CHAPTER 1:

PEOPLE, PLACE, HEALTH: CONTEXTS FOR RESEARCH AND ACTION.

Chapter one introduces readers to the contextual setting, players and theoretical bases for the research foci, methodologies and argument.

Indigenous Territorians are suffering poor health in its broadest definition; physically, socially, emotionally and culturally (National Aboriginal Health Strategy, 1989; Harris and Richardson, 1994; Ring and Firman, 1998; Australian Institute of Health and Welfare, 2000; Condon, Warman and Arnold, 2001). Poor food and nutrition are significant contributing factors (Lee, 1992; National Health and Medical Research Council, 2000; Rae, Hobson, Priestly and Mackerras, 2001). A broad picture of health services in the Northern Territory (NT) is presented. Indigenous community workers and community nutritionists are striving to improve the health and wellbeing of the
population together. The chapter reviews relevant theoretical frameworks and models for health promotion action and indigenous health research that guide the efforts of these partners and this research project.

The context – people, place, poor health and health services.

In 1994, the 200 participants of an Indigenous nutrition workshop in the NT recommended that: more community based nutrition workers and nutritionists be employed to work in Aboriginal and Torres Straight Islander communities (Strong Together Committee, 1994). These recommendations were supported by considerable community consultation undertaken to develop the NT Food and Nutrition Policy (Territory Health Services, 1996a). As a result the THS Food and Nutrition policy set a target for the employment of 20 trained Community Nutrition Workers (CNWs) within 5 years. In addition, 20 women were employed as Strong Women, Strong Babies Strong Culture (SWSBSC) project workers (SWWs) in 8 communities between 1995-97. Both groups are supported by nutritionists and SWW Coordinators. This thesis is a story about these partners, their work and relations and some of the important lessons learnt over 25 years of action.

People and place

In 1996, 51,900 Indigenous Aboriginal people lived in the Northern Territory (NT), representing 28.5 percent of its population and approximately 13 percent of the total Australian Indigenous population (Australian Bureau of Statistics, 1997). Seventy five percent of Indigenous Territorians live mainly in remote communities of 2000 people or less, some out-station camps and cattle stations, 25 percent live in one of the 5 main

Indigenous Territorians are generally young, 38 percent being aged 0-14 compared with 22 percent of other Territorians and 21 percent of the general Australian population (Australian Bureau of Statistics, 1998b). Twenty one thousand, seven hundred Indigenous Territorians live in the “Top End” or northern half of the NT extending south to Daly Waters, east to Queensland border, on Islands in the Gulf of Carpentaria, west to the Western Australian border and north into Islands in the Arafura sea. The Indigenous Territorians maintain strong cultural identity and links. They rarely move interstate compared with the non-Indigenous population, including health professionals, who are highly transient.

**The burden of poor health**

The National Aboriginal Health Strategy provides an Indigenous definition of health as

>a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self esteem and justice ...health is not just the physical wellbeing of the individual, but the social, emotional and cultural wellbeing of the whole community

(National Aboriginal Health Strategy, 1989: ix)
The wholistic focus of this definition is supported by the World Health Organisations (WHO) similarly broad definition of health a complete state of physical, mental and social wellbeing (WHO, 1978).


Indigenous Territorians are now more likely to survive childhood then suffer an exceptionally high burden of chronic disease as they age (Weeramanthri and Clark, 2001). They develop chronic diseases (renal disease, diabetes, hypertension, ischaemic heart disease and chronic obstructive airways disease) at much younger ages than other Territorians and Australians, experiencing rates similar to those non indigenous people 10 to 20 years their senior (Dempsey and Condon, 1999). Circulatory disease is the major cause of death. The incidence of end stage renal failure in Indigenous Territorians has been doubling every 4 years from 1984 to 1996 (Spencer, Silva, Snelling and Hoy, 1998). Indigenous Australians are 2-5 times more likely to develop Non Insulin Dependent Diabetes than non-Indigenous Australians, having the forth highest rate in the world (International Diabetes Institute, 1996).
Substance misuse, poor nutritional status and environmental condition’s are the major direct causal factors of the ill health of Territorians which are underpinned by many complex underlying causes (Condon et al, 2001). The food and nutritional factors will be comprehensively detailed below. Indigenous communities still face many significant challenges in environmental health conditions; adequacy of housing, sewage and waste disposal, safe water, power and supplies and vector control (Tardrew, Schobben and Standen in Condon et al 2001). They experience the negative effects of tobacco, alcohol, cannabis, petrol sniffing and kava misuse with much greater personal, social and economic costs than experienced by other Australians (Crundall, Richards, Measey, Townsend, Trevena-Vernon and Neill in Condon et al 2001).

Personal Lifestyle choices resulting in poor eating habits, smoking and excessive alcohol consumption are themselves the result of the complex interaction of people within their physical, social and cultural environments (THS, 1995a). Indigenous Australians have experienced immense change and shock since the European invasion and dispossession of their land. The general social determinants of health are well documented (Wilkinson and Marmot, 1998; Marmot, 1999). These include the direct effect of social gradient, stress, the effect of early life, work, social exclusion/isolation, unemployment, addiction, limited food supply and transport systems. The sociocultural and economic marginalisation of Australian Indigenous peoples is unequivocally recognised as being the major antecedent to their poor health status (Australian Bureau of Statistics, 1995; Miller and Torzillo, 1996; Mathews, 1998; Deavitt, Hall and Tsey, 2001). Historical dispossession and disempowerment underpin this phenomena (Mobbs, 1991; Deavitt, Hall and Tsey, 2001). Tilton’s (2001) historical analysis of Aboriginal health demonstrates its multi dimensional nature. He proposes:

the changing patterns of Aboriginal health arise from changes in the relationship between Aboriginal people and the non – Aboriginal settlers; changes in
Aboriginal peoples ability to control their own lives, land and health; and changes in Aboriginal peoples access to health services and the nature of those services

(Tilton, 2001:143)

Poor food, nutrition and its significance to health

Access to a safe and adequate food supply is one of the basic requirements of life. Humans eat food not just to nourish themselves. Eating is intrinsically a social and cultural activity. The beliefs, rituals and activities surrounding the collection, preparation, distribution and consumption of food can carry great significance both traditionally and as part of more contemporary Indigenous culture (Mills and Ryan, 1995; NHMRC, 2000). Food is medicine for Indigenous Territorians (Personal Communication Devanesan, 2001). Food and health are big business, big business is political (World Health Organisation, 1998). Inadequate and unbalanced dietary intake is one of the major risk factors for premature mortality and morbidity in Australia (Upston and Woods, 1992). A conservative estimate of the cost of diet related morbidity and mortality for the NT in the 1989/90 financial year was between ($AUS) 41 to 67 million (Gough, 1995). This is equivalent to between one fifth to one third of the total NT government budget. Indigenous Territorians experience over and under supply of food and have an increasingly more sedentary lifestyle. Both malnutrition and obesity can be experienced in the same family. *Their diet barely meets survival needs and provides few options for better health* (Lee, 1992 in THS, 1996b:1).

The rapid historical transition of the diet of Indigenous Australians from a nutrient dense varied diet to a generally energy dense, nutrient sparse one has had a serious impact on the health of this race (NHMRC, 2000). Lee, Bailey, Yarmir, O’Dea, and Mathews papers provide striking examples of the nature and nutritional inadequacy of dietary intakes of
Indigenous Territorians living in remote communities via store turnover methodology and regular community health screening (Lee, 1987; Lee, Bailey, Yarmir, O’Dea, and Mathews, 1994; Lee, O’Dea and Mathews, 1994). This work identified that on average Indigenous Territorians consume 50% of their energy from 3 foods; Beef, white flour and sugar. Average fat intake is in the vicinity of 37 teaspoons (148 grams) per day and sugar intake 50 teaspoons (250 grams) per day, vastly exceeding recommended amounts for adults (Lee, 1992). They ate on average only 0.5 medium piece (72 grams) of fruit and 0.3 cup (62 grams) of vegetables per day compared with recommended core food group quantities of 300 (2 pieces) and 350 grams (approximately 2 cups or 5 serves) per day respectively (Cashel and Jefferson, 1993).

Social, socioeconomic, geographical, environmental and factors influence food availability and cost for Indigenous Australians (NHMRC, 2000:2). All Territorians are heavily dependent on imported food (Rae, Hobson, Priestly and Mackerras, 2001). Remote Territorians generally put up with a limited, inequitable and often unreliable and poor quality supply from a very small number, or only one, outlet. Availability of fresh fruit and vegetables generally decreases with increasing distance from NT urban centres. On average only 7 types of fruit and 12 kinds of vegetables were available from the 45 remote community stores surveyed in 1998 (THS, 1998a). This report also identified that people could have paid up to 70% more for these items than if they brought them in southern capital cities. The fact that people are forced to pay these exorbitant prices for food when the majority are only receiving social security benefits further disadvantages their ability to eat enough good food to promote good physical health and wellbeing.

The first week of the new millenium was “off pay” or “milo” week for many Indigenous people living in remote communities in the Northern Territory (NT) of Australia. “Milo” means “miola” which in Aboriginal language means “nothing”. Milo week means “nothing week” … no money, no tucker (Mills and Ryan, 1995). Most of the fortnights
social security payments would have been spent, so by this time people often only had money for a small amount of basic foodstuffs, were relying on "bookup" credit at the local store or were going hungry. Desperate, hungry people might steal something to eat. In February 2000 a young man was sent to prison for 1 year for stealing biscuits and cordial on the previous Christmas day because he was hungry. Just the week prior to this a 15 year old boy hanged himself whilst in jail. This example demonstrates the consequences of hunger in a desperate, seemingly hopeless and hostile environment can be deadly serious.

Aboriginal women of child bearing age in the Top End are much more likely to be malnourished and produce babies with low birth weights (Rae, 1989; Sayers and Powers, 1997; Mackerras, 1998). They are also more likely to experience anaemia during pregnancy, 18.9 percent as opposed to 3 percent in non-Indigenous Territorians in 1995 (Markey, d’Espaignet, Condon and Woods, 1998) and at rates of up to 41 percent in some communities (Makerras, 1998).

In October 1999, 22 percent of rural Aboriginal children under the age of 5 years old who participated in the growth assessment and action program were defined as not growing well (THS, 1999b). This means they were either wasted, stunted or both as defined by having Z scores of more than -2 standard deviations compared to the mean of the American National Centre for Health Statistics data set for their age and sex (THS, 1999b). This compares with an expected prevalence of 3 percent of children in a normally distributed population of children growing in optimal conditions (Hamill, Drizid, Johnson, Reed, Roche and Moore, 1979; Beaton, Kelly, Kevany, Martorell and Mason, 1990). During the early 1990s, strong evidence emerged of the link between chronic diseases like Non Insulin Dependent Diabetes Mellitus, hypertension, cardiovascular disease and renal disease in later life and foetal and infant nutritional status via the ground breaking work of Professor Barker and colleagues (Barker, 1994). Locally, research in the
NT has also linked these low birth weights with a higher risk of renal disease later in life (Hoy, Kyle, Rees and Mathews, 1998).

Screening for anaemia in remote areas of the NT over 1995–1998 indicates that around half of the children under 5, and 22 to 44 percent of children 6-11 years are anaemic (d’Espaignet, Kennedy, Paterson and Measey 1998; Kruske, Ruben and Brewster, 1999). Iron deficiency increases a child’s risk of experiencing delayed intellectual and physical development, can result in poorer education outcomes in the longer term (Lozoff, Jimenez and Wolf, 1991) which ultimately contributes to the excessive burden of ill health experienced by these people.

Lee and colleagues identified that 40 percent and 63 percent of adults had greater than recommended levels of serum triglycerides and total cholesterol respectively (Lee et al, 1994). In the 1994 National Aboriginal and Torres Straight Islander survey, most indigenous people in the Katherine region were measured and 14 percent were underweight, 38.4 percent acceptable weight and 47% were overweight or obese (Australian Bureau of Statistics and Aboriginal and Torres Straight Islander Commission, 1997). In comparison 55% of Australians were overweight or obese in the 1995 National Nutrition Survey (Australian Bureau of Statistics and Department of Health and Family Services, 1997).

At the beginning of a new millennium, Indigenous Territorians are still paying an unacceptably heavy personal price in the form of poor physical and emotional health for the impact of colonisation. They deserve preferential support to remove the imbalance and enjoy a better state of health comparable to other Australians. This thesis will go on to explore, amongst other things, some of the efforts being made towards this goal.
A picture of health services

The political and social contexts in which health services are provided are in a constant state of change; locally, nationally and internationally. In the 1990s interest in health outcomes and evidence based medicine has emerged all over the world as health services adapted to the need for accountability in the face of escalating costs. Rapidly advancing medical technology is giving more choices and posing more dilemmas (Harris and Richardson, 1994). Health services are required to critically examine the way they provide services, and to deliver high quality, integrated, customer focused services, which maximise health outcomes in a cost effective manner. There is increasing focus on the privatisation and outsourcing of health services traditionally operated by government departments.

The Northern Territory Government, through it's department, Territory Health Services (THS), was responsible for the provision of comprehensive primary health and medical services via a network of remote and urban Community Health Centres and hospitals to the majority of the NT population. In late 2001, its name was changed back to the NT Department of Health and Community Services (NDHCS), the title it previously held up until 1996. The THS and NDHCS acronyms are both used in this text depending on the year the activity in question was undertaken. Its remote facilities are staffed by registered nurses and/or Aboriginal Health Workers, the occasional resident doctor and a network of visiting support staff and specialists. Numbers of non-government health service providers in the NT have been rapidly increasing (Connors, Woodhouse, Tilton and Cleary, 2001). They are developing as a result of both Indigenous peoples desire and organisation for self determination (Tilton, 2001) and government priorities to privatise service delivery (Territory Health Services 1999c). Figure 1 – A Map of Health Services in the Northern Territory 2000 (following page) shows the distribution of health service provision at that time. By 2001, 45 percent of Indigenous Territorians were being serviced by Indigenous health organisations in Central Australia, with the numbers being less and unquantified in the Top End (Tilton, 2001).
Figure 1 – Map of Health Services in the Northern Territory 2000

(THS, 2000a)

Health districts

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Frameworks for action to improve health inequities and outcomes

Solutions to Indigenous health problems are multi dimensional (Tilton, 2001). Good medical care cannot prevent most of the major current causes of death for Indigenous Territorians. It can improve its management, severity and rapidity of consequences but services are still not provided at adequate levels (Deavitt, Hall and Tsey, 2001:17). Communities and individuals need access to services that will assist them to address non medical problems, often beyond the reach of the health sector. Efforts must consider health issues in the wider context of community life and encouraging positive aspects of old and new indigenous lifestyles. (National Aboriginal Health Strategy, 1989; Spark, 1991; Mathew’s, 1991). It is now well recognised that all these services and programs need local control and action to address locally identified problems and solutions (Scrimegour, 1997). Ultimately, policies and action to improve health need to address the social determinants of health (WHO, 1998).

Primary health care (PHC) is the system model approach that was adopted by the World Health Organisation (WHO) in 1978 (WHO, 1978). It focuses on key values of the right to health and equity in health, community responsibility, community participation, system support, political and societal commitment and inter sectorial collaboration. Over time, Australia became signatory to the Ottawa Charter (WHO 1986), and other World Health Organisation health promotion policy documents; the Liverpool Declaration on the Right to Health (WHO Healthy Cities Project, 1988), the Sunsvall Statement on Supportive Environments (WHO, 1986) and the Jakarta Declaration on Health Promotion (WHO, 1997). The latter sets out 5 priorities for the 21st Century around the key themes of social responsibility, investments for health development, partnerships, community capacity and securing infrastructure. More recently the WHO has released its global strategy for the prevention and control of non communicable diseases (WHO, 1999).
The THS Aboriginal Health Policy (THS, 1996b) and Aboriginal Public Health Strategy (THS, 1997b) provide frameworks for action based on the WHO policy documents preceding them. The THS Aboriginal Public Health Strategy is aimed at providing staff with a framework for planning and strengthening public health activities, programs and services. It advocates partnerships with the community, non-government agencies, local government councils and departments to increase community control, build and coordinate capacity for health improvement and implement healthy public policies and legislation.

The goals of the THS’s corporate plan ‘Strategy Twenty First Century’ include increasing the Indigenous workforce and strengthening community capacity (THS, 1999c). Smoking, alcohol misuse, poor nutritional status and environmental conditions, the major direct causative factors of ill health, are the priorities for public health action (THS, 1999a). The THS Preventable Chronic Disease Strategy has identified a number of nutrition related “best buy” interventions for prevention and minimisation of the impact of these diseases (THS, 1999f). These include improving maternal health to improve infant birth rates, the promotion of child growth, nutrition, and physical activity and weight loss programs in high risk populations.
Frameworks for improving food and nutrition action

National, state and territory food and nutrition policies and plans provide the framework within which the nutrition workforce can sustain the relevance, efficiency and effectiveness of their work (Carter, 1993). Whilst the majority of this project was undertaken by the Commonwealth Department of Health, Housing and Community Services (DHHCS), National Food and Nutrition Policy (1992) directed action at the national level. Similarly the Northern Territory Food and Nutrition policy 1995-2000 directed action at the local level (THS 1996a).

The national policy aimed to improve the health and reduce the preventable burden of diet related early death, illness and disability among Australians (DHHCS, 1992: 3). It was explicitly built upon the values of social justice with regard to expanding choices and opportunities of all groups to improve the food supply and system and quality of life. It recognised that coordinated effort was required, seeking participation and support across the food and nutrition system and the wider community. One of its 4 policy objectives recognised and targeted the special needs of Aboriginal and Torres Straight Islander peoples.

The 1995 Northern Territory Food and Nutrition policy aimed to ensure that all Territorians have access to enough good quality food and information to improve their nutritional status and health (THS, 1996a). It had four priorities for action;

- Improve the quantity, quality and affordability of the food supply in remote Aboriginal communities.
- Encourage public and commercial food services to adopt nutrition policies consistent with the Australian Dietary Guidelines and the Core Food Recommendations.
• Increase access to nutrition education in the Territory for consumers, educators, health professionals and for training the nutrition workforce.

• Develop a food and nutrition information system to monitor changes in the food supply and nutritional status of Territorians.

These policies have been recently replaced by Eat Well Australia (Strategic Inter Governmental Nutrition Alliance, 2001) at the national level and the Northern Territory Food and Nutrition Policy and Strategic Plan 2001-2006 (THS, 2001b). The updated policies build upon the priorities and achievements of their predecessors with changes focused by new evidence and the evaluation of previous actions. In addition, the importance of strategic action to improve the health of Indigenous Australians has been recognised with the implementation of a National Aboriginal and Torres Strait Islander Nutrition Strategy and Action plan (NATSINSAP) 2000-2010 (Strategic Inter Governmental Nutrition Alliance, 2001).

Indigenous Territorians have been working in the food industry since their land was explored and invaded. During the mid 1990s they are employed in stores, market garden projects, running meals on wheels and children’s meal programs. Very few are employed in planning and managing food and nutrition systems in the NT (Mills and Ryan, 1995). Until the early 1990s, few had been employed in specialist food, nutrition and health education roles. In 1994, however, the 200 participants of an Indigenous nutrition workshop in the NT recommended that; more community based nutrition workers and nutritionists be employed to work in Aboriginal and Torres Straight Islander communities (Strong Together Committee, 1994). These recommendations were supported by a considerable amount of comment arising from the community consultation undertaken to develop the NT Food and Nutrition policy (THS, 1996a). As a result the THS Food and Nutrition policy set a target for the employment of 20 trained Community Nutrition Workers (CNWs) within 5 years. Interim targets included the employment of 8
Community Nutritionists to work with at least 10 part or full time Indigenous Community Nutrition Workers/ Advisers (CNW/As) in 9 remote rural communities by July 1997. In addition, 20 women were employed as Strong Women, Strong Babies Strong Culture project workers (SWWs) in 8 communities between 1995-97. The Strong Women Workers are supported by Aboriginal Coordinators and nutritionists.

Introducing the local nutrition workforce

Community Nutrition Workers (CNWs) work with their own communities to promote and facilitate the communities’ aspirations for better food, health and well-being, wholistically. They do things like running cooking sessions, taking people hunting for bush foods/medicines, sharing stories about food, culture and health and working with the store management and staff to market healthy food choices in the store. It also includes evaluating and reporting on key indicators as determined by the community in conjunction with local health staff. Again it is noted that remote Indigenous “communities’ are new settlements created post colonisation (Lea and Wolfe, 1993) and “may consist of a whole set of intermeshing communities and factions”(Stanner, 1968 cited by Lea and Wolfe, 1993:3).

The community nutrition advisers (CNAs) are trained Aboriginal Health Workers who specialise in food and nutrition action. Besides undertaking roles similar to the CNWs, CNAs provide more specialised support to people with chronic disease or other health problems at health centres and in the community. They also have a more extensive role as advisers and teachers to many other health professionals.

Strong Women Workers (SWWs) are community based workers employed specifically to provide culturally appropriate health care, advice and support to women before, during and after pregnancy. The program has a strong focus on nutrition and personal hygiene due to
the nature of health issues of pregnant indigenous women in the NT (Fejo and Rae, 1996). Strong Women Coordinators (SWCs) support and train community based workers, promote the Strong Woman, Strong Babies, Strong Culture program to other staff and the wider community in the NT but also nationally and internationally.

The role of Community Nutritionists as outlined in the Job and person profile is;

In partnership with CNWs, communities, government and non government service providers, and other health professionals, and using primary health care principles:
- promote and facilitate the improvement of community knowledge and skills in nutrition
- assist in the development, implementation and evaluation of culturally acceptable community nutrition plans and activities
- assist Aboriginal communities to improve their access to and the cost of their local food supply.
- provide orientation, intensive support and training at community level for CNWs and Strong Women, Strong Babies, Strong Culture project Workers.

(THS, 1998 d and e.)

The social relations between these groups within this complex environment give impetus to this current research project. It generated a desire to tell a story about these partners, their work and relations and some of the important lessons learnt over 25 years of action and also, to help them improve their interactions promoting health gains.
Appropriate research and health promotion methods

Research is an integral part of a primary health care approach to health promotion (WHO, 1991; Wass, 1994). Quality health services demonstrate the active participation of communities and practitioners in relevant research (Baum, 1996; NHMRC, 1997).

Planning appropriate research into Indigenous health issues

_The framework, the cultural, and philosophical value system within which the research is conceived, designed and conducted comes into question in the cross cultural situation and deserves examination._

(Garrow and Colin, 1994:20).

Historically, extensive research has been conducted into the health status and problems of Indigenous Australians, predominantly by non Indigenous people (Waterford, 1982; Mathews, 1998). Minority and Indigenous communities the world over are suspicious of research endeavors based on past negative experiences of its processes and negligible outcome benefits to their communities (Mathews, 1998; Trudgen, 2000; Humphery, 2001; North American Primary Care Research Group, [NAPCRG], 2001). The practise of research in Indigenous settings is inextricably bound with the historical progression of colonisation (Humphery, 2001). It is highly problematic (Mathews, 1998; Humphery, 2001).

The development of research guidelines for Indigenous health has attempted to deal with some of these problems. The National Health and Medical Research Council Guidelines (NHMRC) concerning Aboriginal and Torres Straight Islander health research (NHMRC, 1991) were considered in the development of this proposal. The guidelines cover key areas of Indigenous participation and control, use of culturally sensitive methods, focus on research that meets community identified needs and benefits and ownership and
control of outcomes. But ethical guidelines cannot guarantee quality research practice (Humphrey, 2001). Scrutinizing of the methods of research inquiry in planning, implementing and evaluating work is a function of any good research project.

With the benefit of fifteen years experience leading initiatives in Indigenous Health research in the NT, John Mathews advocates a number of priorities for researchers (Mathews, 1998). Two of his recommendations which are particularly pertinent to this project include finding better ways of working across cultural boundaries and ensuring that existing knowledge is taken up and acted upon (Mathews, 1998:626).

**Participatory action research theory**

Participatory action research (PAR) encompasses action research and the principles of community development (McTaggart, 1993). It is a cyclical, reflective, action orientated process that provides a framework for implementing the values and fundamental action advocated by the Declaration of Alma Ata (WHO, 1988) and the Ottawa Charter for health promotion (WHO, 1986). It incorporates planning and evaluation being conducted simultaneously, by a variety of stakeholders, and recognises the fundamental importance of the links between theory and practice (Carr and Kemmis, 1986; Foot-Whyte, 1991; Winter and Munn-Goodings, 2001). Learning occurs through emergent and iterative processes (Dick, 1999). Wadsworth provides a diagrammatic model for a participatory action evaluation research process (Wadsworth, 1997: 117) and summary of McTaggart's fundamental principles of PAR (McTaggart, 1989 cited by Wadsworth, 1997: 79). These are attached as Appendix A and B respectively.

PAR has a humanistic basis, requiring what Reason and Bradbury (2001) describe as an *emergent participatory worldview* (xxiii) whereby the development of knowledge occurs through the development of relationships and dialogue. Firstly, it attempts to demonstrate
an awareness and respect for the integrity of individuals (Meyer, 1993). Secondly, researchers and participants must acknowledge their differing values but work together in partnership (Wass, 1994), sharing the decision making and action. Collaboration, education and action are key elements providing a framework from which to respond to health issues within a social and historical context (North American Primary Care Research Group (NAPCRG), 2001:4). Theory development is dependent on the meanings and interpretation placed on them by participants (Gaventa and Cornwall, 2001; Kemmis, 2001).

PAR involves bi directional, or two way learning processes, whereby researchers and community participants learn from each other and together to develop shared understandings. It is consistent with education for the development of critical consciousness as advocated by Friere (1973) (Zuber-Skerritt, 1990; George, Green and Daniel, 1996). This technique should serve to maximise socio-cultural sensitivity and outcome benefits. It strengthens the capacity of individuals, groups and communities to do their own research and undertake sustainable action to improve health after the initial project has finished (NAPCRG, 2001). Thus, PAR can be emancipatory, serving to assist people to overcome oppression, promote socioeconomic development and improve health holistically (Zuber-Skerritt, 1990, George, Green and Daniel, 1996; NAPCRG, 2001).

Many of the strengths of PAR outlined above have their own potential weaknesses. Rhetoric surrounds some of the key principles underlying PAR especially when you enter the cross-cultural realm. In reality it can be difficult to implement (Webb, 1989, Brady, 1990; Meyer, 1993; Green, George, Daniel, Frankish, Herbert, Bowie and O’Neil, 1995; NAPCRG, 2001) Problems include intra personal issues, barriers to collaboration and participation and the division of responsibility for achieving goals and outcomes (Winter, 1989; Street, 1995). Historical manifestations of power differentials across cultures and between dominant and marginalised groups can manifest as conflict in attempts at PAR
(NHMRC, 1997). Unresolved conflict generally diminishes participation. Green, George, Daniel, Frankish, Herbert, Bowie and O'Neil (1995) have developed a set of guidelines and categories for classifying participatory research protocols in health promotion (reproduced in NAPCRG, 2001). Essentially, quality is demonstrated through increasing levels of participation in decision making and action, and it provides criteria against which to critique the extent to which this research project’s processes and outcomes align with the principles of participatory research.

Many have acknowledged the relevance of PAR for research into Indigenous health improvement nationally (Houston and Legge, 1992; Colin and Garrow, 1994; NHMRC, 1997; Angus, 1999) and internationally (Green et al, 1995; NAPCRG, 2001). The rise in its popularity and use has been attributed to the increasing autonomy of Indigenous peoples (NAPCRG, 2001). Garrow and Colin explicitly describe the relevance of a participatory action research for Indigenous health promotion projects:

> It recognises the centrality of Aboriginal participation in the project as well as the evaluation. It enables Aboriginal intentions for the project and Aboriginal monitoring of the project to be part of the evaluation. It allows for reflective process whereby method and practise can be developed and improved by reflection. The evaluation assists in modifying and improving the delivery of the health promotion project

(Garrow and Colin, 1994:3).

They adapted Wadsworth’s more detailed model for use in evaluating the Mai Wiru program for the Nganampa Health Council in 1993 (Colin and Garrow, 1996). Figure 3 is the English version of their model. This simplified model was considered more appropriate in the traditional western sense for use in the context of this project, where many participants have limited literacy skills. This research project put this model to the test.
Figure 1.2  Colin and Garrow’s Action Research Evaluation Map for Aboriginal Health Projects 1996.

Our Questions might be...
what do we think of this?
how do we think it’s going?

Reflect, Watching and thinking as you go along ...

Look for answers.. agree on a plan of how to find answers..

Gather information; Watch, listen talk measure, write it down

What does this mean...? Think carefully about what the information means, come to decisions

Keep on going.... Keep watching and thinking as you go along

Feedback and Report.... tell participants, the community, the health service and project founders what you found out

Adapted from Wadsworth (1991).

Lessons from participatory action research with Indigenous Australians

A limited number of PAR projects involving Indigenous Australians had been documented prior to the commencement of this research project (Brady; 1990; Garrow, 1991; Dawson, 1993; Fejo and Rae, 1996). Two of these projects focused on food and health issues for Indigenous Territorians (Garrow, 1991; Fejo and Rae, 1996). Their work provides many recommendations for other groups embarking on PAR projects. Consistent themes abound; the importance of personal relationships with Indigenous people, the
pivotal role of Indigenous co-researcher/s and Indigenous leadership and a strong commitment cooperative action.

Garrow (1991) and Dawson (1993) both concluded that the formation of longstanding personal relationships was significant in facilitating open, detailed discussion on issues and provide shared knowledge of examples, events, concepts and language to demonstrate meaning. Both advocate the need for research to be undertaken over an extended period of time. Firstly to assist in the development of relationships and to allow research activities to be undertaken flexibly and opportunistically within the demanding realities of peoples lives and responsibilities. The Yuendumu Women’s Centre aged care team, from Central Australia, worked within a PAR model over a 4 year period. They emphasised the value of continuous spiral of PAR working with the priority issue of the time. At times their priority issues seemed distinct from their broader and longer term aspirations for their program but over time they managed to achieve many of these through the nature of the process (Personal notes from Very Very Remote Allied Health Conference, 1997). Dawson (1993) also supports this notion.

Garrow (1994) reinforces the crucial and pivotal role of the Indigenous co researcher in facilitating participation of Indigenous people and the development of respectful two-way learning processes. The need for strong Indigenous leadership is again exemplified in the Strong Women, Strong Babies, Strong Culture project (Fejo and Rae, 1996). Lorna Fejo, a Wuramunga woman, collected a wealth of community specific information prior to developing the project. Her traditional knowledge, experience and the high respect in which she is held enabled her to identify and appropriately link common themes of information from a variety of traditional and contemporary Aboriginal and scientific viewpoints. Her pioneering work was initially enabled and facilitated through the work of a senior nutritionist, Cheryl Rae. She convened an Indigenous steering committee, then stepped back and continued to support Lorna and the women’s convictions about how the
project should develop. Though not planned and documented as PAR, it followed the PAR approach. It has been deemed successful from both Aboriginal and non Aboriginal perspectives (Fejo and Rae, 1996; Mackerras, 1998).

Brady had a less positive experience with the use of PAR. She believed this occurred because a primary requirement was lacking; a degree of cohesion amongst participants (Brady, 1990). She encourages people to consider that Indigenous Australians are not homogeneous population, with many geographically close groups being traditional adversaries in competition for limited resources. She suggests researchers should consider the existence of historical conflict when contemplating using PAR in a situation.

Since the inception of this research project many more PAR projects have been undertaken into the health issues of Indigenous Australians (Salisbury, 1997; Angus, 1999; Kerdel, 1999). The lessons of concurrent and subsequent efforts will contribute to the discussion of outcomes from this research project.
Storytelling

children, before they can read, before they can engage in more technical rational
learning activities, learn their basic values and basic approach through stories in
the very early years of their lives. .... we find this goes way beyond their childhood
and people are masterful in their ability to tell stories and they are full of subtlety
and depth and incredible complexity, but they can be told very simply

(Community Development Resource Association, 2001)

Storytelling is a key communication mechanism in traditional and contemporary
Indigenous Australian culture (Edwards 1994; Newman, Acklin, Trindall, Arbon, Brock,
Bermingham and Thompson, 1999). Storytelling is much more than just a method of
information sharing. As Frank Spry, an Indigenous Health promotion officer says:

Aboriginal people have relied on story as an important and fundamental part of
life, culture and maintenance of society. The passing on or handing down of
important information about society and culture is one of the examples of the
functions of story. Story is about; who tells the story, how you tell that story, when
you tell that story, why you tell that story, who you tell that story to, where you tell
that story and what that story is about

(Fry cited in THS, 1997b: 8)

Storytelling is a culturally and theoretically accepted mechanism for research and health
promotion with Indigenous Australians (Weeramanthri, 1996; Newman, Acklin, Trindall,
Arbon, Brock, Bermingham and Thompson, 1999). Storytelling has been used very
successfully locally (Fejo and Rae, 1996) nationally (Commonwealth Dept of Health and
Family Services, 1996, Newman et al, 1999) and internationally (Community
Development Resource Association, 2001) as key methodology in Indigenous health

J Priestly  Chapter 1: People, place health: contexts for research and action. 35
promotion programs. Storytelling in health promotion usually involves a range of media. It can be verbal, via paintings, music, other art forms or a combination of these. Storytelling for health promotion in the NT often includes pictures, photographs, painting and diagrams that are regularly recorded in the form of storybooks, posters and/or video film. A resource entitled *Sharing Good Tucker Stories* was produced as a national resource for Aboriginal and Torres Straight Islander communities (Commonwealth Dept of Health and Family Services, 1996).

Storytelling processes can be facilitated in such a way as to encourage the development of shared understandings and respect (Territory Health Services 1999d). It can be used to clarify and acknowledge people’s pre-existing knowledge and values which Weeramanthri (1996) believes is fundamental prior to commencing any health improvement action planning. Evaluation of the NT Good Tucker Workshop, 2001 noted that participants repeatedly mentioned that they enjoyed sharing and hearing other people’s stories (NT Good Tucker Workshop, 2001). Many “storybooks” have been developed and implemented as educational resources for food, nutrition and health programs in the NT including the *Strong women, Strong Babies, Strong Culture Storybook* (THS, 1996e) and the *Store book* (THS, 1997g). The NT nutrition team are very familiar and comfortable with the use of such resources to stimulate discussion and share information. These brightly coloured, predominantly pictorial A3 sized resources are highly portable and easy to use. Writing is minimised, being replaced with message concepts portrayed with familiar local images, photos, drawings and symbols. These attributes capture people’s attention and help the messages transcend language and literacy barriers to some degree. Facilitative storytelling with the use of such resources is a means of sharing knowledge, developing partnership opportunities and collaborative, cooperative and supportive actions. Unfinished stories have been used as evaluation tools of projects such as the Diabetes Story project on the Tiwi Islands (Kitasaka, 1992). As
such story telling can and has been an integral process in PAR and strengthening capacity in the local environment.

**Capacity building to improve health**

During the course of my professional work I became aware of the emerging theory of capacity building for health improvement and was struck by its applicability as an analytical tool for aspects of this research. Capacity building is an emerging approach in community development and health promotion theory and practise; internationally, nationally and locally (Goodman, Speers, McLeroy, Fawcett, Keleger, Parker, Rathgeb-Smith, Sterling and Wallerstein, 1998; Hawe, King, Noort, Gifford and Lloyd, 1998; Kaplan, 1999; THS, 2000c). It is being implemented by development and service organisations and various levels of government locally, nationally and internationally in its broader manifestations (Funnel, 1998).

The origins of capacity building are somewhat obscure, emerging in international health promotion literature in the early 1990s (Kaplan, 1999). Nationally and internationally much discussion and debate has occurred defining just what people mean by capacity building in health promotion. Capacity building as a concept has different meanings for different people. Various definitions exist (Goodman et al, 1998; Hawe et al, 1998). All indicate that capacity building is multi-dimensional, complex and dynamic. It incorporates community development, organisational development and adult learning theories. Common characteristics include knowledge, skills, infrastructure, systems, resources, partnership, networks, leadership and the mobilisation of these characteristics or “assets” towards common goals of social and health improvement. It is a developmental methodology that promotes both positive interaction and interdependence (Kaplan, 1999) and develops independence (Eade, 1997). Various models exist including the *NSW Health Framework for Building Capacity to Improve Health* (NSW Health,

For the purposes of this work the following, commonly accepted definition and model of capacity building by the Australian health promotion practitioners Hawe, King and Noort will be used:

*Capacity building to improve health is an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over*

(Hawe, King and Noort, 1999:1).

Their work, is presented in Figure 1.3 The New South Wales (NSW) Health Department *Capacity Building Framework* (following page).
This model indicates the need to develop an integrated mix of strategies operating at a number of levels of health and broader community systems. They believe that movement from building infrastructure capacity towards building capacity for problem solving involves the relinquishment of control and power by the practitioner (Hawe et al., 2000:8). In other words it encourages the reorientation of health services. They have identified 4 key principles that must exist to underpin effective practice in capacity building:

- Respect and value pre-existing capacities of participating individuals and groups
- Activities must be grounded in the particular context of the situation and how it can and does change over time.
• **Effective strategies are multi dimensional and integrated, working at a number of levels with different people depending on the aims and objectives desired.**

• **Capacity building focuses on using a range of developmental processes relevant for the particular context at particular point in time.**

( NSW Health, 2001:4-5)

As with PAR, equality, empowerment and the positive use of power are values, which must be demonstrated to underpin the development of relationships for effective capacity building (Skinner, 1997 cited by Bush, 1999; Goodman, Speers, McIeroy, Fawcett, Kegler, Parker, Rathgeb Smith, Sterling and Wallerstein, 1998). From chapter 2 onwards the term “strengthening capacity” as opposed to “building capacity” will be used except when referring to specific theoretical descriptions. This is intended to more adequately acknowledge and respect the underlying principle that all people have pre-existing capacities from which they contribute and develop, a point that Lea and Wolfe (1993) note is an important starting point for community development planning. The term “strengthening capacity” is favored by local health promotion professionals and appears in formal THS documentation (THS, 1999c and 2000c).

The practical relevance of this theory to food, nutrition and health promotion efforts is now well identified. Eat Well Australia (SIGNAL, 2001), the National Aboriginal and Torres Straight Islander Nutrition Strategy and Action plan 2000-2010 (NATSINSAP, 2001) and the Northern Territory Food and Nutrition Policy and Strategic Plan 2001-2006 (THS, 2001b) have very clear emphasis on capacity building for health improvement.
Summary

Indigenous Territorians suffer very poor health. They deserve preferential support to enjoy a better state of health, comparable to that of other Australians. Indigenous Territorians want to work to improve food, nutrition and health in their communities. Community Nutrition Workers, Strong Women, Strong Babies, Strong Culture Workers and Community nutritionists are working together towards this aim.

Participatory action research, storytelling and strengthening capacity for health improvement are mutually supportive research and strategic health promotion methods in this context. They are all built on fundamental principles of authentic participation, collaboration and learning in a particular context. Participatory action research and storytelling have been used in Indigenous food and health projects most successfully with strong Indigenous leadership and participation. Therefore, it is appropriate that this project should use these methods, building on the lessons of earlier efforts. A model of capacity building to improve health provides a strong, relevant framework with which to analyse the strengths and weaknesses of food and nutrition action in the NT over the last 25 years.
CHAPTER 2: 
MAKING AND WORKING THE RESEARCH PLAN

This chapter details the goals of the original participatory action research (PAR) plan, then presents and discusses the actual course of the research. It has been written to provide the detail to enable the reader to clearly audit the project’s decision and action trail, thereby demonstrating the reliability, replicability and credibility of the research process (Appleton, 1995).

The first section making the plan details the processes that lead to the development of the original research objectives and plan. Like most participatory action research the actual processes and outcomes are somewhat different from the original plan. Some readers might define this as the difference between the idealism of plans and the realities of practise. The project metamorphasised into three research activities; a consultative and participatory action research process and two qualitative research activities. Reasons for the deviation from the original plan, the 3 activities undertaken and their interrelationships, are summarised in the second section working the plan. Part A outlines the processes employed in collecting and discussing nutritionist’s reflections on working with Indigenous community based workers and promote the development of Indigenous community food, nutrition and health programs generally. Part B documents the cyclical
action research processes involved in the development, implementation and evaluation of
the facilitative storybooks; *Sharing Stories about Seasons and Seasons for Workers* and
the *Good Stew, Good Project Storybook*. Part C details the processes used to produce a
historical summary and critique of the strengths, weaknesses and gaps in nutritionist’s
efforts in strengthening capacity for health improvement from 1974-2000.

*Making a plan*

Many commentators acknowledge research cannot be neutral and advocate that the
intentions of action researchers must be openly clarified as part of the research process
(McNiff, 1988; Meyer, 1993). I openly acknowledge my interests in undertaking this
work are both personal, professional and altruistic. My primary personal motivation was
to improve my professional competence, confidence and satisfaction. The achievement of
an academic qualification that would improve future employment opportunities was
another goal. But ultimately my primary professional motivation stems from a desire to
help improve the lives of fellow Australians, to feel I could help to make a difference.
This is not something achieved by individuals working in isolation. Therefore the primary
focus was to facilitate practical, professionally and ethically sound activities with other
nutritionists and their Indigenous partners to improve interactions, competence and
confidence which might ultimately contribute to better Indigenous health outcomes.

The preliminary development work for this project was conducted during 1996 and early
1997. The initial project concept was discussed with 5 CNWs that attended a planning
workshop in September 1996. The author visited each CNW/A and community
nutritionist across the NT to discuss the initial project concept and development process
as they recommended (Fieldwork diary, November 1996). Support for the project was
obtained from the Acting Director of the Food and Nutrition (policy) uni, and the

*J Priestly  Chapter 2: Making and working the research plan.*

All nutritionists agreed that the work could be very useful and that local Indigenous workers must choose an Indigenous coordinator/s to work on the project. They said this person should have demonstrated competence working cross culturally with professionals, ideally on health issues (Fieldwork diary, December 1996). The newer nutritionists expressed a real urgency for process guidelines and tools. One Strong Women Coordinator said that it should not be called a project, there are too many projects. people get confused and it is seen as something that is part of our everyday work together (Personal communication Hampton, 1996). Lorna Fejo, NT Coordinator of the Strong Women, Strong Babies, recommended my preliminary work on a basic, more generally accessible PAR model should be continued as it is easy for Aboriginal people to understand and fits in well with many traditionally important concepts (Personal communication Fejo, 1996). She felt the Strong Women Workers should also be involved and volunteered to co facilitate a workshop with all the SWW’s, CNW/As and Nutritionists which was held in mid April 1997. Attendance was thirty five which included all but 2 workers and the Nutrition Manager. The women expressed a need for “user friendly training, orientation and support guidelines that cover empowerment and the fact that we have a structure” and “they should not be restrictive, but help us deal with problems that come up” (Fejo and Priestly, 1997). They discussed the proposed PAR model presented. Most questions and comments pertained to the identification of Indigenous coordinator/s, which was deemed to be the crucial factor in ensuring the project would be culturally appropriate and successful. They identified a selection panel representative from each district to interview the 2 women from the group who expressed interest in the position.
Consultation with other groups of key Indigenous stakeholders was also conducted. An Aboriginal Advisory committee was established to provide broad Indigenous leadership for food and nutrition priorities and action in the NT over the life of the to the NT Food and Nutrition Policy Project 1995-2000 (THS, 1996b). I presented the modified action research methodology of Colin and Garrow (1994) to this group in July 1996 (THS, 1996c) to ascertain their views on the suitability of the model for use in nutritionists work supporting Indigenous community nutrition projects. The committee endorsed and strongly supported its use in CNW projects. They particularly liked the cyclical style of the model, which related well to traditional concepts of the cycle of life (THS, 1996c). Five Aboriginal Health Promotion officers from across the NT were consulted regarding the project concept and process. All expressed their support and offered suggestions to strengthen the proposed process. They suggested that Health Promotion Incentive grant funds be sort to facilitate participatory project activities, which were used for the Side by Side workshop in April 1997(Fejo and Priestly, 1997).

As a result of these consultation processes an original project plan was developed. This plan proposed to use participatory action research (PAR) methodology to improve CNWs, SWWs and Nutritionists ability to perform their work. Its objectives were to improve knowledge, skills and personal confidence in facilitating and supporting community nutrition strategies through storytelling, workshops, support visits and the production, use and evaluation of:

- a guide for professionals, mainly Nutritionists, supporting the establishment, development and evaluation of community based Nutrition Worker Projects.
- a kit of useful process ideas, tools (checklists, session outlines, posters, stories, games) and a list of other useful resources to help communities establish and develop community based CNW and SWW projects.
An Indigenous co researcher/s and I were to facilitate the PAR process. This included the collection, collation and analysis of information, providing support to the participants and developing appropriate guides and tools and progress reports. The original PAR cycle and the general project information sheet are attached as Appendices C and D. This project was to be run from July 1997 to December 1998.

The research proposal considered the requirements of the National Health and Medical Research Council Guidelines concerning Aboriginal and Torres Straight Islander health research (National Health and Medical Research Council, 1991) and Territory Health Services Privacy Code of Conduct (Territory Health Services, 1996b). Three different levels of consent forms were incorporated; one for CNWs and Nutrition team staff, a Community Agreement form and a Personal agreement form for community participants. Potential benefits, risks and risk management strategies were detailed extensively in the applications for ethical approval. Potential risks anticipated included cross cultural and other power issues, for example insufficient control of project process and outcomes by Indigenous participants. Others included the identification of interpersonal conflict or bringing to light sensitive information. Also, operational demands limiting time for project work and participant concerns regarding the use of information collected were also recognised as potential risks. Mechanisms to monitor and act on any harm that may result from the project were planned. Applications seeking permission to undertake this research were submitted to the University of Western Sydney Human Research Ethics Committee in April 1997, and the combined Territory Health Services/ Menzies School of Health Research Ethics Committee in September of 1997. Approval was subsequently granted (Approval Numbers 97:05 and 97/46 respectively).

The Public Health Operations North Manager and Nutrition Manager identified operational budget efficiency savings to employ both the author and an Indigenous co researcher for a period of 5 months in 1997, in recognition of the perceived value of the
project. Two districts provided $5000 funding for the Side by Side workshop in April 1997 via a Health Promotion Incentive Fund grant.

Working the plan

Major changes, new directions and their antecedents

As McTaggart (1993) comments the cyclical nature of action research recognises the need for action plans to be flexible and responsive given the complexity of the real world. A number of issues arose that had a major impact on the research process necessitating significant changes to the original research plan. These issues were the inability to secure funds to employ an Indigenous co researcher; significant staff turnover, vacancies and movement of staff in nutritionist positions; the commencement of the health promotion Bush Book project, development of a local policy focus on capacity building and my own changing employment circumstances.

The inability to secure funds to employ an Indigenous co researcher shifted the focus of the project from a predominantly cross cultural participatory action endeavour towards a more reflective review of the practises of NT nutritionists via qualitative research and consultative action research activities. Workforce issues meant funds allocated to enable me to work off line on the project and the employment of the Indigenous co researcher, had to be redirected. Public Health Services, Operations North made an application to the Cooperative Research Centre (CRC) to fund the employment of a part time Indigenous Co researcher in late May 1997. It was not successful. Similarly an application for a Commonwealth Rural Health Support Education and Training grant in 1997 was unsuccessful. It was deemed ethically inappropriate to ask an Indigenous colleague to assist in pursuing the project in addition to their normal workload for no personal gain.
(Fieldwork diary, November 1997). Also, I was seconded to management positions over the majority of the study period, spent many months working on the Katherine Flood Recovery process in early 1998 and had 12 months maternity leave in both 1999 and 2001-2002. These circumstances limited the opportunities to redirect the activities to working with a stronger community project focus. These issues tend to highlight the complex requirements of commitment, expertise and resources in research of this kind.

Significant turnover, vacancies and movement of staff in Nutritionists positions limited the availability of nutritionists to participate in participatory action research processes during 1997-98. The THS organisation and workforce underwent considerable change and stress. Twelve people were employed in 7 nutritionists positions in the Top End over this period, often only 50 percent of positions in each district were filled. The author was seconded to act as Nutrition Manager over this period and was acutely aware of the additional pressures on the remaining professional and Indigenous staff, CNWs and SWWs (Fieldnote diary, November 1997). Recruitment, orientation and support for nutritionists and CNWs facilitating the development of community nutrition projects were high priorities.

