# It's like having to trade on the personal:

## Changing work, changing identities of public health learning and development practitioners

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**Certificate of Authorship and Originality**

I certify that the work in this thesis has not been previously submitted for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have had in my research work and in the preparation of the thesis itself has been acknowledged. In addition, I certify that all the information sources and literature used are indicated in the thesis.

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# Abstract

As a practitioner involved in the planning and development of educational activities in the field of public health, I have worked within many pedagogical traditions and program parameters. Through this work, I have experienced both subtle and radical shifts in the range of skills, knowledge and relationships required to collaboratively plan and evaluate educational work. In this professional and community-based landscape, competing and often overlapping models of education and evaluation have led to much conceptual confusion and ambiguity around narrowly defined notions of best practice, evidence and knowledge legitimacy.

Drawing from Dorothy Smith's (1999) standpoint theory from which my inquiry was developed as a result of my participation with colleagues in the field, I explore how three professional practice networks of learning and development practitioners speak of the skills, knowledge, relationships and worker identities in a changing field. This research seeks to explicate the kinds of informal and largely unarticulated knowledge that is produced through the changing contexts of work.

This research maps the changing conditions of educational work through my own case stories of educational practice and uses these as a springboard for discussion among three diverse professional practice networks. The Story/Dialogue Method (S/D-M) developed by Labonte and Feather (1996), is a constructivist methodological approach that, in this application, structures group dialogue into reflective insights and theories about how educational work occurs in varied settings among different professional and community-based groups.

A strong reliance on interpersonal skills was articulated by all three networks to build trust, assess individual and organisational learning needs, to build partnerships and to motivate learners. Skills were often described vaguely and summarised as a series of situational specific attributes. A valuing of reflexive, working knowledge as opposed to professional or discipline-based expertise was raised as an important aspect of partnership building and in negotiating program parameters. The need to build individual and organisational relationships through formal and informal encounters was cited as a series of legitimate yet often 'behind the scenes' professional practices. Aligning with the notion of worker identity described by Chappell, Rhodes, Solomon, Tennant and Yates (2003) as process, practitioners spoke of their identities as constructed and temporary, negotiated through newly emerging roles and changing relationships with peers and learners.

This study suggests that evidence-based practice is a contested term drawing its meanings from multiple theoretical and pedagogical traditions including that of intuition. Perhaps unsurprisingly then, evidence guiding educational approaches is viewed as a pragmatic and eclectic mix of tools stored to be adapted for use in new ways. Additionally, this study concludes that all participants (including myself) regard educational practice as a collaborative and continually negotiated endeavour.

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# Chapter 1

## Professional Starting Point: Public Health Learning and Development

Over the past ten years I have worked as a community health educator, a trainer, a professional development officer, an educator, a health promotion officer, a consultant and a program manager in a range of government and non-government public health-related settings. My job titles have changed for each short-term contract, and while they differ in specifics, the general focus has been to develop a range of learning activities on related health issues for disparate community and professional groups. For each change of contract, the 'essential and desirable' criteria for the job subtly shift, the position title changes along with the educational models, skills and relationships needed to develop legitimate and professionally appropriate learning programs. As these components to my work change, so do the relationships with my colleagues and target groups (or learners), the specialist and generalist skills and knowledge required to complete the project and lastly my professional or worker identity. Despite these shifts, the professional and community networks I work with are inter-connected, and over time have periodically formed into small partnerships whose purpose is to collaboratively develop learning programs over short to medium term project time-lines.

Public health is a broad field where competing and often overlapping models of education and evaluation have lead to a great deal of conceptual confusion and ambiguity around issues of best practice, evidence and knowledge legitimacy. The focus of this investigation examines, with learning and development practitioners working in the public health field, how the evolving contexts of their work, gradually but unevenly shape their skills, knowledge, relationships and worker identities. By drawing from the practice experiences of three existing interagencies of public health practitioners who have an ongoing educational component to their work, I identify the shared meanings and themes that inform and challenge daily educational work with a view to using these insights to develop adaptable, legitimate and strategic approaches to learning and workforce development. Furthermore, as a practitioner involved in this collaborative daily work, I recognise the varied professional disciplines, community memberships and personal experiences that inform beliefs about pedagogical approaches despite working within a public health framework that draws on narrowly defined notions of educational best practice. By using a structured process of dialogue that focuses on tensions within our daily professional practices, I elucidate and

challenge notions of best practice in public health education as a unified and mutually agreed on term.

