioning • Bringing groups of people together • Planning lo use *Ta/lcing better health*	Changing practice • Evaluating the training course • Future planning

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Chapter 4
Day 3

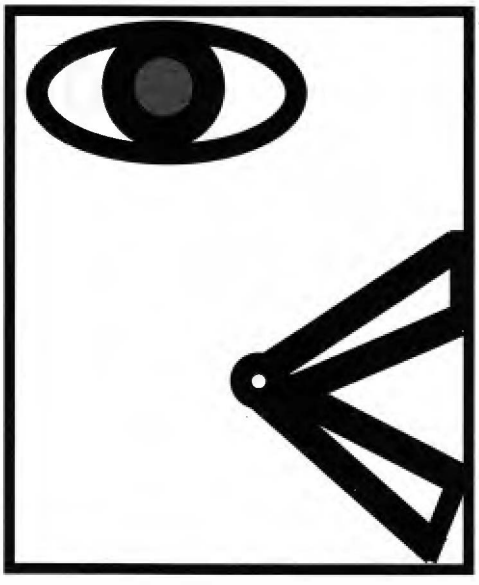
Changing practice

Talking better health is concerned with change. It is designed to empower communities to make more of the decisions which affect their health and wellbeing. People can bring about major and important changes in their own health, their environment, and the health system which is designed to serve them. Talking better health works from personal narrative about and direct experience of health to bring about change.

The training program too is designed to help people make changes in their own practice. It does this by providing an overarching philosophy, an organising framework, and a set of strategies to use with other people.

The approach to health which **Talkingbetterhealth** represents presents a challenge to the conventional health system and practices and is not universally accepted. We have found that many people who have undertaken the **Talkingbetterhealth** training sometimes find it difficult to implement the approach in their own settings. This tends to occur for a number of reasons. Some individuals and organisations are not sympathetic to the community's involvement in health decision making. Structural and systemic barriers can exist which make it extremely difficult for people to participate in the decisions which affect them and their communities. People who have been involved in the training course sometimes see the task as too big and they don't quite know where to start. Others find it difficult to translate the ideas and strategies of the training into their own settings.

The purpose of the third day of the training is to support participants in using **Talkingbetterhealth** in their own work. The purpose is also to share experiences among the group of ways in which people have incorporated the approach and strategies in their work.



People have used **Talking**better **health** in many ways. The various case studies suggest some approaches which have either used **Talking**better **health** or other strategies which are consistent with those given in the manual.

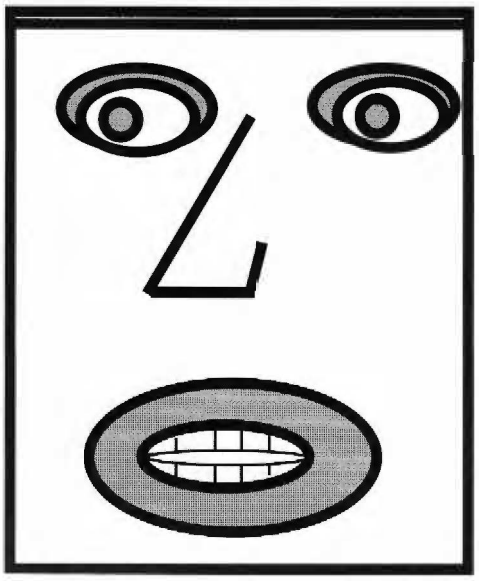
There has been some effort not to prescribe the ways in which **Talkingbetterhealth** should be used. People who have completed the training will use the approach to suit their particular needs and circumstances. This is one of the strengths of **Talking**better **health.** The flexibility of the approach does, however, place somewhat of a burden on those people who are in a leadership or facilitating role. Facilitators are required to make an assessment of the people with whom they are working. On the basis of this assessment they must choose or develop appropriate strategies which suit the group and the health issues which are of concern. This is not always easy and can be a daunting task.

Many people begin in quite small ways. For example, some workers used **Talkingbetterhealth** as a professional development tool with colleagues and linked it into a strategic planning exercise. Using some of the techniques with other workers was seen as less threatening.

Other people have used the approach as a means of undertaking community consultations around a specific and preset agenda such as the type and style of services which should be provided for older members of a rural community. These consultations were held in day centres and senior citizens clubs. Each consultation took approximately two hours.

A more'"extensive use of **Talking**better **health** was with a number of groups of HIV+ gay men who wanted to provide mutual support for each other. This took the form of regular groups which met over many months.

Talkingbetter **health** can accommodate this diversity. The third day of the training is designed to canvass



some of the ways in which people have used the philosophy, framework and techniques of **Talkingbetter health.** The methods used in this third day are the same methods we have used to explore other issues during the course of the training. Participants will be asked to tell stories about how they have implemented **Talking**better **health.** Ideas should be grounded in real events rather than abstractions.

The following questions are crucial:

+ **What did you do?**
+ Where **did you do it?**
+ **How did you do it?**

These questions can lead on to:

+ **What was** the effect of **what you did?**

On the basis of these stories, we can begin to reflect on and analyse the broader issues. This can lead to the question:

+ Where **might you go from** here?

Telling stories and reflecting on the issues does not have to be confined to discussions. For example, resistance to change may be one of the key issues to emerge. As a way of reflecting more deeply on this issue, groups may devise role plays which look at the variety of creative ways people use to resist and sabotage change. This could be done in pairs or in small groups.

Many of the techniques described in Chapter 2 can be used in this part of the training course. The philosophy and framework of **Talking better health** and the training course come full circle.

Evaluating the training ourse

As mentioned at the beginning of this manual, **Talking better health** and the training course have changed and developed over quite a number of years. It is likely that **Talking better health** will continue to develop as the context of primary health care changes and the insights which we have about health in general change.