The Public Health *Bush Book* project, a large well funded multi-disciplinary initiative commenced in 1996. This project aimed to develop a comprehensive “toolkit” to meet a generally expressed need to support and strengthen public health practice in community settings to strengthen community capacity and achieve better health outcomes (THS, 2000d; 2000e). As that project developed into 1997, I came to realise that that project could potentially meet many of the expressed needs of the nutritionists and CNWs.

Indeed, the NT nutrition workforce became heavily involved in activities to develop both the general public health volume (THS, 2000e) and the specialist food and nutrition facts, approaches and stories segments of this resource (THS, 2000g). It was not appropriate for this research process to duplicate the activities and potential outcomes of the *Bush Book*.
project. Instead, the focus shifted towards developing and implementing tools that met more immediate needs; encouraging the development of strong cross cultural partnerships and community development processes in the early stages of community nutrition and SWSBSC project development and implementation. This lead to the development of the two storybooks to facilitate inter and intra cultural problem based learning and action.

Other activities were conducted in association with the research project but mainly as part of the authors professional role as manager of nutrition services in the Top End over 1997 and 1998. These included an activity based orientation program for nutritionists (Priestly, 1998a), and workshops to develop a set of Top End nutrition team values (THS, 1998c) and document empowerment promotion strategies (THS, 1998d). A discussion of these processes and outcomes is beyond the scope of this thesis and therefore is not included here.

During the late 1990s an increasing focus on capacity building for health improvement developed both nationally and locally. The THS Strategy 21st Century (THS, 1999c) prioritised strengthening community capacity as one of its four stretch goals for the following 3 years. The other stretch goals were; a quantum shift to service delivery by others, a significant increase in Aboriginal Involvement in the health workforce and total health solutions through intersectoral collaboration (THS, 1999:7). I identified an opportunity to analyse the historical development of nutrition services in relation to the growing body of scientific literature that was detailing and arguing capacity building aimed at health improvement. This process would allow the lessons of the past to be framed within the context of current theory and generate ideas to inform future actions.

In short, and in retrospect, it could be said that the original project plan was too optimistic and idealistic, being firmly based in the rhetoric of participatory action research models. The contextual realities meant that the actual project processes were less participatory and much slower than originally planned.
Concurrent and interrelated research endeavours

The project metamorphised into three concurrent research activities, each using sub methods essentially of a qualitative nature. Each part involved varying degrees of consultation with and participation from nutritionists and Part B also involved consultation with Indigenous health professionals and community based workers as this and the following chapters will outline in detail. Part A outlines the qualitative research processes employed in collecting and discussing nutritionists and nutrition managers reflections on attempting to work side by side with Indigenous community based workers and promote the development of Indigenous community food, nutrition and health programs generally. Part B documents the consultative action research processes involved in the development, implementation and evaluation of the facilitative storybooks Sharing Stories about Seasons and Seasons for Workers and the Good Stew, Good Project Storybook. Part C details the qualitative processes used to produce a historical summary and critique of the strengths, weaknesses in nutritionists’ efforts in strengthening capacity for health improvement from 1974-2000.

Each part is summarised in Figures 2.1, 2.2 and 2.3 below. The format of Part B, the action research cycle was developed and modified from traditional models (Wadsworth, 1997; Colin and Garrow, 1994) during this activity. Each figure is accompanied by a discussion detailing aspects of the qualitative sub methodologies, decision making and tools employed. For the sake of consistency the same headings are used to present summaries of the various aspects of the qualitative research in Parts A and C as in the consultative action research cycle presented in Part B.
Although each of the research cycles is presented as separate entities below they are closely interrelated; informing and complementing each other. The information collected from interviews in Part A informed the search for data via historical records and literature and contributed materials for the discussion in Part C the historical analysis. Part A interview outcomes also informed the action that took place in Part B by contributing to the list of particular "ingredients" for strong community projects in the Good Stew, Good Project Storybook in Part B. The Part B Seasons Storybook development process contributed an additional step in research Parts A and C; Sharing the Work Story. Each activity complements the other by providing perspectives on different issues involved in the development and delivery of nutrition services in the NT. The micro community level issues are collected and presented in Part B with the development of the Good Stew, Good Project Storybook. Part A focuses on organisational level workforce issues. Then the systemic development of nutrition services is incorporated in Parts C and B covering both historical analyses and contemporary action to develop standard process guides. Thus the outcome of these complementary relationships is a comprehensive qualitative analyses of service issues culminating in action efforts to improve cross cultural understanding and action.
FIGURE 2.1 | PART A
Nutritionists reflections on working in partnership to strengthen capacity in indigenous food, nutrition and health.

<table>
<thead>
<tr>
<th>Watching, listening and thinking</th>
<th>March 1996-June 1997</th>
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<tbody>
<tr>
<td>♦ Investigation of participatory, qualitative and indigenous research issues, methods and tools</td>
<td></td>
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<tr>
<td>♦ Fieldwork diary commenced Sept 1996</td>
<td></td>
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<tr>
<td>♦ Preliminary consultation with key stakeholders re project concept and process (n=25) Sept 96 – March 97</td>
<td></td>
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<tr>
<td>♦ Identification of key issues of concern to stakeholders via discussions and Side by Side Workshop April 1997</td>
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<tr>
<th>Making a plan</th>
<th>February 1997-Sept 1997</th>
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<tbody>
<tr>
<td>♦ Development of research plan and proposal</td>
<td></td>
</tr>
<tr>
<td>♦ Draft plan submitted to stakeholders, supervisors for comment, modification and endorsement</td>
<td></td>
</tr>
<tr>
<td>♦ Research proposal submitted to University and local ethics committees</td>
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<tr>
<th>Working the plan</th>
<th>December 1997 - November 2002</th>
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<tr>
<td>♦ Design and trial questionnaire on 3 nutritionists, Dec 97-April 98</td>
<td></td>
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<tr>
<td>♦ All NT community nutritionists working in NT over 1997-1999 offered an interview, including those in management and other positions</td>
<td></td>
</tr>
<tr>
<td>♦ Interview nutritionists and transcribe outcomes</td>
<td></td>
</tr>
<tr>
<td>♦ Enter into Qualitative data management package NU,DIST</td>
<td></td>
</tr>
<tr>
<td>♦ Analysis of themes and relationships between them</td>
<td></td>
</tr>
<tr>
<td>♦ Summarise, discuss and critique results in thesis chapters 4 and 5</td>
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<tr>
<th>How is it going?</th>
<th>December 1997- November 2002</th>
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<tr>
<td>♦ Record of nutritionists and personal reflections into fieldwork diary</td>
<td></td>
</tr>
<tr>
<td>♦ Verbal feedback to nutritionists at annual NT nutrition workshops 1998, 2000 and other opportunities</td>
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<tr>
<th>How can we do it better next time?</th>
<th>May 1998- November 2002</th>
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<tbody>
<tr>
<td>♦ Record of nutritionists and personal reflections into fieldwork diary</td>
<td></td>
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<tr>
<td>♦ Modification of original questionnaire after trialed implementation with first 3 respondents – May 1998</td>
<td></td>
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<tr>
<td>♦ Compilation of personal reflections for thesis</td>
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<td>♦ Reflection in comparison with literature</td>
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<tr>
<th>Sharing the work story</th>
<th>March 2000- June 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>♦ Annual reports to university and 2 ethics committees</td>
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<tr>
<td>♦ Presentations as above to NT Nutritionists/Dietitians nationally</td>
<td></td>
</tr>
<tr>
<td>♦ PowerPoint presentation to Nutrition and Physical Activity (Funding) unit for corporate memory and distribution</td>
<td></td>
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<tr>
<td>♦ Compilation of thesis – distribution post assessment</td>
<td></td>
</tr>
<tr>
<td>♦ Summary papers to be submitted for publication post assessment including local nutrition and chronic disease networks, professional and health promotion periodicals</td>
<td></td>
</tr>
<tr>
<td>♦ Thesis to be offered to Cooperative Research Centre for Indigenous and Tropical Health for publication as plain English</td>
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Associated literature research activities

Literature reviews were used to inform all steps of the research process. The search for relevant literature to inform the many stages of the cycle began with the author’s knowledge of existing literature on similar research activities and searches of THS library and professional collections. It was expanded using electronic health and social sciences database searches and internet searches on related topics or organisations for example, the National Indigenous Health Clearing House (NIHCH) website (NIHCH, 2000). Personal contact enriched this process by locating a number of very useful reports that have not been professionally published.

Reflective fieldwork diary

A reflective fieldwork diary was used for a number of purposes. Firstly, it recorded the occurrence and progression of methodological process as they occurred. Secondly, it was used throughout the course of the project to record the ideas and comments of the regular contributors. Finally, it was used to document my own and others ongoing reflections on the activities and issues over time and how these reflections contributed to ongoing action planning and emergent themes for discussion. The explicit field note instructions of Neuman (1992:362) were used to provide analytical direction for defining emerging themes and concepts.

Questionnaire development and implementation

The key issues of inquiry were determined from key themes identified during discussions with stakeholders in the projects developmental “watching, listening and thinking” phase and outcomes of the Side by Side Workshop in April 1997 (Fejo and Priestly, 1997). A
semi structured interview questionnaire was drafted for use with community nutritionists. It included questions covering perceptions of partners roles, knowledge, skills, resources and confidence and workshop on perceptions of what makes the work easier or more difficult/frustrating. This questionnaire was piloted with 3 Top End Nutritionists in December 1997-March 1998. Empowerment emerged as a key theme in these early interviews and fieldwork diary entries. Therefore, an additional question focusing on this subject was added in an updated version of the nutritionists questionnaire, attached as Appendix E.

Long term NT nutritionists felt that the history of the development of nutrition services in the NT could make a significant contribution to this project (Fieldwork diary, 1998). Therefore I made a decision to capture the perspectives of these women and others that had held nutrition management positions, using a separate questionnaire. The questions for this group sought to record significant historical issues and management perspectives on the key themes of barriers and threats, the promotion of sustainability and empowerment. The managers questionnaire is attached as Appendix F.

Sixteen women in total were interviewed for this project. Ten responded to the nutritionist’s questionnaire alone, four to the managers questionnaire alone, and 2 responded to both questionnaires as they had recently worked as both community nutritionists and nutrition managers. Each of these questionnaires were designed with open ended questions in order to allow respondents wide scope with their answers in relation to the issues of inquiry. Both questionnaires sought to record the length and nature of each respondent’s experience to enable more detailed analysis of emergent themes.

All interviews were conducted by myself with each respondent in English, on a one on one basis. Where possible every effort was made to conduct them face to face, however
this was not always feasible, due mainly to financial restrictions limiting travel, and so some conducted by telephone. Face to face interviews were arranged in times and locations to suit the convenience of contributors and maximise privacy. A small number of interviews were rescheduled up to 2 times at short notice to suit the convenience of respondents. Venues included homes of the respondents and author or various workplace locations including outside in gardens. All contributors were provided with a copy of the interview schedule and consent form prior to interview to assist them with personal preparation if desired. Many had made personal notes. The majority of interviews (n=10) lasted between 45 minutes to one hour, the remaining varied from between 25 minutes to one and a half hours. The long term nutritionists spoke at great length. Telephone interviews tended to be shorter in length. Initially the nutritionists interviewed were all from the Top End of the NT. The Director of the Food and Nutrition Unit encouraged me to interview as many nutritionists as possible who had worked in the NT over 1997-98 to maximise the range and credibility of the results (Fieldwork diary, November 1998). Central Australian based nutritionists were actively encouraged to participate, and all did so by phone. With the permission of participants, all interviews were taped onto micro cassette and I made only limited notes during the interview processes in order to actively listen and maintain the flow of the conversation. Note taking was limited mainly to a list of key words and was more extensive for telephone interviews.

Consent and confidentiality

Three different levels of consent forms were incorporated in the original project plan; one for CNWs, SWWs and Nutrition team staff, a community agreement form and personal agreement form for community participants. Due to changes in the project implementation process only the first form was used. It is attached as Appendix G. Sixteen nutritionists (100%) completed forms. Two respondents completed both the
managers and nutritionists interviews as they had recently worked as community
nutritionists. All respondents were asked to indicate if they would prefer to have their
direct or paraphrased comments kept confidential or clearly recognised. Nine indicated
that they wanted their quotes kept confidential (56 percent). Six preferred to have them
directly attributed unless they particularly specified otherwise (38 percent), this group
included the 3 nutritionist managers with over 20 years NT experience. One wanted to be
specifically consulted about source recognition. All Nutritionists were offered the
opportunity to select their own code name.

Participant names were coded in diary entries and typed interview transcripts to protect
privacy and confidentiality. Community names were also coded as Community 1,
Community 2 and so on. Participants were given draft copies of their transcripts. All were
informed of their code names. I transcribed the majority of interview tapes.
Administrative staff bound by THS Privacy Code of Conduct (THS, 1996d) and a private
typist transcribed less than 40 percent of the interviews. The private typist signed a
declaration to ensure her confidentiality before transcribing tapes. Tapes, and copies of
code breaker lists, diary entries and transcripts were kept either in a locked filing cabinet
in the Katherine nutritionists office or in a secure location in the researchers home whilst
on periods of leave. Electronic copies were held at the researchers home.

Final drafts of chapter four and five were forwarded to interviewees just prior to the
completion of the thesis. Respondents were asked to check the context in which any of
their own quotes were used and provide feedback if they felt the conclusions drawn from
the quote were inappropriate. They were encouraged to make any other comments and
particularly constructive criticism.

A decision was made to code all informants names for the quotes appearing in chapters
four and five because the act of identifying 40 percent of the interviewees quotes would
have allowed some readers to correctly recognise the identity of some code names thus breaching confidentiality agreements.

*Data preparation, management and analysis*

A large volume of qualitative information was collected via interviews and field note diary entries over 1997-1999 including interview transcripts in excess of 60,000 words. These were originally transcribed into Microsoft Word 97 files. The NUD.IST qualitative data management package (Version 3) was used to facilitate the sorting and analysis of data and themes from the interviews (Richards and Richards, 1993). A summary of the node “tree” is attached as Appendix H.

Again, Neuman’s fieldnote instructions (1992:362) provide analytical structure to the process of defining emerging themes and concepts. It involves 3 stages of coding. Firstly, open coding of recently collected data to assign themes and secondly axial coding to review the initial codes and ask questions about interaction. Finally, selective coding to look selectively for examples of information that demonstrate themes and concepts, which might guide a researcher’s search. The NUD.IST program was used to organise and review data into these progressive layers of themes which were coded into nodes. Interview data was scrutinized and analysed interactively on at least 9 occasions following the steps outlined below:

1. Transcribing and coding for confidentiality.
2. Identifying and coding for respondents, major themes in each of the key issue into NUD.IST which usually involved reading each interview at least twice (open coding)
3. Checking node (theme) printouts and recording to ensure accuracy of original coding
4. Initial selection of significant quotes from each node
5. Recording for emergent themes was done at least twice for nutritionist’s interviews and three times for the manager’s interviews, for example. Identifying comments relating to appropriate performance indicators (axial coding). Themes were summarised in word documents and I drew rough relational diagrams for the key issues under investigation. This stage included comparing and contrasting the nature and frequency of themes emerging from managers and nutritionists’ group responses. This enabled the development of a matrix of response categories – the outcome of which is presented via the tables included in chapters 3 to 5.


Given the large volume of qualitative data the transcription and analysis process was extremely time consuming. It made a significant contribution to lengthening the duration of the research project.

Specific themes from individual interviews were grouped under common major themes for each question. Results were then summarised in table form. Geertz (1983) believes scholarship should be a continuous dialogue between the most local of detail in comparison with global structure and theory in a way that brings them into continuous view. The analysis process attempted to consider the “thick description” or complexity of an issue presented in the data rather than merely over simplifying it (Geertz, 1983). I achieved this by coding qualitative data under multiple themes depending on the complexity of the issues included in the comments, for example unsolicited comments on performance indicators. Reflection on the themes and the critical inferences made by the frequency or absence of particular comments informed the search for literature to contribute to the verification and discussion of the results. Direct and paraphrased excerpts of transcripts are included to demonstrate explicit and emergent themes, analytical inferences and conclusions.
Promoting reliability and credibility

The interviews followed semi structured questionnaires to promote consistency and were taped and transcribed to promote accuracy and reliability (Appleton, 1995). The accuracy of preliminary explicit and emergent themes and my associated inferences were checked with nutritionists attending the Operations North Nutrition workshop in March 2000 (Priestly, 2000b) and later with 7 Nutritionists who attended presentations on the outcomes in 2001 (Priestly, 2001). These processes provide a degree of member validation (Neuman, 1992) and reinforce the credibility of the findings (Appleton, 1995) because they attempt to ensure the work reveals accurate descriptions of individuals experiences (Sandelowski, 1986). Multiple information sources were used in discussing the results and the conclusions drawn from them. Triangulation was employed to improve the consistency and credibility of the conclusions (Kemmis and McTaggart, 1988)

Potential bias

I was direct line manager for 5 of the 12 nutritionists at the time they were interviewed. I acknowledge this factor may have had an impact on the respondent’s comments particularly in relation to sources of difficulties, frustrations, barriers and enablers. My personal reflections are also included in the data pool as is appropriate with the use of a PAR approach. One of the 2 principal research supervisors is a nutritionist and manager with 25 years experience working in the NT. These associations are declared to indicate potential sources of bias. To some extent the idea of credibility replaces objectivity in qualitative research and simple objectivity is not really considered possible. Collaboration and reflexivity in the PAR approach, however, are designed to balance abundant personal interests (Wadsworth, 1997). Repeated rounds of feedback and cross checking with respondents and supervisors are other examples of processes that were employed in an attempt to minimise bias.
FIGURE 2.2 Part B - Development, implementation and evaluation of facilitative Storybooks; A Story about Seasons for Workers and the Good Stew, Good Project Storybook via consultative action research. September 1997 – January 1999

- Literature research and reflection on related topics including story telling, community development, participatory action research and cross cultural practise.
- Research and consider suitability of other available resources.
- Reflection on themes from personal use of original seasons model and storybook, interviews with nutritionists and field note diary entries.

Making a plan February 1998 - January 1999

- Developed consultation plan for version 2
- Developed implementation and process evaluation plan for version 3.

Working the plan January 1998 to January 1999

- Version 2:
  - Updated original version of storybooks based on process evaluation of original trials and feedback.
  - Trailed Version 2 of storybooks with CNWs on 2 communities as part of normal work responsibilities.
  - Interactive demonstration and extensive consultation with 10 nutritionists and 7 other Indigenous nutrition professionals. March-Nov 1998
  - Presented storybooks to 17 other health/education professionals.
- Version 3:
  - Developed in conjunction with 2 other co authors Dec 1998- Jan 1999
  - Negotiated production and distribution of storybooks, including demonstration training by Food and Nutrition Unit and co authors
  - 20+ copies distributed to all NT community nutritionists (May 1999), NT and Western Australian SWSBSC Workers (September 1999).
  - 3 new nutritionists received introductory demonstrations 2000.

How is it going? March 1998 – November 2002

- Version 2: completed process evaluation forms + fieldnote diary
- Evaluation interview with nutritionists leaving the NT and known to have used the books (n=3).
- Evaluation questionnaires e-mailed to all NT Nutritionists and Strong Women Coordinators September 2001.

How can we do it better next time? May 1988-November 2002

- Suggestions for improvement on version 2 recorded and included in version 3.
- Co-authors review evaluation feedback and develop ongoing implementation plan Nov 2001.
- Compilation of personal reflections in thesis.
- Progress check on this ongoing implementation plan October 2002

Sharing the work story May 2001- June 2003

- One day workshop on empowering partnerships for Dietitians and Indigenous workers nationally at Dietitians Association of Australia 20th National Conference (Priestly and Liddle, 2001).
- Compilation of thesis – distribution post assessment
- Summary papers to be submitted for publication; local nutrition chronic disease networks and health promotion periodicals.

J Priestly Chapter 2: Making and working the research plan.
Associated research activities

The search for historical documentation was informed by the authors knowledge of existing literature on similar local research activities, electronic database searches in health and social sciences and internet searches on related topics or organisations. As with Cycle A, personal contact enriched this process by locating a number of very useful resources that had not been professionally published.

Aims of the storybook development processes

These tools were aimed at helping non Indigenous and Indigenous partners share knowledge from their different worldviews and experiences and work together more constructively to improve health and wellbeing. They are designed to link the development of new knowledge and different viewpoints using analogies to concepts in everyday life that appear in both cultures. This approach is consistent with adult learning (Friere, 1973; Knowles, 1980; Wass, 1994) and Indigenous education theory (Harris, 1976: Trudgen, 2000). *Sharing Stories about Seasons and Seasons for Workers* is aimed at strengthening skills and knowledge in collaborative participatory action research based planning and evaluation. *The Good Stew, Good Project storybook* promotes the development of shared understandings about positive factors likely to improve the success of community health projects.

Implementation and evaluation processes – plans and modifications

I produced both the first and second versions of each storybook then presented them to members of the NT nutrition team. This was conducted mostly by interactive
demonstration; where participants were encouraged to do each of the activities/questions posed in the storybooks. Feedback and suggestions for improvement received during the process was recorded during and/or immediately following each session. Two other people self selected to co-author version 3; Marlene Liddle, Strong Women, Strong Babies Strong Culture Coordinator for Operations North and Vivienne Hobson, Director of the Food and Nutrition Policy Unit. This version was to be implemented and evaluated by the Community Nutrition and Strong Women, Strong Babies, Strong Culture programs across the NT. Comments collected on Version 2 during the consultation processes were combined with co-authors individual ideas to produce Version 3.

In all thirty five copies of both storybooks were produced in April 1999 at a cost of just over $2000 for colour photocopying. Distribution by the Food and Nutrition policy unit (FaNU) occurred from May to September 1999. Top End nutritionists and FaNU staff were sent copies in May as most of them had attended the interactive development sessions of the book. NT and Western Australian SWSBSC workers were introduced to the Storybooks at a workshop in September 1999, by Marlene Liddle, SWSBSC Coordinator and co-author. The other co-author, Vivienne Hobson was to have run a workshop for Central Australian nutrition staff in mid 1999, however this was cancelled as she had to take urgent leave. The Central Australian Public Health Nutritionist was given the task of distributing copies to staff in that region.

Process evaluation was designed and built into version 3 of the storybooks by the co-authors as a way of encouraging and enabling ongoing evaluation of the book. Completed forms were to be faxed back to the THS Food and Nutrition Policy unit. This mechanism of evaluation was being used in a number of other health promotion resources around that time (THS, 1999c and 1999g; NSW Health, 2000). Top End nutritionists had decided that the evaluation forms should be compiled and reported on 6 months following the implementation (Fieldwork diary, 28 November 1998). This did not occur. No evaluation
forms had been returned by the end of September 1999 (Personal communication Hobson, September 1999). Verbal consultation in early 2000 determined that many nutritionists had not used the books very much therefore a planned mail out of an evaluation form was postponed. It was eventually mailed out in September 2001.

The stew storybook was to have been implemented in the evaluation of SWSBSC projects and CNW projects during 1999. I was to have been involved as an adviser in planning and evaluating this process for the purposes of this study but this did not occur. No other specific Indigenous evaluation of the storybooks has been planned or implemented subsequently. The issues created by the inability to facilitate Indigenous evaluation of the storybooks will be discussed in detail in Chapter 7: Critical Reflections; Idealism and Realism.
FIGURE 2.3  Part C The Northern Territory Nutrition team grows stronger 1970-1999; an historical summary and analysis of efforts to build capacity for Indigenous health improvement.

<table>
<thead>
<tr>
<th>Watching, listening and thinking</th>
<th>Jan 2000-August 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♦ Research and reflection on the historical documentation of cross cultural partnerships to promote improved Indigenous food, nutrition and health in the NT.</td>
</tr>
<tr>
<td></td>
<td>♦ Research and reflection on capacity building policy directions and literature 2000-01.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Making a plan</th>
<th>May 1998-Sept 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♦ Questions on historical activities and significant factors contributing to the development of CNW projects included in plan for managers interviews</td>
</tr>
<tr>
<td></td>
<td>♦ Research list developed and added to over time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Working the plan</th>
<th>October 1998 to October 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♦ Interview nutrition managers</td>
</tr>
<tr>
<td></td>
<td>♦ Analyse and reflection on themes from interviews with nutritionist managers regarding historical activities and significant factors in the development of the community nutrition worker projects.</td>
</tr>
<tr>
<td></td>
<td>♦ Compile summary documents – history of nutrition services in the NT and significant factors influencing the development of CNW projects.</td>
</tr>
<tr>
<td></td>
<td>♦ Drafting chapter presenting historical summary and discussing strengths, weaknesses and future challenges using capacity building framework theory and format.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How is it going?</th>
<th>December 2000 to August 2001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♦ Checking accuracy of data and themes; circulated copies of documents to the three nutrition managers with 20+ years NT experience. Feedback from all including comments to improve accuracy of information from two.</td>
</tr>
<tr>
<td></td>
<td>♦ Reflection on capacity building policy directions and literature</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How can we do it better next time?</th>
<th>Jan 2001-November 2002</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♦ Reflection of need to present historical critique and lessons of past against current conceptual models and priorities.</td>
</tr>
<tr>
<td></td>
<td>♦ Drafting chapter presenting historical summary and discussing strengths, weaknesses and future challenges using capacity building framework theory and format.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sharing the work story</th>
<th>August 2001- June 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>♦ Compilation of thesis – distribution post assessment</td>
</tr>
<tr>
<td></td>
<td>♦ Summary paper to be submitted for publication post assessment including local nutrition and chronic disease networks, professional and health promotion periodicals.</td>
</tr>
<tr>
<td></td>
<td>♦ Thesis to be offered to Cooperative Research Centre for Indigenous and Tropical Health for publication as plain English document</td>
</tr>
</tbody>
</table>
Analysis of themes from managers interviews

Interviews were analysed to identify themes using open, axial and selective coding technique of Neuman (1992) and with the assistance of the NUD.IST qualitative data management package Version 3 (Richards and Richards, 1993) as outlined in detail for project Cycle A.

Associated research activities and efforts to maximise accuracy of information

The search for historical documentation was informed by my knowledge of existing literature on local activities, the particular projects and activities mentioned by long term nutritionist managers in their historical reflections and the bibliographies of NT Food and Nutrition policy documents. Where possible every effort was made to verify the accuracy of historical information from at least 2 different sources consistent with the technique of triangulation as a way to enhance the credibility of the data (Kemmis and McTaggart, 1988; Neuman, 1992; Yin, 1994;). Historical workforce information was obtained from managers’ recollections cross referenced with reports where available. The summary of recent workforce statistics was confirmed by email with the Director of the Nutrition and Physical Activity funding unit, Public Health Nutritionists in each region using email in August 2001 and the CNW review report (Bonson, 1999). The historical summary document was sent twice to each of the 3 nutritionists with over 20 years NT work experience for checking.

Early drafts of an extensive historical summary of community nutrition services in the NT presented a comprehensive picture of activities in the Top End but provided a much weaker summary of Central Australian based activities (Priestly, 2000). This occurred
principally because I was unable to travel to Central Australia to collect local reports and the sample of nutritionists interviewed did not include any working in Central Australia in the late 1980s early 1990s. Therefore that document has not been widely released. Instead a more concise summary of key activities and events has been incorporated into chapter three.

Choice of analytical conceptual model

As detailed in chapter 1 capacity building literature was used because it provided a highly appropriate and relevant current theoretical approach with which to analyse and critique the historical strengths and weaknesses of NT nutrition services. This approach could also be used to classify relevant challenges and priorities for the future in the context of locally and nationally current health promotion priorities (THS, 1999c; NSW Health, 2000).

The NSW Health model (2000) provides a detailed framework with which to analyse the strengths and weaknesses of food and nutrition action in the NT over the last 25 years as also previously detailed in Chapter 1. This detail incorporates 5 different action foci and 3 overall dimensions of progress with which to approach analysing activities to date and planning stronger service futures. The use of this model was supported and encouraged organisationally, from the director of the Nutrition and Physical Activity (funding) Unit and the Director of the Health Gains Planning Unit (Fieldwork diary, May and July 2001).

An updated edition of this framework was released in 2001 (NSW Health, 2001) which did not contain the same detail on the 3 dimensions of capacity building outlined; infrastructure and program development, problem solving and program maintenance and sustainability. I felt the analysis of the historical activities in relation to the earlier more
detailed model was more detailed and valuable because it involved more analysis and reflection on the issues of problem solving and program sustainability in particular. Use of the updated framework would have excluded the historical lessons pertaining to these currently important issues.

The process of analysing the historical progression of nutrition services in the NT against this model provides valuable contextual background information in which to ground the other project outcomes. Therefore, the results of this cycle of action will be presented first in chapter 3, preceding the results of the other research processes.
Summary

Chapter 2 presents the original plans and the actual process realities of this work. In short the original project plan was too optimistic in its commitment to the principles of participatory action research. Human and financial resource issues were major constraints inhibiting participation and the completion of the work. What eventuated were 3 concurrent research activities incorporating various sub-methods like qualitative research and varying degrees of consultation with, and participation from over 30 NT nutritionists, Indigenous health professionals and CNWs and SWWs.

Sixteen nutritionists were interviewed about various issues relating to working in partnership with Indigenous workers to promote Indigenous food, nutrition and health in the NT in Part A. Two facilitative narrative resources or “storybooks” were developed, implemented and evaluated over a period of 4 years in an attempt to strengthen capacity for bi-cultural planning and evaluation, in Part B. In Part C, capacity building theory was used to analyse and critique the strengths and weaknesses of the development of nutrition services in the NT from 1974-2000.

Ethics clearance was obtained from both the University of Western Sydney and the Territory Health Services and Menzies School of Health Research Human Ethics Committee in 1997. Multiple information sources and converging lines of inquiry were employed to improve the reliability and credibility of the outcomes and conclusions through the process of triangulation (Neuman, 1992; Yin, 1994).

The results of each of these three research activities are presented and discussed in chapters 3 to 6. Chapter 7; Critical reflections and opportunities for strengthening practise will discuss the strengths and limitations of each of the major cycles of action and their outcomes.

J Priestly  Chapter 2: Making and working the research plan.
CHAPTER 3:
NORTHERN TERRITORY NUTRITION SERVICES GROW STRONGER

*just looking back I think we have achieved a lot and we should really pat ourselves
on the back*  
(Personal Communication Lion, 1999)

This chapter will leave the reader in no doubt that the capacity to act on food, nutrition
and health issues in the NT has improved immensely from 1974 to 2000.

Section one, a short chronological history, summarises and substantiates the breath of
workforce development and its activities from 1974-2000. It provides the historical
context in which to place the subsequent work of this project. The second section
summarises and discusses six nutrition managers reflections on the factors leading to the
development of the CNW program in the 1990s. Section three presents the strengths,
weaknesses and gaps in the areas of capacity building for health improvement as defined
in the NSW Health model (2000); workforce development, organisational development
and resource allocation, leadership and partnerships. The final section maps performance
in each of the 3 dimensions of capacity within that model; infrastructure and service
development, problem solving and program maintenance and sustainability.
The NT nutrition workforce, key activities and events; 1974-2000.

Table 3.1 following summarises the development of the Northern Territory nutrition workforce, its key activities and events from 1974 to 2000. It is intended to provide a broad overview on which to base the commentary that follows it. The range of activities listed for this time period is restricted to examples of major works or those considered significant to the thesis.

Material gathered during interviews with 3 nutritionists with over 20 years experience working in the NT (Personal Communications Hobson, 1998; Rae, 1998; Lion, 1999), 2 other nutrition managers (Personal Communications Kelly, 1998; Stronach, 1998) and my own personal knowledge of working in NT from 1989-2001 contributed facts presented in the Table 3.1. In addition, historical DHCS/THS reports and many numerous publications were sourced which are all referenced in an expanded version of this Table (Priestly, 2001b). Workforce data for 2000 was obtained by electronic mails from the Director of the Nutrition and Physical Activity Unit (Hobson, 1999) and the Public Health Nutritionist in Operations Central Region (Gough, 2000), and was supplemented with my own knowledge of staffing levels in Operations North region.
<table>
<thead>
<tr>
<th>YEAR</th>
<th>WORKFORCE AND ORGANISATIONAL EVENTS</th>
<th>KEY NUTRITION ACTIVITIES AND EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1974</td>
<td>Originally 2.5 Dietitians employed in NT - 1 at Darwin Hospital (DH), 1 Divisional Dietitian, 1 part time at Alice Springs Hospital (ASPH) Now 2nd Dietitian employed at DH</td>
<td>Divisional Dietitian main role to monitor ration scales. Hospital Dietitians handled clinical nutrition support to in patients and out patients</td>
</tr>
<tr>
<td>1975-76</td>
<td>ASPH position goes full time. New Divisional Dietitian employed</td>
<td>AHW Basic skills curriculum. Go Grow and Glow NT Indigenous nutrition education model</td>
</tr>
<tr>
<td>1978</td>
<td>Dietitians employed in each of the 3 administrative regions of the NT, 1 in Health Education + 1 Principal.</td>
<td>Support for AHW community nutrition projects Collection and analysis of Bush foods in partnership with Army and Uni of Sydney starts.</td>
</tr>
<tr>
<td>1980</td>
<td>2 new community Dietitians in Alice Springs</td>
<td>Tucker Today video launched demonstrating AHW nutrition projects from 1970s</td>
</tr>
<tr>
<td>1981</td>
<td></td>
<td>1st annual NT Dietitians workshop, 1st list recommended foods for remote stores released</td>
</tr>
<tr>
<td>1982</td>
<td>8 Dietitians now, based at Darwin, Gove, Katherine and Alice Springs.</td>
<td>Documenting traditional bush foods supply with AHW partners and families. AHW post basic skills nutrition modules and resources developed.</td>
</tr>
<tr>
<td>1985</td>
<td>1st Nutritionist employed without dietetics training.</td>
<td>Growth Monitoring + Promotion Program starts</td>
</tr>
<tr>
<td>1986</td>
<td>NT National Heart Foundation and Menzies School of Health Research employ Dietitians.</td>
<td>“Market Basket Survey” implemented. 1st software package developed for local growth monitoring. “Eat to Peak” urban healthy diet model</td>
</tr>
<tr>
<td>1987-88</td>
<td>Diabetes Australia (NT) employs first full time NGO Dietitian.</td>
<td>Research begins; “Store Turnover” dietary analysis, prevalence of Diabetes and Heart disease + 3 Dietitians start research degrees.</td>
</tr>
<tr>
<td>1989</td>
<td>11 Dietitian/ Nutritionist positions no Indigenous nutrition positions</td>
<td>Minjilung project commences</td>
</tr>
<tr>
<td>1990</td>
<td>1st Aboriginal Nutrition Adviser (ANA) employed RDH.</td>
<td></td>
</tr>
<tr>
<td>1993</td>
<td>1st Barkly Nutritionist employed. Katherine District employs ANA</td>
<td>Audit of food and nutrition programs in the NT</td>
</tr>
<tr>
<td>YEAR</td>
<td>WORKFORCE AND ORGANISATIONAL EVENTS</td>
<td>KEY NUTRITION ACTIVITIES AND EVENTS</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>1994</td>
<td>Food and Nutrition Policy unit formed; 3 Nutritionists (1 as manager) and 2 Aboriginal Project Officers employed.</td>
<td>NT Food and Nutrition Policy (NTFNP) development commences. Policy Intersectoral Advisory Group and Aboriginal Advisory groups formed. 1st NT Indigenous Nutrition workshop. NT hosted 13th National Dietitians Association of Australia conference at Yulara. NT breast feeding policy and strategic plan 1994-2000 launched</td>
</tr>
<tr>
<td>1996</td>
<td>THS Prevention and Growth Funds allocated; 2 CNW grants each for Darwin Rural, East Arnhem and Katherine, 1 ANA for Darwin urban + 2 Nutritionists in Top End; 1st Senior Public Health Nutritionist for Alice Springs + Barkly.</td>
<td>Success of the SWSBSC project documented and marketed. Commenced work on the NT Food and Nutrition strategic plan projects including the Food and Nutrition monitoring and information system.</td>
</tr>
<tr>
<td>1997</td>
<td>Management of Nutrition Services in Top End moved to regional Public Health Unit, 12 part time CNWs across the NT. SWSBSC Coordinator employed in Central Australia. SWSBSC management moved from FaNU to Public Health</td>
<td>Community Market Basket food supply assessment system developed. SWSBSC project stage 2 commences; eventually 10 communities participate. THS purchased rights to teach Certificate 1 in Health (Aboriginal comminutes) to community based workers.</td>
</tr>
<tr>
<td>1998</td>
<td>World Vision provides grant for CNWs in Central Australia. Growth Assessment and Action (GAA) Coordinators employed in Top End and Central Australia. 2nd nutritionist in Alice Springs remote.</td>
<td>New growth &quot;road to health&quot; chart, training video and GAA guidelines and strategic plan 1998-2003 launched. THS Central Australia redeployed funds from closure of Child Health Unit into GAA including first GAA workshop for AHWs, SWWs, CNWs and others. Needs Assessment of Darwin Urban ATSI population</td>
</tr>
<tr>
<td>2000</td>
<td>Nutritionist employed by Katherine West Health Board. 1st remote community based Nutritionist employed by Jawoyn Association and Fred Hollows Foundation at Beswick. Total 26 Dietitian/Nutritionists, 1 ANA + 34 Community based ANA/ workers employed in food, nutrition and GAA projects in the NT. 30 Indigenous women in the SWSBSC program</td>
<td>Development work for NT Food and Nutrition Policy and strategic plan 2001-06 undertaken. 4 NT Indigenous organisations win National Child Health Nutrition grants.</td>
</tr>
</tbody>
</table>
The table demonstrates that the food and nutrition workforce has improved substantially. It has evolved from a handful of imported professionals working for one organisation in the mid 1970s to an extensive network of local Indigenous and non Indigenous people working in many diverse locations and organisations in the year 2000. These people are working at many levels within and across systems on a wide variety of food and health related issues.
Significant Factors in the Development of CNW Projects

Any action to strengthen capacity for health improvement cannot be divorced from the specific and ever changing context in which it develops (Bush, 1999). Eight experienced NT Community Nutritionists were employed locally in management positions during this research project. They all had extensive first hand knowledge of the contexts in which the CNW program developed in the NT over the early to mid 1990s. Both personal reflection and a longstanding nutritionist (Personal Communication Hobson, 1998) suggested that this experience could provide valuable qualitative insights into key aspects of the program’s developmental processes for this research project. Hence a decision was made to ask these people the question: What key factors do you believe led to the funding and development of the Community Nutrition Worker projects? Six of them were subsequently interviewed and a summary of the six responses is presented in Table 3.2 on the following page. Two did not respond to repeated invitations to participate or provide any reason for not participating, although one of them left the NT. It was deemed beyond the scope of this project to interview a wider group of stakeholders on this question. Also, it was inappropriate to attempt to capture Indigenous opinions of the issue without the use of an Indigenous co-researcher.
**TABLE 3.2  Significant factors in the development of community nutrition worker projects**

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Respondents (total = 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited access to AHWs from late 1980s</td>
<td>5</td>
</tr>
<tr>
<td>Availability of new funds and redirection of existing funds</td>
<td>5</td>
</tr>
<tr>
<td>Demonstrating + marketing successes from NT nutrition projects</td>
<td>4</td>
</tr>
<tr>
<td>Changes in administrative management of AHW training in 1991</td>
<td>4</td>
</tr>
<tr>
<td>Developing long term relationships with AHWs and communities</td>
<td>3</td>
</tr>
<tr>
<td>AHW training changed to stronger clinical focus in 1990s</td>
<td>3</td>
</tr>
<tr>
<td>Organisational support for specialist community based workers</td>
<td>3</td>
</tr>
<tr>
<td>Consistent focus and marketing at community, organisational and national levels</td>
<td>3</td>
</tr>
<tr>
<td>Development and government endorsement of the NT Food and Nutrition Policy 1995-2000.</td>
<td>3</td>
</tr>
<tr>
<td>NT Nutrition strategies based on strong research evidence</td>
<td>2</td>
</tr>
<tr>
<td>Indigenous expressions of need for community based workers locally and nationally</td>
<td>2</td>
</tr>
</tbody>
</table>

As a sub question they were specifically asked ‘What impact, if any, do you believe socio political issues have had on the funding and development CNW projects?’ the answers to this question are incorporated in the discussion.

Essentially, their responses fall into two groups. Firstly, predominantly positive socio-political-organisational factors manifesting over the 1980s and 90s, and secondly the professional paradigm of early practitioners and leaders.

**Socio-political-organisational factors**
The socio-political and organisational contexts changed significantly from the mid 1970s to the early 1990s. The majority of nutrition managers believed that a national and local political focus on promoting Indigenous self-determination was important. They described its manifestation in various ways including citing that national and local government departments prioritising self-management and community based projects.

Nutritionists were becoming frustrated by increasingly limited access to AHWs in the late 1980s. The numbers of AHW were rapidly decreasing, for a variety of reasons (Franks and Curr, 1992; Josif and Elderton, 1992). A decline in the accessibility of AHWs was also attributed to changes in the management and administration of AHW training from the Department of Health and Community Services to Batchelor College in 1991. This change limited the extent of opportunities to develop relationships with trainee AHWs. AHW training became more clinically orientated with the goal that AHWs would take over more clinical functions and ultimately run health centres. This conflicted with nutritionist’s primary health care priorities and needs. As Hobson puts it:

we looked for other ways of getting community workers... having Strong Women Workers and Community Nutrition Workers was a way

(Personal Communication Hobson 1998).

Clear expressions of need for community based workers came from the local and national indigenous nutrition and health forums in the early 1990s (Mathews, 1991; Strong Together, 1994). This was reinforced in community consultation during the development of the NT Food and Nutrition policy (THS, 1996b).

Many different organisational factors were mentioned. These included the external review of the DHCS by the CRESAP consultants in 1992 (CRESAP, 1992). Darwin Rural and Katherine District executives both redirected funds from empty AHW positions to the employment of specialist Nutrition AHWs in the early 1990s, putting
money behind these recommendations. Joint NT and Commonwealth funding for the development of national and NT Food and Nutrition policies demonstrated political commitment to action to improve food supply and nutrition related health issues. The NT policy reinforced consistent messages and the critical mass of support for the CNW program approach. The NT policy also helped to secure outside funding:

...in Central Australia the communities got their own funding ... having the policy gave them ammunition ... they had a policy to work within, there were strategies they could take on immediately

(Personal Communication, Kelly 1998).

Territory Health Services prevention and growth funds gained in 1996 secured the implementation of CNW projects in all districts in the Top End. In the late 1990s the development of the Coordinated Care Trial projects in Katherine West and the Tiwi Islands provided more resources for community controlled food and nutrition initiatives.

Whilst the development of CNW positions in Operations Central was influenced by the same Territory wide initiatives, and national and international contextual factors, their development was quite different. There the nutritionists promoted the notion of CNW workers to communities before funding was available. Once individuals, mostly AHWs, expressed an interest in becoming CNWs, funding was sought. Later in the 1990s there was a considerable increase in dedicated financial support for community based prevention projects. Funds were redirected from closure of the Alice Springs Child Health Unit in 1998 into remote community based nutrition initiatives that supported child growth and health. Growth assessment and action for children 0-5 years became the first of 5 core business strategies for health centres in the region (THS, 1998f). Not all managers were willing or able to prioritise funds for CNW projects. Barkly district's
failure to redirect existing funds towards CNW projects during the mid to late 1990s was a notable variant (Fieldwork diary, 1998).

Professional Paradigm

The partnership focused approach to community nutrition activities in the NT began in earnest in the mid 1970s. Notable factors were the employment of nutritionists with a community development focus and the inception of the Aboriginal Health Worker (AHW) program. The three nutritionists who commenced during this time lead the profession for over 20 years. These women had strong philosophical commitments to adult education and community development for Indigenous self determination. They all testified that the relationships they developed with AHWs in initial AHW training were very important to the subsequent development of food and nutrition opportunities and priorities in rural communities. Many AHWs became interested in working on food and nutrition issues and later worked on a variety of community projects through the 1980s and 90s. Building relationships and productive partnerships takes time. The need for consistency of contact over time, developing mutual trust, and understanding and respect, were recurring themes. However, none of them directly mentioned the importance of nutritionists making long-term commitments to living and working in the NT. These commitments are very significant, they enabled the development of strong intercultural relationships and activity. The early leaders set the local professional paradigm. Subsequent community nutritionists were orientated and socialised to working in this way.

Hard work underpinned the development of a local organisational environment supportive of the development of community based nutrition workers. Nutritionists developed and maintained a high profile within communities, the organisation and their
profession nationally. They developed informal communication and marketing processes within their extensive networks, keeping various stakeholders informed about what they were doing and how it was going. They seized leadership opportunities within the organisation and profession. As Lion explains:

"in 1991 Cheryl and I were still pretty much in an executive role, we had a fairly influential role in the executive and consequently we lobbied strong and hard to get community based nutrition workers. We had Alberta who had already shown an interest through the Diabetes Story, so we won a position in Darwin in rural…

I think Cheryl [Rae] was very good at working at that national level by moving into areas like DAA [Dietitians Association of Australia] and taking up a leadership role there [as National President]. She could redirect the focus of our professional organisation into a primary health care mode and made a very supportive environment for us to access funds at a national level

(Personal Communication Lion, 1999).

The nutrition teams approach incorporated a reliance on good quality, cutting edge research to provide a strong evidence basis for action planning. This basis supported the credibility of the cross cultural partnerships and the prioritisation of resources for nutrition action. The success of the Minjilang project (Lee et al, 1994) and Strong Women, Strong Babies, Strong Culture project (Fejo and Rae, 1996) engendered a large degree of support for the CNW and other nutrition projects in general in the mid 1990s.

Managers’ responses validate the need to focus on leadership, partnerships and marketing to strengthen capacity for health improvement. Long term commitments to working in a cross-cultural context are significant factors underpinning these strategies.
The relevance and application of capacity building theory

As chapter one demonstrated, the foci and values of capacity building to improve health are highly pertinent for work in the diverse and complex sociocultural contexts of the Northern Territory. The NSW Capacity Building Framework (NSW Health, 2000) provides an evaluative tool that enables the presentation of local history within a currently relevant paradigm. This process therefore provides up to date insights and interpretations into the strengths and weaknesses of historical activities.

Table 3.3 (following page) summarised the analysis of the historical performance of NT nutrition services against the 5 key areas of the NSW Health Framework (2000); partnerships, leadership, workforce development, organisational development and resource allocation.