## Who does education in public health?

By focussing on public health practitioners who undertake a range of educational or information provision activities, but who may not chiefly identify as 'educators,' I acknowledge the different theoretical models and varied settings that educational practices occur in. Foley (2001) describes the need for this expansive definition of 'the educator':

> Fewer and fewer people, even those whose primary work role involves the education of adults, see themselves as 'adult educators' (rather they see themselves as 'human resource developers' or 'literacy teachers' or 'nurse educators' and so forth).
> (Foley, 2001: 23)

The need to 'do' education, in a variety of forms, is increasingly incorporated into job descriptions as part of a set of core responsibilities. In public health, education is a responsibility of a range of clinical, allied health, service planning, health promotion and administration professionals as well as community-based professionals, community members and arguably, any other individual, organisation or sector that work to "protect people from disease and to promote their health" (Baum, 2002: 531). As well, informal educational activities are required on an ongoing basis as part of collaborative program management, public health advocacy and management or supervisory duties. Education then, becomes part of everyday work for many health professionals. The notion of 'educator' as a distinct professional identity is therefore less apparent in these workforces. The scope of this investigation acknowledges this shared role and capitalises on the diversity of players and occasions where education occurs. The public health practitioners participating in this research consist of a broad base of clinicians, allied health professionals, community educators, health service managers, health promotion project officers and workforce development program managers working in both government and non-government (or community-based) settings. The common point of discussion and enquiry with these practitioners is their educational work –often embedded with other clinical, management or administrative components to their daily work.

## Who is the public health workforce?

The public health workforce is also broad in composition, drawing from "a range of professional or occupational backgrounds, most performing one major function but generally also involved in a number of other functions" (Dept of Human Services and Health, 1995: 5). The expanding definition of what Baum (2002) terms "The New Public Health" includes not only a professionalised workforce, but significantly "the participation of communities in activities to promote health" (Baum, 2002: 531). Much of contemporary public health literature today,

emphasises the growing significance of community participation in the development of a range of formal public health programs and services (Baum, 2002; Eager, Garrett & Lin , 2001; Freeman, Gillam, Shearin & Pratt 1997; Green & Haines, 2002). Community-based models of education such as peer education or, more broadly, community development programs, are increasingly recognised in state health policies for their value in achieving targeted public health outcomes. These models co-exist with other forms of education in public health such as professionally accredited programs, traineeships, education through professional associations and less formal models that include the need for ongoing organisational partnership building activities.

The acknowledgement of educational work that is often embedded in more routine duties and in the shared development of public health programs draws from contemporary adult and organisational learning theories addressing the interface between work and learning. Much has been written recently about models of learning that identify more informal, continuous learning at work (Boud & Garrick, 1999; Garrick & Rhodes, 2000; Gonczi, 2001; Johnston, 2001). A number of descriptive indicators have been proposed that describe these more educationally integrated models of workplace learning. These include increased organisational integration (internally and externally), flatter hierarchies (Field & Ford, 1996), flexible and multiple learning systems and more collaborative team-based approaches to work (Argyris, 1990; Boud & Garrick, 1999; Garrick & Rhodes, 2000; Senge, 1990). The notion of 'work' is now almost inseparable from the notion of 'learning' with the development of the term 'knowledge workers' (Boud & Garrick, 1999) in which 'workers must be willing and able to learn and perform new tasks, take on different roles and be easily redeployed in the flexible new workplace" (Casey in Boud & Garrick, 1999: 18). The "construction of the competent worker emphasizes problem-solving, consultative committees, quality circles, formal and informal on the job training" (McIntyre, Chappell, Scheeres, Solomon, Symes & Tennant 2001: 13) in order to achieve a "continuing process of relearning and updating (Hawke, 2001: 6). Productive and 'performative' workplaces are now recognizing, valuing and promoting learning that was once primarily viewed as informal, embedded and largely unrecognized (Solomon & McIntyre, 2000 in McIntyre et al, 2001). Workplaces are increasingly being re-legitimised as valid sites for learning (Casey, 1999; Harris, Simons and Bone, 2000). The "fostering of organisational learning as opposed to individual skill formation" (Johnston, 2001: 3) further emphasises the value of shared learning activities as a key dimension of organisational activity and "a driver of organisational competitiveness" (Johnston, 2001: 3).