An evaluation of the training course makes a useful contribution to the development of both **Talking better health** as a whole and of the training course itself. Evaluation in this context is directed towards improvement of the training course.

Feedback will occur naturally as part of the training course when participants make comments about the various activities or the structure of the days. This gives valuable information to the person who is running the course so that they can fine-tune the program to ensure that it meets the needs and interests of the .particular group of participants.

It is useful at the conclusion of each segment of the training for the whole group to reiterate *what* the activities were, *how* they activities were undertaken and *why* the activities were chosen and pursued in the way they were.

At the conclusion of the training course, a more formal evaluative 'snapshot' of the participants can be undertaken. Over the page there are some questions that may be useful as a structure.

Name:
Organisation:
(optional)

+ **Why did you undertake the Talking better health training course?**

+ **What were your expectations of the training?**

1.

2.

3.

+ **Were your expectations fulfilled?**

Not at all

A little

A great deal

The training course

+ **Did you find the format of the training course:**

Very useful

Quite useful

Not very useful

Can't say

Example:

+ **What would you change:**

+ **Did you find the content of the training program:**

Very useful

Quite useful

Not very useful

Can't say

Example:

+ **What would you change:**

+ **Do you have an intsntion to use aspects of the training course in your work?**

A lot

Some

A little

Can't say

Example:

+ **What would you change to make the program more applicable?**

+ **How did you find the facilitation of the course?**

1 2 3 4 5

Poor Excellent

photocopy

The Manual

+ **Have you had a chance to read the manual?**

Yes/No

+ **Did you find the format of the manual:**

Very useful

Quite useful

Not very useful

Can't say

Example:

+ **What would you change:**

+ **Did you find the content of the manual:**

Very useful

Quite useful

Not very useful

Can't say

Example:

+ **What would you change:**

+ **Do you have an intention to use aspects of the manual in your work?**

A lot

Some

A little

Can't say

Example:

+ **What would you change to make the manual more applicable?**

+ **Do you now lee/ equipped to introduce thel'alking better health approach into your work?**

A lot

Some

A little

Not at all

Can't say

+ **What other support would you need to implement Talking better health?**

Barriers and Helpers

+ **What are the barriers to using Talking better health in your work place?**

+ **What helps you to use Talking better health in your work place?**

+ **Would you recommend that colleagues or people in your situation undertake the Talking better health training?**

Yes/No

DAY 3

Conclusion

As on overview of the training course, it is useful to look at both the limitations and the benefits of Talking better health.

This manual provides participants in the Ta/king better health training course and the general reader with a philosophy for working on health, a framework for organising activities, and a range of strategies. The strategies, philosophy and framework are combined in social action. Without a philosophy and a framework, the strategies are tools without application. Without the philosophy, the framework and strategies are not meaningful; and without the framework, the philosophy and strategies lack organisation and context.

It is hoped that Talking better health will contribute to people having more of a say in the decisions which affect their wellbeing and health.

Benefits of Talking better health	*Limitations of Talking better health*
• The approach helps to structure thinking and clarify processes.	• It is not a panacea for social change.
• It provides a framework for change which incorporates social factors affecting people's health.	• It can be manipulated to achieve predetermined outcomes.
• Health is viewed from a holistic social perspective.	• It is not a neat package - it requires local interpretation and creative facilitation.
• The training course clearly specifies the philosophy and principles upon which the program is based.	• It looks easy but requires skilful leadership.
• The course and manual include practical strategies for community participation and development.	• Facilitators can be seduced by the dynamics of the strategies and lose sight of the purpose and principles of the approach.
• These strategies are an effective way of building a coherent group and exploring health issues even if they do not produce community action.	• We can sometimes get stuck into reflecting on our own experiences and forget to address social action.

Talking better health is an approach to dealing with health. It builds on people's own experiences, sharing what is common and listening to what is different. *Talking better health* helps to locate people's experience within the bigger social and health pictures to try to find ways of exploring strategies for action.

Talking better health is an approach to community development in health; it is an essential tool in primary health care. *Talking better health* takes a sequential approach which is based on story-telling:

- Everybody has direct experiences of health and illness, of seeking health care (and of caring for others) and of trying to stay healthy. These experiences provide the basis for developing the 'big picture'.

- People make sense of these experiences by talking about them.

- Telling their own stories in a group can lead people to discover similar issues and identify with each others' experiences. Gradually the separate stories merge into a shared picture of problems and possibilities.

- Shared stories provide common ground upon which communities can plan for and take action which will lead to better health. The action can be at the personal, community, institutional or political levels.

Talking better health is presented as a training course which is structured around the sequence of telling (and listening to) stories, developing a sense of the big picture, planning and taking action. The training course works through a number of techniques and small group exercises which can be used in facilitating this kind of developmental sequence.

This manual is the record of the training course.

Participants in the training course have the opportunity of working through the *Talking better health* approach to community development and of acquiring the various group skills which may be used.

Participants include primary health care workers who are interested in applying community development strategies in their work or people who are interested in community or consumer health issues and are looking for ways of taking more effective action for change.

The *Talking better health* training course normally runs for two and a half days.

The training course aims to:

- Introduce the Talking better health approach to community development and the specific small-group techniques and strategies that can be used to facilitate this approach.

- Enhance the participants' skills of working with groups, listening and questioning.

- Develop participants' confidence in the use of story-telling as a starting place for learning about health issues; as a strategy for building consensus and a shared commitment within diverse groups; as a way of testing possible strategies for action; and as a means of reflecting on our own practice and learning collaboratively from that.

- Assist participants in applying the Talking better health approach and the small group skills across a variety of purposes and settings.