Again the material analysed during this activity was obtained from personal and official sources; the interviews with nutrition managers, departmental and published documents and reflections on personal experience. Major strengths, weaknesses and gaps are detailed but, the examples cited in each section are by no means exhaustive or exclusive. The discussion that follows will elaborate on these conclusions.
<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES AND STRENGTHS</th>
<th>WEAKNESSES AND GAPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnerships</td>
<td>♦ Standard establishment of Indigenous and/or expert steering and advisory committees for projects.</td>
<td>♦ Workforce turnover</td>
</tr>
<tr>
<td></td>
<td>♦ Most project undertaken by multi disciplinary/cultural working groups</td>
<td>♦ Limited partnerships with food industry</td>
</tr>
<tr>
<td></td>
<td>♦ Multi level partnerships; at community organisational and system levels + various levels of government</td>
<td>♦ Not all attempts at partnerships successful, sustainable or transferable if one or more individuals change</td>
</tr>
<tr>
<td></td>
<td>♦ Long-term commitments made by professional and Indigenous people</td>
<td>♦ Constructive critiques of partnership efforts limited. Few done not distributed to inform collective workforce of lessons learnt.</td>
</tr>
<tr>
<td>Leadership</td>
<td>♦ Professional readiness to give up, share power and encourage and support the development of leadership in others</td>
<td>♦ Workforce turnover inhibits leadership development.</td>
</tr>
<tr>
<td></td>
<td>♦ Establishment of Indigenous and/or expert steering and advisory committees for major projects standard for 25 years.</td>
<td>♦ Mechanisms to reward and remunerate Indigenous leadership is very limited and inhibits progress on issues</td>
</tr>
<tr>
<td></td>
<td>♦ Increasing number of health zones and coordinated care projects is improving Indigenous leadership and control of services.</td>
<td>♦ No consistent Indigenous Advisory committee for CNW program development and problem solving.</td>
</tr>
<tr>
<td></td>
<td>♦ Many Indigenous and professional nutrition staff have taken up positions of leadership within and outside health sector.</td>
<td>♦ Limited day to day Indigenous leadership in govt health services</td>
</tr>
<tr>
<td></td>
<td>♦ NT Food and Nutrition policy + projects provided formal mechanisms to foster and demonstrate leadership</td>
<td>♦ Leadership turnover in late 90s.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>♦ Need stronger focus on demonstrating leadership in impact and outcome evaluation</td>
</tr>
</tbody>
</table>
Table 3.3 (Continued) Historical performance in the 5 key areas of Capacity Building for Health Improvement

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>ACTIVITIES AND STRENGTHS</th>
<th>WEAKNESSES AND GAPS</th>
</tr>
</thead>
</table>
| Workforce Development | ♦ Strong team culture of cross cultural or “two way” learning to develop understanding of an issue and action planning  
♦ Annual professional development workshops for Professional and Indigenous staff  
♦ Workforce development incorporated in 1995-2000 Food and Nutrition strategic plan  
♦ Focus on delivering accredited training for Indigenous AHWs CNWs and community workers  
♦ Indigenous people can now do accredited study nutrition from Certificate 1 through to part of a Degree in the NT.  
♦ Strong learning culture; many nutritionists undertake further study and/or research  
♦ Orientation program for nutritionists | ♦ Workforce turnover  
♦ Intermittent/variable access to onsite community support for Indigenous workforce development; limited number and turnover of nutritionists  
♦ Lack of Indigenous nutrition career structure to motivate and reward formal study  
♦ Infrequent Territory wide and regional Indigenous nutrition development workshops  
♦ Few men involved in the nutrition workforce + projects.  
♦ 2001-2006 does not specify workforce development targets unlike its predecessor. |
| Organisational Development | ♦ Annual plans made since late 1970s dictating key priorities and collaborative actions strategies  
♦ Formal strategic plans developed though extensive consultation and commitment NT Food and Nutrition Policies and strategic plans 1995-2000 and 2001-2006  
♦ Systems, policies and procedures for activities like growth assessment and action, monitoring the remote food supply from (1980’s-1990s)  
♦ Establishment of Indigenous and/or expert steering and advisory committees standard for 20+ years. | ♦ Limited day to day Indigenous management in NT Govt health services  
♦ Limited outcome focused research and evaluation  
♦ Increasing diversity of workforce and sponsoring organisations complicates strategic planning process  
♦ Performance management very isolated. |
| Resource allocation | ♦ Research and submission efforts won project funding from various sources.  
♦ 70s-early 90s funding often pooled and/or used flexibly to pursue Indigenous priorities for action and achieve efficiency.  
♦ Indigenous and other NGO’s - greater variety of funding avail now  
♦ NT Food and Nutrition polices set broad priorities to inform funding allocation.  
♦ Potential for increasing resources with Primary Care Access Program | ♦ Increasingly difficult for THS-NTDHCS projects to use funding in a flexible manner and reallocate existing funds  
♦ Sophisticated cost benefit, capacity and outcome focused funding models not used yet  
♦ No resource targets incorporated within Strategic plans  
♦ Documentation of resource leverage is not done routinely to demonstrate the intersectoral resources committed to NT Nutrition projects. |
One of the central tenants of strengthening capacity for health improvement is the importance placed on the issues of unique context, leadership and partnerships in supporting the development of capacity for health improvement (Goodman et al, 1998; NSW Health, 2001). Mathews, long time director of the Menzies School of Health Research in Darwin, makes the following point in relation to leadership in Indigenous health service provision:

*Leadership in Indigenous health is demonstrated through a capacity to encourage cooperation between disciplines and to build and sustain cooperative partnerships with Aboriginal stakeholders, health services and governments in Northern and Central Australia*  
(Mathews, 1998:629)

From the mid 1970s significant action has occurred to foster successful partnerships with Indigenous Territorians and together these early participants demonstrated cross cultural and bi cultural leadership. Many of the long term nutritionists comments demonstrated that they knew about and made philosophical commitments to a primary health care approach to delivering community nutrition services at a time when this was an exceptional position. They did this instead of conforming to the biomedical norms of the time. Indigenous Territorians, mainly AHWs made long term commitments to learning scientific information to share with their community and also to share their traditional knowledge about food and health with non Indigenous health professionals. Pat Gamananga, an AHW who had trained in the early 1980s self selected to become the first nutrition specialist AHW in 1990. She involved staff in routine collection of bush tucker for hospital patients to support recovery and wellbeing from a cultural perspective. This also provided positive cross-cultural leadership and learning experiences for staff (Personal Communication, Stronach, 1999).
The isolated and multi-disciplinary nature of work in the NT means that both Indigenous and professional staff have to provide leadership in nutrition action in their own particular geographical area. They also work together with each other and other disciplines and stakeholders on special regional or NT wide priority projects, which provide best practise leadership. They often managed the administrative functions of partnerships they were involved with in an effort to encourage and support collaborative action. Examples of these projects include the Breast feeding policy (DHCS, 1994) and Growth Assessment and Action (GAA) program initiatives like the *Road to Health* [growth] charts (THS, 1998b). The breadth of their partnership networks would have made them better partners to some extent because this provides broader knowledge, resources and support systems to draw upon in their work on individual projects. Examples such as these concur with the work of Goodman et al (1998) who advocate that the demonstration and promotion of leadership, partnerships and diverse networking are important dimensions of capacity development.

Many facts illustrate the development of leadership capacity in Indigenous and non-Indigenous nutrition staff. At least 3 CNWs have become members of their local Community Government Councils. One ANA became Chairperson of the Tiwi Health Board managing the Tiwi Islands Coordinated Care Trial project. In 2000, 5 of 33 Nutritionists in the NT (15 percent) held general and executive management positions across the NT in THS. This builds wider supportive environments, networks and capacity for intersectoral action or as Goodman and others (1998:262) put it *social networks can reinforce participation by connecting individuals to resources and power bases.*

In the new era, individual leadership is supported by other aspects of leadership, such as policy development and strategic planning. Undoubtedly the biggest organisational development has been the implementation of the NT Food and Nutrition Policy and
strategic plan 1995-2000 (NTFNP) (THS, 1996). A second NTFNP and strategic plan has been launched (THS, 2001b), that essentially builds upon the themes and achievements of the first policy. These policies have been developed and ratified by an extensive range of stakeholders, engineering wide commitment to their implementation. They make the aims and functions of partnerships, hopefully, more achievable, sustainable and less vulnerable to the impact of ongoing threats like workforce transience.

Partnership activities have tended to develop and reap rewards incrementally. Nutritionists began working with AHW delivering basic and post basic skills training in the late 1970s. These partnerships extended to work on documenting bush foods in the early 1980s and the extent of under nutrition in early life, chronic disease and the store food supply in the late 1980s. Then they acted on these issues together via special projects in the late 1980s and 1990s. The change in historical focus also demonstrates key elements of PAR; cooperative learning, research and reflection followed by informed cooperative action.

Despite the generally positive history, conflict is inevitable between groups with such diverse backgrounds and values (Wise, 1997). Constructive critiques of specific partnership efforts have been very limited or not widely released. For example an evaluation of the NT Food and Nutrition Policy development process (Elsegood, 1995) was not released publicly given the sensitive nature of some of the comments about partnership and associated power issues (Personal Communication Rae, 1998). I believe this is an example of what Foote-Whyte (1991) calls "social and structural undiscussibility". Social undiscussibility involves the reluctance to discuss issues which are personally embarrassing or likely to cause hard feelings and structural undiscussibility involves reluctance to broach subjects defined as out of order according to organisational “ground rules” which are explicit expressed or generally alluded to.
(1991:98). Failure to undertake and/or publicise these kinds of frank analyses restricts learning (Foote-Whyte; 1991). It restricts the development of knowledge and skills about partnership activities for both the people involved and the broader collective workforce. It ultimately undermines the workforce’s ability to strengthen capacity for health improvement given the pivotal role of partnerships in this process. Dealing with issues that are socially undiscussible is particularly problematic in this context, however, where traditional Indigenous culture very carefully avoids shaming individuals (von Sturmer, 1991:28).

From the mid 1970s action has focused on strengthening the capacity of Indigenous Territorians to improve their food, nutrition and health. Initially this was conducted by the delivery of basic, and post basic skills certificates for AHWs. Nutrition was of one the specialty areas offered for AHWs wanting to pursue post basic skills in the 1980s and one of the most frequently completed post basic units (Personal Communication Rae, 1998). Indigenous Territorians can now gain nationally accredited qualifications in nutrition in both the community and institutional settings. Units of the Certificate I in Health (Aboriginal Communities) was being delivered by nutritionists to CNWs, SWWs or other interested community workers in their community by Nutritionists in the late 1990s. Diploma and Advanced Diploma level courses in nutrition became available through Batchelor Institute of Indigenous Education in 1999 and are no longer restricted to people who have basic AHW qualifications (Adams, 2002). Thirty three students were enrolled in the diploma course in 2001 and 40 enrolments were expected for 2002 (Adams, 2002). The first local Indigenous nutritionist, Leisa McCarthy, was employed in 2000. This was considered a significant milestone in workforce development (Fieldwork diary, 2000).

Many activities have strengthened capacity in more than one action area, an example being the annual NT nutrition workshops, which incorporate planning and professional
development. They facilitated the development of a strong informal culture and group identity. New members are socialised to the group through these processes and informed of key values, collaborative learning and action. Workshop programs have focused around reflecting on individual and collective action in the previous year and strategic planning for better quality services in the coming year/s (DHCS, 1981; THS, 2000c). Priorities, policies and procedures are developed at these forums and/or working groups are designated to progress these tasks throughout the year.

Access to resources for general health and food and nutrition promotion initiatives in the NT has increased substantially and incrementally since the late 1970s. At the end of 1999 funding for food and nutrition activities in the NT was estimated to have exceeded $AUS 2 million/annum. It is impossible to accurately document the extent of funds because money is being allocated from many different government and non government sources to many different organisations and projects. Exponential growth began in late 1980s and early 1990s. The research and submission writing skills and efforts of nutritionists were significant factors in starting this phenomenon. In recent years, increasingly, greater proportions of funding are being allocated to Indigenous organisations for the provision of nutrition services. This shift in capacity is focused on promoting Indigenous control, participation, self determination and ultimately better health outcomes. These organisations are generally better placed to access funding from other sources that government providers are often not eligible to apply for like Commonwealth Child Nutrition Program grants (Commonwealth Department of Health and Aged Care, 2001a). The implementation of the Primary Care Access Program funding grants (Commonwealth Department of Health and Aged Care, 2001b) should further enhance the financial capacity to provide public health nutrition services.

Nutrition services have made a positive contribution towards the objectives of the Aboriginal Career Development and Employment strategy (THS, 1997g; THS, 2001b).
Many factors in the government health system however, have and are still inhibiting organisational and career development opportunities for Indigenous Territorians. There is still limited Indigenous participation in the day to day management of NTDHCS nutrition services. Mainstream qualifications and experience are required to win professional, management or executive positions. During interviews for this project, nutrition managers noted that organisational development has failed to provide clear guidelines and mechanisms to adequately recognise and remunerate Indigenous people that are not AHWs for their unique cultural knowledge, skills, experience and roles.

There is an AHW Career Structure and a limited number of AHW management and executive positions. The socio-cultural and power issues underlying this and other similar phenomenon will be discussed in more detail in chapters 4 and 5.

There is strong demand to expand the CNW program to other communities (Hobson, 1999). Various sources have recommended broader range of funding options be available (Bonson, 1999; THS, 2000a). Territory Health Services/NTDHCS resources were highly committed, however. Redirection of available funds away from traditional allocations to other initiatives that promise better health gain is required (THS, 2000a). It is a very political issue, requiring great capacity for change management (Personal Communication Kelly, 1998). It is another structurally “undiscussible” issue (Foote Whyte, 1991:98) that is likely to cause “hard feelings”, embarrassment for those services providers committed to activities which are deemed to be less appropriate and where there is much contention surrounding the transfer of financial resources and its associated power. The only significant local example is the closure of the Child Health Unit in Alice Springs, where some funds were redirected into community Growth Assessment and Action initiatives in Central Australia (Grieve and Hampton, 1998). This has been able to effect and demonstrate significant improvements in child health outcomes recently (NTDHCS, 2002b).
Efforts to boost resource capacity for food and nutrition services did not involve more advanced mechanisms of financial modeling until 2001 when the Nutrition and Physical Activity Unit was assisted by the Health Economics Branch to undertake cost benefit analyses of Growth Assessment and Action initiatives (Fieldwork diary, 2002). An analysis of project outcomes in relation to the NHMRC levels of evidence for public health interventions (NHMRC, 2000) provides one mechanism to argue the credibility of action plans and the success of outcomes. Many public health nutritionists and others, however, recognise the use of this classification system for public health nutrition interventions is complicated and problematic (Lee, 2001; Mackerras and Warden, 2001; Rychetnick, 2001; Truswell, 2001).

**Dimensions of capacity to improve health**

The NSW Capacity Building Framework (NSW Health, 2000) offers three dimensions to capacity building; 1. Health Infrastructure or service development, 2. Program maintenance and sustainability and 3. Problem solving capability of organisations and communities. This depicts the major ways their health promotion leaders believe it is conceptualised in the literature (Hawe et al, 2000). Action in the 5 areas of leadership, partnerships, workforce and organisational development and resource allocated as listed in the previous segment of this chapter all contribute to the development of these dimensions. Each dimension or “level” represents a different approach to facilitating health promotion at the community and population levels. As an example, level 2 is focused on efforts to strengthen or lengthen the life of a program, building on the developmental activity of level 1. The following discussion explores how nutrition services in the NT developed in each of these dimensions.
Health Infrastructure and service development

Health Infrastructure and service development capacity is defined as the

*Capacity to deliver particular program responses to particular health problems.*

*Usually refers to the establishment of minimum requirements in structures, organisations, skills and resources in the health sector* (Hawe et al 2000:4)

Health Infrastructure and service development is considered the basic dimension of capacity required to address health problems and the gains in this dimension, based on the evidence available, have been substantial and relatively greater than in the other dimensions. This relatively better performance is both appropriate and expected because structures and resources are required to generate and support action to improve health.

In 1974 the NT Nutrition workforce comprised of 3 Dietitians. By late 2000, 15 community nutritionists, including 1 Indigenous nutritionist working in the policy unit, 3 nutrition managers/public health nutritionists, 4.5 clinical dietitians, 2 nutrition project officers were directly employed by THS to promote better health through better food and nutrition (Hobson, 1999; Gough, 2000). This includes those working on the Growth Assessment and Action program.

It is very difficult to accurately quantify the numbers of people employed or actual full time equivalents of Indigenous positions in community food and nutrition related projects in the NT. Firstly, because the actual number of people employed to work in community projects at any time changes because workers often take leave for personal reasons. Secondly, some use their grant money to employ workers in different ways. For example some communities might only employ 1 worker full or part time or they may employ 6 or more workers to work with different clans by “topping up” Community Development and Employment Project (work for social security) wages to employ many
workers on a limited casual basis for a few hours a week. A crude estimate puts the Indigenous workforce at about 62 people in late October 2000, but funding for these people is likely to equate to less than half this number in full time position equivalents. There were approximately 16 Indigenous people employed as Aboriginal Nutrition Advisers (also SAHWs), GAA specialist health workers or community workers and CNWs employed by in 8 communities Central Australia in October 2000. There were approximately 16 working in the Top End at this time from my personal knowledge. These positions were funded from many sources including THS, the Commonwealth Government Home and Community Care program, Indigenous Health Organisations, the National Heart Foundation and World Vision. Only 3 of these positions serviced urban areas of the NT.

The Strong Women, Strong Babies, Strong Culture program employed 4 full time Indigenous coordinators and approximately 26 community women on a part time basis in 8 communities the Top End and 16 women in 5 communities in Central Australia (sub total = 30).

Four other nutritionists were employed by non-government agencies. Therefore approximately 35 Indigenous and 26 non-Indigenous people were employed to work specifically on nutrition promotion programs in the NT in late 2000.

In summation, including all CNW and SWSBSC workers, approximately 65 Indigenous and 26 non Indigenous nutrition professionals working on nutrition related projects in the NT at the end of 2000. Over the 25 year period there was a crude increase in professional nutrition positions by 870 percent. Also, where as there were no Indigenous nutrition professionals in 1975, they now physically outnumber the non Indigenous professionals by more than 2 to 1. It should be noted the seven nutritionists who were
working on other health projects, management or research positions in the NT at the end of 2000 are not included in these totals.

Whilst at face value the gains in Indigenous workforce capacity are substantial there are associated issues that question the quality of these developments. Most Indigenous community based workers are employed on a part time or casual basis. Non-Indigenous full time position equivalents still greatly outnumber those for Indigenous Territorians. Various Indigenous sources welcomed this part time tenure on the premise that it allows people to balance work with family and cultural responsibilities (Personal Communication Clements and Rogers, 1998). Others have commented that lack of full time work opportunities perpetuates oppression (Personal Communication Mills, 1998). Indigenous and non-Indigenous professionals have noted that the use of CDEP funds, especially without “top up” wages, devalues the job and participants contributions (Fieldwork diary Priestly, 1998, 1999, 2000; Bonson, 1999) perpetuating the oppression of Indigenous people. I speculate that funding for non-Indigenous professional positions is still greater than that spent employing Indigenous people. Again, it is impossible to accurately quantify the facts to support this statement when so many employers are involved. Until more Indigenous Territorians attain formal qualifications and other competencies required to win professional positions this imbalance is likely to be perpetuated.

The infrastructure and service development capacity of food, nutrition and health programs has been weakened by the transience of the workforce. Higher turnover through positions in the late 1990s has limited the development of services and program sustainability in the Top End in particular. As I was Top End nutrition manager during 1997-98, I know that 12 nutritionists were employed through 7 positions. I also know there was a similarly high turnover of CNWs. Transience contributes towards the
creation of tensions between strengthening capacity and achieving more immediate health gains. Instead of demonstrating health outcomes, the major outcome of CNW projects in the Top End over 1996-98 was the number of Indigenous people who received some degree of nutrition training (Stronach, 2000).

It is well recognised that capacity to achieve health gains is also limited by the fact that the nutrition workforce is predominantly (>90 percent) female (Katherine West Health Board and THS, 2001). This factor limits the participation of men in food and health improvement activities on the basis of cultural traditions. Senior Indigenous male health professionals and CNWs generally believe the lack of involvement and ownership by men is inhibiting health development for families and communities (Bonson, 1999; Miller, 2001; Ryan, 2001). This is an important sociological and cultural issue. It displays the tensions between apparent health needs and service structures.

Significant developments in system infrastructure have occurred. This began with the development of curricula for AHW basic and post basic training in the 1970s and 80s and the use of standard procedures and programs for growth and food supply monitoring in the late 1980s. The incremental development of a systematic organisational approach, through standard procedures and policies has strengthened individual action and helped to reduce the impact of common issues like geographical isolation and workforce turnover. This organisational infrastructure reached a new level with the release of the NT Food and Nutrition policy and strategic plan and other associated policies and guidelines in 1995 (THS, 1996). Partnerships developed via the policy production process have broadened government and non government infrastructure for nutrition programs, for example within the NT Education and Sport and Recreation Departments.
Program maintenance and sustainability

Sustainability is a complex concept and it can be defined in many different ways. For the purposes of this discussion program maintenance and sustainability is defined as:

*the capacity to continue to deliver a particular program through a network of agencies, in addition to, or instead of, the agency which initiated the program*

(Hawe et al 2000:4)

Many nutrition programs have either been established with, or transferred to other government and non-government organisations in an attempt to promote program maintenance, sustainability and successful outcomes. The examples provided below will demonstrate that this has often, but not always worked.

The strategy of funding grants for community organisations to employ their own SWSBSC workers and CNWs was aimed at maximising community ownership and participation. The SWSBSC program has been running in 2 Top End communities successfully for over 7 years (Mackerras, 1998). One CNW program ran in the Top End for over 5 years. Others have repeatedly stopped and started, usually because of changes in Indigenous workers and to a lesser extent their key support staff. Thus, workforce commitment and consistent support promotes program maintenance and sustainability regardless of whether workers are employed by local or Territory government organisations or Independent Health Services. Sustainability may not be achievable in the realities of some community contexts. This has been experienced by other community services and health programs (Willis, 1991; Standen, 1998; Clark, 1999; Stronach, 2000). Community priorities and capacities fluctuate for many, many reasons, and this issue will be discussed in more detail in chapter 5.
Nutrition services relinquished line management of a number of programs in organisational restructuring in THS in an attempt to broaden commitment and participation in these in these initiatives. Management of the SWSBSC program moved from the nutrition team to public health in the Top End, who also managed Growth Assessment and Action (GAA) resources. The GAA initiatives in Central Australia are managed by the Public Health Nutritionist. It is one of 5 key priorities for action and has been well resourced and supported from the region generally (THS, 1998b). These investments are now demonstrating health gains (Swift, Turner, White, Hattch and Grieve, 2001; NTDHCS, 2000b).

Implementation of the NT Food and Nutrition Strategic plan (NTFNSP) 1995-2000 has expanded local capacity for program maintenance and sustainability as evidenced by the many examples already provided through this chapter (THS, 1996a). The second NTFNSP 2001-06 (THS, 2001b) aims to build upon the efforts and achievements of its predecessor. It specifically addresses the issue of strengthening capacity for sustainability to ensure ownership of strategies does not remain only with people working in the area of nutrition (THS, 2001b:1).

Maintenance, sustainability and future development of food, nutrition and health promotion funding is dependent on demonstrating health gains within politically motivated short to medium time frames (less than 3 years but preferably within 12 months). Unfortunately, the CNW program has not been able to demonstrate links between improved capacity and substantial health gains in the 4 years to 2000. It is speculated that this has occurred for a number of reasons including that many projects have been run intermittently due to staff turnover and also, the projects have tended to have very broad foci and limited resources have been allocated to program impact and outcome evaluation (Fieldwork diary, 1998,2000, 2002). The SWSBSC program and the GAA program in Central Australia have demonstrated health gains as previously
mentioned. In comparison to the often broader focused CNW programs the SWSBSC and GAA programs are focused on very specific issues. Seven nutritionists have been noted to speculate that this specificity does seem to improve the likelihood of health gains occurring (Fieldwork diary, 2001 and 2002).

**Problem solving capabilities of organisations and communities**

Problem solving capacity is defined as

> The capacity of a more generic kind to identify health issues and develop appropriate mechanisms to address them, either building on the experience with a particular program or as an activity in its own right  

(Hawe et al 2000:4)

Successful projects have *put the rhetoric into action* to borrow a term from McLay, Field and Lynch (2001:119). Projects that have been deemed successful from both biomedical and cultural viewpoints have all involved strengthening capacity in problem solving. Problem solving has often followed a PAR type approach. In these projects time was taken to share personal understandings of the nature of the health problem from both Indigenous and professional perspectives, usually through storytelling, and build new shared understandings and action plans. Indigenous workers have been encouraged to develop their own appropriate action plans, strategies and messages incorporating both sets of knowledge. Professionals have then supported Indigenous efforts to implement these strategies. These projects have tended to focus on specific nutrition and health issues in particular areas and have been relatively better funded with dedicated human resources in particular. Projects employing some or all of these approaches to problem solving include the Diabetes Story (Purantatatmeri, Daniels and Lion, 1992) and Strong Women, Strong Babies, Strong Culture program (Fejo and Rae, 1996). More recently the Laramba Diabetes Project (McLay, Field and Lynch, 2001) and the Central Australian GAA initiatives (Swift, Turner, White, Hatch and Grieve, 2001). The bi-
cultural success of these projects provides important evidence to validate the inclusion of PAR and storytelling skills and processes in lists of capacities relevant in this context. This is of course is important to the development of this thesis argument.

Nutrition services have often demonstrated lateral and efficient problem solving skills. Whist PAR provides a very flexible approach to problem solving, systems have also been used to solve common problems in a more conventionally organised way. Many examples of efforts to achieve efficiencies exist; for example the organisation of Diabetes screening activities in the 1980s and the purchase of standard scales for growth monitoring in the 1990s (Personal Communication Rae, 1998).

Transferability of capacity from one health program to another is an indicator of more developed and complex problem solving capacity (Kaplan, 1999). Statistics outlined in the section on leadership would indicate that sustainability and transferability of individual problem solving capacity has been a strength within the NT Nutrition Team.

At the system level, implementation of the NT Food and Nutrition Strategic plan 1995-2000 (THS, 1996b) has helped to develop broader capacity for problem solving. Partnerships with members of the Aboriginal and Intersectoral advisory groups including the NT Government Education and Sport and Recreation Departments, Office of Consumer Affairs and Fair Trading (OCAFT) and a few individual store managers and wholesalers have been particularly productive.

Less progress has been made in relation to problem solving and sustainability for other issues which require more complex, multifaceted capacities and action such as with the remote food supply (Mackerras and Mortimer, 1999). Problem solving action to address similar issues with less resources has not been so successful. For example Growth Assessment and Action (GAA) activities in the Top End in the late 1990s have been less
comprehensive and not as successful as Central Australian initiatives in terms of reducing poor growth parameters in the 0-5 year old age group (NTDHCS, 2002a). Since 1999 the prevalence of malnutrition in 0-5 year old children in Central Australia has fallen by 25 percent, and the rate of anaemia has fallen by over 20 percent (NTDHCS, 2002b). Many nutritionists speculate the poorer outcomes in the Top End are associated with the fact that Top End GAA activities have not been well resourced up to the year 2000 (Fieldwork diary, 1998, 2001, 2002). It is well recognised that tensions exist in the application of finite capacities to the wide range of issues that are seeking attention at any one time.

The interim review of the implementation of the original NT Food and Nutrition Strategic plan specifies some weaknesses (Mackerras and Mortimer, 1999). Failure to achieve whole of government endorsement for the NT Food and Nutrition Policy has limited improvements in the food supply, mainly because food supply is a complex issue, beyond the scope of the health sector alone. Greater engagement and involvement of other programs like health promotion and environmental health to progress common issues were recommended. The NTFNPSP 2001-06 (THS, 2001b) clearly states a broad focus and aims for strengthening capacity for improvements in food, nutrition and health but does not detail specific targets against which to focus and evaluate progress. Relevant targets have since been included in Service Agreements commencing with the 2001-02 financial year.

There has been much discussion about the capacities required to promote the successful development and maintenance of community based food and health improvement programs in local contexts. Many nutrition workers have documented lists of qualitative requirements based on practitioner and Indigenous experiences, and this research project itself is a major contribution to this endeavor (Mills and Ryan, 1995; Priestly, Liddle and Hobson, 1999a). The need for a more systematic analysis of factors or indicators
recurring in successful and unsuccessful initiatives is well recognised (Mackerras and Mortimer, 1999; Dietitians Association of Australia NT Branch, 2001). This type of analysis would be invaluable in planning and evaluating capacity building for community health promotion generally, too.
Summary

The capacity to act on food and nutrition issues in the NT has improved substantially and systematically from 1974 to 2000. Food and nutrition services have developed a strong identity, and a productive and positive history. Significant factors leading to the development of CNW projects include strong Indigenous and non Indigenous leadership, partnerships, marketing and positive systemic socio-organisational factors.

Major gains have been made in infrastructure and service development capacities. Workforce transience does inhibit progress, however, long term professional and Indigenous commitments to food and nutrition research, assessment and action have underpinned many of the gains made. The bi-cultural success of some nutrition projects provides important evidence to validate that participatory action research and storytelling methods and skills are valuable for developing problem solving capacities within this context. Gains have been achieved in problem solving and sustainability capacities in relation to some specific nutrition and health issues in particular areas that were well funded. Less progress has been made in relation to problem solving and sustainability for other issues that require more complex, multifaceted capacities and action. Notions of social and structural “undiscussibility” are introduced. These constrain learning and action in relation to issues like the evaluation of partnership efforts and the redirection of existing resources towards more effective initiatives.

A systematic evaluation of projects is required, including an analysis of capacities and contextual issues recurring in successful initiatives like the degree of Indigenous participation. It could be used to define good quality practise, improve the visibility of it and better focus ongoing effort. Producing evidence of indicators, pathways and progress between improved capacity and improved health are primary tasks for this group, as they are for many other health promotion professionals.
CHAPTER 4:

TALKING STRAIGHT ABOUT TRYING TO BE STRONG PARTNERS

Chapters 4 and 5 contribute to the very limited body of research into the beliefs and practices of health professionals in Australia generally, especially those working on the Indigenous health issues (Humphery, Weeramanthri and Fitz, 2001). The chapters present and critically analyse the views of non-Indigenous nutrition professionals from the ‘dominant’ biomedical model.

Ten community nutritionists and six nutritionist managers from all over the NT were interviewed between 1997-1999 using the questionnaires attached as Appendices E and F. Together the respondents had over 125 years combined experience working in the Northern Territory and over 160 years professional experience as dietitian/nutritionists. All are women. They represent 80 percent of the community nutritionists and nutritionist managers working in NT over 1997-1999. Three nutritionists who worked in the NT for short periods over this time were also offered the opportunity to participate but chose not to. This group included the only male nutritionist. Two of them did not participate because they left the NT quite suddenly. One experienced nutritionist manager who was working in another sector did not respond to the opportunities to be interviewed.
Two managers completed both questionnaires as they had worked as community nutritionists within the preceding 3 years. All of the managers had worked as nutritionists in remote communities in the NT in the past. Two had worked in the NT for 5-10 years, one for over 10 years and the other three, for over 20 years. Five of the nutritionists (43 percent) had worked on CNW projects for 2-3 years at the time of the interview, 3 of them in Central Australia. Four (34 percent) had 12-18 months experience, with three of them having worked on CNW projects for less than 12 months (25 percent of the total). Each nutritionist was working on a maximum of 3 projects simultaneously. So, the nutritionist managers were very experienced at working in this context but more than half of the community nutritionists had limited experience.

This chapter is broken into four main segments. The first presents and critiques the community nutritionist’s perceptions of their roles. The second segment explores their feelings of their own and their Indigenous partners personal knowledge, skills and attributes. Both the nutritionists and managers perceptions of enabling factors are examined in the third section. Finally, personal understandings of confidence and satisfaction are explored.
Nutritionists perceptions of their roles in Community Nutrition Worker projects

Nutritionists perceptions of their roles in Community Nutrition Worker projects

Nutritionists responses to the question “What do you do in these projects?” are
summarised in Table 4.1 below.

Table 4.1 Nutritionists roles in Community Nutrition Worker projects

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Respondents (total=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitating Training</td>
<td>10</td>
</tr>
<tr>
<td>Supporting Community Nutrition Workers (CNWs)</td>
<td>8</td>
</tr>
<tr>
<td>Promoting CNW projects and CNWs</td>
<td>7</td>
</tr>
<tr>
<td>Facilitating planning</td>
<td>7</td>
</tr>
<tr>
<td>Building relationships</td>
<td>4</td>
</tr>
<tr>
<td>Brokering professional networks and resources</td>
<td>4</td>
</tr>
<tr>
<td>Motivating and encouraging workers</td>
<td>3</td>
</tr>
<tr>
<td>Working within a settings context</td>
<td>3</td>
</tr>
<tr>
<td>Specific nutrition activities</td>
<td>3</td>
</tr>
<tr>
<td>Problem solving and liaison</td>
<td>3</td>
</tr>
<tr>
<td>Empowerment activities</td>
<td>2</td>
</tr>
<tr>
<td>Building confidence of CNWs</td>
<td>2</td>
</tr>
<tr>
<td>Activities mentioned once only:</td>
<td>1</td>
</tr>
<tr>
<td>Administration and reporting, Health Promotion Incentive Fund projects, being a nutrition “expert”, provide “clinics”, undertake evaluation</td>
<td></td>
</tr>
</tbody>
</table>

Community nutritionists are consistently clear about the nature of their key roles within
CNW projects. They perceive that their role is to essentially strengthen the capacity of
their Indigenous partners and communities. The responses provide included a long list of
quite specific functions. Four key roles were identified; facilitating training, supporting
CNWs, promoting the projects and workers and facilitating planning. The nature of this list shows that most projects were predominantly in the developmental stage in comparison with the NSW Capacity Building Framework (NSW Health, 2000).

The most regularly mentioned role was that of a facilitating training (83 percent of Nutritionists). This role is a direct reference to a key target in the NT Food and Nutrition Policy (THS, 1996b) via the Certificate 1 in Health (Aboriginal Communities) (Pundulmarra College, 1997). Three respondents mentioned that training was specifically achieved via working together, another three mentioned that training activities were planned within CNWs priorities. “Lauren” explains her perception of the importance of this role, specifically in relation to developing a positive environment for reciprocal adult learning, which involves personal challenges:

*all the while you are trying to create an atmosphere where it's easy for you to share information, so you've got an environment that is allowing that worker to be able to extend herself and challenge new areas that they haven't done before. Often you're learning about them and they're learning about you at the same time, and there's quite a lot of that stuff to get through before you can achieve any outcomes. That's a real focus*

(Lauren)

Nutritionists support CNWs and SWWs in many different ways. Four nutritionists specifically said that it was their role to provide support as requested by the workers and the wider community involved in the project. This accords with the principles of community development whereby support staff work to community directions and priorities (Kenny, 1994). General requests for assistance are more likely to arise in communities where there is limited administration or general support. Willingness to
provide more holistic support for the CNWs, groups or a community’s general
development priorities helps to strengthen relationships within the projects.

Fifty eight percent of nutritionists said one of their roles was to promote CNW projects
and CNWs roles inside and outside the community. This promotion is predominantly
targeted at council and health centre staff, store management, other visiting professionals
and health executives. This advocacy role is intended to promote participation and
collaboration in the projects and support for the CNW, project goals and activities.

Facilitating and participating in planning processes in the community was rated (equally)
third important (58 percent of nutritionists). The types of key terms used included
“process facilitator”, “identify realistic goals”, “consultation regarding (project)
development”, “help to set up program”, “establishing the roles and responsibilities” and
“project planning and evaluation”. As one nutritionist said:

to a certain degree [I was] the process facilitator when that was required, certainly
at Community X I had a greater role than at Community Y where the coordinator
was a very organised and talented young woman (...) I think I came to it with a
feeling that I couldn’t predict the outcome with clarity and that part of the planning
process was to identify what was realistic to achieve.

(Jan)

Jan’s comment provides another of the many examples indicating that that nutritionist’s
roles could vary significantly depending on the capacity of the CNWs and the community
supporting them. The range of less frequently mentioned functions could also reflect this
variation.
Only two nutritionists specifically said it was their role to “empower” CNWs. Most made it very clear that their role was not to specifically lead CNW projects, supervise or manage CNWs or overtly direct the course of each community project’s priorities for action. Many of the specific functions described are in fact aimed at empowering CNWs and communities, such as ensuring CNW and/or community control in decision making and implementing project activities:

I try and make it a point of having every decision made by them [CNWs and Indigenous community members]. Certainly [I am] providing suggestions, but [I am] not doing the doing. Allowing [CNWs and Indigenous community members] being the front person all the time

(Paula).

This nutritionist is demonstrating a conscious awareness of the need for Indigenous control of decision making and leadership in activities. Another nutritionist describes this process as involving the conscious suppression of any personal agendas:

You’ve got to be careful not to put your own agenda in their [CNWs and Indigenous community members] mouths (...) It is really important to sit back and listen and take things in (...) the outcomes you want to see [are] quite different within each of the communities depending on what the workers motivations are

(Angela)

It is relevant to note here that the roles of CNWs are set by the project priorities of each community and often by the worker themselves. The community may decide that they want the worker to concentrate on child health and growth but the CNW will often decide what she will do and who she is comfortable working with in relation to that priority. A
nutritionist can only make suggestions and offer encouragement for different potential courses of action.

Health professionals strengthen community capacity to improve health outcomes by sharing up to date scientific knowledge about food, nutrition and public health issues, action strategies and indicators. Only one nutritionist mentioned, *my role was really to be the content expert* (Jan). Activities that would involve sharing scientific knowledge were generally mentioned as practical examples of training and support provided by working “together” or “side by side” in a particular community context. Specific activities mentioned included:

- planning recipes, menus and food orders in meal programs for children, elderly and disabled people
- market basket surveys, feeding back results and follow up action to improve the quality, quantity and affordability of the food supply
- diabetes awareness projects and diabetes education for individuals
- supporting growth assessment and action programs run through health centres,
- specifically encouraging and supporting community action to promote the growth and health of children
- healthy food promotions and education activities in community settings like stores, women’s centres and schools

These nutritionists primarily defined their roles in terms of strengthening capacity for action per se. Their description did not focus on food, nutrition and health targets. None of the Nutritionists directly mentioned that their role in these projects was to achieve the objectives of the NT Food and Nutrition Policy; better food and health for Territorians (THS, 1996b). This is surprising given that it is the overall aim of the community nutritionists job profiles from 1996 onwards. One nutritionist said, *the goal of the role*
was to improve the nutritional status of the local population through prevention strategies (Lindy). Perhaps they did not mention that their ultimate aim was to improve nutritional status and health outcomes because they were interviewed by another NT nutritionist (myself) whom they know is well aware of the broader aim of nutrition services. Knowing the group well, as I do, I think this is a highly plausible explanation for this omission.

The emphasis of their responses indicates that at that time they were interviewed nutritionist role was predominantly focused on strengthening capacity as an end in itself not strengthening capacity as a means to an ends; better health. This lack of regular direct connection to health outcome targets could be viewed as alarming. Health services are funded to improve health. Clark (1999) exposed a lack of connection between capacity building as a means to achieving better Indigenous health in the themes discussed by Environmental Health Officers (EHOs) working in the Aboriginal Environmental Health (AEHW) program in the NT. She concluded that the AEHW program was therefore seriously at risk of leaving environmental health problems unresolved. But is this conclusion necessarily equally applicable in the case of the nutritionist’s responses? Possibly it is, but probably it is not. Responses here need to be considered in conjunction with responses to other questions. Other segments demonstrate that nutritionists are clearly striving to achieve food, nutrition and health gains.

Three of the nutritionists (25 percent) mentioned that building relationships with workers and community people was an important role. This appears to contrast somewhat with their responses to a later question on enablers, when eight (two thirds) of them mentioned relationship building as a key enabler. Perhaps it is under reported as a role because relationship building is perceived as being integral to the roles generally. Two nutritionists provided specific examples of how the legitimacy of “relationship building” activities is often questioned by other health professionals or non-Indigenous community
members. Two of the three nutritionists (16 percent of total respondents) who mentioned that relationship building was a role were relatively inexperienced. This is consistent with Clark’s (1999) finding that less experienced EHOs were more likely to discuss relationship building as part of their role. Clark expressed concern that a number these EHOs were demonstrating “cultural paralysis” by over emphasising relationship building or perceiving that it needed to precede other activities. There is insufficient evidence here to conclude that a similar “paralysis” existed amongst some of these nutritionists.

Evaluation was identified as a role by only 1 nutritionist. Perhaps it was not mentioned more frequently because many of the projects were in their early developmental stages, where most nutritionists interviewed were still focusing on developing relationships, training and planning. It is expected, however, that evaluation is planned from the beginning in health promotion projects, so lack of focus on this issue here is a significant omission. It could indicate that evaluation is a poorly valued function. Fortunately, this suggestion is contradicted by answers to subsequent questions. This example alludes to tensions underlying the demonstration of nutritionist’s commitments to evaluation.

Generally the roles listed were generic and not specifically focused on food and nutrition promotional activities or outcomes. The top 2 roles, training and support are the same as those described by 15 Environmental Health Officers working in Aboriginal Environmental Health Worker programs in the NT (Clark, 1999). The top three roles; training, supporting and facilitating confer exactly with the key roles for local and regional community nutrition professionals in Australia as defined by Steele (1995). The appropriateness of this emphasis was reinforced by the National Specialty Program in Public Health and Community Nutrition (Campbell, Steele, Woods and Hughes, 1997). These perceptions are generally very consistent with national pubic health, nutrition and health promotion practise priorities (King and Ritchie, 1999; National Public Health Partnership, 2001; National Aboriginal and Torres Straight Islander Nutrition Strategy
and Action Plan, 2001; Strategic Inter Governmental Nutrition Alliance, 2001); and recent editorial summation of key functions to work effectively to improve Indigenous nutrition in Australia (Pollard, 2002).

**Nutritionists perceptions of key knowledge, skills, resources, personal attributes and experience for themselves and their indigenous partners**

Twelve Community Nutritionists interviewed were asked the following 2 questions;

- What key personal knowledge, skills and resources have you felt to be most useful and important in your side by side work?
- What key personal knowledge, skills and resources do you feel the Nutrition/Strong Women Workers bring to their work?

This section summarises and discusses their responses. Table 4.2 and 4.3 (following page) provide a summary of the themes in their responses.
<table>
<thead>
<tr>
<th>Response</th>
<th>No. Respondents (total=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KNOWLEDGE</strong></td>
<td></td>
</tr>
<tr>
<td>Scientific and professional knowledge</td>
<td>5</td>
</tr>
<tr>
<td>Cross cultural</td>
<td>4</td>
</tr>
<tr>
<td>Community development principles and processes</td>
<td>3</td>
</tr>
<tr>
<td><strong>SKILLS</strong></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>7</td>
</tr>
<tr>
<td>Creative education</td>
<td>7</td>
</tr>
<tr>
<td>Relationship building and networking</td>
<td>4</td>
</tr>
<tr>
<td>Diplomacy and liaison</td>
<td>4</td>
</tr>
<tr>
<td>Personal learning</td>
<td>3</td>
</tr>
<tr>
<td><strong>RESOURCES</strong></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>6</td>
</tr>
<tr>
<td>Nutrition team and management support</td>
<td>4</td>
</tr>
<tr>
<td>Process models and plans</td>
<td>3</td>
</tr>
<tr>
<td>Practical education resources</td>
<td>3</td>
</tr>
<tr>
<td><strong>PERSONAL ATTRIBUTES</strong></td>
<td></td>
</tr>
<tr>
<td>Patience</td>
<td>8</td>
</tr>
<tr>
<td>Flexibility and innovation</td>
<td>3</td>
</tr>
<tr>
<td>Non dominating personality</td>
<td>3</td>
</tr>
<tr>
<td>Motivator/optimistic</td>
<td>3</td>
</tr>
<tr>
<td><strong>EXPERIENCE</strong></td>
<td></td>
</tr>
<tr>
<td>Indigenous cross cultural work experience</td>
<td>8</td>
</tr>
</tbody>
</table>
### Table 4.3 Nutritionists perceptions of Community Nutrition Workers

**key knowledge, skills, resources, experience and personal attributes**

<table>
<thead>
<tr>
<th>Response</th>
<th>No. Respondents (total=12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KNOWLEDGE</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>11</td>
</tr>
<tr>
<td>Cultural</td>
<td>8</td>
</tr>
<tr>
<td>Knowledge of food and food behaviors</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal Health Worker training</td>
<td>2</td>
</tr>
<tr>
<td>SKILLS</td>
<td></td>
</tr>
<tr>
<td>Communication skills and networks</td>
<td>8</td>
</tr>
<tr>
<td>RESOURCES</td>
<td></td>
</tr>
<tr>
<td>None mentioned specifically</td>
<td>0</td>
</tr>
<tr>
<td>PERSONAL ATTRIBUTES</td>
<td></td>
</tr>
<tr>
<td>Sense of realism</td>
<td>3</td>
</tr>
<tr>
<td>Role model</td>
<td>1</td>
</tr>
<tr>
<td>Motivated/motivator</td>
<td>1</td>
</tr>
<tr>
<td>OTHER COMMENTS</td>
<td></td>
</tr>
<tr>
<td>Fundamental importance</td>
<td>5</td>
</tr>
<tr>
<td>“Brokering” role assists Nutritionists</td>
<td>4</td>
</tr>
</tbody>
</table>

In addition to knowledge, skills and resources, preliminary analysis of the data collected indicated the presence of 2 other groups of personal factors; personal attributes and experiences. Hence these groups of factors are separated out in Tables 4.3 and 4.4. The nutritionists provided more extensive detail regarding their own key personal knowledge, skills, resources, personal attributes and experience than those of their Indigenous partners. The emphasis on asking them to list “personal” knowledge, skills and resources strongly influenced the range of responses to these questions. Only a small number of the factors identified were not of a personal nature.

Personal knowledge, skills, resources, attributes and experience are interwoven. They come together in the nutritionists ability to strengthen the capacity of CNWs and communities to improve health and wellbeing. Paula provided a detailed view:
I think one understanding is the understanding of community development, and the role of the community worker in conducting projects and being at the fore front of those projects, being the key person. Having an idea of when to step back, how to step back, and let people run things themselves. I don't necessarily think that it is any training that I have received in my post-graduate training as a dietitian, but it's more getting an understanding of being a support person and a facilitator and being there and being a listener. I think some of the key things that you learn very quickly, is that there is an understanding of what community development is and putting people at the front of their projects and not taking over and having patience with that because it does take a long time

(Paula)

In this context practical cross-cultural knowledge includes knowledge about what is acceptable and appropriate behaviour when working with a particular group of Indigenous people. New NT DHCS staff now have access to cross cultural training in the form of the compulsory 3 stage Aboriginal Cultural Awareness Program. One nutritionist mentioned that cross cultural training was useful but insignificant compared to what I have learnt from some of the workers on their communities. What they've shared…

(Lauren). Many others shared this view in various ways leading me to conclude that the group believes that practical cross cultural knowledge is primarily acquired through experience.

Nutritionists mentioned scientific and professional knowledge more often than other types of knowledge. Despite this, their emphasis indicated that cross-cultural knowledge and work skills were significantly more important than scientific knowledge in the practical performance of their roles. Communication, interpersonal relationship building and diplomacy skills, creative educational and personal learning skills were described.
often. The development of appropriate cross-cultural skills has its basis in one’s ability to build and maintain relationships with Indigenous people:

_ I think relationship building is important when working side by side with Aboriginal people. I think they value that quite highly. That can’t be underestimated. Like [it helps] if you are not an overly shy person. It helps if you are a sociable person who can make people comfortable and make friends easily. This really helps you get through the early stages and the tough times. Mind you, you can’t be too outgoing or outrageous, particularly with befriending people of the opposite sex. You have to be respectful and careful also. This in turn earns you more respect._

(Angela)

Many of their responses displayed the need for intelligent self-awareness, or critical consciousness, when working with people who have different perspectives. Rachel describes it this way:

_ probably for me it is that awareness or knowing to keep reminding myself … to respect their culture and way of doing things you know and expect to operate that way rather than in my way, …. [to] remind myself that when sitting down working with someone that I’ve go to take time, I’ve got to listen … and give positive reinforcement appropriately and not say everything’s fantastic… give appropriate reinforcement. maybe because that’s something that I think doesn’t come naturally._

(Rachel)

Not withstanding some paternalism ("give reinforcement"), the degree of critical self-consciousness that this quote portrays demonstrates commitment to the deconstruction of knowledge from the dominant worldview and reconstruction of new understandings that are respectful of differing worldviews. These insights and perceptions of the creation of knowledge, respect and trust are consistent with the principles of grounded adult learning.
theory and practise espoused by Freire (1972) when he describes learning as a dialogue between individuals who are both teachers and learners. Wass (1994) says that practitioners must reflect on their beliefs and values to enable them to effectively respond to individuals with different values. This deconstruction and reflective, inclusive reconstruction of knowledge is also a hallmark of cross-cultural competency (Fitzgerald, Mullavey-O’Byrne, Clemson and Williamson, 1996; Trudgen, 2000). Fitzgerald, Mullavey-O’Byrne and Clemson, (1997:14-15) suggest that because all practitioners and all clients are “cultural beings”, “this suggests that [cross] cultural competency is simply best practise for all practitioner-client interactions. I think that many NT Nutritionists, such as myself, would agree with this statement based on our personal experience and reflection. This evidence leads to the conclusion that the application of education theory designed to raise practitioner’s critical self awareness of the nuances of power in their interactions with people is crucial for the development of professional competency in this context and beyond.