By working with multiple educational projects over time and developing new professional partnerships along the way, learning and development practitioners in public health need to construct and re-negotiate their worker identities (Johnston, 2001: 3; McIntyre et al, 2001: 11) –assuming varying roles and changing relationships with learners and peers.

## Exploring worker and learner identities – a case study

The concept of worker and learner identities is an area of investigation that requires some theoretical positioning within this research. It is particularly relevant where multiple professional traditions of identity, expertise, and/or notions of community attachment are used to describe pedagogical practices and professional relationships. Here, the use of worker and learner identities draw from the work of Chappell et al (2003) and argues "that concepts of the 'self' should not be seen as neutral representations of the subject-person but rather as discursive interventions that do important political and cultural work in constructing, maintaining and transforming both individuals and their social world" (Chappell et al, 2003: 28).

The notion of identity is grounded in particular and historical experiences that will continue to change and evolve:

> … the self is configured as a contingent and constructed concept, one that is subject to continuing social and historical transformation…moreover, the term has come to mean a process rather than a product; a process that involves a construction of sameness that is continually evolving and incomplete.
> (Chappell et al, 2003: 28)

My relation to this research is one that has gradually developed through my participation in the public health workforce. It is a deliberately reflexive approach in that my investigation draws explicitly from my experiences and uses these as a starting point for discussion and critical analysis with the practitioners I work with. In part, this acknowledges Salomon's (1991) concept of ecological validity and Robinson's (1993) models of problem-based learning. As in Dorothy Smith's (1999) account of writing from a particular standpoint: "The situated knower is always also a participant in the social she is discovering. Her inquiry is developed as a form of that participation". (Smith, 1999: 6). Furthermore, my initial and ill-defined inquiry was also prompted as a consequence of that participation –as in Smith's (1999) account of her personal starting point to developing a research question:

> These studies have started very differently, with a feeling of uneasiness or problem in some aspect of my working life as a participant in various discourses… but I have not started writing on the basis of research data. Rather, I have started with a sense of problem, or something going on, some disquiet, and of something there that could be explicated.
> (Smith, 1999: 9)

As a practitioner involved in the development over time of a range of learning activities in community-based and government public health settings, I have experienced both subtle and radical shifts in the range of skills, knowledge and relationships needed to achieve targeted learning or service development outcomes. For instance, the peer-based educational interventions and broader community development approaches primarily relied on by community-based AIDS

Councils to prevent the spread of HIV epidemics in the early 1990s, relied heavily on gay men and "the culture of existing gay communities" to plan and deliver preventive education (Dowsett, 1996: 69). My identification and experiences as a gay man or peer, alongside other required skills and knowledge, were capitalised on in the development of peer-based networks and in the training curriculum developed (ACON, 1996). Knowledge and learning was viewed as a generative process, informed by the experiences and ideas of the learners (or community members) themselves. Learning was fundamentally viewed as a process of individual and community transformation and activism rather than primarily a process of acquiring facts from experts. In contrast, as a Professional Development Officer in a state-wide government health organisation a few years later, my role as a 'trainer' with expertise in particular content areas, along side qualifications and experience in adult education and training, was significantly different. Education here aimed at imparting knowledge from clinical or health promotion experts to learners in training room settings. Skills in developing assessment strategies, articulating competencies, drawing together a range of public health 'experts' in the delivery of training and program planning and evaluation (with clearly identified behavioural learning outcomes) were some of the key roles and areas of expertise expected of Professional Development Officers. The educational philosophies drawn on in these two examples are epistemologically very different. In my capacity as a Professional Development Officer, knowledge was deemed as more uncontroversial, scientifically rigorous and true. As a gay community development officer within a community-based AIDS Council, knowledge, and in particular public health HIV knowledge was already a socially contested issue. HIV prevention education grew from gay liberation movements and networks of gay men responding to a public health crisis directly affecting their community (Dowsett, 1996: 68). Education was a politically radical and transformational activity that directly challenged the accepted primacy of medical knowledge and in the design and delivery of public health education. Dowsett (1996) describes the historical and political roots informing HIV prevention education in the late 80's and early 90's:

> During the early years, the various print materials produced concentrated on the symptoms of HIV infection and a growing list of judgements about the safety of, or risk associated with, certain sex practices. In the hands of the gay community AIDS organisations, these print materials were a far cry from dry clinical lists of do's and don'ts of the sort typical, for a time, of government-produced materials. Increasingly, images and iconography from gay communities themselves have shaped the form, tone and delivery of their educational materials and programs.
> (Dowsett, 1996: 70)

These two examples highlight multiple and often conflicting philosophical, theoretical and methodological approaches to education in the public health. I argue that as contemporary public health literature continues to espouse principles of intersectoral collaboration, partnerships and community participation in our public health responses, along with the use of ambiguous terms

such as educational 'best practice', public health practitioners will need to expand their awareness of different models and theories of education along with notions of evidence that support these interventions.

With these ongoing professional and relational shifts over time, came changes to my worker identity and to the ways in which learners are conceptualised or positioned within the educational context. Drawing from Chappell et al (2003)'s position that "…various educational and learning 'programmes' are best seen as technologies for constructing particular kinds of people or 'subjects'" (Chappell et al, 2003: 10), this research attempts to elucidate notions of educational best practice among professionally disparate networks of practitioners and examine how this term becomes used as a technology for constructing professional identities. In this participatory research I explore with learning and development practitioners the ways in which our range of tacit skills, knowledge, relationships and worker identities are shaped by the evolving context of our work and our multiple professional and personal histories.

To make explicit the development of shared meanings or lessons learned through the telling and analysis of professional practice stories, this research will draw from Labonte and Feather's (1996) Story-Dialogue Method (S/D-M): "Derived from constructivist, feminist and critical pedagogical theory, and with roots in qualitative methods, the method structures group dialogue around case stories addressing particular generative practice themes." (Labonte, Feather & Hills, 1999: 39). The group dialogue is grounded in the experiences of individuals telling professional practice stories about their educational work that raise a tension or broader question about their work. The methodology has broad application and can extend to program planning and evaluation in a range of settings. Here it will be drawn from to make explicit the assumptions (theories) about the learning and development work of three interagencies or professional practice networks of public health practitioners who plan, coordinate and review educational activities in public health.

Practitioners from three professional practice networks from the broad public health field participated in one three-hour facilitated S/D-M workshop. The networks include multi-disciplinary professional practice networks as well as single profession networks. The participating professional practice networks are:

**Heplink**

Heplink is a statewide, multidisciplinary network (including clinical, health promotion and community-based practitioners) who address issues relating to hepatitis C in their work. The aim of Heplink is to share information, resources and support.

**Network of Alcohol and other Drug Agencies Inc (NADA)**

The Network of Alcohol and Drug Agencies (NADA) is the peak organisation for the alcohol and drug non-government sector throughout NSW. Through its Workforce Development Project, it provides organisational development support and staff training and development strategies to its target agencies. The Network is multi-disciplinary (including clinical, health promotion and community-based practitioners and educators and program managers from other sectors) and focuses on a broad public health topic: alcohol and other drug-related harms.

**Practice development midwives**

This is a local network of midwives who work together to advance midwifery practice through advocating for continuity of care models for women – a key public health access strategy. The midwives in this network include those directly involved in midwifery practice with mothers and who also work as health service managers, Area administrators or directors, clinical educators and researchers.

In this research I aim to make explicit, the ways in which three professional interagencies or networks of public health practitioners construct and negotiate worker identities over time by exploring strategies (work practices), knowledge (discourses) and relationships in a changing professional landscape that draws from a range of educational models and philosophies. The significance of this research relates to the growing interest in explicating the kinds of informal and unarticulated knowledge that is produced through work. A key area of investigation in this research involves an examination of how individuals and groups working in this sector adopt notions of educational 'best practice' in a field dominated by multiple and often competing forms of evidence.

In the next chapter I examine literature related to the public health workforce in Australia and notions of professionalism, evidence and best practice that influence our ongoing educational practices. I identify competing theoretical models of education, along with an expanding and

increasingly diffuse workforce. This discussion serves to situate and provide a context to my ongoing work and the educational work of the three public health interagencies participating in this research.

In Chapter Three I map a brief history of my learning and development work within this field as a case story, along with the learning philosophies, theories and organisational contexts and policy frameworks that have guided or impacted on my work along the way. This case study is particularly relevant in that it contributed to my current standpoint of 'uneasiness' with dominant, scientifically informed paradigms of best practice in public health education. It was also through this uneasiness and a desire to open up discussion through multiple perspectives about how education work really gets done, that informed the rationale for this research. The professional history in this chapter describes multiple pedagogical traditions in a range of organisational settings. Here, I highlight the temporary nature of project work and the variety of expectations, knowledge, skills and relationships required to collectively or individually organise educational programs. This case story emphasises the need for public health education to be an adaptable endeavour, whereby learner expectations and worker identities are regularly negotiated throughout the life of these educational programs.

In Chapter Four I draw on my professional practice case story by using it as a springboard for structured discussion among three public health interagencies who undertake education as part of their ongoing work. This method is described as a participatory means of facilitating group reflection and the creation of more generalised knowledge. This chapter describes the development of the Story-Dialogue Method (S-D/M) as group problem solving strategy in public health with multiple applications. It outlines the stages of group enquiry as ideas are gradually negotiated and produced as Insights. As critical discussion continues, these Insights are further refined as broader, more generalisable theories about their educational work. The methodology is explicitly participatory and includes my own voice as facilitator and participant in the analysis.

In Chapter Five, these Insights and Theories are thematically grouped and presented by myself and workshop participants. The analysis identifies key themes arising through the telling of each case story and describes the allocated Insights and Theory Notes participants generated as an outcome from their structured dialogues. Themes such as relationship building, assessing learning needs (both individually and organisationally), evaluating our practice and worker identities and learner expectations provided a basic structure to begin investigating how learning and development practitioners speak of their changing skills, knowledge, relationships and worker identities. The analysis identified a strong reliance on and use of interpersonal skills to build trust, assess individual and organisational learning needs, to build partnerships, to encourage collaborative learning and to

motivate learners. All groups spoke of a continuing need to negotiate, build flexibility into, or balance expectations of their learners or peers. Although knowledge of how to build relationships was a fundamental part of all three professional practice networks, discipline-based knowledge was a relatively small component compared with knowledge required of organisational planning frameworks and believable use of the associated rhetoric, or multi-disciplinary group learning and planning processes including those that aim to establish rapport and build trust. Relationship or partnership building was an explicit benchmark or ongoing alliance-building process to all three interagencies' work. In relation to our everyday work, participants spoke of notions of identity as a changing construct negotiated over time, through multiple settings and different forms of work. By negotiating the parameters and pedagogical approaches for programs, such as shifting from a more traditional and individualistic approach to learning to a broader organisational approach that entails work not conventionally identifiable as education, participants described notions of worker identity as a changing process informed by a mix of professional, organisational, historical and personal experiences.

Chapter Six describes the emerging themes and theories relating to learning and development practitioners changing skills, knowledge, relationships and worker identities. Educational work is described as a dispersed and often buried process defined by characteristics of negotiation, relationship building and collaborative planning. The notion of worker identity emerges as a transient and often ambiguous term that is also constructed through different forms of participation with our colleagues through short-term collaborative work. Multiple evidence bases and professional traditions informed the types of relationships, skills and temporary worker identities of participants. The increasing focus on multi-disciplinary and inter-sectoral approaches to public health education poses further challenges to our efforts in articulating (and being aware of) the emerging volume of literature on evidence-based practice. The investigation describes evidence as a contested term, shaped by multiple theoretical and professional traditions including opinions by us about what works in the field at the moment.

# Chapter 2

# Public Health, Learning and Evidence:
## Exploring multiple perspectives of evidence and educational practice

This chapter sets the broader context of the public health field by describing the dominant scientific paradigm of evidence-based knowledge production and challenges it as a single perspective that guides the multiple workforces and community groups involved in public health education. A need for greater pluralism of perspectives is argued for when considering the types of evidence and experiences to draw from. Several examples from clinical and from within health promotion fields of public health highlight divergent views about what constitutes best practice in educational research and practice. As contemporary definitions of public health expand to recognise increased participation of communities and other non-traditional players (ie local councils, schools, police) along with broad policy and planning frameworks that call for more collaborative and multi-sectoral approaches, I argue for a greater recognition of multiple pedagogical traditions.