The most useful and scarce resource mentioned was time. Time, to concentrate on working with communities and workers to learn from community people and to visit whenever CNWs or communities request it. The realities of community life and responsibilities are that motivation can be rapidly lost or demanded and transferred elsewhere so they acknowledge that requests need to be supported as best as possible.

Patience is a mandatory personal requirement for working successfully within a community development model. This is another reason why time is an important resource. Three more experienced members believe nutritionists are personally more successful if they have the ability to stand back and listen easily, enjoy working with Indigenous people and are passionate about it. For some people this is more difficult and two nutritionists in the sample surveyed acknowledged this point.

J Priestly  Chapter 4: Talking straight about trying to be strong partners
Experience can make a valuable contribution to the development of culturally appropriate interpersonal skills. It helps develop a realistic understanding of the time it takes to build relationships, get things done and the up and down cycles of community life. Also, it equips people with an understanding of the sorts of activities that are likely to be interesting, engaging and realistic. Ella relates the value of experience in her personal story:

one of the greatest things is that I have previous work [experience] with Aboriginal people...and understand what it's like to work in communities and how many interruptions like funerals and cursing can really affect your work. ... what it is like to educate and train people and what things can impact on the effectiveness of training... I draw upon that all the time. I think that experience has enhanced my work with Aboriginal people, that I can say I have worked on the community before and it puts me onto a different level.... I believe I've got a realistic and practical view  

(Ella)

Unfortunately four of the nutrition managers were not asked this question. Two managers were asked, only, because they answered both questionnaires. Comparative analysis of the managers perspectives would have provided valuable data for this critique. Analysis of data from other questions to managers indirectly suggests that they would support the major factors identified by the nutritionists. These managers have been responsible for the development of job profiles and selection criteria over the last 10 years. The fact that the 5 most commonly mentioned factors are represented in the selection criteria for these job profiles provides circumstantial support for this assumption (THS, 2001c and d).

Nutritionists responses provide an indication of their perceptions of their professional weaknesses. Many comments demonstrate that commitment to this approach is often not "natural" or "easy", precisely because it is not commonly learned in one’s primary general or professional socialisation. Therefore, the origins of many weaknesses lie in the
fact that they belong to a dominant and different culture to that of the people they are employed to assist. It exposes the fact that their primary professional training and socialisation poorly equips them for work in this Indigenous cross-cultural context. This situation may be a result of the fact that this group of nutritionists all originally trained as clinical dietitians. This conclusion is in accordance with that of research cited by the National Specialty Program in Public and Community Health Nutrition (Steele 1996, cited in Campbell et al, 1997:23) where public health nutrition practitioners expressed many learning needs which are inadequately included in dietitian’s academic training in Australia. This conclusion is consistent with that expressed by many other health professionals working in this context and across Australia (Standen, 1998; Clark, 1999; Valadian, Chittleborough and Wilson, 2000; Humphery et al, 2001). Valadian et al (2000) note that 87 percent of the SA Department of Human Services staff respondents in their study believe they and their clients would benefit if the workforce attended Indigenous cross-cultural awareness training.

Nutritionists display a detailed understanding of the unique knowledge, skills and experience of the CNWs and SWWs and clearly value these attributes highly. Their cultural and community knowledge and relationships, communication skills and networks, sense of realism and ability to act as a broker, are most widely recognised. Almost half of the nutritionists demonstrated a high degree of respect for the fundamentally essential role of CNWs as Indigenous nutrition professionals. One nutritionist puts it very bluntly *it’s really important that we do work in partnership with the nutrition workers on projects otherwise you may as well just forget it basically* (Melissa). This view is consistent with the views expressed by many EHOs working on Aboriginal Environmental Health programs in the NT (Standen, 1998; Clarke, 1999).

Eleven nutritionists (92 percent) mentioned that they highly valued CNWs knowledge and skills, which are the result of their membership of an Indigenous race and
community. Long term community members bring a detailed knowledge of the community and it's culture, the relationships between the individuals and culturally appropriate ways of working with different people in different situations. This also includes knowledge of food habits, skills and resources and lifestyles. This is important background information required to design nutrition promotion strategies and messages. Community members know the realities of family's lives and how they live. This includes knowledge of traditional and non-traditional food availability, collection, preparation and distribution methods. Their knowledge is crucial to ensure project plans are realistic, achievable and hopefully successful. This knowledge is power and strengthens capacity to promote health improvement.

Some of the CNWs have been practising AHWs. Basic health worker knowledge, skills and experiences are an advantage for a CNW or SWW, it means they already have some scientifically based food and health knowledge. It makes getting started on their own food and nutrition projects and supplementing their scientific knowledge is much easier.

Communication skills and networks were the second most frequently mentioned key personal attribute of CNWs (by 67 percent of nutritionists). These skills include being fluent in local languages, knowing how, and to whom, to present information and how to make it interesting. Knowledge and skills in local languages is so important to improve the reach and effectiveness of the nutrition messages. Non-verbal communication is extremely important in NT Indigenous culture (Harris, 1976) so the SWWs and CNWs non-verbal communication skills are vital to improve communication effectiveness.

Qualitative researchers have identified that non Indigenous health professionals in the NT often verbalise a perception that a key role of Indigenous health workers is to act as cultural brokers or assistants (Standen, 1998; Humphery, Weeramanthri and Fitz, 2001). One third of nutritionists mentioned a brokerage role for CNWs when responding to this
question. An equal number, however, mentioned this is also a role that nutritionists play for their Indigenous partners. They are acknowledging that each group has a reciprocal brokerage role, opening up access to information, networks and resources between individuals and cultures. This is a more egalitarian perception of the notion of cross cultural brokerage than that identified by the Environmental Health Officers in Standen’s (1998) study and more like the community based practitioners “active” descriptions of AHWs brokerage roles in the work of Humphery et al (2001:80).

A comparison of the similarities and differences in nutritionist’s reflections on the key knowledge, skills, resources, personal attributes and experience of each cultural group is revealing. Surprisingly few factors appeared in both lists; communication skills, scientific and professional training of some form, a sense of realism and being motivated and able to motivate action for change in their community. The major differences reveal that nutritionists most valued the different and unique personal strengths of their partners. They acknowledge that each group has a reciprocal brokerage role, opening up access to information, networks and resources between cultures and individuals.
Enabling Factors

our scientific nutrition knowledge is why we are there largely... for us that is the easy part, I don’t think it’s something we should overlook ....but the things that actually make it easier for us  [are different]

(Grace)

Twelve nutritionists were asked, what makes (this work) easier? Essentially they listed a range of factors that enabled them to do their work more easily. Their responses are summarised in table 4.4 below. Many of the six nutrition manager’s responses to the range of questions they were asked included many general “enabling” factors. This is a natural consequence of the fact that they all have considerable experience working on food and nutrition projects with community based workers of various kinds. The frequency of their responses on the themes presented by nutritionists is summarised in the last column of Table 4.4 for comparison with the nutritionist’s list and to facilitate a more detailed critique.
Table 4.4 Nutritionists and Managers perspectives on enabling factors

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Nutritionists Total n=12</th>
<th>Number of Managers Total n=6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GROUP 1: DEVELOPING PARTNERSHIPS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spending time forming and maintaining relationships with Indigenous workers</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>Developing support networks and collaborating with other community people and professionals</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td><strong>GROUP 2: PERSONAL ATTRIBUTES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritionists personal attributes</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Strong motivated community workers</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td><strong>GROUP 3: COMMUNITY + MANAGEMENT SUPPORT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good community support for workers and the projects generally</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Good quality management support for nutritionists and program</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>GROUP 4: FUNDING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible and accountable funding</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td><strong>GROUP 5: REALISTIC GOALS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Realistic goals</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td><strong>GROUP 6: PROCESS GUIDELINES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having and implementing community development process guidelines</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Having guidelines for, and implementing, evaluation</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td><strong>OTHERS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate recruitment procedures including culturally appropriate procedures for community workers</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Professional experience in food and nutrition projects in remote Indigenous communities.</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Marketing and promoting CNW projects</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Responses to this question included extensive examples. On analysis eleven main themes were delineated, each having been described in the examples of at least 3 respondents.

These included six main groups of enablers; the first group related to developing
collaborative partnerships and second group to the personal attributes of key project workers. Community and management support was the third group followed by flexible and accountable funding then, realistic goals as the fourth and fifth groups respectively. Having and implementing community development and evaluation process guidelines was the sixth most common group of themes. Given the volume of data obtained enablers listed by less than 3 respondents (25 percent) of nutritionists are not presented here. Many of the enabling factors had already been exposed in responses to previous questions.

Activities that promoted the establishment of collaborative partnerships were the most commonly mentioned group of enablers (8 nutritionists=67 percent). This included forming partnerships with both Indigenous workers and other stakeholders from both community and organisational settings. The personal attributes of key project workers; nutritionists themselves and their Indigenous partners were the second most commonly listed group of enablers. Much of what was mentioned here has already been detailed in the previous section on key knowledge, skills, personal attributes and experience. This time they spoke more specifically about the need for “strong” motivated community workers. The term “strong” was used to refer to people who had clear ideas about what action should be taken and, who were self motivated and confident. The following comment is typical of the examples provided on this theme:

where nutrition workers have come forward and said I want to do some stuff for nutrition or I want to run a project or I want to do that, that’s where we have had most success.

(Paula)

The third most commonly mentioned group of enablers related to good support. This included good community support for workers and the projects and good quality management support for nutritionists and the CNW program. This includes strong
community support for the worker on a day to day basis and the community’s objectives for the project. A variety of support is best, from community people, their employees like council staff and significant others like store managers, women’s centre and health centre staff. The evidence demonstrates that intersectoral support is very important to get things going and achieve results.

Positive management support was described in different ways, most frequently as support to manage the enormous levels of real and “potential” demands on nutritionist’s time that can overwhelm them, especially in the early years:

I guess in my position I was overwhelmed that there were 18 communities and 1 nutritionist. I think that support at the managerial level is important, so that I’m just concentrating on 1 or 2 communities.

(Angela)

Her story exemplifies the widely held belief that each professional can realistically only work with 1 or 2 communities intensively in any one period of time. This view is shared by Environmental Health Officers working in similar contexts (Standen, 1998). Community nutritionists support the generalised relevance of this enabling factor nationally (Steele, 1995). Other nutritionists mentioned the need for good quality mentoring and support from management, which included receiving clear advice on management expectations from the beginning.
I think the most helpful resource has been the nutrition team and the management of the nutrition team. Always being there supporting, guiding and training us as we’ve needed, which has given great strength to the work. You don’t feel like you are fighting. I mean there’s bureaucracy but the actual work, you feel like you have a lot of support towards what you are actually doing.

(Lindy)

This extract also serves to demonstrate the generally high degree of cohesion, strong professional culture and collaborative organisation amongst nutritionists in the NT in the late 1990s. This support and social unity undoubtedly reduced and helped nutritionists cope with the range of difficulties experienced. The fact that the Public and Population Health managers in both Operations North and Central (Regions) were both nutritionists over this time was undoubtedly another enabler. So, too, was the presence of the NT Food and Nutrition Policy. Nutrition was the only allied health group to have a departmentally ratified policy to direct the course of their professional practise at that time.

Nutritionists felt that more flexible and accountable funding mechanisms were useful to them personally, for individual community projects and the CNW program as a whole. More flexible and accountable funding mechanisms were usually expressed as a perceived need, things that were required but not necessarily readily available. The use of community development and evaluation processes guidelines was mentioned by one third and one quarter of nutritionists respectively. Comments demonstrated that the models and examples available were helpful to a certain extent.

Appropriate recruitment procedures and selection criteria are vital to secure nutritionists with the personal qualities identified as enabling factors. In particular implementing, supporting and respecting Indigenous selection processes. Three nutritionists also mentioned that it is important that community members select CNWs, as they themselves
have no conception of what criteria the community feel would be most appropriate from a
cultural perspective. Community members are the only people who can choose who is the
most culturally appropriate person/s to undertake the proposed responsibilities of the
CNW/s in their community. Two mentioned the need to sensitively seek an understanding
of why a particular worker/s was chosen. This enables professionals to respect the
workers cultural suitability so their expectations of the workers are more realistic. This
finding is supported by the work of Mitcalfe (1993) who came to similar conclusions in
her study of issues in program development and delivery for Indigenous Territorians in
remote communities. The insightfulness of many of these comments demonstrates the
depth of cultural awareness that they have developed.

Surprisingly, only 3 nutritionists (25 percent) mentioned that experience made the work
easier. Perhaps this occurred because they felt they had already covered the value of
experience, in another part of the interview. Eight respondents (66 percent) mentioned
experience when asked what personal knowledge, skills and resources were felt to be
most useful in their work side by side.

Enabling factors not specifically mentioned by more than one nutritionist included
communication, formal training and qualifications and leadership. Good communication
skills are fundamentally important to the development of the most frequently mentioned
group of enablers; developing collaborative partnerships with community workers and
other stakeholders. It is an integral component of the second most common group of
enablers listed, the personal attributes of nutritionists, and strong, motivated community
workers. The omission of reference to any formal training or qualifications, even in
something like health promotion strategies and methods, indicates these things might be
considered to be of limited value in a practical sense. Alternatively, perhaps they just
have taken these things for granted. Nutritionists talked about practical examples of
leadership from various sources, instead of referring to leadership as a specific enabler.
The enablers identified by the managers were very consistent with the factors the nutritionists spoke of. This consistency in views highlights the strength and importance of this list of themes and therefore their reliability and credibility. The managers were the only group to mention marketing and promotion of the program as a key enabler to facilitating firstly, greater systemic support for the program and secondly, greater participation at the community level. Managers were less likely to list personal attributes of community based workers, partners having realistic goals or implementing process guidelines. These differences are possibly because their involvement with the programs is more structural, in that they are not working on the project at the community level but are supporting the project from an executive perspective through resourcing, advocacy, support and perhaps problem solving and evaluation.

In a study of the Aboriginal Environmental Health Worker (AEHW) program in the Top End, the regionally based non Indigenous people interviewed identified a number of reasons for the achievements of that program (Standen, 1998). This list bears a strong resemblance to the lists of enablers and knowledge, skills and personal attributes identified by nutritionists in this current work. Their list of enablers includes good support, community dynamics/attributes, clear roles and responsibilities, personal qualities, partnerships, cultural knowledge, consistency of activities and education, skills and training. The replication serves to cross validate the findings of both research endeavors. Dianne Clark’s doctoral thesis is a detailed sociological analysis of both the history of Indigenous Environmental Health Worker Program in the NT and its current developments against the framework of critical theory (Clark, 1999). Primary analysis of the interviews she conducted with professionals generally reinforced the overt enabling factors listed in Standen’s work and those of this current study. Her work also identified a more detailed range of sociological barriers and enabling factors for the program as a whole. Humphery, Weeramanthri and Fitz (2001) investigated issues related to the
biomedical concept of patient “non compliance”, in which they documented and discussed the reflections of predominantly non-Indigenous Health professionals. They uncovered similar themes in relation to the value of experience and cross-cultural training.

In relation to capacity building theory the enabling factors listed incorporated elements of the five major action areas outlined in the NSW Capacity Building Framework (NSW Health, 2000); partnerships, leadership, workforce and organisational development and resource allocation. Therefore, the major enablers all contribute in some way to strengthening capacity in each of the three major dimensions of that model; infrastructure and program development, program maintenance and sustainability and problem solving.
Personal Confidence and Satisfaction

Eleven nutritionists were offered the opportunity to answer an optional question; “Please describe your own sense of personal confidence in performing this role in these current situations?” Their answers are summarised in Table 4.5 below.

Table 4.5 Nutritionists sense of personal confidence

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally confident</td>
<td>10</td>
</tr>
<tr>
<td>Not very confident</td>
<td>1</td>
</tr>
<tr>
<td>Confidence is variable</td>
<td>2</td>
</tr>
<tr>
<td>Experience increases confidence</td>
<td>5</td>
</tr>
<tr>
<td>Improving networks increases confidence</td>
<td>4</td>
</tr>
<tr>
<td>Observing and learning from peers, colleagues and Indigenous workers increases confidence</td>
<td>4</td>
</tr>
</tbody>
</table>

Generally NT community nutritionists feel confident about performing their roles in community based projects. Adjectives like “fairly”, “mostly” and “generally” were used often. This terminology and the tone generally indicates that they are not overly confident and display critical self-awareness as this following comment demonstrates:

So I wouldn’t say that I’m overly confident but I’m happy with the way things are progressing (...) there is certainly a lot to learn and I think that if I continue to take it slowly and listen and learn from the Health Workers that there will be some good outcomes and my confidence will only improve with it

(Rose)

Only one Nutritionist who had very limited experience indicated that she did not feel very confident. All respondents made some comments about the factors affecting their sense of confidence. Experience undoubtably increases confidence. Experience provides
opportunities to improve personal networks and learn from other Indigenous and non-Indigenous health professionals. In a sense they are saying that when workers from different cultures work closely and cooperatively together, sharing different worldviews, this strengthens capacity to work in cross-cultural contexts reciprocally. This reciprocity and its value in improving professional competence in the community development field is similarly acknowledged by Kenny (1994) and Wass (1994).

Two nutritionists mentioned that their sense of personal confidence is variable, essentially being dependent on how things are going in a particular community context and/or with particular workers. Again these were relatively inexperienced practitioners. Their descriptions linked their sense of personal confidence to their ability to “effect, “deliver” or demonstrate progress in particular community projects. The comments of these relatively inexperienced nutritionists are indicative of a lower level of awareness of power issues generally. Generally, the analysis of responses indicates that experience in this context develops greater awareness that many of the variables affecting a project’s progress are, and should be, subject to the control of Indigenous people.

Nutritionists have often been heard to comment that it is good to work with at least one community that is clearly focused and taking action at any particular point in time. This provides a sense of balance if progress is more difficult in another community.

Workshops and opportunities to observe other nutritionists at work can give people a sense that other people are experiencing the similar issues and frustrations. The observers usually leave feeling more confident about their own performance. Working alongside and debriefing with peers, generally provides highly valued learning experiences, and often promotes practitioner confidence. Positive and constructive feedback from peers and colleagues about one’s own performance is highly valued in the examples given. Fitzgerald and others (1997) came to a similar conclusion about the value of practical learning experiences: our work suggests that the development of cultural competency
based on issues associated with actual events "is best practise" for addressing the needs of all clients and practitioners (Fitzgerald et al, 1997: 1).

Experience, commitment, confidence and satisfaction are closely linked as the following comment demonstrates:

the work becomes easier, more productive and more satisfying with experience (…)
I am more open to small indicators of success (…) I think that we should be encouraging [new professional] people to stick around for at least 3 years.

(Liz)

None of the nutritionists or managers was asked to comment or describe on how satisfied they felt. Seven Nutritionists and four managers, however, did comment on their sense of satisfaction throughout the course of their interviews. The nutritionists usually mentioned satisfaction when talking about their personal feelings of confidence.

The majority of both nutritionists and managers described feelings of satisfaction in terms of personal connections with Indigenous people and indicators of community development. Increased capacity, confidence and action by Indigenous co-workers and community people generally were often described. Some talked about the fun and unique experiences they have had, describing feeling “lucky” and “privileged”. Satisfaction was very infrequently described as being derived from improved health outcomes. Many respondents with at least a few years experience expressed a belief that disempowerment and poor self-esteem lie at the root of Indigenous health problems, that general community development is the most highly valued outcome from which improved health will flow. Some derive feelings of satisfaction from having played some small part in the development process. The following comment exemplifies these themes:
I see the root of the difficulties is loss of self-esteem, purpose and culture. Being swamped by the dominant white culture. (...) what I want to see is a strong community that has pride in themselves and has a strong culture, which might be a different culture from the traditional culture but they are doing something for themselves. I think that's what I'm sort of working for. When we achieve that the nutrition will improve as well (...) if we can be a part of increasing people's esteem... I think we have had a small part to play in that success.

(Angela)

It is inappropriate to attempt to draw any firm conclusions from the frequency of these comments as not all respondents were asked to comment on these issues specifically. Although, these examples demonstrate that commitment, informal cross cultural learning and professional experience may lead to the development of a greater awareness of power issues and the need to work towards increasing Indigenous control and independence.

The NT health professionals surveyed in Humphery, Weeramanthri and Fit's (2001), study on 'rethinking compliance' also often expressed strong contradictory feelings of both satisfaction and frustration. They concluded, however, that interest and experience in Indigenous health does not necessarily translate to a greater consciousness about issues of professional and biomedical power, inter-cultural relationships or the socio-economic realities of everyday life (2001:48).
Summary

Common themes reverberate and are closely interrelated: relationship building, commitment, cooperation, communication, capacity building for health improvement, and critical reflective adult learning.

Community nutritionists perceive that their role is to essentially strengthen the capacity of their Indigenous partners and communities to improve health, through training, support, promoting and facilitating action. They demonstrated a high degree of respect for the fundamentally essential role of Indigenous community based Indigenous health professionals. They were adamant about the need to form strong mutually supportive partnerships with a variety of stakeholders. The unique knowledge, skills and experience of the CNWs and SWWs are highly valued by nutritionists. So, too, are positive interpersonal attributes, good community and organisational support mechanisms, flexible and accountable funding and process guidelines.

Experienced nutritionists believe that self-awareness of the nuances of power in interpersonal and inter-cultural interactions with people is crucial for the development of professional competency in this context. Therefore educational and methodological approaches that promote self-awareness of power issues and strive for more equitable power relations are fundamental to appropriate professional practice.

Mainstream dietetics training poorly equipped these women for work in this context. Experience contributes to the development of reserved personal confidence, restrained by a conscious awareness of the limitations of their socialisation. Those who have made medium to long term commitments derive feelings of satisfaction from the relationships they make with their Indigenous partners and playing some small part in community and health development processes.
CHAPTER 5:
MORE STRAIGHT TALK ABOUT TRYING TO BE STRONG PARTNERS

Chapter Five is divided into four main segments. The first presents and critiques community nutritionists and managers perceptions of their personal frustrations, difficulties and the general barriers they have experienced in working with CNW projects. The second segment examines the strategies nutritionists use in attempting to promote the empowerment of their Indigenous partners. It also details managers approaches to facilitating and encouraging these efforts. Managers perceptions of what “sustainability” incorporates and strategies to improve the sustainability of CNW projects are presented and analysed in the third section. Finally, professionals thoughts on performance indicators required to better demonstrate project and program performance are explored. The range of issues presented and discussed here are interrelated with each other and with the issues previously discussed in chapter four.
**Barriers and frustrations**

Twelve nutritionists were asked ‘What makes this work hard and/or frustrating?’ Their responses are summarised in Table 5.1 below. Many of the six nutritionist managers responses to the range of questions that they were asked included lots of general “barriers”. This probably stems from the fact that they all have considerable experience working on food and nutrition projects with community based workers of various kinds. To facilitate a more detailed critique, the frequency of managers responses on the themes presented by nutritionists is summarised in the last column of Table 5.1.

**Table 5.1 Barriers and Frustrations**

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Nutritionists Total n=12</th>
<th>Number of Managers Total n=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple demands and expectations made of community based workers</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Multiple demands and expectations made of nutritionists</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Cross cultural differences in values and expectations</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Turnover of community based workers and support people</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Selection processes for community based workers</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Funding; limitations and inequities in availability, accountability and management.</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Weaknesses in evaluation planning, implementation and marketing of results</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Community dynamics and capacity; availability of support, interest and participation in projects</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Frequent interruptions to community life and plans</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate executive support and leadership for sustainable program planning, problem solving + evaluation</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Communication issues; language barriers, limited literacy and numeracy skills</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Difficulties contacting people on communities with limited communication infrastructure</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>
Nutritionists spent a considerable amount of time providing very detailed responses to this question with an extensive number of practical examples. Closer analysis of the data revealed 12 main themes listed by at least 3 nutritionists (25 percent). Given the volume of data obtained, barriers that were listed by less than three nutritionists are not detailed. The range and emphasis of nutritionists responses reflect the personal focus of the question they were asked. They also display a detailed understanding of the diverse range of complex factors that act as barriers to project and overall program implementation. Essentially the key themes can be summarised into groups under the headings of personal, community or organisational capacities and politics.

Tensions between a large number of competing demands on both CNW and nutritionists time were acknowledged. This was particularly pertinent for those nutritionists working outside Darwin and Alice Springs regions where their job profile involved balancing clinical, urban and rural responsibilities. The tension described here is consistent with national research into the workforce management issues of community dietitian/nutritionists (Steele, 1995). Other demands on community based workers often slow the pace of work; community, family and ceremonial responsibilities and the high burden of ill health. Many admit to finding these factors frustrating in their early experience then “that’s something you learn to understand and deal with” (Lauren). Nutrition workers who are qualified Aboriginal Health Workers often get called to help with clinical duties in times of staff shortages. This is frustrating if these demands are frequent and substantial. Indigenous commentators have also noted that competing demands are a source of frustration and stress for community based workers (Personal Communication Fejo and Clements, 1998; Bonson, 1999).

Over half of the nutritionists reported experiencing barriers and frustrations relating to time pressures in their early experiences. This included time taken to build relationships and generate interest in taking food and nutrition action and travel time to very remote
communities (7 hours one way for some communities). Time itself isn’t really the problem, but personal and/or outside expectations about what should be achieved within certain timeframes is the underlying issue.

Many of the problems experienced are the direct result of power issues. Many of the nutritionist’s most critical comments were about organisational dynamics related to funding and problem solving. Over half the nutritionists mentioned funding related barriers. These included the short term, limited and often uncertain nature of funding. Also, that relatively small and inadequate amounts of funding limit the ability to employ suitable people and offer appropriate and equitable financial remuneration to workers for their involvement. Inadequate funding to cover appropriate wages perpetuates colonial exploitation and disempowerment. The following comment, from a nutritionist who wished to remain anonymous, demonstrates other aspects of apparent poor organisational dynamics. Essentially, it describes an awareness of socio-political antecedents to operational barriers the program was experiencing in the late 1990s:

> From an organisational perspective, the “laissez faire” attitude to accountability issues is really frustrating. There is a distinct lack of strong leadership by Non Government Liaison to request and ensure that projects are accountable. (...) Many of the problems that have paralysed projects for too long could have been recognised and dealt with earlier. We’ve had a longstanding problem with working with one community but it’s been really difficult to get constructive support to deal with that problem from an organisational perspective. Money is power and its distribution is a very political issue. If we threaten to cease funding due to poor performance we have to be very certain that we have done everything we can to deal with the problem.(...) Politicians and some very senior departmental staff, like to give out money and get good publicity, but they do everything to avoid withdrawing money and bad publicity. Ultimately this paralysis and inability to act
is harmful, disempowering both communities and staff via the establishment and
maintenance of contempt for authorities inaction, poor standards and leadership.

This quote reflects on poor organisational problem solving processes of the THS, and
their failure to adequately apply existing capacities at that time.

Frustrations deriving from conflict between different expectations and values are
commonly experienced, between and within cultures. For example, in relation to the fast
pace of activity:

I think often we want results tomorrow and so we jump in and think that people
can’t do it themselves instead of sitting back and listening and understanding and
having some patience in the whole process of capacity building and community
development.

(Paula)

Most Nutritionists completed their comments about the slow pace of work by saying that
they had to learn to deal with this frustration because it is part of respecting community
self determination. Other non Indigenous professionals and community members lack of
understanding of and commitment to community development and the time it takes to
achieve quality outcomes are other sources of tension. Nutritionists often said they felt
that other professionals perceived them as being “slack” when they are undertaking
general community development activities (Lindy). The biomedical, management, and
political desire for demonstrable outcomes in short time-frames is another tension.
Nutritionists readily admitted an awareness that this phenomenon is the result of different
world views. Many responses gave the impression that nutritionists felt they were often
cought “in the middle”, having some understanding of both world views.
Weaknesses in evaluation planning, implementation and marketing of results were also seen as a significant problem. One manager commented that the Nutrition Outreach program in the Top End was weakened because evaluation processes and performance indicators were not well thought out, planned and funded from the beginning.

The capacity of community organisations and management is often limited and can change relatively rapidly; usually due to changes in the availability of key individuals with special skills and motivation. The inconsistent nature of community administration and management support poses problems like lack of leadership and direction, limited assistance with community problem solving, poor financial management, frequent changes in workers and non-Indigenous support staff. These problems are often the result of a very small number of people having an unmanageable list of responsibilities: *It comes back to that community capacity thing, that there is limited capacity in communities* (Rachel). Turnover of community-based workers and support staff is a related issue. This includes turnover in a wide variety of positions that can provide substantial support for, and participation in, project activities including; council staff, women’s centre coordinators, store managers, nurses, doctors. The message was the same; project progress takes a backward step. The following quote exemplifies this:

> *I started working at community X ... only 8 months ago. Since then there’s been one change in the store manager; ... 2 relief nurses, ... the District Medical Officer, it goes on and on. You get people on side and involved in the project, they leave and you have to start again all the time*

(Melissa)

Similar comments about the rapid turnover of support staff have been mentioned by both health professionals and Indigenous Territorians in other qualitative studies on health and human service provision in the NT (Willis, 1991; Mitcalfe, 1993; Standen, 1998; Clark, 1999; Humphery, Weeramanthri and Fitz, 2001).
Nearly half of the Nutritionists have experienced issues that they believe have their origin in the selection processes for community based workers. Three expressed concerns that workers had been chosen to fulfil a particular role by other members of the community but these workers themselves were either not very interested or confident about undertaking that role. Some alluded to the fact that the allocation of jobs and the valuable pay that comes with them can be a manifestation of power within a community. All said that they had to respect community appointments even if they had some concerns about it; community control of workforce selection is an important element of self-determination.

Managers were more likely to comment on issues related to evaluation, problem solving and the personal skills of CNWs. They placed less emphasis on the selection processes and demands placed upon CNWs. This variation in focus is again likely to be the result of their engagement with the overall program rather than with individual projects.

The opposite of many of the barriers and frustrations mentioned have already been listed in the section on enabling factors. Therefore, the influence of these factors operates along a continuum where the impact can be positive or negative depending on the absence or presence of the particular factor, the quality of how it is done or levels of initial and existing capacities.

The major difficulties, frustrations and barriers listed by nutritionists are mostly described as external factors beyond personal cause or influence. Only a few were classified as having personal cause or influence, firstly recognition of the impact of cross cultural differences in values and secondly, expectations of the many stakeholders involved with the program. Humphery, Weeramanthri and Fitz (2001) found similar predominant externalisation of barriers and frustrations in NT Health professionals they interviewed.

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for the rethinking compliance project. They believe that professionals need to accept
more responsibility for affecting organisational change and should initiate reforms in their
local setting.

The range of barriers and frustrations identified by the nutritionists is very similar also, to
the list of obstacles identified in the Indigenous review of the CNW program (Bonson,
1999). The CNWs placed greater emphasis on specific community obstacles in relation to
the food supply, the need to get more men and urban workers involved in nutrition
promotion and also, strengthening the focus of education on the younger adult generation.
They did not mention any bureaucratic difficulties apart from the need for greater job
tenure and security. These differences are to be expected given the fact that CNWs have a
community focus and are not generally employed by a large regional organisation. All
these recommendations from the CNW review were reiterated again 2 years later in
recommendations from participants at the NT Aboriginal Nutrition Workshop held in
August 2001 (Katherine West Health Board and THS, 2001).

With few exceptions, the range of frustrations, difficulties and barriers identified by the
nutritionists were very similar to those identified by non Indigenous health professionals
supporting AEHW projects (Standen, 1998; Clark, 1999). Standen concluded that many of
the AEHW program barriers originated from limitations in the initial program
establishment process. This is equally relevant for weaknesses in evaluation, financial
issues and problem solving in the CNW program. Clark’s work demonstrated that EHOs
also struggle with balancing conflict between Indigenous and western paradigms. This
included tension between THS’s commitment to primary health care and community
development on the one hand, and the demands for quantitative health improvement on
the other (Clark, 1999:339).
Managers mentioned CNW educational disadvantages being a major factor inhibiting the Indigenous achievement of mainstream qualifications and the development of Indigenous capacity to promote health. None of the respondents mentioned major cultural differences in learning styles as an overt barrier. According to Trudgen, this is one of the key socio-cultural barriers to the development of effective health care with and for Indigenous Territorians (Trudgen, 2000), Harris (1991) supports this notion. Many nutritionists comments emphasize the need to develop and practise good adult and cross cultural learning and education skills in other sections of this work. This demonstrates that most nutritionists are aware of this issue but do not place the same degree of emphasis on it as do Trudgen and Harris.
Strategies NT nutritionists and nutritionist managers use to promote the empowerment of their Indigenous partners

Key policy documents including the Aboriginal and Torres Straight Islander Commission community based planning model (ATSIC, 1993) and the Jakarta Declaration on health promotion (WHO, 1997) demonstrate that there was considerable focus on promoting empowerment in health and human services nationally and internationally in the 1990s.

Interviews conducted with this project attempted to describe the efforts of nutritionists and managers to promote empowerment. Nine community nutritionists were asked Please describe the ways you try to empower community workers. Their responses are summarised in Table 5.2 below. The three nutritionists that were interviewed in the initial phases of this project from Dec 1997 to March 1998 were not asked this question. It was added as a result of reflection on themes and issues emerging from these interviews. The six nutrition managers were asked How do you facilitate and encourage staff to promote the empowerment of community workers? Managers listed many strategies to promote empowerment generally so the frequency of these answers has been included alongside nutritionist’s responses in Table 5.2 below. Manager’s comments that specifically relate to facilitating and encouraging staff to promote empowerment are presented separately in Table 5.3.
Table 5.2 Strategies NT Nutritionists and Nutritionist Managers use to promote the empowerment of their Indigenous Partners

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Nutritionists Total n=9</th>
<th>Number of Managers Total n=5 #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoting Indigenous control, responsibility and action</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Providing people opportunities, encouragement and support that raises confidence</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Modifying own expectations, don’t impose own values</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Acknowledge and try to deal with difficulties and frustrations</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Define empowerment and regularly remind yourself to work in an empowering way</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Promoting the worker, their knowledge, skills and achievements inside and outside the community</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Respect people’s opinions and choices even though they might be different from your own</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Build community and Indigenous capacity generally via things like accredited training, sharing health information, facilitating Indigenous networks and support activities</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Provide whatever assistance they request</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Recognise each persons unique strengths, expertise and contributions</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

# Note: The last part of one manager’s interview did not record on tape so her response to this question was lost.

Generally most respondents spoke at length about their personal efforts to promote the empowerment of their partners, providing a wide variety of very specific examples. This focus and specificity indicate that this topic is significant to this group and they have reflected on it and their own practise at length. The range of answers demonstrate that NT nutritionists have many practical notions of how they attempt to promote the empowerment of their Indigenous partners.
Unfortunately, this interview process did not seek to actively determine what this group perceived the term “empowerment” to mean. Nor did it to provide a specific definition to focus the responses. The lack of clear definition limits the scope of conclusions that can be drawn from this analysis. Empowerment is a difficult concept to define. Definitions abound, ranging from the paternalistic to give [somebody] the power or authority to do something (Collins Dictionary, 1989: p270), to more humanistic, community development based notions of developing positive collective power to improve the lives of disadvantaged and oppressed peoples (for example see Kenny, 1994). From the responses, however, empowerment can be framed as recognition and improvement of Indigenous capacity, choice and self determination. The majority of nutritionists believe promoting empowerment includes managing any urge to take control.

The frequency with which particular strategies were mentioned was generally consistent between both groups of respondents. This consistency reinforces the relative importance of the strategies. Promoting Indigenous control, responsibility and action was the most frequently mentioned theme by both groups: I try and make it a point of having every decision made by them... certainly providing suggestions, but not doing the doing, allowing them to be the front person all the time (Paula). Some mentioned that this specifically involved allowing people to make and learn from their own mistakes. The notion of “allowing” people to be the front person or make mistakes has paternalistic connotations, which the nutritionists would passionately argue are completely unintended. However, this example serves to demonstrate the influence of automatic conditional power relations based on their primary socialisation. They may want to do the right thing, but they do it from a position of power nevertheless.

The strategies suggested can be classified as personally or externally directed. Essentially, nutritionists recognise the need to make personal efforts and changes in order to promote the empowerment of CNWs. The need to modify ones personal expectations and

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consciously refrain from imposing ones own values and critical professional standards is demonstrated by the following reflection:

one thing that’s crucial for empowerment, is again changing your own benchmarks. (...) you’ve got to let community people do things and if it’s not quite up to the standard that you are used to being the critical nutritionist that you are, then that’s just bad luck.

(Lauren)

Nutritionists feel that they have to cautiously consider how they might go about promoting empowerment in culturally appropriate and respectful ways. This stems from their appreciation that there are so many cultural conventions and rules that non Indigenous professionals are unaware of. They recognise that professionals cannot assume that their conceptual notions or action ideas are relevant. Fitzgerald, Mullavey-O’Byrne and Clemson (1997) believe this is a critical issue in the development of culturally competent practitioners and satisfying, successful inter cultural interactions as observed through their research with Occupational Therapists and Physiotherapists. Sadan and Churchman (1997) reiterate the need for professional critical consciousness as a primary requirement of any efforts to promote empowerment.

Kenny (1994) writes that empowerment involves processes which are full of dilemmas and contradictions (114). Responses to this question demonstrate some of the dilemmas the nutritionists have faced. Tensions exist in trying to promote increasing capacity, confidence and promoting best practise without being overzealous or inappropriately applying or modifying personal values and professional standards. The second most frequently mentioned empowerment promotion strategy involved providing opportunities, encouragement and support that specifically raise workers confidence. They were not just talking about any form of “support”. The need to focus support activities towards raising confidence and self esteem was repeatedly reinforced with many examples. These

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included repeatedly offering CNWs opportunities and encouragement to try new or challenging things without being “bossy” or “forceful”. More detailed reflections on this theme introduced the notion that workers are being oppressed if they are not being supportively challenged to develop and apply new skills and knowledge. For example if a nutritionist always does the computer work because it is quicker and easier for them than the CNW the development of the Indigenous worker’s professional capacity is actually being oppressed (Lindy). Shields (1993) advocates that good support should provide challenges and encourage accountability sensitively and judiciously (108).

Many nutritionists recognise the need to be very careful in applying and modifying personal values and professional standards especially when assessing and supporting community workers performance: *It's a really fragile balance sometimes* (Rachel). The modification of professional standards could be oppressive, particularly, if it is based on a value judgement about the applicability or usefulness of a certain service or specific information to a different culture (Marie). The practise of restricting the quality of professional advice provided to Indigenous Territorians based on some professional notion of cultural inappropriateness or unlikely “compliance” has been acknowledged by other writers (Trudgen, 2000; Humphery, Weeramanthri and Fitz, 2001). The need for professional vigilance and action on this issue is acknowledged by them. Trudgen (2000) advocates that Indigenous Territorians must be given detailed best practise health information. Trudgen believes health professionals must work with interpreters, learn language and use appropriate educational strategies to share detailed health information so that it can be clearly understood. Traditional functions that aim to strengthen capacity via information sharing and training were listed less frequently. An associated sub theme was the need to provide information and advise via culturally appropriate communication strategies to maximise understanding.
The nutritionists list of strategies were very consistent with empowerment strategies listed in the Aboriginal and Torres Straight Islander Commission (ATSIC) Community based planning model (ATSIC, 1993). This document lists appropriate strategies under key terms; promote participation, include, communicate, build relationships, coordinate and promote acceptance and ownership.

Nutritionists and managers generally report that cross-cultural competence and assertiveness, as characterised by respecting ones beliefs whilst respecting the beliefs and rights of others (Kenny, 1994), develops with increasing experience in this context.

Nutritionists talked about promoting empowerment predominantly in the form of practical strategies and personal requirements. There was little or no allusion to critically, politically or structurally focused strategies. The breadth of these responses could be used to reinforce the view of Solas (1996) that empowerment action in human service work during the 1990s was focussed on improving individual capacity but not affecting structural and social change to diminish oppression. The individual focus may have occurred because the question specifically asked nutritionists to describe ways they try to empower their Indigenous partners not, Indigenous peoples or communities in general. Also, structurally focused strategies were mentioned by most nutritionists in comments about enablers and barriers to the CNW program, for example the importance of developing and implementing the NT Food and Nutrition Policy (THS, 1996).

During the interviews only one nutritionist said I can't empower someone as such you've just got to give them positive reinforcement (Rachel). The scope, definitions and appropriateness of empowerment were discussed at length by one group of relatively experienced community nutritionists in an activity on empowerment that I conducted during the 1998 NT Nutritionists workshop (Priestly, 1998b). This experienced group also reached a similar conclusion to “Rachel”. It is a view that is consistent with that of

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Foucault (1984) when he suggests that individuals cannot empower others because they do not own power. Kemmis (2001) says others cannot do the empowering, people can only be empowered in their own terms.

None of the respondents suggested that they needed to engage in a dialogue about empowerment and ways it could be promoted with their partners. Shields (1993) and Solas (1996) attest that professionals and their client partners need to engage in processes to examine, define and share their perceptions of empowerment, what promoting empowerment might involve and what it is striving to achieve. Similar recommendations can be found in commentaries on capacity building (Eade, 1997; Kaplan, 1999). This reinforces the need for PAR processes that include power analysis to promote the development of critical consciousness of both the Indigenous and non Indigenous partners. The challenge then becomes how to facilitate this process in a way that does not overwhelm, alienate members or shift the focus away from the primary tasks of building capacity and improving health.
Table 5.3 Strategies NT Nutritionist Managers use to encourage staff to promote the empowerment of their Indigenous Partners

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Managers Total n=5#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate broadening of partners networks and support systems with both other Indigenous people and professionals</td>
<td>4</td>
</tr>
<tr>
<td>Recruit nutritionists with the right personal philosophies and skills to promote empowerment</td>
<td>3</td>
</tr>
<tr>
<td>Demonstrate the promotion of empowerment within team management</td>
<td>2</td>
</tr>
<tr>
<td>Be vigilant for oppression</td>
<td>2</td>
</tr>
<tr>
<td>Be vigilant for paralysis in professional practise arising from cross cultural over sensitivity</td>
<td>2</td>
</tr>
<tr>
<td>Raising the focus on empowerment promotion and the implementation and evaluation of associated strategies within teams</td>
<td>1</td>
</tr>
</tbody>
</table>

*Note: The last part of one manager’s interview did not record on tape so their response to this question was lost.

The managers listed a limited number of strategies specifically focused at encouraging and supporting staff in their efforts to promote the empowerment of their Indigenous partners. The most commonly mentioned theme demonstrates that they firmly believe the development of networks and partnerships will help to improve personal power. Two managers reinforced the need to allocate resources to promote and facilitate the development of Indigenous and professional networks and partnerships. Some points might appear straightforward enough, but for example, understanding what is meant by the “right” personal philosophies and skills is not always so easy.

The first step to the promotion of empowerment is to prevent disempowerment (Sadan and Churchman, 1997). So most significantly, nutrition managers noted the need to be vigilant for the many ways in which organisational processes and staff actions may be
oppressing Indigenous partners and clients. One example already mentioned is the reduction in professional standards or the completeness of information and advice provided, because of some ethnocentric value judgement. Shields believes that oppressive attitudes and behaviours must be identified and changed within a supportive environment if groups are going to promote empowerment (Shields, 1993:81).

The same two managers agreed that all professionals working in this context probably experience some degree of cross cultural over sensitivity sometimes in their career. This over sensitivity and lack of confidence can strain relationships and inhibit the productiveness of partnerships. It can contribute to a paralysis in professional competence. This over-sensitivity is also disempowering for Indigenous people. Clark (1999) supports this notion, concluding that EHOS can be at risk of being paralysed with confusion from the range of poor and high cross cultural information circulating and the potential seriousness of the impact such a paralysis might have in their service provision. It would seem important, therefore, that managers understand this phenomenon, so they can implement supportive strategies. It highlights that focus on empowerment of Indigenous workers should support a system of relations and culture that underpins good equal partnerships for everyone regardless of personal differences or similarities.
Promoting sustainability

Six managers were asked the following 3 questions during 1998-1999:

♦ How well do you think THS management is promoting the sustainable development of these (CNW) projects at present?

♦ What else do you think THS nutrition and public health managers could do to promote sustainable development?

♦ What do you think THS operational staff could do to promote the sustainable development of these projects?

Their responses to each question are summarised in Tables 5.4 (question 1), 5.5 (question 2) and 5.6 (question 3) respectively and discussed below. Unfortunately the interview process failed to provide a specific definition of “sustainability” or determine what this group perceived the term “sustainability” to mean. Analysis of responses indicates that managers view sustainability to include the maintenance, expansion and/or transfer of infrastructures and action to promote and achieve better food and health. These themes encompass many of the elements of formal definitions of program sustainability such as the delivery of a program through a network of agencies, in addition to, or instead of, the agency which initiated the program (NSW Health, 2000: 4). As with the section on empowerment, the lack of clear definition maybe seen to limit the scope of this analysis, but the responses of participants themselves provide an important basis for an understanding of “sustainability” and interestingly, it is consistent with the literature relevant to this field.
Table 5.4 Nutrition Managers perceptions of how well THS managers were promoting the sustainable development of CNW projects during 1998-99.

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Managers Total n=6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choosing accredited training that can be delivered on communities</td>
<td>3</td>
</tr>
<tr>
<td>New nutritionists getting better quality orientation and support</td>
<td>2</td>
</tr>
<tr>
<td>General management and executive more understanding and supportive of community development approach within Preventable Chronic Disease Strategy</td>
<td>2</td>
</tr>
<tr>
<td>Public Health (Senior) nutritionists doing well within organisational limitations</td>
<td>2</td>
</tr>
<tr>
<td>Working with a project focus on specific issues like antenatal care or infant growth</td>
<td>1</td>
</tr>
<tr>
<td>Documenting and sharing ways of working side by side</td>
<td>1</td>
</tr>
<tr>
<td>Maintaining strong support systems within the nutrition team</td>
<td>1</td>
</tr>
</tbody>
</table>

The responses to this question were generally very brief and limited to a small number of variable examples with little repetition of themes. The majority of the responses comment on the efforts of nutrition managers. Two respondents spoke about the commitment of other generic and executive managers. Essentially the bulk of the comments relate very broadly to program infrastructure development. This may be a reflection of the fact that CNW projects were generally in the early developmental stages at the time respondents were interviewed. Also, it might reflect definitional issues. It could be concluded that promoting program sustainability was not a high priority at that time.

The establishment of accredited community based training was thought to be the biggest contribution towards the promotion of ongoing program sustainability at that time. Respondents explained that this was because it made education more accessible and appropriate. It was deemed to be more appropriate because it allowed facilitators to ground learning activities in the opportunities and realities of the students own environment. Grounding of learning in participants real life issues and priorities like this
is consistent with the Frierean approach to education for self determination (Friere, 1972), and the recommendations of local health education commentators and researchers (Harris, 1991; Clark, 1999; Trudgen, 2000). The on the job nature of the course was also deemed to maintain interest and improve self esteem, thereby promoting sustainability: this gives people a way to work and earn some money and feel good about themselves and to have what they do recognised. If it inspires some people to go on ... terrific (Marie).

The majority of the other comments related to perceptions of the level and quality of support for staff and the projects generally. Two managers said they were particularly happy to report that they felt executive were displaying a better understanding of and commitment to the importance of community development in their contributions towards planning sessions for the Preventable Chronic Disease Strategy during 1998 (Liz and Rachel). One commented she felt the public health nutritionists were doing as much as they can (Lyn) but did not provide a rationale for this conclusion. Another said that organisational limitations inhibited the ability of people to do more (Amanda). Others said oorientation and support had improved and the increased focus on documenting ways of working side by side was very valuable.
Table 5.5 Nutrition managers perceptions of what else THS nutrition and public health managers could do to promote sustainable development of CNW projects

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote and resource a stronger focus on evaluation</td>
<td>5</td>
</tr>
<tr>
<td>Develop more flexible funding models and levels linked to different types of outcomes</td>
<td>4</td>
</tr>
<tr>
<td>Strengthen Indigenous involvement in program management, support and problem solving</td>
<td>3</td>
</tr>
<tr>
<td>Provide better support for operational staff; especially with workload management and evaluation</td>
<td>3</td>
</tr>
<tr>
<td>Develop stronger career path for Indigenous workforce</td>
<td>3</td>
</tr>
<tr>
<td>Strengthen procedures to better enable the recruitment and retention of staff with positive personal attributes, competencies and experience.</td>
<td>3</td>
</tr>
<tr>
<td>Investigate and develop opportunities for intra-sectoral public health grant management, support and training</td>
<td>2</td>
</tr>
<tr>
<td>Development and implementation of administrative procedures to share organisational memory and lessons</td>
<td>2</td>
</tr>
<tr>
<td>Proactively identify and deal with problems</td>
<td>2</td>
</tr>
<tr>
<td>Maintain community based training options</td>
<td>2</td>
</tr>
</tbody>
</table>

Nutritionist managers had very clear notions of how CNW program sustainability could be promoted in future. Responses to the question “What else do you think THS nutrition and public health managers could do to promote sustainable development?” display both inwardly and outwardly focused criticism.

The most frequently mentioned strategy to improve sustainability was a stronger commitment to evaluation. They suggested aspects of this focus needed to include competency development, formulation of appropriate performance indicators and marketing of results. Many said that resources must be specifically designated for
evaluation. Similarly evaluation to promote Indigenous capacity, empowerment and sustainability requires the participation of all project stakeholders, rather than being predominantly undertaken by outsiders.

Program funding models were limited to the direct employment of workers or the allocation of community grants up to $20,000. Managers saw the lack of flexibility as restrictive. Four (66 percent) felt program sustainability could be significantly improved if a range of more flexible funding alternatives were available. Many suggested that communities should be able to apply for different amounts of funds for specific projects over variable time frames. This approach would hopefully enable a broader range of initiatives to benefit a wider range and number of people. All concurred that funding needed to be more carefully outcome focused.

They also identified that there were many general advantages and efficiencies to be had in better collaboration with other groups in training, support and problem solving. Specific suggestions included the need to investigate and develop opportunities for intra-sectoral public health grant management, support and training or intersectoral collaboration with other government departments, community based services and organisations in the food, health, community services and education systems. Top End nutritionists agreed this is an option worth careful consideration by all stakeholders (THS, 2000a). Members of other public health professions were reaching similar conclusions independently (Personal communication Standen, 2000).

Half of the respondents mentioned the need for managers to strengthen Indigenous involvement in operational and overall program management and problem solving. One suggested that the organisational structure should be changed to provide bi-cultural leadership of regional nutrition services via the employment of an Indigenous co-manager. Another suggested the employment of a coordinator to provide support to
CNWs. A third person’s comment was much broader, suggesting the need for better mechanisms for engaging communities in discussions of such issues. The appropriateness and significance of this general suggestion is widely supported (Trudgen, 2000; Deavitt, Hall and Tsey, 2001; Humphery, Weeramanthri and Fitz, 2001). What is surprising is that a minority of nutrition managers mentioned its relevance to promoting program sustainability. Taking a critical view, it weakens their demonstrated level of commitment to self determination through organisational reform. The need to strengthen Indigenous control of general program management and decision making was also strongly emphasised in the review of the NT Aboriginal Environmental Health Worker program (Standen, 1998).

Half of the managers recognised the need for management action to develop a stronger career path for the Indigenous nutrition workforce, to act as an incentive to stay involved and to strive for and demonstrate greater personal capacities. In turn greater personal capacities are likely to strengthen program resources, successes and their sustainability. Many of their suggestions are reiterated by the recommendations from the review of the CNW program (Bonson, 1999) and the NT Aboriginal Food and Nutrition Workshop in August 2001 (Katherine West Health Board and THS, 2001).

The development and implementation of better professional administration procedures to facilitate and share organisational memory was another repeated suggestion. Managers believed it could support smoother handover between professional staff, minimising repetition of mistakes. They also said it would enhance the quality of support for community people thereby promoting general program efficiency and outputs.
Table 5.6 Managers perspective’s on what operational staff can do to promote the sustainable development of CNW projects

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactively recognise and develop better support networks via collaboration with other community people and professionals</td>
<td>5</td>
</tr>
<tr>
<td>Strengthen focus and action on evaluation, promotion and action on its outputs</td>
<td>4</td>
</tr>
<tr>
<td>Marketing and promoting Nutrition and CNW projects across the health system and communities</td>
<td>3</td>
</tr>
<tr>
<td>Develop clear role descriptions via community development processes</td>
<td>3</td>
</tr>
<tr>
<td>Promote greater Indigenous ownership and accept community aspirations for their projects</td>
<td>2</td>
</tr>
<tr>
<td>Implement administration procedures to develop and share organisational memory and lessons of evaluation</td>
<td>2</td>
</tr>
</tbody>
</table>

Nutrition managers thoughts on what operational staff could do to promote more sustainable development of CNW projects mirror many of the themes raised in the list of enablers and strategies to promote Indigenous empowerment. Great emphasis was placed on the role of operational staff in facilitating more extensive collaborative support networks to improve program maintenance and sustainability. The need to improve focus on evaluation again featured highly. Two of the four managers (33 percent of the sample) who made comments on the need for better evaluation suggested that more frequent review of community project plans would enable the development of more realistic performance indicators. They reiterated the need for this information to be compiled and shared to inform collective organisational and community capacities. The need for better documentation and analysis of the way health services are delivered for the purposes of informing better practise in the NT has also been recommended by Humphery, Weeramanthri and Fitz (2001).
The development of clear descriptions for the roles of various people is considered to be a fundamental step early in a project. Again this conclusion was replicated in the works of Standen (1998) and Clark (1999) in relation to the AEHW program. The need to promote greater Indigenous self determination in terms of ownership of programs, their successes and failures was repeated here. This involves staff accepting that community aspirations may be more modest or quite different to professional aspirations. For example, communities may not want to run long term projects.
Indicators of capacity and performance

Chapter three introduced the notion that the NT nutrition team needs to identify indicators that can be focused upon to demonstrate links between program investments, capacity building and improved health outcomes. Unfortunately, the nutritionists or nutrition managers were not directly asked to comment on indicators of capacity or performance during the interviews. Despite this, many comments and examples on these subjects were gathered from four nutritionists (one third of sample) and four nutritionist managers (two thirds of sample) during the research process. Given the significance of the subjects, the presentation and examination of these comments is warranted. The themes and examples are not considered to be representative of the full range of respondents views on the topic. Also, given the small sample size it is inappropriate to draw conclusions from how often each of the themes were mentioned. For these reasons the themes and frequencies are not presented table form.

Respondents recommended that a combination of indicators are required that reflect increasing capacity, confidence and self esteem, independence and outcomes. This combination of both qualitative and quantitative indicators from different world views would give a much more holistic indication of the impact and outcomes achieved for the investment.

Indigenous food and nutrition workforce statistics are important indicators of infrastructure capacity for the CNW program. An example of this is the number of people employed in CNW projects and the percentage of Indigenous staff employed by THS and other Indigenous or non government organisations. Some respondents stressed that workforce indicators need to be linked with demonstrated improvements in capacity and achievements. Rachel commented that some of the problems being faced by different
CNW projects could be attributed to a strong community focus on the employment of local people with less regard for what they do once they are being paid.

Multiple indicators of increasing personal development and capacity, independence, confidence of participants were suggested. A worker's increasing participation in wider community affairs could be viewed as a positive performance indicator for the CNW program generally through the competencies and confidence they have developed during the nutrition project.

A range of indicators is entirely appropriate given the broad conceptual definitions of health as not merely the absence of disease but complete mental, spiritual, social and physical wellbeing (WHO, 1978). The demonstration of confidence to perform certain tasks or roles they have been reluctant or frightened of doing in the past, like talking to doctors about clients, is an example of this. Also, standing up in front of community people at food, nutrition and health workshops or forums confidently talking about issues would also serve as a demonstration of confidence. Recording comments from other Indigenous people about how more confidently and actively certain workers are performing is another example. Reflection on the nature of these suggestions identifies that they could all be viewed as very western examples of the concept of confidence, and it is important to recognise that Indigenous notions of the display of increasing confidence might be quite different.

Many indicators of increasing community development and capacity, confidence, program recognition, program ownership, independence and outcomes were listed. These included recording examples of community understanding of the project plan and the roles of various participants. Recognition for the project via the number and nature of unsolicited requests for assistance and support from individuals, families and groups was mentioned more than once. For example: at community A, the nutrition team is clearly
recognised...there are requests for different activities (Jan). The number and variety of
community people participating in training and promotional activities and achieving
qualifications can be easily recorded and compiled. The collection, compilation and
sharing of “good stories” is a tried and true simple and appropriate method that just
requires the allocation of sufficient resources to document in one of a multitude of
potential mediums; posters, video’s, paintings, reports, murals, storyboards or books.

Two managers commented that indicators of increasing community “ownership” of
program activities are very important. One suggested they may be highly predictive of
success in terms of health outcomes (Lyn). Another felt that ownership of “failures” and
analysis of the reasons behind them, is also important in terms of developing community
capacity to take more positive action in the future (Rachel). Sadan and Churchman (1997)
believe that the ownership of failures and problems is an important indicator of increasing
capacity. The presence of a formal project plan with specific goals, plans with evaluation
from community and biomedical perspectives and evidence of regular reviews of the
project plan were also mentioned as performance indicators.

More than one manager recognised that indicators of professional performance need to be
both independent and dependent of indicators for community projects. This is because
many things that are outside the influence of the nutritionist affect the performance of
community projects. As such, examples of suitable professional performance could
include the presence of documentation regarding how individual nutritionists attempt to
meet minimum support requirements for each project they are involved with.

Most respondents commented on the need for better project and program evaluation and
to demonstrate performance more quantitatively. Makerras and Mortimer (2000) made a
similar recommendation in their evaluation of the NT Food and Nutrition Policy 1995-
2000. The indicators chosen must be realistic given project funding and reporting periods.
Few managers mentioned specific quantitative performance indicators. The types of examples given included; increased school attendance linked to sandwich making initiatives at the school and reduction in the numbers of children suffering from under nutrition in a community. Standen's (1998) review of the NT Aboriginal Environmental Worker (AWHW) program noted a similar preoccupation with qualitative and capacity outcome indicators and limited quantitative improvements in health.

The number and depth of these unsolicited comments reinforces the urgent need to dedicate resources to the development of a set of realistic performance indicators to plan and report on CNW projects, both individually and collectively. Planning, measuring and demonstrating improvements in capacity and performance can rapidly consume precious resources. The identification of a few indicators of performance that are most likely to efficiently and effectively indicate progress towards improved health outcomes is recognised as a challenge by this group and health professionals generally (NSW Health, 2000b).
Summary

The high turnover of both Indigenous and non Indigenous workers and support staff is a major threat to achieving potential health gains in individual community nutrition projects. Intra and inter organisational and community dynamics that inhibit the development and application of capacity in infrastructure, problem solving, program maintenance and sustainability are the greatest systemic threats. The respondents are aware that the origin of many problems lies in intercultural differences and power differentials.

Nutritionists promote empowerment by strengthening Indigenous capacity to promote health and wellbeing. Many nutritionists report that engaging in personal reflective practise about power inequities is very important to promote the empowerment of their Indigenous partners. Little mention was made of the need to discuss the notion and goals of empowerment promotion with their Indigenous partners, which, is recommended as an essential activity to promote empowerment by many health and development commentators (Friere, 1972; Shields, 1993; Kenny, 1994; Solas, 1996; Eade, 1997; Kaplan, 1999). Managers can assist staff to develop inter-cultural competence by raising and demonstrating a critical focus on empowerment within teams and project partnerships. These processes could assist in preventing or dealing with some of the tensions arising regularly.

Nutritionist manager’s perceptions of sustainability include the maintenance, expansion and/or transfer of infrastructures and action to promote and achieve better food and health. Most emphasised the need for a stronger focus on evaluation, more flexible funding options and collaborative training, support and action in the future. The need to promote greater Indigenous ownership and control at the community level and greater
Indigenous involvement in operational management, support and problem solving was prioritised.

Both groups of respondents generally believed there was an urgent need to dedicate resources to the development of a combination of performance indicators that can better reflect increasing capacity, Indigenous participation, independence and health outcomes. Qualitative and quantitative indicators from different world views will give a holistic indication of the impact and outcomes achieved for the investment.

Tensions exist in attempting to balance the development of Indigenous capacity and self determination and demonstrate health gains. Differences between western biomedical and Indigenous worldviews and associated power inequities are the origin of many problems. The data and analysis presented in this chapter reiterates the argument that participatory action research, educational approaches and capacity building techniques that facilitate new, shared and critical understandings are complementary approaches in this context.
CHAPTER 6:

SHARING STORIES TO STRENGTHEN SOCIAL RELATIONS AND PROMOTE HEALTH IMPROVEMENT.

Sharing Stories about Seasons and Seasons For Workers is a facilitative narrative aimed at strengthening skills, knowledge and processes in collaborative participatory action research based planning and evaluation. The Good Stew, Good Project Storybook is aimed at strengthening knowledge, infrastructure and processes in collaborative community based Indigenous health promotion projects. The storybooks are practical tools designed to assist public health professionals implement the theories of health promotion, community development, capacity building and adult learning into action in their work supporting Indigenous communities. Both were developed and trialed as part of this research project in association with community food and nutrition projects and Strong Women, Strong Babies, Strong Culture projects in the Northern Territory between 1997 and 2001.

Chapter Six is broken into four sections. Section one is a narrative to detailing the development of each storybook. Section two discusses the design of each tool and what each part strives to achieve. The third section discusses how the storybooks are tools to promote a fundamentally different set of social relations and progress broad health and
humanitarian priorities. The fourth and final section begins evaluating these resources by critically reflecting on their design in relation to emancipatory and Indigenous education theory.

*Sharing Stories about Seasons and Seasons For Workers and The Good Stew, Good Project Storybook* are presented as Appendices G and H respectively and are mostly referred to as the *Seasons Storybook* and *Stew Storybook* in the following discussion.

**Storybook Histories**

As part of the development of this research process Top End SWWs, CNW/As and nutritionists (total=35) attended the Side-by-Side workshop at Springvale Homestead in April 1997. Only two workers and the Nutrition Manager did not attend. The women expressed a need for “user friendly training, orientation and support guidelines that cover empowerment and the fact that we have a structure” and “they should not be restrictive, but help us deal with problems that come up” (Fejo and Priestly, 1997). The newer nutritionists expressed an urgent need for process guidelines and tools. All the workers were keen to have tools that would help partners to start out “strong together”. These priorities guided the production of tools produced as part of this research process.

Many good resources already existed to help people learn about working together on community based planning and evaluation. For example, the THS Aboriginal Health Promotion training workshops and manuals, *Bridging the gap; a participatory approach to health and nutrition education* (Kechn, 1982), the *ATSIC Community Based Planning: Principles and Practise* manual (ATSIC, 1993), the Indigenous project evaluation guide *Thinking, listening, looking, understanding and acting as you go along* (Colin and Garrow, 1996) and *Sharing Good Tucker Stories* (Bear-Wingfield, 1996). Also the participatory action research guides such as *Everyday Evaluation on The Run*
(Wadsworth, 1997) and the model of Colin and Garrow (1994). It is difficult to encourage people to talk and share ideas about these concepts across cultures, language barriers and with those people who have limited literacy skills. We needed tools to help get people talking and sharing knowledge, experiences and ideas together.

**History of Sharing Stories About Seasons And Seasons For Workers**

Early in my professional practise as a community nutritionist in remote areas of the NT I struggled with encouraging and assisting community based workers to clarify community and health staff concerns and develop action priorities and plans. In one community in which I worked, workers seemed to be looking to me for direction. I did not want to set the agenda or see my interpretation of local food and health priorities become project goals. Chapters four and five have demonstrated that many of my peers have also experienced these issues.

As part of my university studies in primary health care, I had undertaken research to locate process resources that might prove useful in encouraging the development of community action plans. The resources I located were many and varied. I felt that Anne Garrow and Tjikalyi Colin's (1994) modified participatory action research (PAR) cycle developed for use in the Mai Wiru nutrition project in Central Australia could be very suitable. A copy of this model has already been presented in chapter one. I was trying to come up with a way of introducing their PAR cycle in a manner that linked the development of new knowledge to familiar concepts of daily life in both broad cultural groups. This approach is consistent with recommended strategies to promote adult learning for critical consciousness (Friere, 1973) and Indigenous education theory (Harris, 1976; Trudgen, 2000).
Originally one of the nominated Community Nutrition Workers in a community I worked with was a very senior woman. She shall remain nameless as I am unable to ascertain if she is still alive and do not wish to offend Indigenous readers who might know her if she has passed away. She had been a health worker many years ago. I felt that I really needed to acknowledge her experience and knowledge to develop a good working relationship with her. One day I turned over a page in a calender from the local language centre, and there as the picture for the month was a diagram of the Jawoyn peoples seasons model presented as a cyclical diagram. Hannah had been involved in the development of the diagram. It was just what I needed. The use of that diagram would at once both acknowledge her knowledge and status and provide a perfect cultural analogy for the introduction of Colin and Garrow’s PAR cycle (1994). The first version entitled A Story About Seasons For Workers was made that day. It was 10 pages long with black text and diagrams photocopied onto coloured paper.

Lorna Fejo, NT Coordinator of the Strong Women, Strong Babies, Strong Culture project encouraged the use of the PAR model, believing it was easy for Aboriginal people to understand and fitted well with many traditionally important cyclical concepts (Personal communication Fejo, 1996). The model was presented in a workshop format to the Aboriginal Advisory committee of the NT Food and Nutrition Project in July 1996 (THS, 1996c). The advisory committee said they were happy for it to be used in nutritionists work with CNW projects. Consequently, the original storybook was refined and used in 2 other communities by another nutritionist, Sharon Muller, and myself.

I produced another version of the Season’s Storybook and presented it to members of the NT nutrition team and Top End Aboriginal Health Promotion officers over a two year period from 1997-1998. This was conducted mostly by interactive demonstration; where participants were encouraged to do each of the activities and questions posed. Feedback
and suggestions for improvement received from over 30 people during the process was recorded during or immediately following each session.

**History of The Good Stew, Good Project Storybook**

A recipe is a common concept in everyday life for many Australians and is one tool used extensively to promote healthy eating skills and behaviors. Two Indigenous leaders, developed a recipe for a good community health project as part of their contribution to background papers for the NT Food and Nutrition Policy 1995-2000 (Mills and Ryan, 1995). Quite by coincidence, I had independently developed my own version of a recipe for community health promotion projects as a public speaking tool for a rural health careers presentation in Newcastle in 1994 (Boyes, 1994).

Reflection on the recommendations of the Side by Side workshop (Fejo and Priestly, 1997) led me to conclude that the Mills and Ryan (1995) recipe would be a very useful tool to incorporate into resources to enable partners to ‘start out strong together’ on their community projects. It recognised existing Indigenous knowledge and experience and the fact that the use of a recipe analogy had originated from these well respected Indigenous leaders provided some credibility for the proposed concept. Furthermore, the recipe concept could be expanded and used to collect and present the reflections of many more experienced Indigenous and non Indigenous nutrition workers. For example, it could be used to present information gained through interviews with the community nutritionists as part of this project. The decision to focus on a stew type recipe was immediate.

Indigenous families in remote communities regularly cook one pot stew type meals, usually on an open fire, sometimes on a stove. The first version of *The Good Stew, Good Project Storybook* was made in early 1998. It was 17 pages long with coloured text and a
very simple coloured motif of a stew pot cooking on an open fire printed onto yellow paper.

As with the *Seasons Storybook*, a preliminary version of the *Stew Storybook* was demonstrated to members of the nutrition team, SWSBSC workers and Health Promotion Officers in the Top End but over a shorter period from March to August 1998. Again, feedback and suggestions for improvement received were recorded during or immediately following each session.

**Final storybook production and implementation plans**

Two people self selected to co-author an improved version of the *Stew Storybook* in November 1998. They were Marlene Liddle, Strong Women, Strong Babies Strong Culture Coordinator for Operations North and Vivienne Hobson, Director of the Food and Nutrition Policy Unit. These women, together with Camille Damaso, Nutrition Project Officer, also volunteered to co-author the next version of the *Seasons Storybook*.

Constructive criticism collected from extensive consultation on earlier versions were combined with co-authors individual ideas to produce the final version of the books in April 1999. Top End nutritionists, Strong Women, Strong Babies, Strong Culture program coordinators and the Food and Nutrition Policy Unit staff decided the new versions should be implemented and evaluated by the Community Nutrition and Strong Women, Strong Babies, Strong Culture programs across the NT in 1999.

I produced these versions of the storybooks whilst on maternity leave in January 1999. In addition, I developed additional worksheets as an appendix to the *Stew Storybook* to use in discussions on the positive ingredients and processes in existing projects. Both storybooks were copied and distributed by the NT Food and Nutrition Policy Unit in
April of 1999 in the format presented in Appendices G and H. Additional background
details are included on page 3 of each storybook.

**Storybook Design**

**Similarities in Storybook design**

There are similarities and differences in the design of each storybook. *The Good Stew,*
*Good Project Storybook* focuses on infrastructure and support ingredients linked with
successful problem solving. *Sharing Stories about Seasons and Seasons For Workers*
focuses on processes to promote participatory problem based learning and problem
solving.

Both Storybooks are designed as facilitative narratives based on the principles of problem
solving discovery education as advocated by Freire (1972), Knowles (1980) and Wass
(1994). The local relevance of this approach has been recently reinforced by
recommendations in the THS Public Health Bush Book (THS 2000d) and by Trudgen
(2000). This approach starts by identifying and working on issues of concern to the
Indigenous people involved. This involves linking the development of new knowledge
about community development projects to familiar concepts of daily life in Indigenous
and mainstream culture. Indigenous and non-Indigenous users are both teachers and
learners and the dialogue focuses on the needs and interests of Indigenous people to
acknowledge and strengthen existing knowledge on the topics discussed. This two way
learning process promotes the development of understanding between different
worldviews and mutual respect. These tools are designed to be implemented with the
participation of different project stakeholders to provide diversity of viewpoints from
different life experiences and knowledge. Mitcalfe (1993) believes such a process
provides a mechanism for training Indigenous community people in bureaucratic
expectations and processes and training service staff in community expectations. She
states such activities promote the development of programs, which integrate different
cultural perspectives.

Each storybook attempts to make contribution towards the request for orientation
guidelines and processes made by CNWs, SWWs and nutritionists at the Side by Side
Workshop in 1997 (Fejo and Priestly, 1997).

The CNWs and SWWs are very familiar with the use of flipchart type resources for
sharing food, nutrition and health promotion information. Flipcharts in A3 and A4 size
are easy learning materials to transport even on light aircraft with tight weight restrictions
that many staff regularly use to travel to communities. It would have been preferable to
produce the Storybooks on A3 sized paper but the cost of producing so many pages in
such brightly coloured format was beyond available resources.

Both storybooks use English because so many different Indigenous languages are spoken
in the NT. The body of the book is written in plain English in an attempt to use English
words that Indigenous people may be more familiar with and to facilitate translation. The
authors recognise the limitations of relying on the written English language in developing
this resource. For many Indigenous CNWs and SWWs English may be their second or
subsequent language and many have limited English literacy skills. It was informally
recognised that when working with people who have limited English language or literacy
skills the storybooks processes would best be implemented with the assistance of an
interpreter. This limitation is one of the reasons why so many pictures accompany the
written story, in addition to providing visual appeal. The use of Indigenous language and
other communication methods are promoted by encouraging people to make their own
version of the Seasons for Workers cycle.
Process evaluation was designed and built into both storybooks for two reasons. Firstly, to demonstrate a commitment to evaluating everything that we do and secondly, to facilitate ongoing evaluation of storybook use. Exactly the same format was used to enable a direct comparison of the outcomes of the evaluation of both storybooks. Given design similarities, it is hypothesised that some similarities will emerge regarding the strengths and weaknesses of both resources, as chapter seven will reveal. A similar in-built evaluation format has been used by other resources including the THS Public Health Bush Books (THS, 1999e and f) and national resources like Indicators to help with Capacity Building in Health Promotion (Hawe et al, 2000).

Design of Sharing Stories About Seasons and Seasons For Workers

The storybook purposefully encourages people who use it to consider seeking and incorporating the views of a wide range of people in planning and evaluating the project they are working on. The model recognises that different people can have different views about an issue or how a project is going. Step 1; Watching, Listening and Thinking, Step 4; How Is It Going? and Step 5; How Do We Do It Better Next Time? all reinforce the need to seek and listen to other people’s opinions before reflecting the relative significance of the information gathered and then taking appropriate action. Many Indigenous languages do not have a specific word that is equivalent to the English word “health” (National Aboriginal Health Strategy, 1989.ix). In contemporary Indigenous health promotion in the NT the word “strong” is widely used as a substitute for the word “health”. The Strong Women, Strong Babies, Strong Culture project is one high profile example. The notion of strength is a complex concept; it can refer not only to physical strength, but emotional, social and spiritual strength, too. In this context it is synonymous with quality and its manifestations are highly valued. Page twelve of Sharing Stories about Seasons and Seasons for Workers asks people to consider “whose ideas are most
important for this work to be strong?” It is intended to facilitate discussion and identify which people’s opinions should be sought and most highly valued in decision making processes. Although it does not state it, this is the point at which the centrality of Indigenous opinions and choices is realised.

In 1991 participants of an ATSIC Regional Councillor workshop in Darwin noted that community development for Indigenous Australians must be linked to their relationship with the land (Wolfe 1991, quoted in Lea and Wolf, 1993:3). Sharing Stories about Seasons and Seasons For Workers recognises the importance of the physical environment to Indigenous life and knowledge in the process of asking Indigenous people to share their knowledge and opinions about seasons in the local environment. The PAR cycle concept Seasons for Workers builds new knowledge onto existing traditional knowledge about seasons. Sharing of Indigenous knowledge and concepts of the seasons affects power relations in cross cultural partnerships. The Indigenous person becomes the teacher, sharing their knowledge with the non Indigenous health professional. This is just one example of how the resource aims to improve power relations and enhance mutual respect by encouraging people to seek, share and listen to different worldviews. Therefore the Seasons Storybook provides a mechanism that should assist in limiting the demonstration of automatic historical patterns of power relations particularly by non Indigenous professionals inexperienced at working in cross cultural and community development contexts.

An Indigenous health promotion professional recommended that the flow be changed from its original anticlockwise direction (as per the Colin and Garrow model, 1994). She suggested it should flow in a clockwise direction as this a more familiar and therefore easier way to read a circular model for people with numeracy skills (Fieldwork Diary, 1997).
Australian rules football is extremely popular with Indigenous Territorians. The inclusion of the analogy “goal posts to aim for” in Step 2: Making a Plan, is again designed to build new knowledge onto familiar concepts. Similarly strategies are synonymous with steps taken from where people are now to where they want to be. At least 4 community projects are known to have documented action strategies in footsteps diagrams, one regularly made planning posters using the format on page 15 of the book. The use of the analogy of looking for signs to check that we are on the right track in Step 4; How is it Going? is another link to traditionally familiar concepts. The Seasons Storybook enables the introduction and explanation of professional terms such as evaluation and performance indicators because the concepts of seeking opinions on “how is it going?” and the “signposts” that people use have already been introduced.

Step 3; Working the plan, Keep on Doing It reminds people to expect that projects don’t often run to plan. It encourages people to modify plans as they go along to keep working towards their goals and to record what they are doing as they go along.

The most significant change between versions 2 and 3 of the Seasons Storybook is the inclusion of an additional major activity Step 6; Sharing Our Work Story, in the PAR cycle. This change occurred as a result of my own reflections on frequent comments made by both Indigenous and non Indigenous health professionals about the positive value of storytelling as a learning and motivational tool. The validity of this inclusion is supported by nutritionists and nutrition managers interview comments on the limits of organisational memory. The writings of senior health researchers like Mathews (1998) who advocate for the prioritisation of research that facilitates the sharing and uptake of existing knowledge within and across cultures supports the inclusion of this step. PAR models focused on evaluation include feedback in the cyclical series of steps, for example Wadsworth (1997) and Colin and Garrow’s (1996) Thinking, listening, looking, understanding and acting as you go along, a guide to Indigenous health promotion
evaluation. Although, the emphasis of feedback in Wadsworth’s model is checking the accuracy and validity of the data and conclusions and this occurs before planning new actions or How do we do it better next time? as we put it. Colin and Garrow’s (1994) original model did not include a feedback or sharing step. Their updated PAR evaluation model (Colin and Garrow, 1996) includes “feedback and report” as the second last step before “decide what to do next time” (1996:43). In comparison to these 3 resources, the emphasis in the Seasons Storybook is on sharing the whole work story with project stakeholders and other people who are interested in health development in similar settings which includes reflections on changes required to promote more informed action in the future. This is done after completing How do we do it better next time?. It is specifically designed to build collective memory in response to many comments regarding limitations in organisational memory and information sharing during the nutritionist’s interviews.

Step 6; Sharing Our Work Story details the potential benefits of sharing work stories to encourage people to take the time to share their story. It contains very few visual images, which admittedly is not very attractive or useful for people with limited English literacy skills. This step was designed as a prompt and to be demonstrated and discussed with the aid of many different examples of stories from food and health projects including posters, written and pictorial reports, photo albums, videos and traditional paintings. Along with other Katherine nutritionists, I carried many of these in a folder called “the nutrition storybook” for a few years. The CNWs and SWWs at the Katherine District Nutrition Meeting in 2001 requested that this storybook be updated and held by both THS and non government nutritionists to bring along on their community support visits (THS, 2001e). The nutritionists decided that the storybook would best be updated and shared in electronic form to minimise and spread associated printing costs.
In addition, Step 6 encourages workers to consider the interests of various stakeholders and discuss appropriate methods for sharing their story with different groups. This step provides an opportunity to discuss marketing, promotion and advocacy strategies.

**Design of The Good Stew, Good Project Storybook**

Part one of *The Good Stew, Good Project Storybook* focuses participants on familiar aspects of everyday life, making and enjoying a stew. It recognises personal preferences and that certain ingredients or cooking process can enhance, or detract from the flavour or quality of the final product. The concepts of different personal preferences and quality of outcome will recur via analogy in parts 2, 3 and 4 where the production of a good community project is likened to the production of a good stew.

Part two introduces the notion that a community project has ingredients and can be produced in different ways just like a stew. Senior Aboriginal Health Promotion Officers suggested that some pages should be made with blank spots for ingredients so people could record their own ideas to start with (Fieldwork diary, 1998). They also felt that it was important to discuss and present the methodology of how things are done or “cooked”. Therefore part two draws out participant’s perceptions of key groups of “ingredients” and processes, acknowledging existing knowledge and experience prior to building upon it in part four. A senior nutritionist suggested that the notion of what improved or spoiled a stew or project should be included (Marie, 1998). Part two also encourages people to identify those ingredients and processes that may be more difficult to include. This step is designed to identify potentially unrealistic aspirations or things that may cause difficulties.

Aspects of infrastructure and support or “ingredients” known to be linked with successful community health and development initiatives were designed to be discussed under 5
headings; community workers, community support and resources, support from other Aboriginal people outside the community, professional support and money. These groups emerged from discussions with Indigenous contributors, groups of themes on barriers and enablers arising out of the interviews with nutritionists. One of the authors suggested that groups of project ingredients could be likened to the five food groups. This later concept could then be used to introduce notions of the relative importance of each food group to make a healthy project recipe namely, more community support and community workers or less professional involvement. This last concept did not make it into the final version of the Stew Storybook because it was getting too long.

The Good Stew, Good Project Storybook can also be used to inform project evaluation. The three SWSBSC Coordinators said the stew storybook could be very useful helping community projects who were having problems identify things they could do to help improve their project “ingredients” (Fieldwork diary, 1998). The director of the Food and Nutrition Policy unit said the tool could be used as part of the process of evaluating existing CNW projects in 1999 (Personal Communication Hobson, 1998). Part three is designed so that existing projects could identify infrastructure “ingredients” and processes that they feel have made a positive contribution to their project. An additional page was originally included in part 3 to facilitate the identification of “bogs and sidetracks” that slowed projects down. This page was removed from the Stew Storybook by the Food and Nutrition Policy Unit just prior to printing to reduce its length.

Part four builds on the existing knowledge and opinions of participants regarding the aspects of infrastructure and support that contribute to active, successful projects. It offers the opinions of over 20 Indigenous and non Indigenous health professionals involved in food, nutrition, SWSBSC and general health promotion projects to compare with the ideas developed in part 3. Three SWSBSC Coordinators and an Aboriginal Food and Indigenous Nutrition Project Officer made extensive suggestions on what ingredients
should be included in each of the categories of ingredients and how they should be written, for example “Strong, steady workers” (Fieldwork diary, 1998). Themes recurring in the interviews with nutritionists and nutrition managers were incorporated into each version. Aboriginal Health Promotion Officers from the Top End and one from Central Australia also contributed ideas or made comments on the criteria already listed (Fieldwork diary, 1998).

As analysis of the nutritionist interviews in chapter 4 and 5 has already indicated, the personal qualities and skills of both community based and professional workers are considered to be very important factors in promoting the success of community based projects. The fundamental nature of these issues was reiterated in informal individual and group discussions with Indigenous health professionals and community people about project enablers. Notions of respect repeatedly arose when talking about positive selection criteria for community workers; self respect, respect for others and cultural respect. Four Indigenous contributors regularly said that both community workers and the professionals that support them need to be good role models, they cannot hope to motivate others about healthy living if they are not seen to be practising it themselves (Fieldwork diary, 1998). Workers and support staff must be team players and have respect for different opinions and ways of doing things.

The inclusion of aspects of cultural responsibility in this section is designed to facilitate consideration and discussion of the fact that people had specific cultural responsibilities, which influence what they can and cannot do. For the most part that means that people can usually only work with people of their own sex and mainly within their own clan and family as Garrow also experienced in the Mai Wiru project (Garrow, 1994). Discussing this point can help partners develop realistic expectations of what individual workers can comfortably do and help to minimise tensions associated with unrealistic plans and expectations made by professionals in particular.
The page on community support and resources highlights the pivotal role of the community in promoting project success through the provision of leadership, support and management of issues like workforce appointment and resource allocation. It demonstrates program commitment to Indigenous self determination and the responsibility that comes with it. It also incorporates the need for and value of local intersectoral support and collaboration. One colloquial term requires explanation. In the sentence: *not too much humbug to do lots of different things*, “Humbug” refers to the pressure and harassment that people feel as a result of the demands made of them.

The segment on support from other Aboriginal people outside the community was added to encourage and support the strengthening of Indigenous networks and support systems. Again note here Indigenous Territorians are referred to as “Aboriginal” as that is the title they use locally and specifically wanted included in these tools (Fieldwork diary, 1998). This provided an opportunity to introduce and promote the role of people like the SWSBSC Coordinators and Aboriginal Health Promotion Officers and groups such as the SWSBSC Steering Committee and the Aboriginal Advisory group for the NT Food and Nutrition Policy. It alludes to the benefits of participation in regional and NT Aboriginal nutrition workshops where workers share stories, plan and problem solve together. This segment ensures project outcomes covered the fact that Indigenous structures exist to support community based activities as requested by CNWs and SWWs at the Side by Side Workshop in 1997 (Fejo and Priestly, 1997).

Professional support was added to enable Indigenous people to articulate their expectations of good quality support from non Indigenous support staff. This section essentially acts like a simple job description outlining professional behaviour that helps to promote the primacy and empowerment of community workers. It makes a contribution
towards the request for outcomes that cover empowerment from CNWs and SWWs at the
Side by Side Workshop in 1997 (Fejo and Priestly, 1997).

The “money business” section was added because so many of the questions and issues
Indigenous workers had about the CNW and SWSBSC programs related to grant funds,
particularly funding availability, flexibility and administration at the community level.
Community based workers wanted the “money business” demystified and for the most
part desired greater accountability from both government departments and the community
organisations that administered the project funds (Fieldwork diary, 1997 and 1998). They
expressed the need for more flexible and realistic funding to be provided by government
departments just like community nutritionists mentioned in the interviews conducted for
this project. Workers were frustrated with reticent and rigid departmental financial
processes. This included restricted funding flexibility, which was often at odds with
preferred action plans and the realities of changes in community responsibilities and
resources that can slow or expedite a project.

Whilst The Good Stew, Good Project Storybook was predominantly designed to use in
project promotion and orientation activities it is also potentially valuable for problem
solving activities with existing projects. It has been specifically set up to focus on positive
ingredients and process linked with active successful projects in recognition that direct
criticisms, particularly of individuals, is to be carefully avoided as it is very offensive in
Indigenous culture (von Sturmer, 1991). Drawing out or providing additional ideas that
might help improve a project takes a positive approach to problem solving. The passive
avoidance of apportioning blame and/or not providing positive reinforcement is in
accordance with traditional Indigenous communication (von Sturmer, 1991:28). This
process provides people with an opportunity to think about limitations in existing
activities. But, in light of this cultural information, any verbal comparison of existing
projects with these criteria has to be approached with great caution and sensitivity.
Page 32 of part four reiterates the primacy of Indigenous control as the primary ingredient to promoting action and success through the control of action planning. It also recognises that different people can have different views about what infrastructure “ingredients” can help to make a successful program. Part 4 then moves on to refer to the *Seasons for Workers* model and *Sharing Stories about Seasons and Seasons for Workers*. It provides a condensed version of the steps this process involves when attempting to make a good project. It acts as a point where action can then progress to using this other storybook. At the time the *Stew Storybook* was being developed THS began switching the administration of grants from grant and service agreements to service contracts. Therefore page 34 was added to introduce the role of these contracts in determining community and departmental responsibilities and providing a mechanism for accountability with both organisations.
Tools to promote social relations and progress health priorities.

Both Storybooks have been designed to complement each other. *The Good Stew, Good Project Storybook* provides an introduction to *Sharing Stories About Seasons and Seasons For Workers*. Together these resources provide guidelines and processes to assist cross cultural partnerships to develop, implement, evaluate and market community health development projects. They are tools that can be used to guide and inform participatory action research (PAR) processes that strive to promote a fundamentally different set of social relations and make a contribution towards broad local, national and international nutrition, health promotion and humanitarian priorities.

The processes advocated by these tools seek to promote egalitarian social interactions. They do so by encouraging and supporting the primacy of Indigenous decision making and control and strengthening the capacity of Indigenous Territorians to improve their health, wholistically. The resources demonstrate that nutrition and health professionals are not the experts who have all the answers. They reorient the role of professionals as advocates and informants to Indigenous decision making. Professionals act as sources of support, workforce development services and provide access to other networks. They affirm Indigenous support networks and leadership structures such as the reference to Aboriginal Advisory Committees in *The Good Stew, Good Project Storybook*.

The processes these resources promote can provide many opportunities for non Indigenous professionals to learn more about Indigenous culture and the everyday realities of contemporary Indigenous life. Both tools attempt to promote Indigenous control and participation in health service planning and action. This learning, the empathy that it can generate and the promotion of Indigenous participation and control might assist in the efforts against racism and oppression in keeping with our national and international obligations (Council for Aboriginal Reconciliation, 1996; United Nations,
All Australians have obligations in relation to the United Nations Convention on the Elimination of All forms of Racial Discrimination (United Nations, 1965) that was recently reaffirmed at the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (United Nations, 2001).

In terms of international health promotion priorities the PAR processes that the storybooks advocate can promote the development of personal skills, contribute to the reorientation of health services and can strengthen community action as advocated by the Ottawa Charter for Health Promotion (WHO, 1986). For example the Senior Aboriginal Health Promotion Officer identified that use of The Good Stew, Good Project Storybook would encourage reorientation of health services as advocated by the Ottawa Charter for Health Promotion (WHO, 1996) (Fieldwork diary, 1998). These PAR processes can contribute to two of the five priorities of the Jakarta Declaration on Health Promotion including consolidating and expanding partnerships for health and increase community capacity and empowering individuals (WHO, 1997).

In relation to national priorities, the processes these tools promote can contribute to Eat Well Australia’s strategic focus on building human resource capacity (SIGNAL, 2001). With regards to the National Aboriginal and Torres Straight Islander Nutrition Strategy and Action Plan (NATSINSAP, 2001) the processes advocated are particularly relevant to it’s third action area; family focused nutrition promotion, resourcing programs, disseminating and communicating “good practise” (NATSINSAP, 2001: p29-30) and developing the capacity of the nutrition workforce to support food and nutrition initiatives for Aboriginal and Torres Straight Islander communities.

Four of the 10 core functions of public health practise in Australia prioritised by the National Public Health Partnership (NPHP, 2002) can be supported by these endeavors. These core functions include the assessment, analysis and communication of population
health needs and community expectations, the promotion and support of healthy lifestyles and behaviors through action with individuals, families, communities and wider society. Also, to strengthen communities and build social capital through consultation, participation and empowerment and the promotion, development and support of actions to improve the health status of Aboriginal and Torres Strait Islander people and other vulnerable groups.

Locally these processes can make a contribution towards achieving the NT Department of Health and Community Services stretch goal of strengthening community capacity in the Strategy 21 strategic plan (THS, 1999c). They demonstrate the NT Food and Nutrition policy’s guiding principles of increased participation of Aboriginal people in decision-making, program implementation and evaluation, capacity building and promoting community control and ownership (THS, 2001b).

The development of the storybooks was not explicitly informed by recently emerging theory on strengthening capacity for health improvement, however, their format and objectives are in harmony with the ethos of this approach. Using the NSW Capacity Building Framework (NSW Health, 2001) as an analytical tool *Seasons Storybook* is principally directed at strengthening capacity in problem solving. It does this by promoting cross-cultural and intra Indigenous problem based learning and action. The process it encourages can contribute positive action in each of the 5 priority areas of this model. It strengthens capacity to form respectful productive partnerships by fostering shared understandings, goals, planning, implementation and evaluation. It can act as a tool to broaden the information that informs Indigenous decision making. *Sharing Stories about Seasons and Seasons for Workers* promotes workforce development of both non-Indigenous and Indigenous peoples, improving community development and cross-cultural skills. Widespread implementation could inform organisational development by
promoting standard procedures and by demonstrating leadership and commitment to
collaborative problem based learning and action.

The use of *The Good Stew Good Project Storybook* has the potential to strengthen
capacity to improve health by predominantly strengthening project infrastructure. Better
infrastructure can in turn support better program maintenance and sustainability and
enhance problem solving. It can act as a tool to broaden the information that informs
Indigenous decision making. The information presented in part 4 of the *Stew Storybook*
corresponds with many strategies promoted in each of the NSW Framework’s 5 action
areas of resource allocation, leadership, partnership, workforce and organisational
development (NSW Health, 2000). Here are two examples of how it achieves this. Firstly
many of the “ingredients” for a good health project strengthen capacity in resource
allocation by developing human, financial, administrative resources and specialist advice.
Also, advocacy for support from professionals and the broader Indigenous health
workforce promotes capacity for partnerships.

As the storybooks promote participatory action research and strengthening capacity for
health improvement they have relevancy beyond food and nutrition projects in the
Northern Territory. Positive feedback has been received from a variety of public health
professionals during the development phase of the storybooks. These practitioners
included Indigenous and non Indigenous health promotion officers, NT Education
Department Hearing Program nurses, and doctors, nurses and allied health staff attending
a number of public health interest group meetings where the storybooks were presented
(Fieldwork Diary, 1997, 1998 and 1999). A decision was made to restrict the trial of the
storybooks to nutrition and SWSBSC projects because the resources required producing
more copies, train more people in their use and evaluate their implementation, were not
available at the time. It was hoped that results of this initial trial with CNW and SWSBSC
projects could be used to secure the support and resources required to expand their availability and use.

Critical reflections on the storybooks in relation to education theory

Adult Learning, education for critical consciousness, health and Indigenous education, and primary health care theory can be used as analytical tools in critically reflecting on the storybooks design and implementation (Freire, 1973; Harris, 1976; WHO, 1978; Knowles, 1980; Carr and Kemmis, 1986; Wass, 1994; THS, 2000e; Winter and Munn-Goondings, 2001).

The storybooks do acknowledge people’s existing knowledge fulfilling an important issue according to Carr and Kemmis (1986) who write that education must have its basis in the current self-understandings of learners and educators. The primacy of attaching new knowledge to individuals existing conceptions is reinforced by other individuals and organisations (WHO, 1978; Knowles, 1980; THS, 2000d). New knowledge is linked to existing conceptual and cultural knowledge (Harris, 1991; Trudgen, 2001). They use a problem centred approach based on peoples immediate needs and interests in relation to their health promotion project as recommended by Knowles (1980) and Harris (1991). The importance of engaging in a dialogue with many other people who are stakeholders in the issue is reinforced in accordance with the principles of primary health care (WHO, 1978, Wass, 1994). The processes promote independence and self direction by encouraging people to be in control of decision making in the Seasons Storybook. Both storybooks seek to challenge the disempowering practise of education by imposition and to encourage two way learning processes, professionals and Indigenous people and other participants all become teachers and learners in the process of education by dialogue, reflection and action (Freire, 1973; Wass, 1994; THS, 2000).
The storybooks do not attempt to actively facilitate the development of critical consciousness beyond benignly encouraging people to seek and reflect on the viewpoints of different stakeholders in project processes. Therefore in their current form they are not tools for emancipation. According to Carr and Kemmis (1986), critical self reflection is the central tenant of emancipatory education, a notion which is supported by the writings of Freire (1973) who discusses the need for developing critical consciousness. Winter and Munn-Goodings (2001) concur, citing the works of Bhaskar (1989:124-25 in 2001:261) who describes the development of knowledge as a self emancipatory process. Carr and Kemmis believe that self-understandings need to be challenged by critical social science that:

\[ \text{seeks to offer individuals an awareness of how their aims and purposes may have become distorted or repressed and to specify how these can be eradicated so that the rational pursuit of their real goals can be undertaken} \] (1986:136).

The storybooks do not ensure that decisions about the learning process rest entirely with the community (Friere, 1973; Knowles,1980). This is because professionals are setting the agenda for education about PAR processes and strengthening capacity for health improvement when first sharing the books with Indigenous workers and other community stakeholders. However in the Seasons Storybook participants are asked: who should we talk to? and who’s ideas are important for this work to be strong? If community based workers were to direct and facilitate sharing of the storybook concepts within the community in their own way this criteria would be met.

Trudgen (2000) published a set of criteria in relation to Indigenous education theory. Trudgen’s commentary is built on the insights arising out of over 20 years of living, working and reflecting with the Yolnu people of Arnhemland, NT. The NT academic Watson (2001) writes that Trudgen’s book, is perhaps one of the most important books yet written …it goes to the very heart of issues and seeks to tease out solutions from this
standpoint (2001:141). As Trudgen’s education criteria are locally specific they have been used to inform this analysis in detail.

First, Trudgen says new information must come from a credible source – the owners of the information (2000:202). The conceptual information presented in *Sharing Stories About Seasons and Seasons For Workers* originally comes from non-Indigenous professional culture (Wadsworth, 1991). It was then used and adapted by an Indigenous nutrition project in Central Australia (Colin and Garrow, 1994) and during this work to produce the *Seasons for Workers* cycle. The information contained within both Storybooks was synthesised from the experiences of over 20 Indigenous and non Indigenous health professionals.

Trudgen’s second criterion is that new information must be delivered in a culturally correct way, not just to children or a few elders, but in education for the whole community. This criterion was not met in the implementation of either storybook in individual communities. This was not considered nor would it have been possible given the resources such a large task would have required. In relation to this criterion he also comments:

> problem solving education has not yet reached its full potential in Australia because the aspect of language and its relationship to the learning process has not been truly understood by mainstream, monolingual Australian educationalists

(2000:244).

He believes that educational activities in people’s primary language enables their intellect to concentrate on conceptual and intellectual issues, not communication issues, maximising the learning experience. To meet this criterion these Storybooks would often have to be implemented with the use of Indigenous translators in the community setting.

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This was not specifically recommended. None of the respondents reported using the storybooks with the help of translators, however, none of them were specifically asked if they had done this.

Thirdly, Trudgen says new information must build upon accepted cultural knowledge and truths and elders must approve and be in control of the education processes. This criterion was partially met, firstly because new knowledge is introduced on a basis of culturally accepted traditional knowledge about the seasons and cooking practises. Also, the Seasons for Workers model was scrutinised and approved in an early version of the Seasons Storybook by the Aboriginal Advisory group to the NT Food and Nutrition Policy in 1995 and later by many Indigenous nutrition and health promotion professionals. However there has been only limited Indigenous involvement and no control of the implementation process of these resources through in the nutrition program. The storybooks implementation in the SWSBSC program was controlled by the Top End SWSBSC Coordinator.

Trudgen’s fourth criterion is that new information needs to be able to survive intellectual debate, being correct and building upon accepted cultural knowledge base. He has commented:

\[\textit{the cartoon character, flannel graph, flipchart and poster mentality that prevails in Aboriginal education belittles Yolgnu educational requirements and insults the people intellectually. No wonder it doesn’t work} \ (2000:209).\]

While the Seasons Storybook does use plain English to cover the basics of PAR, the cycle itself is quite a complex model. It is designed to prompt discussion of different world views on particular issues and therefore the outcomes of its use could be quite detailed and complex. The information it contains is correct having been based on earlier works (Wadsworth, 1991; Colin and Garrow, 1994) that have been subject to scrutiny,
trial and evaluation. Plain English terms are used instead of jargon in an attempt to minimise the impact of language barriers. More complicated English terminology is easily added to the discussion. At no time during the demonstration of this resource or collection of any evaluation feedback has any Indigenous or non-Indigenous person indicated that the content of either storybook was considered to be too simple or basic or that it was insulting to people's intelligence. Of course I am aware that cross-cultural politeness may have prevented such comments from being made.

Lastly, Trudgen says new information must receive peer group affirmation to enable it to be accepted, updated and retaught. The intensive participatory nature of both Storybooks development processes described in their introduction provides a degree of inbuilt peer affirmation. The results of the development process and evaluation questionnaire that follows in chapter 7 demonstrate that for the most part the storybooks have been accepted and modified by those professionals who have seen them demonstrated by their peers.

The application of education theory can be viewed as an indicator of quality in efforts at strengthening capacity for health improvement. This is because the use of these theories can enhance the appropriateness and effectiveness of educational activities and attempts to improve social relations. It is an entirely appropriate methodology to incorporate into action and PAR endeavours.
Summary

The facilitative narratives *Sharing Stories about Seasons and Seasons For Workers* and *The Good Stew, Good Project Storybook* were designed to meet the expressed needs of non Indigenous and Indigenous professionals for process guidelines within the food and nutrition and SWSBSC programs in the Northern Territory. They were developed through cycles of predominantly consultative action research with more than 30 Indigenous and non Indigenous health professionals.

*Sharing Stories about Seasons and Seasons For Workers* is different from other PAR and evaluation models used in both mainstream community development and Indigenous food and health projects (Wadsworth, 1997; Colin and Garrow, 1994 and 1996). Firstly, the model is presented within a facilitative narrative that focuses on establishing positive processes to promote interactive cross cultural problem based learning, action and respect. The process uses an analogy likening steps within PAR models to climatic seasons, *Seasons for Workers*. Secondly, an additional step “Sharing our work story” has been added after the formulation of strategies to improve future action. Limitations arising from the use of English language and associated language and literacy issues are acknowledged.

*The Good Stew, Good Project Storybook* likens the production of a successful community health development project to the production of a good stew. It was predominantly designed to use in project development processes but it can also be used as a tool for project evaluation and problem solving action planning. It facilitates a process to draw out, share and strengthen knowledge on the infrastructure or “ingredients” and the processes or “cooking methods” required in a community health development project in remote Indigenous communities in the NT. Focus is given to aspects of infrastructure related to community workers, community support and resources, Indigenous support
from outside the community, professional support and financial resources and administration.

The storybooks are tools that can be used to guide and inform participatory action research (PAR) processes by promoting more respectful and equitable relationships between Indigenous and non-Indigenous Australians and increasing Indigenous control and capacity. National and international health promotion, reconciliation and humanitarian priorities encourage, implore and expect Australians to undertake these activities. The analytical application of Indigenous and emancipatory education theory to the storybooks identifies their strengths and opportunities for improvement. In their current format, their implementation does not actively promote emancipation through the development of critical consciousness. This chapter demonstrates how these theories can be used to appraise and identify issues for improvement in efforts to strengthen capacity for health improvement.
CHAPTER 7:
CRITICAL REFLECTIONS AND OPPORTUNITIES FOR STRENGTHENING PRACTISE

Chapter Seven provides a critical analysis of the work, the challenges experienced, its weaknesses and strengths. It is organised into four parts. Parts one, two and three are commentaries on each of the projects three main foci. Part one attempts to assess the historical efforts at strengthening capacity in food and nutrition services in the NT. Part two examines the qualitative social research into nutritionist’s reflections on working in partnership. Part three critiques the project’s general efforts at PAR throughout the development, implementation and evaluation of the storybooks. Finally part four details recommendations for improved research and practise.

As the following sections will elaborate, the contextual realities meant that the actual project processes were less participatory, thorough and much slower than originally planned. Although the increased time helped facilitate processes to add value and improve the quality of qualitative aspects of this project, these issues had a negative effect on the quality of the participatory action research component. Reflections on both the
strengths and limitations of this work provide insights that are re-framed into recommendations for improved research and practice.

**Analysis of the NT Nutrition services historical efforts at strengthening capacity for health improvement**

Nutritionists who led the profession in the NT for over 20 years suggested that lessons from the historical development of nutrition services in the NT and the CNW program would inform this project (Personal communications, Hobson, Lion and Rae, 1998). Two of these leaders also endorsed my idea to apply the ideas and models of capacity building for health improvement to analyse the development of nutrition services in the NT (Personal communications Hobson and Rae, 2001). Chapter 3 is the result of these activities.

This analysis of NT nutrition services historical efforts at strengthening capacity for health improvement incorporated qualitative research and public health inquiry within a broader framework of consultative action research. According to Foote-Whyte (1991:46) consultative action research incorporates participation in the form of individual consultation. It does not involve substantial proactive community based decision making, learning and action and therefore it cannot be readily classed as PAR (Foote-Whyte, 1991;George, Green and Daniel, 1996:7; Wadsworth, 1997). It is one individual’s analysis and is therefore influenced and restricted by their limitations. In this instance that was largely my own professional socialisation, abilities and the academic requirements of the award I am seeking.

Qualitative data collected from these long term nutritionists and other nutrition managers that informed this chapter was collected and analysed systematically with a minimum of 9 rounds of data analysis. Some segments of data were scrutinized more often when cross checking the relationships between groups of themes, or relationships between themes.

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and respondent characteristics. Sampling was purposeful and comprehensive as required to strengthen research quality (Kuckelman-Cobb and Hagemaster, 1987). The views of the 3 nutritionists with over 20 years experience and six of the seven women who had worked as nutrition managers in the early to mid 1990s were included. The NUD.IST qualitative data management package Version 3 (Richards and Richards, 1993) was used to facilitate the organisation of data into levels of themes.

NUD.IST was primarily used as a data management tool to sort the qualitative data. It’s functional capacities facilitated cross quick cross-referencing of data. Conversely the time taken to become familiar with the program and convert Microsoft Word (Microsoft Corporation, 1997) documents for data entry slowed the process. I cannot help wondering if word processor documents could have been used to undertake this task just quickly. A document outlining the relationships between documents much like a “family tree” could have been constructed to facilitate manual cross referencing similar to the NUD.IST node tree. Each time I had a break from using the program for more than a few months I had to re-familiarise myself with its use.

As advised by Kuckelman-Cobb and Nelson-Hagemaster (1987), the process of seeking criticism helps to strengthen the reliability of the information. Wadsworth’s (1997) PAR Action Evaluation Research Process model, recommends that data and be returned to informants to check its accuracy and to enable them to peruse the conclusions and explanations to ensure that they are plausible and convincing and that no significant issues have been missed or left out. The table summarising nutrition activities and workforce statistics has been sent to the 3 longstanding NT nutritionists on 3 occasions to check the accuracy of the information. Two informants provided comments on the first draft to correct errors and offer more detailed examples of activities particularly from the late 1970s and early 1980s. Two of these nutrition leaders also evaluated the accuracy of the conclusions outlined in chapter 3 of this thesis and corroborated that the conclusions
were sound and accurate. Minor adjustments were recommended to allude to the improvements that had been made in relation so some issues in the last year or so, for example the inclusion of food and nutrition performance targets in service agreements.

A number of variables have influenced the style and quality of the historical analysis. These include potential positive bias associated with my being a member of the NT nutrition team, possible under representation of Central Australian workforce issues and the choice of the NSW Capacity Building Framework (NSW Health, 2000) as an analytical tool.

Humanistic and naturalistic inquiry cannot avoid observer bias (McNiff, 1988). The fact that I am relatively long term member of the NT Nutrition team (1989-2001), means that I am more likely to have more positively overestimated the quality of efforts at capacity building. Someone from another profession may have evaluated the historical development of services with much more objectivity. Conversely, my working knowledge of the breadth of historical activities, particularly the many unpublished efforts would have added value to the discussion that could not have been captured by an outsider. I acknowledge that the efforts of my colleagues based in Central Australia over the last 20 years may have been under represented in the examples provided and the conclusions made. This is because I have always been based in the Top End and had less incidental opportunities to learn the detail of Centralian efforts or source unpublished historical reports, particularly from the early 1980s to the mid 1990s.

This reflective presentation of the development of nutrition services in the NT is essentially just the authors perspective on the written and verbal information collected and reviewed. A more critical account of the development of NT nutrition services could have been achieved through the inclusion and critical comparison of a variety of other stakeholder’s perspectives. The inclusion of negative evidence including differing

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viewpoints or related topics which are omitted or absent from the data collected can be particularly revealing and insightful (Neuman, 1992: 428). This study could have been strengthen involved Indigenous workers and community members, nutritionists (particularly those who had left the NT), nutrition managers and other health service providers and managers involved in the services over the last 3 decades. Also, this study only presents the voice of women in these groups, who make up the majority of the workforce. Therefore, collecting and analysing the opinion of men in these stakeholder groups and comparing them against the material related to the women’s perspectives would add another detailed layer to the critique.

The resources required for these more detailed processes would have been extensive. Given that we could not secure the resources required to implement the stakeholders priority for an extensive PAR project a more detailed critique of the development of services was impossible.

The NSW Framework for Building Capacity to Improve Health (NSW Health, 2000) has been used as an analysis tool because I assessed that it was the most comprehensive, recent, Australian model focused at health improvement available at the time. This was previously argued in Chapter two. It was assessed as being more suitable as an analytical tool than Fennell’s (1999) general recommendations for the Australian Public Service and the international model of Goodman et al (1998) which is more community focused.

In 1998 Hawe et al conducted an extensive series of focus groups and interviews in New South Wales in an attempt to define quality in capacity building practise. They concluded, amongst other things, that there was general agreement that simply making capacity building more visible may be indicative of quality in health promotion. As such chapter three is a quality focused activity because it attempts to make capacity building
more visible and recognise strengths and weaknesses of historical efforts within a
currently relevant paradigm. The weaknesses and gaps that it exposes provide
opportunities for improving efforts to strengthen capacity into the future.

Nutritionists reflections on working in partnership

This segment of the research project again involved qualitative research within the
broader paradigm of consultative action research. Nutritionists were involved in setting
the priorities and reviewing and commenting on the emergent themes, providing the
consultative aspects of the project. Various action outcomes eventuated, as the following
discussion will elaborate.

The collection and analysis of nutritionist’s reflections on working in partnership with
Indigenous community based workers was conducted systematically and
comprehensively. It was a very large task. Interviews were conducted over 3 years. This
included an extra year to facilitate interviews to ensure this work represented the views of
over 80% of nutritionists working in community and management positions in the NT
during 1997-99. That action was prompted by recommendations from the Director of the
Food and Nutrition (Policy) Unit, who also actively encouraged nutritionists who had not
already contributed to do so (Personal Communication Hobson, 1999). The high
contribution rate strengthens the quality of the data. Those that did not contribute
included the only male nutritionist, two females working in one district who left the NT
suddenly and one nutritionist manager working in another sector who did not respond to
the opportunities to be interviewed. The women’s range of experience is similar to that
displayed in the group of respondents so I concluded that non respondents comments
were likely to have been fairly similar to those of the interviewees. Therefore I feel very
confident that the range of comments presented on the issues very reliably captures the
breadth of professional perceptions at the time. The extensive commitment that has
informed this group’s contributions, which totals in excess of 125 years of professional practise in the Northern Territory, provides a strong base of experience for the study.

I underestimated the time required to process analyse and report on such a large volume of qualitative data, which is not uncommon in qualitative research (Meyer, 1993). Over 18 hours of interview discussions were taped and transcribed into over 60,000 words, mostly by myself. I eventually had to pay for administrative assistance to complete this task with the last set of interviews conducted in 1999. Data was scrutinised at least 9 times, some more often, when cross checking the relationships between groups of themes, or relationships between themes and respondent characteristics. Responses to different questions that elicited supportive or conflicting data on similar themes were highlighted in the discussion. As an example, structurally focused strategies to promote empowerment were mentioned by most nutritionists in comments about project enablers and barriers but rarely listed in response to the direct question on empowerment. The presentation of the many unsolicited comments on performance indicators is another example of depth of data analysis.

Again, as recommended by Wadsworth (1997), data was fed back to informants to enable them to peruse the conclusions to ensure that they were credible and that no significant issues have been missed or left. This process provides participant validation and ensures credibility (Kuckelman-Cobb and Hagemaster, 1987; Neuman, 1992; Appleton, 1995). This was done using four different formats over a two year period. Firstly each respondent was sent a copy of the transcript of their interview and asked to check it for accuracy. Three respondents took the opportunity offered to elaborate or add to comments that they had made during the interview process. Secondly, data and primary emergent themes were fed back to Top End nutritionists via a short presentation summary in March of 2000. This presentation elicited questions and discussion. The group’s practical recommendations were similar to the research conclusions I had drawn. These included
the limitations of staff turnover, changes in community capacities, and organisational and workload management issues. Also, such issues as the need for greater focus on project evaluation, flexible funding options, problem solving and accountability.

A power point presentation, *Reflections Of Our Professional Ancestors And Peers; Challenging New Horizons For Our Indigenous Nutrition Partnerships*, was presented to THS and NGO Nutritionists working in Katherine District in May 2001. It was also an invited paper for the 20th Annual Dietitians Association of Australia conference in Adelaide (Priestly, 2001). Four of the respondents viewed this presentation and also three newer nutritionists. In addition an electronic copy was sent to the Director of the Nutrition and Physical Activity (policy) Unit for reference and dissemination and another long term nutrition manager (totalling 37 percent of the interviewees). Feedback received from respondents was overwhelmingly positive. They agreed with the general themes presented and the conclusions drawn from them. They agreed that it was important to tell people that making a medium to long term commitment was essential to enable professionals to develop competencies and confidence and see positive changes in Indigenous capacity and health. Three mentioned that it made them “feel good” about their contribution and that it was validation for the difficulties they had experienced adjusting to work in this complex cross cultural environment. These experiences were considered to be “normal”. A number of Dietitians working in other public health settings who attended the conference presentation identified with the themes and issues in relation to their own community development activities. This concordance demonstrates the generalisability of some of the lessons of this research to contexts beyond the NT (Fieldwork diary, May and June 2001).

Chapters four and five were forwarded to all but two interviewees who had moved interstate and were unable to be contacted. This was done just prior to the completion of the thesis to facilitate a fourth round of insider validity assessment. Respondents were
asked to check the context in which any of their own quotes were used and provide feedback if they felt the conclusions drawn from the quote were inappropriate. They were encouraged to make any other comments and particularly constructive criticism. One replied with specific comments seeking clearer presentation of a point about language and literacy barriers in chapter five. Many general comments were received, three reiterated conclusions relating to the value of experience and making long term commitments to working in this context, two mentioned that this work demonstrates the value of critical reflection. One nutritionist's reply summarises these points:

\[\text{this is an important document for the history of nutrition in the NT. ...} \]
\[\text{What I particularly liked is how you challenged the way we work ...} \]
\[\text{challenges/critical thinking are important particularly to working in this environment and I don't think we experience this enough.} \]

(Rose, 2002)

All respondents completed participant consent forms in which they were asked to indicate if they would prefer to have their direct or paraphrased comments kept confidential or clearly recognised. Nine indicated that they wanted their quotes kept confidential. Six preferred to have them directly attributed unless they particularly specified otherwise. One wanted to be consulted about her preference for confidential or directly attributable source recognition with regard to each quote. A decision was made to code all informant's names for the quotes appearing in chapters four and five and the feedback included in chapter seven. My rationale for this decision was that the act of identifying 40 percent of the interviewees quotes would have allowed some readers to correctly recognise the identity of some code names thus breaching confidentiality agreements. When chapters four and five were forwarded to respondents for evaluation they were informed of this decision and asked to contact me if they disagreed with it. They were
also offered the opportunity to indicate whether they still wanted me to destroy the tape of their interview (as per the ethics agreement) or have it returned to them. This opportunity was offered to enable participants to feel in control of the fate of their personal contribution. Eleven responses were received on this issue (44 percent of respondents). All said they were happy to have code names used and for me to destroy the tapes.

No breaches of ethics commitments occurred. One of my supervisors acted as an independent monitor and project participants were encouraged to contact her if they had any problems or doubts about the research project and my associated conduct. She was well known to all participants and easily accessible. She did not receive any complaints. Progress reports were submitted to both the UWS Human Research Ethics committee and the combined NTDHCS and Menzies School of Health Research Committees annually as required.

Process evaluation regarding the interviews was recorded via fieldwork diary entries. A number of weaknesses were identified in the interview structure. These included the inability to define or have respondents define what they perceived the term’s “empowerment” and “sustainability” to mean. This would have enabled more detailed analysis of their understanding of these issues. The nutritionists should also have been asked the questions relating to the promotion of sustainable development of CNW programs to increase the data on this topic, compared with managers responses and make more detailed conclusions to inform future practise. The original nutritionists’ questionnaire asked them to comment on their perceptions of the role of CNWs. This question was removed in early 1998 because early trials of the questionnaire had demonstrated that as some of the respondents had not yet worked with CNWs and they would only be providing hypothetical examples if interviewed in the short term as originally planned. In hindsight this question should have been maintained because interviews were conducted over a 3 year period and by the time that most of the
respondents had been interviewed they had been working with CNWs or SWWs for at least a few months. The data would have enabled a detailed analysis of nutritionists perceptions of the different roles of themselves and their Indigenous partners including an assessment of the influence of power issues. All the managers should have been asked: 

*What key personal knowledge, skills and resources do you feel the Nutrition/Strong Women Workers bring to the work?* Comparative analysis of the manager’s collective perspectives compared to those of the nutritionists would have provided valuable data for this analysis. Since CNWs, SWWs and nutritionists had asked for resources to help them start out strong together the questionnaire should have included a more direct question about how nutritionists attempt to form productive partnerships with Indigenous people. Of course it would have been very valuable and interesting to have responses to the similar questions from CNWs, CNAs and SWSBSC staff to compare and contrast with the nutritionists views.

The fact that others have undertaken similarly focused qualitative inquiry into the practise of public health activities in the NT (Standen, 1998; Clark, 1999; Humphery, Weeramanthri and Fitz, 2001) and beyond (Fitzgerald et al, 1997) provides outsider validation on the relevancy and appropriateness of this research. This is an original work. Those studies provided alternative sources of information with which to compare and contrast the nutritionists reflections. This process of triangulation lent support or demonstrated differences in the themes and conclusions (Kemmis and McTaggart, 1988; Neuman, 1992; Yin 1994). Reference to these works often contributed outsider validation via the consistency of emergent themes displayed. It also identified variations in themes, for example different perceptions of cultural brokerage roles by nutritionists in this study and the EHOs represented in Clark’s (1999) work.

I openly recognise that the omission of the views of the CNWs does weaken the quality of outcomes of this project. As chapter 2 detailed, many unsuccessful attempts were
made to secure funding for an Indigenous co researcher as a culturally appropriate
initiative to gather and facilitate the synthesis of Indigenous perspectives about the
activities and issues associated with cross cultural nutrition partnerships in the NT. I
could have sought and summarised Indigenous opinions myself in attempt to broaden the
range of perspectives discussed as other NT researchers have done (Standen, 1998; Clark,
1999). Reflection on key lessons from the literature and my own professional experience
challenged the validity and usefulness of undertaking that approach. For example as
detailed in chapter one, the National Health and Medical Research Council Guidelines
(NHMRC) concerning Aboriginal and Torres Straight Islander health research (NHMRC,
1991) stress the primacy of Indigenous participation, control and ownership. In essence, I
concluded that if I could not be involved in undertaking this task in accordance with
current best practise then I should not attempt it at all. In addition I felt that I would be
perpetuating cultural insensitivity and power inequities by attempting to collect and
synthesize CNW opinions myself.

Some readers might conclude that the failure to personally seek detailed Indigenous
opinions could be considered to be an example of the phenomenon of cultural paralysis at
work. In response I would argue that my decision is clearly articulated and grounded in
nationally acknowledged guidelines and confidence developed through extensive
personal experience. It is not a demonstration of inaction that is the consequence of lack
of research, confidence or confusion.

I have attempted to temper this weakness by making reference to published materials
outlining comments from CNWs working during this time, predominantly by making
comparisons of this projects data with some of the outcomes of the CNW review
conducted by Bonson in 1999. But the scope of her project was more general and not
specifically targeted at the detail included in my research project.
Despite process limitations that have been outlined here, this segment of the thesis is an important and valid addition to a steadily increasing body of work presenting and analysing health professionals' reflections on working in this cross cultural context. The reliability of the data is a particular strength.

Many experienced nutritionists expressed feelings of personal satisfaction at undertaking the process of reflection that this project initiated, for example:

*looking back I think we have achieved a lot and we should really pat ourselves on the back...it's a project like yours that makes you stop and review where you've been*  
(Personal Communication Lion, 1999).

The study can and has informed attempts to find better ways of working across cultural boundaries. This is, according to the long time director of the Menzies School of Health Research in Darwin, Dr John Mathews (1998), one of the most relevant research issues in Indigenous health. It has done this via the contributions of early analyses to the list of positive "ingredients" in part 4 of the *Good Stew, Good Project Storybook* (Priestly, Liddle and Hobson, 1999). It also provided valuable insight to guide other personal activities not detailed in this thesis such as an activity based orientation program for nutritionists (Priestly, 1998), the Empowering Partnerships workshop run for Dietitians and Indigenous Health workers nationally (Priestly and Liddle, 2001). It also informed a presentation to my peers at the 20th Annual Dietitians Association of Australia Conference (Priestly, 2001). These aspects demonstrate the benefits of a research approach that is openly informed by the developing ideas and practices of local participants. It can provide valuable data to inform efforts at strengthening capacity for health improvement. This study also demonstrates that as qualitative research is very resource intensive, it can rapidly consume limited resources and therefore its application should be carefully limited.
Evaluation of Efforts At PAR; The Storybook Development and Implementation

The following segment presents and critiques the evaluation of the storybook development, implementation processes and the evaluation processes themselves. Health promotion guidelines on evaluation recommend that process, impact and outcome evaluation be planned to measure progress in relation to a project’s strategies, objectives and its ultimate goals (Hawe, Degeling and Hall, 1990; THS, 1999e). Process evaluation alone is not adequate to demonstrate the effectiveness of health promotion endeavours (Wise, 1997) as the following discussion will demonstrate.

Evaluation of storybook consultation and development:

Evaluation included a) documenting the extent of consultative activities with nutrition, SWSBSC and health promotion staff, b) securing a consensus on the future format, implementation and evaluation of the storybooks, and c) securing funding and administrative support to produce and distribute the resources according to the implementation plan.

One hundred percent of Top End community nutritionists, SWSBSC coordinators, Aboriginal nutrition advisers, Food and Nutrition (policy) Unit staff and all Top End Aboriginal health promotion officers were consulted. One Centralian Aboriginal health promotion officer contributed comments after being sent a copy by the Top End SWSWBSC coordinator. Other Central Australian health promotion or nutrition staff were not consulted because there were no funds to undertake face to face consultation.
Top end nutritionists, policy unit staff and a Top End SWSBSC coordinator collectively defined a basic objective and goals and an associated plan. The objectives and goals became:

the production, use and evaluation of an updated Season's Storybook and Stew Storybook to encourage the development of strong cross cultural partnerships and community development processes in community nutrition and SWSBSC projects.

(Fieldwork diary, 1998)

It was decided that new editions of the Storybooks were to be produced by the end of January 1999 and produced and distributed by the Food and Nutrition Unit to all NT Nutritionists and SWSBSC Coordinators. The Director of the Food and Nutrition Unit and co-author of the new storybook offered to demonstrate the Storybooks to Central Australian nutrition staff and project officers employed to undertake an Indigenous Evaluation of the CNW program planned for 1999. The implementation trial was planned to take 6 months after which time the results of inbuilt process evaluation procedures would be collated and analysed.

At this time we did not actually review or adapt the original project aim which was to improve knowledge, skills and personal confidence of professionals (mainly nutritionists) in facilitating and supporting community nutrition strategies (Priestly, 1997). We did not plan associated impact or outcome evaluation strategies either because of acute time constraints associated with cyclone warnings and the resultant travel restrictions and disaster management responsibilities. The following discussion will demonstrate why these were significant omissions from the implementation plan which impacted on the quality of this projects outcomes.
Evaluation of Storybook Implementation

The Top End nutritionists and the SWSBSC Coordinator had decided that process evaluation forms should be built into each storybook. These were designed to be completed by professionals each time they used a storybook and then faxed into the FaNU (policy unit) to facilitate compilation and the production of a report after 6 months implementation (Fieldwork diary, 1998). But no evaluation forms had been returned by the end of September 1999 (Personal Communication Hobson, September 1999). Verbal consultation in early 2000 determined that many nutritionists had not used the books very much therefore a planned mail out of process evaluation forms focused at multiple use of the books was postponed. Fifteen Nutritionists working in community nutrition, project positions, the policy unit and Indigenous Health Services and the SWSBSC Coordinators were emailed this questionnaire for each storybook in September 2001 (Attached as Appendices K and L). The same questions were included in both storybooks evaluation forms. It was designed to uncover limitations in the storybook distribution process given anecdotal feedback that the other authors and I had already received. Responses were received from 11 nutritionists and 1 SWSBSC Coordinator (response rate = 11/15, 72 percent and 1/3, 33 percent respectively) regarding the Seasons Storybook and from 10 nutritionists and 1 SW Coordinator about the Stew Storybook (response rate = 66 percent and 33 percent respectively).

The results of these questionnaires and fieldwork diary records recording other evaluative comments were compiled by myself and examined by the 3 co-authors. As predicted some themes recurred in feedback pertaining to each individual storybook due to design and implementation similarities. Therefore the results, the major conclusions drawn from them and some of our other experiences using the resources are presented together below in the form of a SWOT analysis; Strengths, Weaknesses, Opportunities and Threats.
Perceived Strengths and Community Utilisation

Both the Storybooks have been implemented in many communities across the Top End of the NT. The *Seasons Storybook* was used by 8 nutritionists and 1 Strong Women, Strong Babies, Strong Culture Project Coordinator (75 percent of respondents), in the Top End of the NT between mid 1999 to late 2001, mostly between 1 to 5 times each. The *Seasons Storybook* has been used to promote participatory action research planning and evaluation processes in remote and urban CNW, SWSBSC and child health projects across the Top End. It has been used most extensively in Katherine District (6 communities) where sustainability of use in 2 communities was linked to community workers use of the *Seasons for Workers* model despite changes in nutritionists. The *Seasons Storybook* has also been used in a number of East Arnhem District communities by 3 other nutritionists and the SWSBSC Coordinator. It has been incorporated into Aboriginal Health Worker training, training and problem solving for public health professionals by nutritionists and the authors. The seasons diagram and the planning and evaluation segments were most frequently used parts of the *Seasons Storybook*. Nine respondents (75 percent) generally only used parts of the *Seasons Storybook* at any one time, focussing on the issue of the day, which for example was planning or evaluation.

The *Stew Storybook* was used by 8 of the respondents including the one SWSBSC Coordinator, predominantly in the development phases of community nutrition projects and ongoing implementation in the SWSBSC projects. It was used for various planning purposes including planning a program aimed at reducing weak blood and community expenditure of grant monies. Others groups used it to plan the roles of the community and THS and to help determine who should be appointed as a CNW. One of the authors, has used it extensively with SWWs including *showing them ways of implementing their programs and who is involved, what other service providers are involved and why we need to evaluate our work* (Personal Communication Liddle, 2001). It was included as
part of the Top End Nutritionists orientation program (Priestly, 1998). Urban based respondents said they had no reason to use the *Stew Storybook*.

Comparison of the feedback with fieldwork diary records demonstrated that both Storybooks were implemented by those people who had participated in their development or received demonstrations, and/or inter-active training in their use.

The limited feedback respondents' received from community participants was positive. Respondents were asked *What have people said about the Seasons /Stew storybook?* It is difficult to draw strong conclusions on what community workers and others thought of the Storybook processes because only five respondents answered this question each time (45 percent). The *Seasons for Workers* model is a very clear analogy which respondents reported was received well in community based activities. Respondents reported that community participants often clearly identified with the analogies of the season's models, signs of seasons changing and planning for a project being like planning for a hunting trip. Typical comments included: *People were able to relate some of the environmental changes which they could use as measure* (Amanda). Also, *a CNW who has worked with this resource has referred to it in her own way eg. it's time for a change (in our program) just like it's now time for the rain to come* (Rose).

Four respondents said that participants who gave feedback on the *Stew Storybook* found it useful and valuable for their work and that the books usually generated lots of discussion. Again typical comments included: *Participants who gave feedback found the book to useful and valuable for their work* (Chris), and *I didn’t actually ask the ladies if they thought the resource was good, but it certainly prompted conversation with them and help elicit good response* (Rose). This last comment demonstrates that professionals often did not seek any process evaluation feedback when they used the storybook even though it was encouraged with the inclusion of an evaluation form. This point again demonstrates
tensions between verbal and philosophical commitments to the value of evaluation expressed in chapters 4 and 5 and the realities of its practise in work settings.

None of the respondents mentioned receiving any negative feedback about the storybooks. One likely reason for this is due to Indigenous peoples cultural reluctance to provide direct criticism. Independent Indigenous evaluation of the storybooks would provide more critical comments, however, the plans that were made for Indigenous evaluation were never implemented as later sections will detail.

Eight people (72 percent of respondents for the Seasons Storybook and 80 percent for the Stew Storybook) said they would recommend both the Seasons Storybook and the Stew Storybook to Indigenous and non Indigenous government and non government community based health workers, health promotion officers, community workers. When asked why they would recommend them, the range of responses encompassed strengthening both professional and community capacity to improve health via encouraging wide participation and information sharing, including project planning and evaluation. For example the following comment was made about both books by one nutritionist:

**WHO** [they should be recommended to]: *Health Promotion Officers, Community Development Officers- anybody involved in planning community projects in partnership with community based workers or anybody who does not have much experience in program development.*

**WHY** [they should be recommended]: *Uses examples people can relate to and provides a simple framework about how to involve the community in developing programs.*

(Claré)

The list of ways the professionals have used the storybooks together with these comments demonstrate that respondents believe that these resources help professionals encourage
community development processes in nutrition and Strong Women, Strong Baby, Strong Culture projects in the Top End.

The demand for the storybooks expressed by Indigenous and non Indigenous nutrition and health professionals nationally provides outsider validation of the relevance and potential usefulness of both Storybooks. Indigenous women from Western Australia received copies of the storybooks at a SWSBSC training workshop in 1999. They requested permission to reproduce the books (Personal Communication Hobson, September 1999). Thirty of the thirty four Indigenous health professionals and eighteen dietitians attending a participatory workshop entitled “Empowering Partnerships” run by myself and one of the other authors, at the 20th Annual Dietitians Association of Australia conference (Priestly and Liddle, 2001) requested copies of both Storybooks.

Perceived Weaknesses and Community feedback

Orientation and distribution of the storybooks was erratic. Central Australian staff did not receive copies of the storybooks or training in their use as planned. Four of eleven respondents (Thirty six percent) had not used the Seasons Storybook. The main reasons cited for this being, either unaware of the resource, unfamiliar with it’s contents or having no occasion to use it. Two nutritionists had reported difficulties accessing a copy in their local office.

People who had just been given, sent or told about the storybooks were less likely to use them. Only one of the five Central Australian based nutritionists who were sent a copy of the questionnaire responded. When I followed up the poor response rate 2 nutritionists said they did not respond because they did not have access to a copy of the storybook or didn’t know about it. One of the authors was to have run a workshop for Central Australian nutrition staff in mid 1999, however this was cancelled. The Central
Australian Public Health Nutritionist was given the task of distributing copies but this did not occur and I am unable to ascertain why because this person has left the NT.

The Storybooks were not used as often as they could have been. They had generally been used between 1 to 5 times by the majority of respondents. Only one nutritionist besides 2 of the authors had used them more than 10 times. Despite this low frequency of use half of the respondents reiterated their potential relevance and usefulness. Here's how one nutritionist described it:

*I know I don't use this resource [Seasons Storybook] as much as I perhaps could. We often get tied up in running programs in a number of different communities, and don't have a lot of time to sit back and think about the best ways to work with people. On reflection, I would have used the resource more often had I had the time or simply thought of it*  
(Rose)

This quote demonstrates that the implementation of the *Seasons Storybook* was affected by the issues that contribute to weaknesses, barriers and frustrations in professional practise as mentioned in earlier chapters which include heavy workload responsibilities and associated time pressures.

Both storybooks are ethnocentric resources using the English language in it's written form. Only a few respondents mentioned the limitations of literacy and language when providing feedback via the process evaluation questionnaire. Four diary entries relating to feedback about earlier versions of the storybooks mention these issues as limiting factors. This is the reason why so much effort was put into incorporating good quality graphics and getting Indigenous advice on the most appropriate words to incorporate into this version. These resources need further adaptation for people with very limited or no
literacy skills, and further feedback and guidance from Indigenous users of the storybooks to lead to improvements in the language and graphics.

Two respondents (18 percent) said the *Seasons Storybook* was too long to be used all at once. Another nutritionist who had used the *Seasons Storybook* more than 10 times before leaving the NT supported this view.

The inbuilt process evaluation mechanisms were only used by 3 nutritionists (27 percent of respondents). Also, they each reported not completing the form every time they used parts of the book. The reason given for this was usually “time pressures”. Likewise, additional work sheets for the *Stew Storybook* were only used by 2 nutritionists. Only the authors have used the *Stew Storybook* to promote problem solving on project management issues as part of their roles as nutrition manager and SWSBSC coordinators.

**Opportunities**

Comments about the potential usefulness of the Storybooks to other public health and community services professionals and Indigenous people made by respondents suggests they should be promoted and shared more widely. Perhaps, the most effective way to achieve this is through participatory demonstrations. I and the other authors believe this is the best way to familiarize people with the storybooks and market their potential usefulness because many individual requests for the resources have originated from circumstances where people had observed or participated in the use of the books. For example a workshop format was designed and implemented to demonstrate the storybooks as tools for promoting communication, cooperation and community development with 18 Dietitians and 16 Indigenous health workers nationally (Priestly and Liddle, 2001). Eighty three percent of participants requested copies of the storybooks as
a consequence. Process evaluation of this workshop was generally very positive and only minor suggestions for improvements were made.

The most cost effective and efficient way to distribute the storybooks is via electronic media. Both storybooks were expensive to produce in small quantities due to the large number of coloured pages. In 2001, in response to requests, electronic copies of the resources were distributed via CD ROM (for under $5) or email (less than $1). It also enabled recipients to modify them based on participant feedback or to use them for special purposes, for example substituting the “footsteps” with bush turkey track symbols given feedback from an Indigenous group using the resource.

Three respondents provided specific suggestions to improve the Seasons Storybook, and four did so for the Stew Storybook. These are included in the next chapter, ‘how can we do it better next time’.

Threats

Many of the weaknesses presented above, can be viewed as threats to the implementation and usefulness of these resources. In addition organisational and system wide restructuring challenges implementation plans. In the Top End the public health nutritionist position was originally made responsible for orientating new nutrition staff to the Storybooks and their use. This position was moved to the Purchasing Unit and was no longer responsible for implementing orientation programs and operational support for new staff. So despite the fact that orientation to the storybooks was part of the Top End nutritionists orientation program it did not necessarily happen because there was no one to facilitate and support the completion of the orientation activities.
Critique of Evaluation Processes

This project was difficult to evaluate and my reflective assessment is that this is a result of the overall project plan changing a number of times and that the goals, objectives and strategies were not clearly articulated each time. This is a necessary requirement to enable process, impact and outcome evaluation to be well planned (Hawe, Degeling and Hall, 1990). *Well written objectives state who will achieve how much of what by when* (THS, 2001:e:167). A common acronym used is that they should be SMART; specific, measurable, achievable, realistic and time bound. To *improve the knowledge, skills and confidence of professionals in supporting CNW and SWSBSC projects* is too non-specific. Critical reflection on the quality of the planning processes and the limitations it places on both the project process, evaluation and outcomes was not conducted in a timely fashion. Therefore to some extent this process was set up to fail. The words of the adage, *fail to plan well and you plan to fail,* appear to be quite relevant as Rae (1995) has previously reminded the group. Major time and resource constraints were antecedents to the failure to reflect on, plan and implement the evaluation more comprehensively.

Whist impact and outcome evaluation is best conducted after process evaluation they are most usefully planned at the beginning (Hawe et al, 1990). In hindsight we could have revisited the goal and objectives prior to emailing the evaluation questionnaire in September 2001. My reflective assessment is that I could have been more vigilant for these problems and provided more leadership on this matter.

The evaluation did not ask nutritionists and SWSBSC Coordinators to describe if and how the use of the resources may have made a contribution towards improving their knowledge, skills and confidence in performing their roles. It did not ask professionals to comment if and how the resources made a contribution towards strengthening non-Indigenous and Indigenous workers partnerships. Respondents were not asked to
specifically list barriers and enablers to the use of this resource. These omissions limited
the scope of the analysis. In hindsight there were important questions that could have
asked about these things.

No specific Indigenous evaluation of the storybooks has been implemented. The Director
of FaNU, at the time, decided that the brief for the Indigenous review of CNW projects
scheduled for funding in mid 1999 should incorporate the use and evaluation of the
storybooks, particularly the Good Stew Good Project Storybook format. The review was
conducted by an experienced Indigenous health and nutrition worker, Annie Bonson.
Hobson demonstrated both storybooks to her. Bonson did not use the resources as part of
the review process methodology, although she was reported to have shown them to
workers in a small number of communities (Personal Communication Liddle, 1999). Her
report (Bonson, 1999) makes no mention of the storybooks and we will never know why.
She left the NT before I was able to interview her about her personal use and evaluation
of the storybooks.

My efforts to promote a more participatory approach to the evaluation of the storybooks
in late 1999 and 2000 were unsuccessful. I questioned the Indigenous co-author about
how she would like to go about evaluating the story books with the SWW's she replied: if
you ask them what they think they will all say it is OK. You won't get much other
feedback (Personal Communication Liddle, 1999). This raises questions regarding the
evaluation methods that Indigenous people might use. This alludes that a direct
questioning approach may not be very suitable. Therefore, indirect and observationary
methods might be more appropriate. It demonstrates, as Garrow and Colin (1996) advise,
evaluation to incorporate Indigenous perspectives must be designed by Indigenous
people.
The other SWSBSC Coordinator had left placing considerable workload pressures on her and the SWWs. I concluded that pressurising her about the need for planning Indigenous evaluation to meet organisational or academic research and evaluation agendas would have been entirely inappropriate. Such behavior would have been in direct conflict with one of the underlying social aims of this research; namely to use power more positively and reduce the perpetuation of oppressive, exploitative behaviors.

These limitations and their effect on the evaluation process have had a negative impact on the quality of this whole study. It raises important issues about the relations of work, academic research, involvement in communities and real social concerns. It highlights the relations of power and the way these various agendas can be played out in action research and PAR as other authors have noted (Foote-Whyte, 1991; North American Primary Care Research Group (NAPCRG), 1996).

The discussion above identifies a number of issues that have undermined the strength of this work. For example lack of comprehensive evaluation planning, and the justification of these weaknesses via staff turnover and associated workload pressures is not a very valid rationale for failing to undertake these important aspects of research and service quality. It attempts to avoid perpetuating the practise of social undiscussibility, where by individuals avoid discussing issues which are personally embarrassing or likely to cause hard feelings (Foote-Whyte, 1991:98). This would be an anathema to the research process precisely because it inhibits learning and the potential to challenge and change practises which inhibit progress towards strengthening capacity for health improvement.
The Use of PAR: An Evaluation.

The comments that one nutritionist made in relation to the implementation of the storybooks makes reference to the rhetoric and realities of attempting to implement PAR generally: *All intentions are there to help follow this process from the beginning to end, but for numerous reasons this does not always occur* (Rose).

Back in the 1940s, Lewin, one of the founding fathers of the action research genre, noted that it was indeed risky business as Alderman (1997) recently reminds us. This project has clearly demonstrated a range of the risks involved and its lessons provide extremely useful fodder for reflecting on the usefulness of action research and PAR. Some of these risks were more of an issue than others.

I never really felt uncomfortable with the unpredictability of attempting PAR. I was quite prepared for the course of the project to change and evolve in response to the participants priorities and changing environmental issues. At the outset of the project I was quite experienced and comfortable with the need for adaptive flexibility having worked on Indigenous health projects for many years. I also knew it would be a fairly long term process. As Reason and Bradbury remind us; *action research in all its forms is a long term, evolutionary and emergent form of inquiry* (2001:453). People considering PAR need to be prepared for a marathon on a mystery course.

Attempts at PAR were affected by the issues that contribute to barriers and frustrations in professional practice as discussed in chapter five. Cooperative action in this context flows out of the relationships and connections formed and maintained through working together as chapters three, four and five have argued. I believe the turnover of both Indigenous and non Indigenous staff and movement between positions had the most significant impact on the degenerating quality of participation in the project. Two
SWSBSC Coordinators and two Nutrition Advisers (AHWs) who had made strong contributions to the storybook development phase left to take up other positions or retire just before they were implemented. I believe I lost significant opportunities to engage with the stakeholders and facilitate, resource and support participatory action on this project when my contract as nutrition manager ceased and then returned from leave to a job where I had limited contact with the broader group. In PAR these relatively small and sometimes personal factors take on a significant meaning.

The fact that this process did not survive these changes is an indication of the limitations of the original PAR plans. Perhaps if stakeholder participation in the original development phases of the storybooks had involved more comprehensive sharing of decision making and action, the commitment that this may have generated could have seen the whole PAR cycle completed despite my withdrawal from an active nutrition position. Also, if planning was more comprehensive it may have anticipated these risks and planned management strategies to implement in the event they occurred.

Evaluation of efforts to promote Indigenous health must involve analysing and discussing many ‘socially’ and ‘structurally undiscussable’ or uncontested issues such as the emergence of power in cross cultural partnerships. As Arnstein (1971) writes, ‘participation is power’ (1971:72).

George, Green and Daniel’s model (1996:7) demonstrating the convergence of research, action and participation in public health can serve as a useful tool to analyse the processes of this research project. Because the development and implementation of the storybooks does not involve substantial proactive community based decision making, learning and action it cannot be classed as PAR in accordance with their model. They would consider it to be action research because it is research incorporating public health practise. An endeavour might only be considered as PAR if it has full participation of the people it is
ultimately aiming to benefit in decision making and action every step of the research cycle (Wadsworth, 1991; George, Green and Daniel, 1996; NAPCRG, 2001). What eventuated is largely what Foote-Whyte (1991) describes as consultative action research; action research that involved consultation mostly with individuals with limited opportunities for participatory discussion and learning. Gaventa and Cornwall (2001) believe that knowledge and power are inextricably linked:

*participatory research which becomes only ‘consultation’ with excluded groups...is limited because it prevents the possibility that investigation and action over time may lead to a change in peoples knowledge...a change in understanding of one's own interests and priorities* (2001:76) and thus promoting empowerment.

Policies and documents are full of the rhetoric of participation, and participation on its own is a nebulous concept (Cohen and Uphoff, 1980; Brownlea, 1987). What constitutes adequate participation in this context? Arnstein's (1971) model or “typology” for assessing levels of participation in public programs is entitled *Eight Rungs In The Ladder Of Citizen Participation* and despite its age it is very useful for analysing attempts at participation. A copy of this model is included as Appendix N. The essence of this model is that:

*...participation without the redistribution of power is an empty and frustrating process for the powerless. It allows the power holders to claim that all sides were considered but makes it possible for only some of those sides to benefit. It maintains the status quo* (Arnstein 1971:72)

As the majority of community based Indigenous involvement in storybook activities was essentially at the level of consultation, Arnstein's model might classify this participation as a degree of tokenism, falling midway between manipulation and citizen control. Brownlea's (1987) comments support this assessment as he says tokenism is the outcome when there is little power behind a participant's contribution. Only one Indigenous
person was in control of decision making in the production of the last draft of the storybook, and their distribution, and in the design, review of the evaluation and ongoing planning. Her participation might be classed as “placation” which denotes: some degree of influence though tokenism is still apparent in Arnstein’s classifications (1971:79-80). This same person also held a position of greater power and influence than the community based workers because she was employed as a SWSBSC Coordinator. It is a fair assessment therefore, that this research process has failed to model any significant change in social relations and the redistribution of power.

Hawe et al (2000) believe that movement from building infrastructure capacity towards building capacity for problem solving involves the relinquishment of control and power by the practitioner (2000:8). Against this criteria this project has been unable to demonstrate any significant improvements in strengthening capacity for problem solving and health improvement. This is because the evaluation of the Seasons and Stew Storybooks implementation has not yet demonstrated if and how Indigenous Territorians living in remote communities have benefited from this research process. In the absence of any credible data stating otherwise one has to conclude that this research has also failed to demonstrate that the storybooks can help Indigenous and non Indigenous partners “grow strong together” by promoting changes in social relations and power.

Despite being unable to demonstrate stronger partnerships at the community level this project has been able to strengthen my own personal partnership with the Top End SWSBSC Coordinator. Together Marlene and I have developed and applied our knowledge and skills in cross cultural professional practise and leadership. This project has enabled us to share knowledge and resources with our colleagues outside of the NT, which would not have occurred if we had not undertaken work together on the storybooks.
From a systems perspective, Brown and Tandon (1983), Alderman (1997) and others (NAPCRG, 2001; Reason and Bradbury, 2001) warn that the politics of organisational systems can hinder the development and realisation of PAR through conflicting and changing expectations and resource availability. Alderman’s experiences in the education setting lead him to conclude that in large organisations like education systems there is a limit to the degree of democracy in the provision of local services which impedes support for and the development of participatory research activities. This project has operated in similar setting, but I think it has predominantly constrained by limited, spasmodic resourcing. In these settings, he believes achievements may be limited to empowering practitioners by raising their consciousness of the social context in which they work. This project supports this notion as much of its outcomes fall into this category of “learning” rather than tangible improvements in power relations.

The processes of the study and the professional environment are complex. Whilst power relations might appear to have remained relatively unchanged important learning and the development of critical consciousness has occurred. I have attempted to justify the weaknesses with the rationale that a geographically diverse workforce was trying to deal with multiple demands whilst often understaffed and under resourced. But Humphery, Weeramanthri and Fitz (2001) believe that many health professionals in the NT do not take enough responsibility for the conflict and dysfunction that they claim inhibits their attempts to improve health services with and for Indigenous Territorians. Wadsworth (1997) too, suggests that similar excuses are common reasons for why people do not make time for evaluation. She believes this reflects people’s perceptions of the low value and legitimacy of evaluation.

The outcomes of this project serve to demonstrate some of the risks and challenges health professionals face in attempting to affect social and organisational change in a complex environment. If it were easy to change entrenched habits and engage in genuine
partnerships there would have been more demonstrated change in Indigenous health before now. This outcome does not demonstrate that PAR is unsuitable or unrealistic in this environment. It highlights, however, the importance of adequate resourcing, commitment and leadership for PAR and realistic high quality plans.

Mc Peake (2000) believes that as public and population health professionals: *we pretend we can do it on a shoestring, we try and do it on a shoestring and often we fail* (2000:3). An indicator of experience and practise based learning in this context could be the ability to decide when not to do something because there is insufficient infrastructural capacity to sustain and demonstrate the benefits of high quality action. Robinson (1995) writes the most effective practitioners in the resource poor community development services are those who can do more with less using innovation and ingenuity. In this politically and biomedically driven context effective practitioners and partnerships are those that demonstrate high quality outcomes whether the projects are big or small. Perhaps if I had already finished the qualitative activities I would have had more time to devote to providing better quality leadership for PAR.

Committing to a PAR project involves commitment personally. There is personal risk; risks of frustrations with the pace and course of work, risk of failure if the group dissolves or can no longer maintain their commitments and risks linked to dealing with power sharing and possible loss of control over the agenda. As Hawe et al (1998) have commented: *when workers are engaged in capacity building they do not have control over program processes and outcomes... because responsibility is shared* (1998:290). Others have reiterated the unattainability of control in PAR (Fook, 1996) and, or cautioned would be PAR partners to carefully consider the risks of exploitation, manipulation, betrayal and abandonment (Stacy, 1988; Meyer, 1993; NAPCRG, 2001).
This whole project has been very emotionally challenging for me and those close to me. This was predominantly because the time commitment required clashed so often with other personal responsibilities and values e.g. changing work responsibilities, caring for my infant children. On numerous occasions I considered ceasing the project but ultimately it was the commitments made by others to the project through their trust, personal and financial contributions and support that drove me to complete it. Having sort and received their support I felt compelled to honor their faith and commitments with outcomes. Many leading authors warn of the degree of flexibility, commitment and tenacity required (Wadsworth, 1997; NAPCRG, 2001) and others provide testimony to the often overwhelming nature of PAR processes (Meyer, 1993; Fals-Borola, 1997) but you don’t really understand how demanding it can be unless you attempt it.

The failure to undertake participatory evaluation could be viewed as an indicator of the personal and systemic limits of capacity in and commitment to evaluation in the nutrition team at that time. This outcome also provides another source of data to support nutritionists awareness of the weaknesses in evaluation and validates their expressions for stronger focus, resourcing, leadership and competency building in evaluation as discussed in chapters four and five.

I remain optimistic that these resources can and have helped to strengthen Indigenous capacity to promote health improvement at the community level. More comprehensive impact and outcome evaluation capturing uninhibited Indigenous opinions, which is sensitive to Indigenous forms of learning, will demonstrate this.

The North American Primary Care Research Group’s policy on PAR states in relation to measuring success that satisfaction may entail acceptance of less than ideal circumstances and extensive compromise (NAPCRG, 2001:15). I and the people I worked with on this project, pressed on with the project in less than ideal circumstances.
and made extensive compromises and yet I do feel quite satisfied with the outcomes. The learning has and will continue to make a significant impact on my approach to interacting with people at work and beyond.

Despite the risks and issues experienced, my commitment to the need for, and value in, participatory approaches to learning and action has been heightened. I now feel I have a much more realistic view about what is attainable and achievable. My earlier optimistic and some might say idealistic notions of PAR, are now tempered with the lessons of long term experience. My commitment to the values of cooperation, open-mindedness and genuine inquiry has been strengthened. I agree with Orlando Fals-Borola, who when commenting on 20 years experience working in development using PAR, says PAR remains a philosophy for life as much as a method, a sentiment as much as a conviction (1997:111).
Recommen dations for strengthening learning and action in the future.

The identification of new subsequent opportunities for improved research and action is an integral stage in the reflective action and participatory action research processes that promote an ongoing continuous spiral of research, reflection, learning and action (Wadsworth, 1997).

A number of environmental considerations have been kept in mind in the formulation of the recommendations for research and action. A new era is dawning. The Northern Territory health service environment is undergoing major changes where power and resources are devolving from predominantly government run services to many Indigenous health organisations (Connors, Woodhouse, Tilton and Cleary, 2001). These organisations receiving coordinated financial resources from many levels of government through programs such as the Primary Care Access Program funding (Commonwealth Department of Health and Aged Care, 2002b), NT government and other sources. Funding for community nutrition projects has become more flexible and is now firmly focused on the demonstration of improved health outcomes.

Major recommendations are incorporated below under the headings of stronger commitments, research, reflection, action and storytelling. Appendix 0 provides a detailed list of more specific recommendations under the topics of strengthening capacity for health improvement, professional practise generally, stronger qualitative research, participatory action research and the storybooks.
Stronger commitment

Cooperative action in this context flows out of the relationships and connections formed and maintained through working together as chapters three, four and five have argued. Chapters 4 and 5 also demonstrated that significant personal time commitment is required to develop the specific knowledge, skills and confidence required for working in this foreign context. Health professionals who come to work in the NT need to commit to a minimum of 4 years here with at least 2 years working with individual Indigenous communities.

Individuals, managers and employer organisations must be supportively challenged to make these kinds of commitments the norm rather than the exception. This necessitates individuals and organisations taking action to recognise and effectively deal with those issues which impede these commitments.

Stronger Partnerships

Chapter five identified that health professionals need to evaluate their partnership activities. Much benefit could be gained from the honest evaluation of individuals and groups efforts in participating and strengthening health promotion partnerships. Chapter five also concluded that health professionals need to discuss the concepts of power and empowerment and the goals of empowerment promotion with their Indigenous partners as part of their efforts to improve power differentials. This is another aspect of developing critical Indigenous and professional consciousness which is recommended as an essential activity by many commentators (Friere, 1972; Shields, 1993; Kenny. 1994; Solas, 1996; Eade, 1997; Kaplan, 1999). As the concepts of power and empowerment can be very nebulous and abstract, any efforts to approach these issues will need to be well thought out and connected to exploring real life issues and experiences. This problem centered or case study based learning fits with Indigenous and adult education theory (Friere, 1973;
Harris, 1976; Knowles, 1980; Trudgen, 2000) and is considered best practise for cross cultural professional competency development (Mulvaney-O’Byrne et al, 1993; Fitzgerald et al, 1997).

**Stronger research, reflection and action**

This study has demonstrated that the use of PAR, capacity building for health improvement, qualitative social inquiry and education for critical consciousness can help health professionals to celebrate the successes and strengths of their efforts. Also, they can be used to plan efforts to move beyond the social and structural constraints inhibiting and frustrating professional practise.

Health professionals are challenged to engage in ongoing personal reflection of their own involvement in perpetuating and acting upon dysfunctional and oppressive institutional and professional practices and issues within their everyday work responsibilities. This involves being vigilant for issues which may be socially or structurally undiscussible, taking responsibility for our own involvement in perpetuating them, and having the courage to talk about and act on these limitations and as Foote-Whyte comments change the organisational and intellectual ground rules (1991:42). Humphery, Weeramanthri and Fitz (2001) in their project ‘Rethinking compliance’ also argue that professionals need to take more responsibility for the structural issues which impede their practise. They suggested professionals concentrate their efforts into local reform groups: focused on developing ideas for the modification of everyday working practices (2001:107).

The development of a PAR network in the NT could be promoted and facilitated to provide a supportively challenging environment in which to progress efforts at health service improvement. Such a group could develop and promote the practical, realistic implementation of knowledge and skills in PAR practise. The work of other networks

*J Priestly  Chapter 7: Critical reflections and opportunities for strengthening practise*
such as the North American Primary Care Research Group (NAPCRG, 2002) provide useful stimulus for ideas on the potential roles for a local group. Authors like Gaventa and Cornwall (2001) and Reason and Bradbury (2001) have recently offered suggestions on enabling factors which may help promote the maximisation of PAR processes for change in both local and broader organisational contexts.

A systematic evaluation of community nutrition health projects is required that includes an analysis of Indigenous participation, capacities, contextual issues and activities recurring in successful and unsuccessful initiatives to develop realistic performance indicators that will inform better planning, action and resource allocation in the future. The identification of a few indicators of performance that are most likely to efficiently and effectively indicate progress towards improved health outcomes is recognised as a challenge in chapters 4 and 5, by other nutrition professionals (Mackerras and Mortimer, 1999; Dietitians Association of Australia NT Branch, 2001) and health professionals generally (Hawe et al, 2000). As McPeake says we have to define what it takes to make a difference (McPeake, 2000:3). Again this needs to incorporate cross cultural and intersectoral viewpoints of value and evidence. National activities focused on determining performance indicators to assist with health promotion planning and evaluation (Bush and Mutch, 1997; NSW Health, 2000) may prove useful in developing focus criteria or tools.

Stronger evaluation must be demonstrated. The realities of limited human and financial resources should not prevent ongoing evaluation as an integral aspect of the approaches and techniques of health promotion. Human and financial resources to conduct process, impact and outcome evaluation need to be allocated within existing budgets, protected and used. There is no point in implementing a service unless we can demonstrate how it makes a difference. This requires personal commitment and effort and strong organisational leadership and support. To some extent this was beginning to happen with the change to the Funder/Purchaser/Provider mechanism in THS/DHCS in 2001-02.
Demonstrated success strengthens capacity for health improvement often improving accessibility to more resources as chapter 3 demonstrated in relation to the SWSBSC program and Central Australian Growth Assessment and Action initiatives.

To be able to demonstrate outcomes, efforts need to be judiciously focused into local, well planned activities that can be completed and evaluated in relatively short to medium time frames, preferably within one year. This work reinforces the conclusion of Bush (2000) who believes a major challenge for organisations and health professionals working with communities is to strengthen capacity of staff, community individuals, families, groups and communities without overloading and overwhelming them (2000:2). This is a very relevant risk working with Indigenous health workers and communities generally (Lea and Wolfe, 1993). One of the main challenges is to realistically focus available resources so that capacity building efforts actually achieve health gains, even if only on a small issue. That is why it’s important to recognise and deal with workload tensions as part of this process. For as Brownlea (1987) comments, participation is only enriching if sufficient resources of the right kind are available to adequately and appropriately resource the efforts otherwise they are tokenistic and will fail to improve knowledge, skill and power imbalances.

**Stronger storytelling**

As chapters three and four demonstrated, historically the NT Nutrition team has been able to generate wide ranging networks of action and support by proactively telling consistent stories about what they are doing at various levels within the health system and communities both informally and formally. This storytelling markets the services and generates interest.
Enhancing the quality and quantity of storytelling is required to promote more active collaborative cross-cultural learning and diffuse the lessons of our experiences to our colleagues and other interested communities. This will speed up the implementation of knowledge which helps deal with common issues and promotes improved health outcomes. The Top End nutritionists and SWSBSC Coordinator added an additional step into the Seasons for Workers PAR cycle; *Sharing the work story*. This step contributes to fulfilling a researcher's generic responsibility to inform the collective memory of interested people and professionals at large (Mathews, 1998). Health professionals need to find the courage to widely share the analytical assessments of the limitations of their activities as much as the successes so that these can help more of us work 'stronger together' in the future. The honest evaluation of the PAR elements of this research project demonstrates the importance of learning that can occur.

Further extensive evaluation of the use of *Sharing Stories about Seasons and Seasons for Workers* and *the Good Stew, Good Project storybook* that incorporates impact and outcome evaluation and captures Indigenous reflections on their appropriateness and usefulness is required. The management of their ongoing use, evaluation and adaptation is threatened by organisational changes within the NTDHCS. In late 2002, Hobson, the Manager of the Nutrition and Physical Activity unit (NaPA), informed me that the unit's mandate is to set priorities and fund outcomes. Neither the NaPA or the Service Development Division can determine what resources and techniques are used to achieve the health outcome targets (Fieldwork diary, 2002). The authors and other interested professionals will need to seek resources to support ongoing evaluation, adaptation, distribution and use of the storybooks. Appendix O suggests an opportunity exists to seek the support of professional and philanthropic organisations to administer and fund these processes. It also details specific suggestions to improve the storybooks developed during this research project.
As the discussion above demonstrates many of the recommendations are not new, they reiterate the lessons and recommendations of other work. For the most part they are relevant for public health practice in general and local level action across a spectrum of organisations, not just for government health service providers and public health nutritionists.

By learning about, and working at, growing "stronger" together as public and Indigenous health practitioners we will improve our ability to encourage and equip Indigenous Territorians to have better control over their health and wellbeing.
Summary

This research project set out to facilitate a PAR process but in the final analysis it was more akin to consultative action research using the methods of qualitative research and applied public health inquiry. The contextual realities of high workforce turnover, incomplete staffing levels and competing workload demands meant the processes were much slower, less participatory and at times less thorough than originally planned.

The outcomes of the qualitative research have been strengthened by the high participation rate (80 percent), seeking multiple rounds of respondent feedback and triangulation with reports and the work of other researchers. The results and conclusions are both credible and reliable. Although, the historical analysis probably under represents the activities and achievements in Central Australia from the mid 1980s.

Some of the objectives have been met. We did produce some tools to assist professionals. They have been implemented by many nutritionists and the SWSBSC Coordinator in the Top End, and they have been partially evaluated. The storybooks have been accepted, modified and used by those professionals who were involved in their development, saw them demonstrated or participated in their use. The majority of Top End nutritionists and the SWSBSC Coordinator used the storybooks to promote community development processes in their work in nutrition and SWSBSC projects in 2000-01.

Limitations in resources and the evaluation planning processes mean we have not assessed if the storybooks have contributed to an improvement in the knowledge, skills and confidence of professionals or whether they have encouraged the development of strong cross-cultural partnerships. Despite the fact that this project was unable to demonstrate improvements in power relations, important learning and the development of a more critical consciousness has occurred.
The idealistic potential of PAR, capacity building for health improvement and emancipatory and Indigenous education theory and techniques must be judiciously targeted in local activities that can be completed and evaluated well within existing resources and linked to health gains. To support this activity professionals need to make long term commitments to working with Indigenous communities and critical, reflective personal practice that is ever vigilant about promoting improved social and power relations.
PLEASE NOTE

The greatest amount of care has been taken while scanning the following pages. The best possible results have been obtained.
Principles for Participatory Action Research

A paper presented to the 3rd Encuentro Mundial de Investigacion Participativa (The Third World Encounter on Participatory Research), Managua, Nicaragua, September 3-9, 1989.

1. Participatory action research is an approach to improving social practice by changing it and learning from the consequences of change.

2. Participatory action research is characterized by an approach to research which is participatory, involving stakeholders in the planning, implementation, and evaluation of the research process. It aims to build more equitable and sustainable social systems by involving people in the decisions that affect their lives.

3. Participatory action research is a process of learning by doing, where the researcher is also a participant in the research process. This process is iterative and cyclical, allowing for the incorporation of new insights and learnings as the research progresses.

4. Participatory action research is a collaborative process that involves all stakeholders in the development of the research agenda and the interpretation of the results. This approach is participatory and involves all stakeholders in the research process.

5. Participatory action research is a process of learning by doing, where the researcher is also a participant in the research process. This process is iterative and cyclical, allowing for the incorporation of new insights and learnings as the research progresses.

6. Participatory action research is a process of learning by doing, where the researcher is also a participant in the research process. This process is iterative and cyclical, allowing for the incorporation of new insights and learnings as the research progresses.

7. Participatory action research is a process of learning by doing, where the researcher is also a participant in the research process. This process is iterative and cyclical, allowing for the incorporation of new insights and learnings as the research progresses.

8. Participatory action research is a process of learning by doing, where the researcher is also a participant in the research process. This process is iterative and cyclical, allowing for the incorporation of new insights and learnings as the research progresses.

9. Participatory action research is a process of learning by doing, where the researcher is also a participant in the research process. This process is iterative and cyclical, allowing for the incorporation of new insights and learnings as the research progresses.

10. Participatory action research involves participants in the realization of their own experiences, and it involves understanding the needs and intentions of people, and it involves understanding the needs and intentions of people.

11. Participatory action research is a political process because it involves people in making changes that will affect others - for this reason, it sometimes creates resistance to change, both in the participants themselves and in others.

12. Participatory action research involves people in making critical analysis of the situations (projects, programs, systems) in which they work. These situations are structured (formally and informally). The pattern of resistance a participatory action researcher meets in changing his or her own practice is a pattern of resistance to change that is often not recognized. When people are involved in the process of transforming themselves from the institutional and personal conditions that limit their power to live their own legitimate educational and social values.

13. Participatory action research is an approach to improving social practice by changing it and learning from the consequences of change.

14. Participatory action research is an approach to improving social practice by changing it and learning from the consequences of change.

15. Participatory action research is an approach to improving social practice by changing it and learning from the consequences of change.

16. Participatory action research is an approach to improving social practice by changing it and learning from the consequences of change.

17. Participatory action research is an approach to improving social practice by changing it and learning from the consequences of change.

Robins McTaggart, Deakin University, Geelong, Victoria 3217, Australia, (Fax (51) 52 442777).
HISTORY
In 1991 2 senior health workers, Alberto Purantatameri and Pat Gamanoga, started full time work on food and health. They were the first full time nutrition workers in the NT.

In 1994, nearly 200 Aboriginal people at the Strong Together; Good Tucker workshop, at Springvale Homestead recommended that
- more community based nutrition workers and nutritionists be employed to work in Aboriginal communities.
- ongoing support and co-ordination be provided between community councils, local councils, funding bodies, the Department of Health (now Territory Health Services - THS) and community people.

The Nutritionists won more funding. By April 1997, 8 Nutritionists will be working with at least 10 part or full time ANW's in 9 communities in the Top End. Most of the Nutrition Workers will be employed by their own communities through grants.

OUR JOBS
ANW's work with their own communities (in town or out bush) to promote better food, health and well-being in their community. They do things like running cooking sessions, taking people hunting for bush foods/medicines, sharing stories about food, culture and health and working with the store management and staff to promote healthy food choices in the store.

The Community Nutritionist job is to give support and share their skills and knowledge about food, nutrition and health with ANW's and communities.

It is hard to get started on community nutrition projects together because most of us have never done this type of work before. Our different cultural backgrounds can cause misunderstandings, especially about how we might think things should work and what is important to do. We are going to make mistakes so we need to learn and make changes along the way.

OUR RESPONSIBILITIES:
The ANW's and Nutritionists have a responsibility to the communities they work for and the government who pays them to help make peoples lives and health better.

We need to show how our work makes a difference, to get more support and funding for community based health projects like these.
A SHARED GOAL:
Some of the Nutritionists and ANW’s + Advisers have a shared goal. We would like to share ideas about working side by side on community nutrition worker projects to make it easier for us and new people doing this work. So it will be a successes in the eyes of both Aboriginal people and funding bodies.

AIM OF THE SIDE BY SIDE WORK
The aim of the side by side work is improve community nutrition workers and nutritionists knowledge, skills, confidence and performance in their work.

HOW WE COULD DO IT
To start with all the ANW’s and Nutritionists could have a workshop together to
- learn more about each other others knowledge, values and skills
- make a clear list of each others responsibilities in community projects
- learn more about culturally appropriate planning and evaluation together

Evaluation means thinking, listening, looking, understanding and doing things(acting) as we go along.

Most of the current nutrition team In Operations North want to have a workshop like this so we have planned one for April/May 1997.

During the workshop we can talk about what we would like to find out more about and do next. Jackie has put together different ideas to get us thinking about what other things could be done like
• nominating coordinators to provide ideas and support for ANW’s, communities and Nutritionists and keep the action evaluation going.

• visiting communities and talking with other community people involved to share ideas on and do evaluation together.

• collect information about problems and make suggestions on what THS and the Nutritionists need to do to better support ANW projects.

• run regular workshops so we keep learning, sharing and caring together over time.

• making, using and evaluating:
  - a step by step guide for professionals, mainly Nutritionists, supporting the community projects.
  
  - a kit of culturally appropriate process ideas, tools (checklists, flipcharts, activity ideas, posters, stories, games) and a list of other useful resources to help communities plan and run their projects.

PARTICIPATION AND CONTROL:
All ANW’s and Nutritionists will be encouraged to join in the side by side work but they don’t have too. People can choose how much they want to be involved. The workshops and visits could be organised and run by a Nutritionist and Senior Aboriginal health person in partnership, like co-ordinators. It would be their job to make sure everyone has input and gets something out of it. The whole group of ANW’s and Nutritionists together would act like the steering group and decide what we should do next.
CHOOSING THE CO ORDINATORS:
Jackie has been thinking and working on this idea for while. The other Nutritionists are happy for her to be the Nutritionist co-ordinator. She will be doing this as part of her work for a Masters Degree at the University of Western Sydney (Hawkesbury) by keeping a diary about the process and writing a report based on the information we have consent to use. We still need to make an agreement about this with all Workers and communities (See the section below about consent and the agreement forms with these pages.)

Lorna Fejo, Aboriginal coordinator of the Strong women, Strong Babies, Strong Culture program will be helping Jackie run the first workshop. But if the ANW’s decide they want the work to continue it will need Aboriginal co-ordinate/s. They would need to chose a person or people who they think are right for the job. It could be them or others they trust and think would be a good leader.

TIME AND FUNDING
We could do this while we have money for the outreach project- till July 1998. Jackie has got some money to help run workshops this year. Everyone who was interested would join in as part of their paid work.

CONFIDENTIALITY AND CONSENT
Everyone who is involved in these projects will be asked if they would like to join in. They will all be given copies of this outline and it will be explained to them. They will be asked to fill in a consent form. This will record
- if and how they would like to join in
- how they want their work properly recognised
(Consent Form C.1 for ANW’s and Nutritionists, Form C.3 for other people)
We will need to make agreements with communities who join in too (Form C.2).

Sometimes we might need to make notes or use a tape recorder to make sure we remember all that people are saying. Any conversations, private meetings or workshop sessions that are written or typed up, will use code names for people and communities to protect everyone’s privacy and encourage them to speak freely

Copies of reports and any published material will be sent to each participating community, ANW’s and Nutritionist. Jackie will also write up a technical report for the Nutrition Team and THS.

A confidential and independent mechanism exists to deal with any complaints or concerns you may have about your participation in this research. You may make a formal complaint or discuss these matters informally by contacting the following person
Human Research Ethics Officer,
Research and Consultancy Unit,
University of Western Sydney Hawkesbury, NSW 2754. Telephone 045 - 701 688.
APPENDIX D: Original Participatory Action Research Project plan

SIDE BY SIDE: WORKING TOGETHER TO MAKE ABORIGINAL COMMUNITY NUTRITION PROJECTS EASIER.

3. Making a plan and goals - deciding how we will gather information to answer the questions
   - by storytelling and asking culturally appropriate questions and sharing information together
   - in workshops 2/year with ANW's, Nutritionists and with community people on community visits.
   - keeping diaries on our work and how we use and develop tools to help us.

4. What does this mean...? How is it going?
   - To ANW's
   - Community people involved in the nutrition and SWSBSC projects
   - Nutritionists and other support people
   - sharing at workshops, community visits
   - How can we make things easier/better
   - how is the work going?

5. Feedback and Report...
   - to each other at workshops and community workshops or visit to people and families.
   - to Territory Health Services by reports

6. The next step...
   - decide what we need to do next at staff and community visits/workshops.
   - plan to develop tools and guidelines
   - start back at step 1 again

1. Think about...
   - working in community Nutrition projects
   - working side by side
   - how we might work together to make things better
   - Jackie talking to people about her draft steps for this work
   - everyone to discuss this idea at a workshop
   - what resources we have to do this work

7. Keep on going...
   - do what you plan to do,
   - keep watching and thinking as you go along

Some ideas on how we might work together, How can we make this plan better?
APPENDIX E: Questionnaire for Nutritionists

PRE INTERVIEW INFORMATION AND PREPARATION SHEET FOR NUTRITIONISTS

Thanks for agreeing to be interviewed for the side by side project. Your contribution will help to enrich the project outcomes and process. This sheet confirms the

1. details of when we have planned to meet.
2. general questions I would like to ask you. You may want to spend a few minutes thinking about how you would like to answer the questions.
You may also want to make some general comments.

It will take us about 10 minutes to review the aims of the project and fill out the ethics permission form. The interview part will last up to one hour, but you can stop it at any time you want too. To be of benefit for you it should be a two way sharing of information and support but I would like to get your story first. This will maintain the purity of your contribution for future reference. We will need another hour to explore action ideas and go through some of the resources and tools that you might find useful.

INTERVIEW DATE: TIME: to LOCATION:

Please call me on 89 738 631 or 0417-812 532 if you need to change it.

INTERVIEW QUESTIONS + Optional Preparation you may like to do that might it a little easier.

The following is a list of the main things I will be asking you to talk about. You may want to make some personal notes or think of some specific examples to tell me about, or reports to show me. These will form an initial structure for our discussion. Were it goes from there is up you.

1. Which community projects have you worked side by side on and for how long?

2. What do you do in these projects?

3. What key personal knowledge, skills and resources have you felt to be most useful and important in your side by side work?
4. What key personal knowledge, skills and resources do you feel the Nutrition/Strong Women Workers bring to the work?

5. What makes this work hard and/or frustrating?

6. What makes it easier?

7. (OPTIONAL) Describe your own sense of personal confidence in performing this role in these current situations?

8. Please describe the ways you try to empower community workers...

9. Would you like to make any other comments on the general theme of working side by side together on community nutrition worker projects?
APPENDIX F:  Questionnaire for Nutrition Managers

PRE INTERVIEW INFORMATION AND PREPARATION SHEET
FOR MANAGERS

Thanks for agreeing to be interviewed for the side by side project. Your contribution
will help to enrich the project outcomes and process. This sheet confirms the

1. details of when we have planned to meet.
2. aims of the interview.
3. general questions I would like to ask you. You may want to spend a few minutes
   thinking about how you would like to answer the questions.
You may also want to make some general comments.

It will take us about 10 minutes to review the aims of the project and fill out the ethics
permission form. The interview part will last up to one hour, but you can stop it at
any time you want too. It is always wise to allow another 30 minutes buffer in case
we get very involved in discussing action ideas.

INTERVIEW DATE: TIME: to

LOCATION:

Please call me on 89 738 631 or 0417-812 532 if you need to change it.

OBJECTIVES:
To explore and document your experienced views on
• historical and current themes in the development of community nutrition worker
  projects in the NT.
• what managers and staff are currently doing to promote the empowerment of
  CNW’s and sustainability of these projects, and
• what else they could do.

INTERVIEW QUESTIONS:

1. Please briefly summarise your involvement in community food and health
   projects in the NT.

2. What key factors do you believe lead to the funding and development of the
   Community Nutrition Worker projects ?

3. What impact, if any, do you believe socio political issues have had ?
4. What do you see as current problems and barriers to the realisation of these projects potential's?

(Probes for organisational/management/operational/community issues)

5. How well do you think THS management is promoting the sustainable development of these projects at present?

6. What else do you think THS nutrition and public health managers could do to promote sustainable development?

7. What do you think THS operational staff could do to promote the sustainable development of these projects?

8. How do you facilitate and encourage staff to promote the empowerment of community workers?

9. Would you like to make any other comments on the general theme of working side by side together on community nutrition worker projects?
APPENDIX G: Participant Consent Form

UNIVERSITY OF WESTERN SYDNEY

 Side by Side; Working together on Aboriginal community nutrition projects
 Consent form for ANW’s and Nutrition team staff

The aim of the side by side work is to make it easier for
- community nutrition workers, community people and nutritionists working side by side now and in the future.
- Community nutrition worker projects to be a success in the eyes of both Aboriginal people and funding bodies.

We would like to do this by visiting the community and invitting Nutrition Workers to come to workshops with other workers + Nutritionists to:
- asking people to tell us their stories about the project, about how things are going, what’s good, what could be better and how.
- listening to what people are saying and keeping a record of what is happening.
- looking at community and THS staff reports about the program.
- working together to come up with some ideas to make things better
- making some guidelines, checklists and tools to make communication and our jobs easier.

MY CONSENT

_____________________________(name) have talked with

Jackie Priestlty, Community Nutritionist and/or
_____________________________( Aboriginal evaluation and support coordinator)

Ways I can help the project ( tick the box’s that you agree to)

I have agreed that I would like to join in by
- □ joining in 2 workshops a year when I can.
- □ invite the coordinators to visit me in my workplace/community to talk about our community project at least twice a year
- □ provide copies of our non confidential program reports to the co ordinators

J Priestly Appendices
☐ trial guides, tools and other resources that are designed for our work and provide feedback

☐ other, (explain here clearly)

I know that it is important to say what I think about the community nutrition work. I know that I do not have to share anything which I do not want to, for example if it is not culturally right or if it might cause lots of shame or other problems.

**Tapes and Reports of what I say - tick your choice**

1. ☐ do ☐ do not give permission for my conversation to be taped. I can ask for the tape to be stopped at any time.

I know any tapes or reports of things that I have said will be kept locked up safe at the THS Katherine Office and will not be shared with anyone without my permission. If I die these should be

☐ destroyed ☐ not destroyed

it should be done by ______________ (person/s) how: __________________

Otherwise they will be burnt in the Katherine Hospital incinerator at the end of the work.

**Recognising my comments and contribution- tick your choice**

1. ☐ do ☐ do not want you to use my name if you directly write things I have said.

1. ☐ do ☐ do not want to be acknowledged for our contribution in the front of any reports or at the beginning of any presentations about the side by side work.

**Support for problems with the project**

I understand that I might have some problems doing this work and I know that I can call Jackie on 89 738628 or ______________ (Aboriginal Coordinator) on 89

If I choose not to talk to Jackie or ______________, or I cannot reach them I have decided I would like to talk to

_____________ (name) ______________ (position)

_____________ (phone/fax and address)
and I will ask them to help me share my concerns to the coordinators or Cheryl Rae, Public Health Services Manager on Ph 08-89 227056.

Signed: ___________________________ Date: __________/
/199

_________________________ (address)

_________________________ (phone) ___________________ (fax) if available

witness*: ___________________________

_________________________ (address)

* to be the person used as an interpreter if required. (copy for file and a copy for the participant).
APPENDIX H: NUD.IST Qualitative data Management Structure
using QSR NUD.IST Version 3 (Richards and Richards, 1993) page 1

I classified much of the information collected during the course of this project under particular themes which are called “nodes” in the QSR NUD.IST program. These nodes can be either “free” meaning they are unrelated. Alternatively they can be closely interrelated and presented in a “tree” like structure. The program then allows data to be accessed in relation to one or a combination of these node criteria. The themes or nodes are not listed in any particular order of importance. Please note that information presented in the thesis tables does not conform directly with the interview structural analysis below for a number of reasons. Firstly, an additional layer of analysis was conducted when summarizing the data held in each node into the tabular format. Secondly, some nodes contain very little data and consequently these themes may have been excluded from the tables, which are intended to summarise the emphasis of the data.

Free Data “Nodes”

<table>
<thead>
<tr>
<th>1. Method</th>
<th>1.1 interviews</th>
<th>1.1.1 planning</th>
<th>1.1.2 method notes</th>
<th>1.1.3 evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1.2 workshop 1997</td>
<td>1.2.1 planning</td>
<td>1.2.2 method notes</td>
</tr>
<tr>
<td></td>
<td>1.3 reports</td>
<td>1.4 tools</td>
<td>1.4.1 Seasons Book</td>
<td>1.4.2 Stew Book</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1.4.4 other</td>
<td></td>
</tr>
<tr>
<td>1.5 NUD.IST</td>
<td></td>
<td></td>
<td>1.6 NT Nutrition Workshop 98</td>
<td>1.6.1 planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.6.3 evaluation</td>
</tr>
<tr>
<td>1.7 evaluation generally</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Power</td>
<td>2.1 overt</td>
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<td>3. Communication</td>
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2.1.2 relationships |
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|                                      | 2.6 socio-political | 2.7.1 early community health  
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2.7.3 national context  
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<td>5.16 expert</td>
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| 6. Nutritionists knowledge, skills, resources | 6.1 knowledge | 6.1.1 cross cultural  
| | | 6.1.2 community setting  
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*J Priestly Appendices*
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*J Priestly  Appendices*
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## INTERVIEW DATA AND ANALYSIS NODE “TREE”

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SHARING STORIES ABOUT SEASONS
AND
SEASONS FOR WORKERS

developed by Jackie Priestly,
with help from Martene Liddle, Viv Hobson, Camile Damaso;
and the Top End Food and Nutrition Team
March 1999.
AIM OF THIS STORYBOOK:

This book uses stories and pictures with the aim of helping people share their experiences and ideas and learn together about

PART 1: SHARING STORIES ABOUT SEASONS
Traditional knowledge of seasons

PART 2: SHARING STORIES ABOUT SEASONS FOR WORKERS
Both ways knowledge on steps to making a good work project.

WAYS IT CAN BE USED:

To help people who will be working together on community health and development projects to start out strong together:

To use at each new stage of work to remind us to think about what is important to make our work strong.

To help project planning, action and evaluation in a clear simple way.

We designed it to help us work side by side on community food and nutrition projects and Strong Women, Strong Babies, Strong Culture projects.

ALSO INCLUDED AT THE BACK OF THE STORYBOOK:

AN EVALUATION FORM

to help collect ideas to make this book better
(Please take 5 minutes to fill it in after you use the storybook).
BACKGROUND

The THS Aboriginal Public Health Strategy and Implementation plan (1997) recommends the use of stories as a culturally appropriate way of sharing information. This strategy and the Preventable Chronic Disease Strategy direct us to focus our work for communities to

- Develop shared understanding of health problems and action
- Build community capacity for decision making

As a team we are committed to the values and principles of community development for empowerment, the Ottawa Charter for Health Promotion and Primary Health Care.

There are already lots of good resources to help people learn about working together on community based planning such as;

- THS Aboriginal Health Promotion training workshops and manuals.
- Thinking, listening, looking and acting as you go along. Garrow and Collins, 1996.

This booklet does not aim to be better than these other guides. What is hard is how to encourage people to talk and share ideas about these concepts. So, this book was made using attractive pictures and plain English to help get people talking and sharing knowledge, experiences and ideas together. (A facilitative visual narrative).

It developed from an original concept and drafts designed by Jackie Priestly, Nutritionist. It is based on the Participatory Action Research model of Yoland Wadsworth(1991), and adapted by Tjikali Colin and Ann Garrow (1994). It was designed to help with her work for community food and nutrition projects but the process became part of her work towards a Master's in Health Science, from the University of Western Sydney (Hawkesbury). Her thesis, when finished, will record and discuss the development process in detail.

The use of this model and seasons story concept was endorsed by the Aboriginal Advisory Committee of the NT Food and Nutrition Policy at Mandorah in 1995.

MANY THANKS TO:

Jackie piloted earlier drafts with Till Rogers + Tilly Raymond, Nutrition Workers at Binjari, NT, then with many other members of the Top End food and nutrition, Strong Women, Strong Babies, Strong Culture teams. MANY THANKS to them and the Top End Aboriginal Health Promotion Officers who also reviewed different versions of the storybook.

This new and better version was developed in partnership with

Marlene Liddle, Strong Women, Strong Babies, Strong Culture Project Coordinator, and

Vivienne Hobson, Manager and Camille Damaso, Project Officer, NT Food and Nutrition Unit

and from general feedback from the Top End Food and Nutrition Team.

Type Font is Microsoft Word 97 - Mead Bold.
Seasons graphics; Microsoft Office 97 Clip Art.

Graphics on pages 11+ 21 are reproduced from the Aboriginal Health Promotion Training Manual (THS copyright).

SEASONS STORYBOOK as at March 1999.
SHARING STORIES:

Draw a picture and tell the story about seasons from your country, language or family.
The seasons come and go, following each other around each year.
Each season can start and stop at different times each year.

SHARING STORIES

what signs tell people the seasons are changing?
SHARING STORIES:

we can think about steps in our work being like seasons

following each other around and around.
A STORY OF SEASONS FOR WORKERS

WATCHING, LISTENING AND THINKING (start here)

Keep going - do the cycle again

SHARING OUR WORK STORY

HOW DO WE DO IT BETTER NEXT TIME?

MAKING A PLAN

WORK THE PLAN - KEEP ON DOING IT

HOW IS IT GOING?

Adapted from models by: Tjikilyi Colin and Anne Garrow 1994, and Yoland Wadsworth 1991.
SHARING STORIES

Tjikalyi Colin and Anne Garrow made their own picture about working this way

"watching and looking as you go along".

They put it into language to help them with their work.
step 1

WATCHING, LISTENING AND THINKING

When we start our work seasons we should start with watching, listening and thinking

Sharing, learning and understanding together.
Different people see, hear and think about things differently.

different community people

different workers

Getting ideas + help from different people can make the work stronger
SHARING STORIES

Who's ideas are most important for this work to be strong?
ASK THESE PEOPLE WHAT THEY SEE HEAR AND THINK

WHAT worries them?

WHAT do they want to see

WHAT they think needs to be done to make things better
step 2

MAKING A PLAN

When the earth is ready the seasons change.

When we are ready we can move on to making our project work plan.
Making a plan is like choosing steps to get from where we are now to where we want to be.
all workers should take time to make a strong plan with their community.

The plan should cover:

WHAT worries you now

WHAT you want to see (goal posts to aim for)

WHO will do WHAT WORK, WHEN
to get to your goal posts
step 3

WORK THE PLAN - KEEP ON DOING IT

When we are ready we can start working our plan,

Moving on just like the seasons.

SEASONS STORYBOOK as at March 1999.
things happen while we are trying to work our plans

😊 😞 😟

sometimes we have to change steps in our plan as we go along
Keep a story of what you do as you work your plan

A good way to do this is by taking photos and writing in a diary or on a calendar about what you did each day.

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<tr>
<th>June 1998</th>
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From Gulin Gulin - Weemol Community Nutrition Project.

*SEASONS STORYBOOK as at March 1999.*
As we are going along we need to make sure we are on the right track.

We should always be looking for signs to tell us we are on the right track.
DIFFERENT PEOPLE SEE, HEAR AND THINK ABOUT THINGS DIFFERENTLY.

different community people

different workers

Asking for and listening to ideas from different people helps make a strong story about how it is going.
Different people use different signs (ways) to tell them how things are going

What sort of signs do community people look for?

What signs do the health staff look for?

What signs do other people look for?
SHARING STORIES:

Who should we ask to find out how they think things are going?
step 5

HOW DO WE
DO IT
BETTER
NEXT TIME?

Everyone learns best by doing

When we do something we
should make time to think about
how we could do it better

to make it easier next time

😊 😊 😊 😊 😊
SHARING STORIES

Who shall we ask to get ideas about how we can make it better next time?

What do they say?
WE NEED TO MAKE AND SHARE STORIES ABOUT OUR WORK SEASONS.
• gets help and support for what we are trying to do. This makes it easier for us to do the work.

• helps us and other people learn from what we do.

• the feedback we get can make us feel really good.

• The people who give us money must hear these stories to keep giving money.
MAKING AND SHARING STORIES

We can make it with pictures, writing or on video.

Look, listen and think about some stories other nutrition and health workers have made to get ideas.
MAKING AND SHARING STORIES

Who are we going to share our story with?

What will they want to know about?

How are we going to make this story?
SHARING STORIES

talk about
these seasons for workers

make your own picture about
seasons for workers
SEASONS FOR WORKERS

WATCHING, LISTENING AND THINKING

Keep going—do the cycle again
(start here)

MAKING A PLAN

WORK THE PLAN - KEEP ON DOING IT

SHARING OUR WORK STORY

HOW DO WE DO IT BETTER NEXT TIME?

HOW IS IT GOING?

Adapted from models by: Tjikalji Colin and Anne Garrow 1994, and Yoland Wadsworth 1991.
FEEDBACK FAX - THE SEASONS STORYBOOK

To help make this book better and more useful for everyone please take 10 minutes to fill this form out and fax it back to the Food and Nutrition Unit 89 992955. Thanks!

WHY + HOW THE SEASONS STORYBOOK WAS USED:  date:

Name/s of people who used the storybook:  
Job title/s:

Who it was used with:  Number of people:

Why it was used:

Which pages were used:

OUR FEEDBACK:

What was good about it:

What was not so good:

Ideas about how to make the storybook better:  (NOTE: if you have lots of ideas to make the storybook better photo copy pages, write your changes on them and fax it back with this sheet.)

Ideas on how I/we could to use it better next time:

THANKS

SEASONS STORYBOOK  as at March 1999.
THE
GOOD STEW
GOOD PROJECT
STORYBOOK

A story book to help people
share ideas about making
good community based health projects

Jackie Priestly, Marlene Liddle and Vivienne Hobson for the
Food and Nutrition and
Strong Women, Strong Babies, Strong Culture Teams.
March 1999.
THIS BOOK AIDS TO HELP PEOPLE
SHARE STORIES +
LEARN TOGETHER;

PART 1
is made to help people share stories about things and cooking ways needed to
make good stews.

We want people to share ideas about something they know really well.
Then we will use these same steps to help people think about
talking about making good health projects in Part 2;

PART 2
is made to encourage different people share experiences and
ideas about
• what things or ingredients are needed to make good health projects, and
• ways of working or “cooking ways” for making good projects.

when planning and evaluating their own food and health projects.

PART 3
To use when looking at and thinking about (evaluating) projects that are
already going;
what has made this project really good, what’s been hard.

PART 4
was made to help feedback what people have told us about
ingredients and cooking ways to make good projects.

part 5 - Evaluation
asks a few questions to help us make this storybook better

GOOD STEW, GOOD PROJECT STORYBOOK 1999
WHO MADE THE STORYBOOK

this storybook was developed from an original concept and drafts by Jackie Priestly, Manager, Nutrition, with help from Marlene Liddle, Strong Women, Strong Babies, Strong Culture Project Coordinator Public Health Services, Operations North; and Vivienne Hobson, Manager, NT Food and Nutrition Unit.

THANK YOU TO:

the people looked at the book and gave us ideas to make it better which we put in;

Gwen Whalley, Aboriginal Health Promotion Officer, OPC. Cheryl Rae, Manager, Public Health, OPN. Jill Rogers, Nutrition Worker, Binjari. Camile Damaso, Project Officer, NT Food and Nutrition Unit.

also to the Nutrition Workers, Advisers, Nutritionists, Strong Women, Strong Babies, Strong Culture workers, Health Promotion Officers and community people who have given us feedback.

GRAPHICAL ACKNOWLEDGEMENTS:

GOOD STEW, GOOD PROJECT STORYBOOK 1999
PART 1
WHAT MAKES

A GOOD STEW?
A stew can have lots of different things or ingredients in it.

What are some you like in your stew?
NOT EVERYONE LIKES THE SAME SORTS OF STEWS

SOMETIMES IT'S GOOD TO HAVE SOMETHING DIFFERENT
DO YOU THINK THE WAY A STEW IS COOKED CAN REALLY CHANGE ITS TASTE?

HOW DO YOU LIKE TO MAKE STEW?
WHAT SPECIAL THINGS CAN MAKE A STEW TASTE REALLY GOOD?

😊 😊 😊 😊 😊 😊

WHAT THINGS CAN SPOIL IT'S TASTE?

😔 😔 😔 😔 😔 😔
PART 2
MAKING A GOOD COMMUNITY HEALTH PROJECT
CAN BE A BIT LIKE MAKING A GOOD STEW
JUST LIKE A STEW
A COMMUNITY HEALTH PROJECT CAN BE

MADE WITH LOTS OF DIFFERENT THINGS OR INGREDIENTS IN IT

“COOKED” OR WORKED IN DIFFERENT WAYS
WHAT THINGS DO YOU THINK A COMMUNITY NEEDS TO MAKE A GOOD HEALTH PROJECT?
SOME THINGS TO THINK ABOUT ARE

WORKERS
+
THINGS IN THE COMMUNITY
+
FUNDING & SUPPORT
WHAT THINGS ABOUT COMMUNITY WORKERS HELP TO MAKE A GOOD PROJECT?

LIKE STRONG STEADY WORKERS

PUT YOUR IDEAS INTO THE STEWPOT
WHAT
COMMUNITY SUPPORT + RESOURCES HELP TO MAKE A GOOD PROJECT?

PUT YOUR IDEAS INTO THE STEWPOT
WHAT
SUPPORT FROM OTHER
ABORIGINAL PEOPLE
OUTSIDE THE COMMUNITY
HELPS TO MAKE A GOOD
PROJECT?

PUT YOUR IDEAS INTO THE STEWPOT

GOOD STEW, GOOD PROJECT STORYBOOK 1999
WHAT THINGS ABOUT PROFESSIONAL SUPPORT THAT CAN HELP TO START UP A GOOD PROJECT

PUT YOUR IDEAS INTO THE STEW POT

GOOD STEW, GOOD PROJECT STORYBOOK 1999
THINGS ABOUT $ MONEY BUSINESS THAT CAN HELP TO MAKE A GOOD PROJECT

Like HAVING A CLEAR BUDGET PLAN FOR THE PROJECT

PUT YOUR IDEAS INTO THE STEWPOT
Sometimes we can’t get things or do things we want in a project.

What things might be hard to get?

What things might be hard to do?
THE WAY A STEW IS COOKED CHANGES ITS TASTE.

THE WAY A PROJECT IS MADE OR "COOKED" CAN CHANGE HOW WELL IT WORKS OUT TOO.
WHAT "COOKING WAYS" OR STEPS ARE NEEDED TO MAKE A GOOD PROJECT?
PART 3
HOW DOES THIS PROJECT STEW TASTE?

WHAT SPECIAL THINGS HAVE MADE IT GOOD?
WHAT IS NOT SO GOOD?

WHAT THINGS WOULD MAKE IT BETTER?
PART 4
HERE IS
KATH MILLS + MAURIE RYAN’S
RECIPE FOR A GOOD PROJECT

MAIN
INGREDIENT: community control

ADD TO THIS community’s selection of nutrition workers

MIXTURE Nutritionist
      Educators
      Aboriginal Primary Health Care Workers

BLEND IN Community participation

LEAVE THE MIXTURE TO SETTLE BEFORE PROCEEDING TO THE NEXT STAGE

WHEN THE PROGRAM IS SET, READY FOR COMMUNITY DEVELOPMENT, MOVE ON AND BE A SUPPORT FACILITATOR

Reprinted with permission from the NT Food and Nutrition Policy Background paper “Good Health through Good Nutrition” 1995.
PEOPLE HAVE TOLD US THESE THINGS ABOUT COMMUNITY WORKERS CAN HELP TO MAKE A GOOD PROJECT

- STRONG STEADY WORKERS - COME TO WORK MOST DAYS
- HAPPY TO DO LOTS OF DIFFERENT WORK
- HAS CULTURAL RESPECT - IS THE RIGHT PERSON TO TEACH OTHERS
- RESPECTS THEMSELVES - IS A GOOD EXAMPLE TO OTHERS
- A GOOD LISTENER - CAN TALK TO ALL Sorts of PEOPLE
- GOOD TEAM PLAYER - BUT CAN WORK BY THEMSELVES TOO
- HAS RESPECT FOR OTHER IDEAS, PEOPLE AND WAYS OF DOING THINGS

GOOD STEW, GOOD PROJECT STORYBOOK 1999
PEOPLE HAVE TOLD US THESE THINGS ABOUT COMMUNITY SUPPORT + RESOURCES CAN HELP TO MAKE A GOOD PROJECT

STRONG DAY TO DAY SUPPORT FOR WORKERS + THEIR WORK GOALS
NOT MUCH HUMBUG TO DO LOTS OF DIFFERENT THINGS

OFFICE USE OF PHONE, FAX AND CAR OR TOYOTA TO DO THE WORK

COMMUNITY PICKS THE RIGHT STRONG STEADY WORKERS + BACK UP WORKERS

STRONG SUPPORT FROM OTHER COMMUNITY WORKERS LIKE CLINIC, SCHOOL, SHOP

GOOD STEW, GOOD PROJECT STORYBOOK 1999
PEOPLE HAVE TOLD US THESE THINGS ABOUT SUPPORT FROM OTHER ABORIGINAL PEOPLE OUTSIDE THE COMMUNITY CAN HELP TO MAKE A GOOD PROJECT

ABORIGINAL ADVISORY GROUPS

STRONG STEADY SUPPORT WORKERS WHO CAN HELP OUT BUT WON'T TAKE OVER

GETTING IDEAS FROM OTHER COMMUNITY STORIES

CULTURAL SUPPORT LEADERSHIP IN PROBLEM SOLVING PEOPLE KNOW US WHEN WE NEED HELP

HELP TO DO EVALUATION CULTURAL WAY

I MEET REGULARLY TO SHARE STORIES, CARING AND LEARNING TOGETHER

GOOD STEW, GOOD PROJECT STORYBOOK 1999
PEOPLE HAVE TOLD US THESE THINGS ABOUT PROFESSIONAL SUPPORT CAN HELP TO START UP A GOOD PROJECT

GIVES ON THE JOB TRAINING THAT WORKERS WANT + ACCREDITED TRAINING (FOR QUALIFICATIONS)

GIVES LOTS OF ENCOURAGEMENT + TRAINING FOR PEOPLE TO DO THINGS THEMSELVES (EMPOWERMENT)

WON'T TAKE OVER

STONG STEADY SUPPORT

ACTS WITH RESPECT AND CARE WHEN VISITING FLEXIBLE VISITING TO MEET COMMUNITY NEEDS

WANTS TO LEARN MORE ABOUT CULTURE, FAMILY + COMMUNITY

HELP WITH EVALUATION, WRITING FUNDING REPORTS AND OTHER HARD THINGS

HELPS MAKE WORK FUN + IS A GOOD FRIEND

LOOKS AFTER US IN TOWN
PEOPLE HAVE TOLD US THESE THINGS ABOUT $ MONEY BUSINESS $ CAN HELP TO MAKE A GOOD PROJECT

- FLEXIBLE FUNDING:
  - SHORT + LONG TERM,
  - DIFFERENT AMOUNTS
  - IT EASIER IF SOME THINGS ARE PAID BY THIS

- TRAINING TO UNDERSTAND MONEY BUSINESS + RESPONSIBILITIES

- PAYMENTS MADE ON TIME TO COMMUNITY + WORKERS

- A BUDGET
  - THE RIGHT MONEY TO COVER COSTS + WAGES
  - GOOD WRITTEN RECORDS

- HELP WRITING FUNDING SUBMISSIONS + REPORTS

- RULES ABOUT WHAT MONEY CAN BE SPENT ON

- WORKING OUT WAYS TO SAVE MONEY AND/OR SHARE COSTS

3 MONTHLY REPORTS ABOUT THE BUDGET + HOW MONEY IS BEING SPENT- NO SECRETS

GOOD STEW, GOOD PROJECT STORYBOOK 1999
KEY STEPS TO MAKING A GOOD PROJECT

NOT EVERYONE LIKES THE SAME TYPES OF PROJECTS. THE COMMUNITY SHOULD DECIDE WHAT THEY NEED WHAT THEY WANT TO DO WHO WILL DO WHAT AND WHEN
KEY STEPS TO MAKING A GOOD PROJECT

USE THE WORK SEASONS STORYBOOK GUIDE or HEALTH PROMOTION TRAINING TO GET IDEAS TO "COOK" A GOOD PROJECT.
KEY STEPS TO MAKING A GOOD PROJECT
A STORY OF SEASONS FOR WORKERS

WATCHING, LISTENING AND THINKING (start here)

Keep going—do the cycle again

SHARING OUR WORK STORY

MAKING A PLAN

HOW DO WE DO IT BETTER NEXT TIME?

WORK THE PLAN—KEEP ON DOING IT

HOW IS IT GOING?

Adapted from models by: Tjikalyi Collins and Anne Garrow 1994, and Yoland Wadsworth 1991.

GOOD STEW, GOOD PROJECT STORYBOOK 1999
KEY STEPS TO MAKING A GOOD PROJECT

SHARE STORIES AND MAKE A SERVICE CONTRACT WITH

GOOD STEW, GOOD PROJECT STORYBOOK 1999
## Key Steps to Making a Good Project

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Spend time watching, listening, talking and thinking together about what people are worried about + what they would like to see.</td>
</tr>
<tr>
<td>2</td>
<td>Take time to make a strong work plan and service contract. The community need to make the decisions + choose workers.</td>
</tr>
<tr>
<td>3</td>
<td>Think about what training the workers need to get started out strong. Allow lots of time for on the job training – working side by side together in the early days.</td>
</tr>
<tr>
<td>4</td>
<td>Talk about how you are going to show that the work is making a difference – community way and health way. Plan what you need to do to show this change.</td>
</tr>
<tr>
<td>5</td>
<td>Make sure everyone understands the project goals and what they have to do, when</td>
</tr>
<tr>
<td>6</td>
<td>Work the plan together, keep a record of what you do with photos and stories</td>
</tr>
<tr>
<td>7</td>
<td>Getting feedback; what does the community think about the project, what do they like about it? how could we make it better?</td>
</tr>
<tr>
<td>8</td>
<td>Watch, listen, talk and think about how it is going together</td>
</tr>
<tr>
<td>9</td>
<td>Make and share your project work story</td>
</tr>
</tbody>
</table>

---

**Good Stew, Good Project Storybook** 1999
PART 5
FEEDBACK FAX - THE GOOD STEW PROJECT STORYBOOK

To help make this book better and more useful for everyone please take 10 minutes to fill this form out and fax it back to the Food and Nutrition Unit 89 992955. Thanks!

WHY & HOW THE GOOD STEW STORY BOOK WAS USED:    date:

Name/s of people who used the storybook:  
Job title/s:

Who it was used it with:  
Number of people:

Why it was used:

Which pages were used

OUR FEEDBACK:

What was good about it:

What was not so good:

Ideas about how to make the storybook better:  (NOTE: if you have lots of ideas to make the story book better photo copy pages, write your changes on them and fax it back with this sheet.)

Ideas on how I/we could to use it better next time

GOOD STEW, GOOD PROJECT STORYBOOK    1999
APPENDIX K:  Work sheet headings to accompany the Good Stew, Good Project Storybook.

WORKSHEETS FOR THE GOOD STEW, GOOD PROJECT STORY BOOK ACTIVITES.

There are 2 sets of worksheets for parts 2 and 3 with slightly different titles. They are designed to be to record discussion under each of the key headings whilst reviewing the story.

WORKSHEETS FOR NEW PROJECTS - to use when talking about starting up a new project.

WORKSHEETS FOR ACTIVE PROJECTS – to use when talking about a project that is underway.

They sheets can be copied onto coloured paper to correspond with the colours in the storybook.

Before you start you will need to discuss who should fill them in as you work through the storybook. Will it be a community member or do they want you to do it?

Once completed these can then be stuck onto a few sheets of coloured cardboard joined together or butchers paper. You might like to draw a camp oven or other type of pot on the poster to stick the pieces of paper inside of.

This poster should be left with the community or laminated and sent straight back so they have something to remind them of their discussions. The story facilitator should write down the key headings, or take photo’s of the poster to keep for their own records.

REMEMBER: The whole idea of the story is to promote sharing, learning and action at the community level. So it’s important the poster includes their words and remains with them.
IDEAS FOR MAKING A GOOD PROJECT BY:
STEPS FOR MAKING A GOOD PROJECT
Headings to Use When Planning New Projects:

$ MONEY BUSINESS $
to help to make our project good

SUPPORT FROM OTHER ABORIGINAL PEOPLE + COMMUNITIES
that could help to make our project good

PROFESSIONAL SUPPORT
that could help to make our project good

COMMUNITY SUPPORT + RESOURCES
that could help to make our project good

THINGS ABOUT WORKERS
that could help to make our project good
Headings For Existing Projects: (magnify to font size 36)

SPECIAL THINGS THAT HAVE MADE OUR PROJECT REALLY GOOD

😊😊😊😊

$ MONEY BUSINESS $ 
That help's to make our project good

SUPPORT FROM OTHER ABORIGINAL PEOPLE + COMMUNITIES 
that helped to make our project

COMMUNITY SUPPORT + RESOURCES 
that helped to make our project good

THINGS ABOUT WORKERS 
that helped to make our project good

THINGS ABOUT PROFESSIONAL SUPPORT 
that helped to make our project good

WHAT IS NOT SO GOOD

😢😢😢😢

WHAT THINGS WOULD MAKE IT BETTER ?

😢 → 😊
APPENDIX L: Questionnaire to evaluate the use of Sharing Stories about Seasons and Seasons for Workers.

SEASONS STORYBOOK
EVALUATION INTERVIEW OUTLINE

DATE: POSTION: 

DISTRICT (OPTIONAL): NAME(OPTIONAL):

---------------------------------------------------------------

Thanks for your time – your feedback is really appreciated!
It will be used to inform plans for better versions and use of the story book in future.

Please post or email the completed form to
Jackie Priestly
5 Davis Court Katherine NT 0850
george@nt-tech.com.au

---------------------------------------------------------------

1. How long have you had a copy of the Seasons for Workers Storybook?

2. How did you get a copy?

3. Roughly how many times would you have used the Seasons storybook?
   0  1-5 times  5-9 times  10+ times
   If 0 times go to question 4 if 1+ times go to question 5

4. If you haven’t used it, why not? (then go to question 9)

5. Briefly list some examples of who have you used the book with and why?

6. Briefly list which parts you find most useful and why?
7. What have people said about the SEASONS storybook?

8. What Ideas do you have to make it better? (If there is a lot of specific suggestions - please attach photocopies of pages with suggestions written on them.)

9. a) Would you recommend the SEASONS storybook to other people to use? Yes or No

b) If yes, briefly list who and why

Thanks again for your time!
APPENDIX M: Questionnaire to evaluate the use of the Good Stew, Good Project Storybook.

GOOD STEW, GOOD PROJECT STORYBOOK
EVALUATION INTERVIEW

DATE:                 POSTION:

DISTRICT (OPTIONAL): NAME (OPTIONAL):

Thanks for your time – your feedback is really appreciated!
It will be used to inform plans for better versions and use of the story book in future.

Please post or email the completed form to Jackie Priestly
5 Davis Court Katherine NT 0850
george@nt-tech.com.au

4. Roughly how long have you had a copy of the Good Stew Storybook for?

5. How did you get a copy?

6. Please circle roughly how many times would you have used the Good Stew storybook?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1-5 times</th>
<th>5-9 times</th>
<th>10+ times</th>
</tr>
</thead>
</table>

If 0 times go to question 4 if 1+ times go to question 5

4. If you haven’t used it, why not? (then go to question 10)

5. Briefly list some examples of who have you used the book with and why?

6. Briefly list which parts you find most useful and why?

7. What have people said about the GOOD STEW, GOOD PROJECT storybook?
7. a) Have you, or any of the workers you work with, done any activities with the worksheets? Yes or No
   b) and why?

9. What ideas do you have to make it better? (If there is a lot of specific suggestions - please attach photocopies of pages with suggestions written on them.)

10. a) Would you recommend the GOOD STEW, GOOD PROJECT storybook to other people to use? Yes or No
   b) If yes, briefly list who and why

Thanks again!
APPENDIX N: Participation

Arnstein (1971) Eight Rungs In The Ladder Of Citizen Participation

EIGHT RUNGS ON THE LADDER OF CITIZEN PARTICIPATION
By Sherry R. Arnstein

J Priestly Appendices
MORE SPECIFIC RECOMMENDATIONS FOR GROWING STRONGER TOGETHER

The reflective nature of action and participatory action research processes will and must identify new subsequent opportunities for improved action in continuous series of cycles (Wadsworth, 1997). This list of more detailed recommendations is designed to be read in conjunction with the discussion in Chapter 7. Specific recommendations for better action and research are presented under the headings of strengthening capacity for health improvement, professional practise generally, qualitative research, participatory action research and the Storybooks. Many of the recommendations are not new, Chapter seven demonstrates that these will often reiterate the lessons and recommendations of other work. For the most part they are relevant for public health practise in general and local level action across a spectrum of organisations, not just for government health service providers and public health nutritionists. By learning about, and working at, growing “strong together” we will encourage and equip Indigenous Territorians to have better control over their health and wellbeing.
Recommendations for the application of theory on strengthening capacity to improve health

- Health professionals, Indigenous Territorians and other stakeholders need to share and learn more about the theory of strengthening capacity to improve health together.

- Local groups of health service providers would benefit from using the theories and tools of capacity building for health improvement to identify strengths and weaknesses in their own work action plans. They could identify a small number of realistic of priorities to focus on improving over relatively short to medium timeframes (3 months to 2 years).

Recommendations for future professional practice:

- Organisations need to be challenged to develop structural mechanisms and incentives to motivate and enable the non Indigenous workforce to make long term commitments to working in Indigenous Health.

- Advocate for more generalist public health community based workers, particularly in small communities, to deal with the communities evolving range of wholistic health promotion priorities.

- Advocate for improved cross discipline support for community based public health workers.
The NT nutrition profession will have to continue to develop, implement and evaluate innovative methods to orientate and support nutritionists new to working in this challenging and changing environment. Organisations such as the Dietitians Association of Australia could have a greater role in (DAA) may be able to provide the professional support and leadership through practical initiatives such as implementing, evaluating and updating the community nutritionist orientation program.

Orientation programs and mentors need to focus on demonstrating and developing critical reflective professional practise in relation to power differentials and the promotion of empowerment.

The use of adult and Indigenous education theory to inform the design of communication and training materials could be demonstrated as an indicator of quality health promotion practise.

A much greater focus on project evaluation planning, implementation and evaluation of evaluation activities is required. Portions of annual human and financial resource budgets should be allocated to evaluation at project and organisational levels.

A systematic evaluation of community nutrition health projects is required that includes an analysis of capacities, contextual issues and activities recurring in successful and unsuccessful initiatives to develop realistic performance indicators that will inform better planning, action and resource allocation in the future.

J Priestly  Appendices
Recommendations for future qualitative research:

- Traditional forms of qualitative research need to be highly focused and carefully limited in environments with limited resources. Conversely, facilitative storytelling techniques provide a relatively efficient approach to collecting and sharing qualitative information and promote learning concurrently.

- Qualitative research needs to focus on Indigenous nutrition workers perceptions on the issues of professional practice, working in cross cultural partnerships, program quality and sustainability. The Cooperative Research Centre for Indigenous and Tropical Health could be approached to offer suggestions or support the quest for, and comparison of, detailed alternative perspectives. To have practical outcomes this research needs be conducted in association with participatory action research processes to develop mechanisms to help workers deal with those major issues they can influence.

- Follow up research and action could be undertaken to capture changes in issues and improve professional practise over time.
Recommendations for Participatory Action Research:

- Participatory action research (PAR) needs to be adequately resourced to realise many of the potential strengths of this method. So if resources are scarce then project goals, objectives and strategies should be small and limited to one location.

- As action and participatory action research processes adapt to changing issues and resources, stakeholders need to make sure they review their project plan to produce new clear project aims, objectives, strategies and associated evaluation plans.

- Advocate for, and facilitate the development of a Participatory Action Research (PAR) special interest group/network in the NT to provide a supportively challenging environment in which to share, learn from and supportively critique efforts at PAR
Recommendations regarding *SHARING STORIES ABOUT SEASONS AND SEASONS FOR WORKERS* and *THE GOOD STEW, GOOD PROJECT* STORYBOOK.

The Storybooks are owned by the Nutrition and Physical Activity Unit. Ongoing adaptation and implementation in the NT rests with Liddle and the NT nutritionists.

- Indigenous evaluation of the storybooks should be conducted as a priority.
- Ongoing implementation and evaluation needs to be managed more comprehensively and efficiently.
- Suggestions received on possible improvements to both storybooks (following) should be considered if and when these tools are updated.
- Seek alternative sponsor/s to administer and secure funding for ongoing evaluation and implementation.

Evaluation conducted in 2001 informed implementation planning for 2002. I initiated the discussion but was not involved in any forward planning as I was leaving the NT within a month. Hobson and Liddle made a detailed plan as follows:

- Storybooks to be owned by THS Nutrition and Physical activity unit (NPAU).
- Targeted rollout to NT Nutrition, SWSBSC Coordinators, Growth Assessment and Action, Health Promotion, Environmental Health and Batchelor College Nutrition program staff in early 2002. This process to be facilitated by Hobson and Liddle using a train the trainer workshop process adapted from the Empowering Partnerships Workshop in May 2000.
- The storybooks are to be distributed in their current form on supply of a blank CD ROM.
- Ongoing orientation and distribution of CD Roms is to be undertaken by a number of designated positions. In nutrition these will be the NPAU staff and the Public Health
Nutritionist in Operations Central. Health Promotion and Environmental Health positions will need to be nominated for this purpose.

- Recipients will be encouraged to adapt them to meet their specific needs and will be required to sign a form agreeing to acknowledge the source before receiving a CD.

- Follow up evaluation of this process to be conducted by phone/e-mail surveys 12 months after implementation training (early-mid 2003). This could be conducted as a student project by NT based staff undertaking additional qualifications or Nutrition and Dietetics students doing a community placement in the NT. The NPAU could manage this process.

(Fieldwork diary, 27 November 2001);

I checked on the implementation of these plans in October 2002 just prior to finalising my thesis. Essentially they have not been implemented and there are 3 major reasons for this (Personal Communication Hobson, 2002). Firstly the role of the NPAU has changed. It is now a funding unit within the Funder/Purchaser/Provider model implemented in NTDHCS. This unit facilitates the development of policies and targets but cannot set organisational procedures for providers such as the widespread implementation of process guides like the storybooks. Secondly there is no senior public health nutrition position in the Top End and the Central Australian position has been vacant for a year until just recently. The NPAU has been unable to organise joint workshops with Environmental Health and Health promotion staff due to financial constraints and differences in scheduling and timetabling priorities between the groups for the limited workshops they can run. These issues reinforce the nature of threats from organisational issues such as restructuring and resource limitations as identified previously in chapter seven.

The NT Branches of the Dietitians Association of Australia (DAA), the Council for Remote Area Nurses (CRANA) or other organisations could be approached to seek and administer funds for these tasks. These organisations are eligible to
apply for funding from sources that are offer limited or no funds to projects
managed by government departments. This initiative, for example, would fit
within the priorities of the Commonwealth Rural Health Support Education and
Training (RHSET) funding program.

Specific suggestions to improve the storybooks:

Three respondents gave specific suggestions to improve the Seasons Storybook. These
included

♦ adding more pictures in the last few pages of the book that are currently dominated
  by writing
♦ including pictures and examples of plans that have been done before using this
  model.
♦ develop a copy of the book that was predominantly pictures on one side of the page
  with discussion points written on the back to prompt facilitators. This is similar to
  the format of the Store Book (THS, 1997). This resource could be used when
  facilitating discussions with participants who had limited English language or literacy
  skills.

Suggestions to improve the Stew Storybook were offered by four respondents. Apart
from reiterating formatting suggestions also made for the Seasons Storybook other ideas
included

♦ producing A3 colour versions of parts 2 and 4 to share, discuss and record
  suggestions for good project ‘ingredients’.
♦ having a version of the footsteps to a good project (like Page 34) with the last column
  blank so people can write in their own steps.
Two said the storybook needs to be easily shortened and adapted by users, distributing it electronically allows people to do this.

Some pages should be added to encourage Indigenous people to identify priority ‘ingredients’ they want to add to their project and get them thinking about how they might go about getting them.

The implementation plan made for the new storybooks in late 2001 was not constructed with Trudgen’s (2000) criteria for the acquisition of knowledge in mind. Reflecting on these criteria, the following recommendations should be incorporated into planning ongoing implementation and evaluation of the storybooks.

An implementation and evaluation plan must be made which focuses on the process of educating people about this PAR cycle. Indigenous leaders must be involved in planning and controlling this process. The resources must be implemented using a train the trainer approach by senior non-Indigenous and Indigenous health professionals.

Whenever possible everyone involved in projects at the community level should receive training about the model; key workers, support people and project participants. It is recognised that resources may limit this process.

Every effort should be made to use professional interpreter services with future community-based activities using the storybooks. It would then be useful to compare process, impact and outcome evaluation of their use with and without professional interpreter services if the resources were available.

A bibliography of references should be attached that enable users to access more detailed practical or intellectual information for each section. For example with the *Seasons Storybook* this should cover topics like participatory action research, needs assessment,
performance indicators, evaluation and marketing. This could include other tools and activities to better stimulate and meet people’s intellectual needs.

Also, any new concepts that are introduced to the story should continue to be connected with cultural concepts and truths. The Stew Storybook should make reference to major resources on capacity building for health improvement (Goodman, 1998; NSW Health, 2000, NSW Health, 2001, THS, 2000c). This would ensure that future editions facilitated access to up to date best practise information to inform community activities.

An opportunity exists to strengthen the connections to these theoretical models and theories in newer editions of both the Good Stew, Good Project Storybook and Sharing Stories about Seasons and Seasons for Workers. For example, the Stew Storybook should make it clear that it is important for people to have clear aims for their efforts at strengthening capacity in terms of health outcomes for individuals (Eade, 1997; Kaplan, 1999; Bush, 2000). That is why it would be important to set these priorities using a PAR process which may be facilitated by the use of resources like the Seasons Storybook or Wadsworth’s PAR cycle (1997).

In feedback from one of the thesis examiners it was suggested that the storybook redevelopment could be enhanced with advice from Indigenous literacy consultants/teachers (Personal Communication Kaufman-Hall, 2003). Perhaps the Batchelor College Education Unit could be approached to assist with this process.

Feedback from thesis examination also suggested that Step 3 Work The Plan, Keep On Doing It could be adapted To Change The Plan and Work the New Plan (Kaufman-Hall, 2003). This title does not include working the plan in the first instance, however. Perhaps something like Step 3 Work the Plan Making Practical Changes as Required more accurately reflects the need to work in changes as the project progresses.
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CONCLUSION

This thesis demonstrates that critical and interdisciplinary social science can provide useful insights into contemporary health promotion practice. One nutritionist clarifies her own personal opinion of the need for a balance of science and art in the practice of public health nutrition:

I've always said that nutrition is like wine making, a bit of science and a bit of art and if we lose either part of it then I don't think we're as good, [as] professionals. I think that it is something that is very special about nutrition, that it's not just science nor is it just warm furry fluffing around stuff, it is the marriage between the two, ... we span sociology, psychology, physiology. I think that is something to get excited about and pass that excitement on to other people so that they actually realise that it is crucial area in so many aspects of everybody's lives in Australia.

(Personal Communication Warden, 1998).

Other commentators agree with the need to balance science and sociology. Moodie (1999), whist editor of the Health Promotion Journal of Australia, wrote that social, historical and personal analyses involving the honest assessment of reality provide important insights to
guide the scientific health promotion practise. Freund and McGuire (1995) believe that substantial health enhancement can only be envisioned through and informed by holistic understandings of the mind, body and society. Weeramanthri and Plummer (1994) demonstrated that Indigenous Territorian’s perceptions of the causality of death, illness and wellness are often categorised in relation to land, body and spirit issues.

Nutrition services in the NT have developed systematically and incrementally in the quarter of a century leading up to the year 2000. Services focused on AHW training and partnership development in the late 1970s and early 1980s. The 1980s also saw considerable nutrition analysis and assessment undertaken; documenting the nutritional composition of Indigenous foods, the nature and cost of store foods in remote communities and nutrition and health indicators like child growth and diabetes prevalence. The 1990s brought exponential growth in the Indigenous nutrition projects, workforce and training. Individual Indigenous and professional leadership was then supported by the organisational and systemic leadership provided by the development of many policies and guidelines which directed collaborative intersectoral and inter-cultural action since the early 1990s.

The size of the NT nutrition workforce has improved substantially. It has evolved from a handful of imported professionals working for one organisation in the mid 1970s to an extensive network of over 60 local Indigenous and 26 non-Indigenous people working in many diverse locations and organisations in the year 2000. The Indigenous workforce now physically outnumbers the non-Indigenous workers who support them, however, less money is still spent on employing Indigenous nutrition professionals. For the most part, Indigenous nutrition workers are still constrained by socio-cultural historical limitations in their access to mainstream educational qualifications and the influence and financial rewards that come with attaining positions which demand them. Thankfully now more Indigenous Territorians than ever are working towards these qualifications (Carter, 2001).
The nutrition workforce is working at many levels within and across systems on a wide variety of food and health related issues. Funding is now sourced from multiple local, Northern Territory and Commonwealth Governments, non-government, Indigenous and philanthropic organisations.

Community nutritionists perceive that their role is to essentially strengthen the capacity of their Indigenous partners and communities. Analysis demonstrates the origin of many of their perceived professionals weaknesses lie in their membership of a dominant and different culture to that which they are tasked to assist. Mainstream dietetics training poorly equips non-Indigenous nutrition professionals for work in this context. Inexperienced nutritionists are likely to feel relatively more frustrated and less competent as evidenced through their perceptions of personal confidence. Experience contributes to the development of reserved personal confidence, which was often restrained by a conscious awareness of the limitations of their personal socialisation. Nutritionists derive feelings of satisfaction from the relationships they make with their Indigenous partners and playing some small part in community and health development processes. Nutritionists rarely spoke of satisfaction in relation to improved health outcomes, perhaps because these health gains have only been demonstrated in a relatively isolated fashion up to this time.

In the late 1990s the nutritionists who contributed to this work recognised weaknesses in evaluation practices, particularly service impact and outcome evaluation and prioritised this issue for service development into the new millennium. The PAR elements of this research project also demonstrated weaknesses in evaluation activity based in part by limited initial planning due to issues like constant competing workload demands and associated time constraints which seem to regularly constrain participatory planning and action. Critical appraisal led me to conclude that even existing resources are not adequately allocated and used to support evaluation. As professionals we must accept some personal responsibility for this major weakness. In a way this issue has been a relatively undiscussible one: too
personally and organisationally difficult and possibly embarrassing to deal with to borrow a

term from Foote-Whyte (1991). Due to changes in the health care system funding is now

firmly linked to the ongoing monitoring of health outcomes and demonstration of health gains

for government and non government health services alike (NTDHCS, 2002b).

The impact of some of the organisational weaknesses the nutritionists identified within the

NT Department of Health and Community Services may be circumvented with system wide

restructuring in the shift of service delivery from government to non government

organisations. The Primary Care Access Funds (Commonwealth Department of Health and

Aged Care, 2001b) are being combined with traditional NTDHCS funding pools for particular

areas to enable local Indigenous Health Organisations to set up and run health services in their

area. By virtue of their structure these organisations enable greater Indigenous control of

decision making, which should therefore promote more appropriate and effective services.

Northern Territory nutrition services have been built on the foundations of strong inter-
cultural partnerships and Indigenous and non-Indigenous leadership, risk and innovation.

Service development hasn’t occurred rapidly and there is still a long way to go.

Demonstrated improvements in Indigenous health are still relatively isolated to particular

issues in discrete settings.

This study has demonstrated that non-Indigenous professionals need to make long term

commitments to learning from and working with Indigenous Territorians in particular settings

and ongoing critically and socially reflective practise if they want to provide competent

services, recognise improvements in capacity and health gains and develop a sense of

professional satisfaction. It suggests that those non Indigenous professionals who fail to

make this intensity of commitment are likely to leave feeling disillusioned about the plight of

Indigenous health and the ability of health services to affect any change.
The issues nutrition services face are not uncommon in the fields of Indigenous health, general public health nutrition and community development practise. For the most part these findings replicate and/or are complemented by the findings of other research into the perceptions of health professionals working in this context (Standen, 1998; Clark, 1999; Humphery, Weeramanthri and Fitz, 2001) or other similar situations (Campbell et al., 1997; Fitzgerald et al., 1997).

Individuals, managers and professional and employer organisations must be supportively challenged to make these substantial commitments the norm rather than the exception. This necessitates individuals and organisations taking action to recognise and effectively deal with those issues which impede these commitments, particularly the tendency for short term employment and inadequate cross cultural and professional orientation and ongoing mentorship and training.

Storytelling is a universally appropriate mechanism for diverse groups to build respectful cooperative relationships and shared understandings provided communication methods transcend language barriers which inhibit intellectual discussion. This can be achieved through the use of interpreters. The collaborative development of the facilitative narratives *Sharing Stories about Seasons and Seasons For Workers* and *The Good Stew, Good Project Storybook* were major outcomes of this study. The former incorporates a ‘new’ PAR model which places extra emphasis on sharing our work stories to inform future health promotion efforts. The Stew Storybook focuses on sharing ideas for strengthening project capacity for health improvement. They are innovative resources, the use of which is intended to promote the sharing of different worldviews and facilitate collaborative learning and problem solving within the context of community nutrition and SWSBSC projects. Their design is based on many principles of adult and Indigenous education theory although they are constrained by the reliance on the English language in its written form.

*J Priestly* Conclusion
These resources have been widely used by community nutritionists and a SWSBSC coordinator in the Top End of the NT who participated in their development or interactive demonstrations of their use. These professionals adapt their use of the resources to suit the individual purposes in which they are to be used, which is usually related to promoting program planning and evaluation. They recommend the resources to a range of health and community service professionals working with Indigenous Territorians. Indigenous Health Workers and Dietitians from outside the NT who have seen the storybooks demonstrated have also requested copies to assist them in their work promoting Indigenous health.

To date impact and outcome evaluation has not been conducted. Therefore we are unable to prove or disprove if the use of the Storybooks have made a contribution to the establishment of stronger cross cultural relations between non-Indigenous professionals and Indigenous Community Based Workers, improved knowledge, skills and confidence of the workforce or better community development processes. Further extensive evaluation of their use that particularly captures Indigenous reflections on the value of the resources is required. Their ongoing use, evaluation and adaptation is threatened by organisational changes within the NTDHCS.

Participatory action research can potentially facilitate capacity building and action for health improvement simultaneously. Many of the issues that inhibit service delivery in this context also inhibit research efforts directed at social and quality improvement. This study has attempted to promote collaborative action and learning across cultures. Although it has been unable to demonstrate a direct improvement in social relations, significant learning has occurred. It is a step in the continuum towards more “automatic” cooperative, egalitarian relations and service paradigms.

Mathews believes that the values of education, aspiration, achievement, optimism, understanding, compassion and cooperation are required to provide a positive future for the
human race (Mathews, 1999). He says these challenge the competitive and exploitative values that have directed so much of human history, challenging the chaos of life on earth, and rising above and beyond it. They can learn from and build upon history. Capacity building, participatory action research, reflective adult learning and storytelling are all built on the foundation of these positive values. They are difficult to employ as this project has shown. They are challenged by communication issues and the chaos, resource inequities and power based competitiveness that is rife in individuals lives, communities, the health system and the world generally.

Indigenous Territorians and the professionals that support them can grow stronger through their work together. The gains that have been made in the previous century can be strengthened by increasing commitment, action and reflection on specific issues particularly improving inter-cultural social and power relations, comprehensive bi-cultural evaluation and communication and storytelling. Reflective, realistic efforts at cooperation are mutually empowering for communities and the health professionals that support them; a win:win situation. Communities attain better wholistic health and health professionals, no matter what their cultural background, demonstrate their relevance and achieve a sense of personal satisfaction.

Non Indigenous professionals acknowledge that their primary personal and professional socialisation often does not prepare them well for work with and for Indigenous Territorians and they have much to learn. This work demonstrates that they must make medium to long term commitments to developing cross-cultural work knowledge and competencies which has to involve ongoing personal socio-cultural reflection. Employer organisations need to be challenged to make significant commitments to medium to long term employment contracts and significant investments in ongoing staff development to improve inter-cultural and specific professional competencies. Local groups of professional organisations can play a role
in advocating and supporting these initiatives in an increasingly devolved and diverse health system.

Ongoing challenges for nutrition services in the NT include identifying and implementing partnerships and local action plans that capitalise on the best mix of environmental opportunity, current bi-cultural knowledge, available resources and stakeholder motivations. Interested partners need to focus on strengthening community and professional capacities and problem solving action together more strategically and sustainably. These efforts must produce evidence of health gains within short to medium time frames and the clarification of key indicators in the strategic pathways between capacity and health gains. A review of the Indigenous participation and control, capacities and activities recurring in successful and unsuccessful initiatives would provide invaluable information to focus existing resources towards more rapid health improvement. There is great potential to improve communication and storytelling to speed up the diffusion of positive accounts and lessons from weaknesses with the people we work with and for, locally and in the broader health system, so that the collective memory and future action is more rapidly enhanced.

This research project has shown that learning and service improvements, or stronger minds and stronger services, can develop from taking a critically reflective approach to professional and service development. It reiterates Winter and Munn-Goodings (2001) summation that action research attempts to realise practical gains by using a critical realism approach to social inquiry and learning that is neither naively idealistic nor destructively negative (2001:263).

This study demonstrates practicing nutrition and health promotion in the modern health system and cross cultural environment of the Northern Territory is both very challenging and potentially intensely rewarding. Nutritionists who make long term commitments to working in the NT derive great satisfaction from their relationships with their Indigenous partners and observing their increasing independence, action and achievements. They look forward to the

J Priestly  Conclusion
day when the cultural heritage of the NT nutrition workforce is representative of the cultural
diversity of the population. For non-Indigenous professionals this will involve giving up
personal power and opportunity, but that is the cost of socially driven practice, which has its
own inbuilt rewards as the following quote demonstrates:

Jenny [Cleary] and I did say we were always working ourselves out of a job, but what’s
so exciting is ... the fact that we’ve been part of the process

(Personal Communication Lion, 1999).

It is the diversity of individual partners, the range of their relationships, sphere’s of influence
and capacities that can ultimately improve social relations and multiply momentum for health
gains.
GROWING STRONGER TOGETHER: 
CROSS-CULTURAL NUTRITION PARTNERSHIPS IN THE 
NORTHERN TERRITORY 

Jacqueline Rita Priestly

A thesis submitted to fulfill the requirements of a 
Masters of Arts (Honors) 
Critical Social Science

UNIVERSITY OF WESTERN SYDNEY 
SCHOOL OF SOCIOLOGY AND JUSTICE STUDIES 

July 2003
PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

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ABSTRACT

This thesis incorporates social history and consultative action research to analyse the development of cross-cultural nutrition services for Indigenous communities in the Northern Territory from 1974 to 2000 and promote the development of stronger partnerships in 1999-2001.

The historical development of nutrition services is analysed against current theory and a model of capacity building for health promotion. Nutrition infrastructure and services have developed systematically, incrementally and substantially. Strengths include the development of enduring and successful inter-cultural partnerships and leadership. Modestly confident practitioners have made substantial commitments to working here and to ongoing critical, socially reflective practise. Two facilitative narratives which aim to improve inter-cultural knowledge sharing, strengthen capacity and promote participatory action in community based projects were developed, implemented and partially evaluated. Issues and tensions that threaten efforts are outlined including many which have their basis in differences between western and Indigenous worldviews and power differentials.

Services can be further strengthened by long term commitments to examining power issues, promoting improved Indigenous control and problem solving and comprehensive bi cultural evaluation that identifies significant indicators to improving outcomes. Participatory action research, facilitative storytelling, capacity building, Indigenous education theory and critical social science can inform and guide these efforts in complementary ways.
STATEMENT OF AUTHORSHIP

I certify that this does not contain any material that has been accepted for the award of any other degree or diploma. Also, to the best of my knowledge and belief it does not contain any material previously published or written by any other person except where due reference is made in the text.

Jacqueline Rita Priestly

December 2002

NOTE

Indigenous people who have made personal contributions have been acknowledged by full name on the following page and by surname at some points in the chapters. I recognise that some Indigenous people may be offended by these direct references if, in future, an individual passes away. I do not wish to be disrespectful of Indigenous culture. People who may be offended by seeing names like this may decide not to read it or to ask someone else to check the document for them before they do.

J Priestly
ACKNOWLEDGEMENTS

Whilst I take full responsibility for the academic output presented in this thesis it is the culmination of the efforts of more than 50 people over a period of 7 years.

I am grateful to my colleagues who so willingly contributed their time, thoughts and suggestions to this work and actively encouraged me to complete the project. The following Nutritionist/Dietitians contributed their thoughts through the interviews; Cheryl Rae, Vivienne Hobson, Robin Lion, Sharon Muller, Monica Kelly, Glenda Trevaskis, Josie Lowe, Megan Wingrave, Belinda Mitting, Fran Kebble-Buckle, Moira Stronach, Alison McLay, Rosemary Warden, Heather Grieve and Jenny Freeman. Most of this group also contributed to the storybook’s development, implementation and evaluation process along with Leisa McCarthy, Danielle Aquino, Julie Horn and Julie Brimblecomb.

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<td>ABS</td>
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<td>AEHW</td>
<td>Aboriginal Environmental Health Worker</td>
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<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<td>ALPA</td>
<td>Arnhem Land Progress Association</td>
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<td>AR</td>
<td>Action Research</td>
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<td>ATSIC</td>
<td>Aboriginal and Torres Strait Islander Commission</td>
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<td>CNA</td>
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<td>CNW</td>
<td>Community Nutrition Worker</td>
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<td>Dietitians Association of Australia</td>
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<td>OCAF</td>
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<td>SAHW</td>
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<td>SIGNAL</td>
<td>Strategic Inter Governmental Nutrition Alliance</td>
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<td>SWSBSC</td>
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INTRODUCTION

In 1994, the 200 participants of an Aboriginal controlled and organised nutrition workshop in the Northern Territory (NT) recommended that; “more community based nutrition workers and nutritionists be employed to work in Aboriginal and Torres Strait Islander communities” (Strong Together Committee, 1994). The essence of this workshop was that Indigenous people, communities and the non Indigenous health professionals that support them need to be “strong together” to promote better Indigenous health and wellbeing. These recommendations were supported by community consultation undertaken to develop the NT Food and Nutrition Policy in 1994. As a result the THS Food and Nutrition policy set a target for the employment of 20 trained Community Nutrition Worker’s (CNW’s) within 5 years (Territory Health Services, 1996a). Interim targets included the employment of 8 Community Nutritionists to work with at least 10 part or full time Indigenous Community Nutrition Workers/ Advisers (CNW/As) in 9 remote rural communities by July 1997. In addition, 20 women were employed as Strong Women, Strong Babies Strong Culture (SWSBSC) project workers (SWWs) in 8 communities between 1995-97. They are supported by Indigenous SWSBSC coordinators and nutritionists.

This project incorporates social history, participatory and consultative action research activities to analyse and promote the development of cross cultural nutrition services for remote Indigenous communities in the NT. It collects and analyses community nutritionists reflections on their efforts to learn and work with Indigenous community based workers thereby “growing strong together” in their capacity to improve food, nutrition and health in the NT in the late 1990s.
The thesis structure follows a participatory action research (PAR) model developed during this study based on Indigenous and Non Indigenous health professionals reflections on other models (Wadsworth, 1991; Collin and Garrow, 1994). Figure I (see page 14) outlines this model entitled *Seasons for Workers*. Like most action based research projects it actually manifests as a number of concurrent activities; conducted by the researcher either alone or in collaboration with Indigenous and non Indigenous colleagues as consultative action research.

This thesis fulfills step 6 "*Sharing our work story*" from a detailed academic perspective.
FIGURE I: SEASONS FOR WORKERS; A PARTICIPATORY ACTION RESEARCH MODEL.

Keep going – do the cycle again

Watch, Listening and Thinking
(start here)

Sharing our work story

Making a Plan

How do we do it better next time?

Work the plan keep on doing it

How is it going?

(Adapted from models by: Wadsworth 1991, Collin and Garrow 1994)
Chapter 1 People, place, health: contexts for research and action documents the first phase of the project. A broad picture of health services in the Northern Territory is presented. The major partners in food and nutrition promotion are introduced. Theoretical frameworks, challenges for wholistic health promotion action and Indigenous health research are summarised. It argues that theoretical and practical evidence demonstrate that participatory action research, facilitative storytelling, adult learning for critical consciousness and capacity building for health improvement are mutually supportive approaches to promote health improvement in this context. The principles of extensive participation, power sharing, collaboration and learning in a particular context underpin these approaches.

Chapter 2; Making and working the research plan: rhetoric and realities, details the original participatory action research (PAR) plan and the actual course of the research. Initially, the project aimed to improve nutritionist’s, CNW’s and SWW’s knowledge, skills and personal confidence in facilitating and supporting community food, nutrition and health promotion projects. It proposed to do this by engaging these players in a participatory action research process involving storytelling, workshops, support visits and the production, use and evaluation of a “toolkit”. As is often the case with PAR, the actual processes undertaken and resultant outcomes varied from the original plans. Inability to secure funds for an Indigenous co-researcher was the major impetus for the changes. For example, it would have been inappropriate and unethical for the non-Indigenous researcher to collect and analyse Indigenous peoples stories alone.

Resource constraints regularly limited opportunities for collaborative participation. This research project then developed into three concurrent groups of activities. Firstly, Part A captures and analyses the nutritionist’s reflections on their efforts at trying to be strong partners via qualitative research. Part B involved the development, implementation and evaluation of resources to promote community development processes and the formation of
strong bicultural partnerships, through a predominantly consultative action research approach as described by Foote-Whyte (1991:46). This involved the development of 2 facilitative narratives or “storybooks”; *Sharing Stories about Seasons and Seasons for Workers* and *The Good Stew, Good Project Storybook*. Part C involved reflection and analysis of the historical material gathered to summarise and critique the professions collective efforts against current theory on capacity building. The results of each of these three phases are presented and discussed in chapters 3 to 7.

Chapters 3, 4 and 5 contribute to the very limited body of research into the beliefs and practices of health professionals in Australia, especially those working in Indigenous health (Humphery, Weeramanthri and Fitz, 2001). Six managers who are nutritionists and ten community nutritionists from all over the NT were interviewed between 1997-1999 using structured questionnaires. Together the exclusively female respondents had over 125 years combined experience working in the NT. They represent over 80 percent of nutritionists supporting remote communities in the NT over that time period.

*Chapter three; Northern Territory nutrition services grow stronger 1974-2000* outlines the contextual history in which to place the subsequent work of this project. Firstly, it summarises the historical development of the nutrition workforce and its key activities from 1974-2000. It moves on to explore long term nutritionists perception’s of the key factors that lead to the emergence of Community Nutrition Worker Projects in the NT.

The NSW Health Department’s *Framework For Building Capacity For Health Promotion* (NSW Health, 2000), was assessed as a most suitable model with which to examine the development of nutrition services in the NT over the last 25 years. The application of this model of a currently relevant health promotion paradigm identifies strengths, weaknesses and gaps in services under the focus areas of leadership, partnerships, workforce and organisational development and resource allocation. It discusses relative progress in the
dimensions of infrastructure and service development, program maintenance and sustainability and problem solving.

The capacity to act on food, nutrition and health issues in the NT has improved significantly albeit, incrementally over this time. The NT Community Nutrition Worker (CNW) program developed as a result of the interplay between a number of personal, organisational and socio-political factors. Significant action has occurred to foster respectful, enduring and successful partnerships with Indigenous Territorians and demonstrate bi cultural leadership. Major gains have been in infrastructure and service development generally.

Food and nutrition services in the NT have a strong, proud and positive history that the research has recorded. This provides a valuable legacy moving into this new century. Issues that constrain and inhibit learning, problem solving and action begin to emerge. The work demonstrates that the potential to improve on this historical legacy is threatened by many longstanding and newly emerging issues and tensions. The origins of many issues and tensions can be traced back to conflict between western and Indigenous worldviews and power issues. Participatory action research and storytelling approaches have been used extensively in successful efforts at problem solving. Issues requiring more complex, multifaceted capacities and problem solving action such as the remote food supply have been more difficult to change.

Once a number of CNW projects were funded in the mid 1990s the challenge was to support their successful establishment, implementation and evaluation to demonstrate health improvement. Chapters 4 and 5 document and explore practitioners perceptions of many issues involved with this task. Chapter 4; Talking straight about trying to be strong partners, is broken into four segments. It presents and critiques nutritionist's perceptions of their own roles moving onto exploring notions of their own and their Indigenous partners key knowledge, skills and personal attributes. Both the nutritionists and managers perceptions of
enabling factors are detailed in the third section. Finally personal notions of confidence and satisfaction are explored.

Chapter 5; More straight talk about trying to be strong partners covers the topics of barriers and frustrations and managers perceptions of what is required to improve the sustainability of CNW projects. It discusses nutritionists and managers approaches to promoting the empowerment of their Indigenous partners. Expressions of power and other tensions that run through their responses are detailed.

The range of issues presented and discussed in both chapters 4 and 5 are interrelated, representing the complex interrelationships of life in particular environments. Common themes reverberate; relationship building, cooperation, communication, capacity building, empowerment and the need for non Indigenous professionals to make long term commitments to learning and working with Indigenous Territorians and critically reflective practise.

The high turnover of both Indigenous and non Indigenous workers poses the most serious threat to achieving potential health gains via these projects. This is partly because of the time it takes for professionals to develop cross-cultural, community development, and bi cultural food and health knowledge and competencies that have not been developed in their primary professional training and socialisation. Intra and inter organisational and community dynamics which frustrate and inhibit capacity for infrastructure development, problem solving and program maintenance and sustainability are the greatest systemic threats. Threats and tensions exist in attempting to balance the development of capacity with the demonstration of health gains. The impact of many issues can manifest along a continuum; from barriers to enablers. The origins of most threats and tensions can be traced back to conflict between dominant and Indigenous worldviews and associated power issues. These lessons are derived from the analysis of the actions and experiences of a particular professional group working in
a unique context. For the most part they have wide applicability in the fields of cross cultural public health practise because they concur with, and thus are validated by, the findings of many other researchers. A few notable exceptions are detailed.

Chapter 6: Sharing stories to strengthen social relations and promote health improvement details the development and the design of the two facilitative narratives or “storybooks” Sharing Stories about Seasons and Seasons for Workers and The Good Stew, Good Project Storybook. These tools were developed, implemented and evaluated as part of this research project in association with community food and nutrition projects and Strong Women, Strong Babies, Strong Culture projects in the Northern Territory between 1997 and 2001.

These were developed to assist non Indigenous and Indigenous partners share knowledge from their different world views and experiences and work together more constructively to improve health and wellbeing. Sharing Stories about Seasons and Seasons for Workers is aimed at strengthening skills and knowledge in collaborative participatory action research based planning and evaluation. The Good Stew, Good Project Storybook promotes sharing of understandings about positive factors likely to improve the success of community health projects.

This chapter also discusses how the storybooks have the potential to promote a fundamentally different set of social relations and progress broad health and humanitarian priorities. It’s final section begins evaluating these resources by critically reflecting on their design in relation to emancipatory and Indigenous education theory. Apart from limitations associated with the use of the English language and limited implementation in the community setting they conform to many central tenants of Indigenous education theory (Harris, 1976; von Sturmer, 1991; Trudgen; 2000). They cannot be classed as tools for emancipatory education as they fail to actively promote the development of critical consciousness of power issues. For
example, in the manner advocated by such authors as Freire (1973), Carr and Kemmis (1986) and Winter and Munn-Goodings (2001).

Chapter 7 Critical reflections and opportunities for strengthening practise details the strengths and weaknesses of each segment of this study and suggests priorities for future action and research. The research processes were much slower, less participatory and at times less thorough than originally planned. This occurred mainly because of the contextual realities of high workforce turnover, incomplete staffing levels, competing workload demands and financial constraints. In the final analysis this project predominantly involved qualitative research and consultative action research, rather participatory action research demonstrating improved power relations. Despite these limitations substantial learning has occurred through the development of a more critical consciousness.

Multiple rounds of respondent feedback and triangulation with reports and the work of other researchers indicate that the results and conclusions of the qualitative research activities are both credible and reliable.

The storybooks were widely implemented in the Top End but not distributed in Central Australia. Professionals tended to use particular sections of each storybook to assist with a priority task or issue. The potential of these resources has not been demonstrated largely because impact and outcome evaluation was not comprehensively planned. Implementation via an active demonstration process promotes more extensive use than mere distribution. The demand for the storybooks expressed by Indigenous and non Indigenous nutrition and health professionals nationally supports the reliability of this finding. Ongoing implementation and evaluation needs to be managed more comprehensively and efficiently. These reflective insights informed planning for the ongoing use of these resources.
General recommendations for improved professional practice and research are incorporated under the headings of stronger commitment, research, reflection, focus, action, evaluation and storytelling. The rhetorical potential of PAR, capacity building for health improvement and emancipatory and Indigenous education theory and techniques need to be judiciously targeted in local activities that can be completed and evaluated well within existing resources. Analysis of the testimony’s of nutritionists elucidates that professionals need to make long term commitments to working with Indigenous communities, to undertake more comprehensive evaluation and critical, reflective personal practice that is always vigilant for opportunities to promote improved social and power relations. Nutrition services must demonstrate more comprehensive evaluation practice and identify process and impact indicators that recur in projects with successful health outcomes. Improved storytelling could disperse the lessons of individual projects to inform the efforts of others more effectively and rapidly. More specific recommendations are listed in the Appendices.

Nutritionists vision for the future was positive and optimistic in the late 1990s. This future must involve Territorians, in all their diversity, growing stronger together, by learning from and with each other, reconciling, participating and achieving better lives together.