### Defining public health: From a branch of medicine to an eclectic mix of evidences, approaches and theories

Public health is broadly defined as "a branch of medicine concerned with the prevention and control of disease and disability and the promotion of physical and mental health of the population on the international, national, state or municipal level." (National Library of Medicine, 2003: Medical Subject Headings MedLine). As a 'branch of medicine,' clinical, educational and program planning approaches traditionally emphasise positivist approaches such as experimental methods, quantitative data collection and analysis, and identification of linear cause and effect relationships (Raphael, 2000: 358). Lincoln and Guba (1985) argue that within this positivist paradigm these methods are viewed as 'objective' and are designed to allow truth to emerge. However, a constructivist approach to public health would argue that this notion of truth discounts experiential knowledge, reinforces passivity of the subjects being researched, and silences other voices (Gaventa & Cornwall, 2001). Throughout the last century, the dominant discourse of Western health has been through a biomedical perspective. (Foucault, 1973 in Baum, 2002: 5; Freidson, 1970; Willis, 1989) Here, the body is studied and articulated through its component parts and is isolated, labelled and systemically classified by diseases (Underwood, Owen & Winkler., 1986 in Baum, 2002: 5).

Clinical professions are educated and inducted into a particular kind of professional culture that values particular ways of knowing:

> The clinical culture values scientific knowledge and research. Through their training, clinical professionals are imbued with the primacy of the scientific method as a way of knowing, and with a profound respect for the research process and its outputs. (Walshe & Rundall, 2001: 439)

The social, psychological and community-related aspects of health remain largely ignored through this discourse. Such scientific and 'evidence based knowledge' is at odds with ethnographic or critical approaches to knowledge development (Raphael, 2000: 358). In their critical review of public health and health promotion evidence, Adams, Amos and Munro (eds) (2002) conclude that "Even where evidence is available, it frequently proves to be the 'wrong type' –occupying a different paradigm to that of the decision-maker –and is unable to support the argument either way.' (Adams, Amos & Munro, 2002: 181).

### The new public health: Workforces with multiple traditions

However, Baum (2002) argues that an eclectic mix of evidences, approaches and theories is needed to work in what she terms "the new public health":

> My starting point is that no theory offers an entire solution to understanding the world and providing a basis for public health action. Consequently, I use theories eclectically, selecting bits here and there as they help me to understand the world and explain it to others. …The one certainty that I cling to is that our world is complex –far too complex to be neatly understood through any single theoretical lens. (Baum, 2002: xiv)

Baum (2002) highlights the need for multiple theories and approaches to public health practice – ones that span over many professional disciplines: "One of my firmly held beliefs is that public health is nothing if not multidisciplinary and holistic." (Baum, 2002: xv). This view is consistent with the trends identified in the emerging literature on work and learning. These include the need for multiple learning and problem solving approaches that are participatory and reach beyond the narrow confines of professional roles (Boud & Garrick, 1999; Chappell et al, 2003). Just as the new public health acknowledges the broader impacts on health by "a wide range of cultural, social and economic factors" (Baum, 2002: 381) so too does our broadening view of learning reflect the awareness of a greater range of influences that impact on learning. This confluence of theories and approaches in public health and those in the contemporary literature on work and learning presents opportunities for more consistent and collaborative approaches to guiding professional practices.

## Evidence-based knowledge: A contested term

Most program evaluation frameworks within the public health field of learning and development tend to honour a positivist approach with indicators generated around behavioural learning outcomes, skills assessment indicators and even the measure of the number of learners attending training programs. These evaluation methods rarely provide the kind of critical feedback that can assist learning and development practitioners to reflect on how they may better understand the changing contexts of their work. Building theories of 'what works' in the field is often approached through anecdotal and informal dialogue among practitioners. However, they rarely become known as "rigorous explanations" (Labonte, Feather & Hills, 1999: 39) as more traditional and narrowly defined standards for evaluative evidence dominates in the broad public health sector (Labonte, 2001; Raphael, 2000). What counts as legitimate evidence (including evidence supporting educational approaches and frameworks) in my changing professional field remains a contested issue. However the notion (and rhetoric) of 'evidence-based' knowledge and program design is a common and often ambiguous phrase used to describe and defend the legitimacy of our work. Health professionals are increasingly being asked to site the phrase 'evidence based practice' or 'best practice' in the marketing and content of their educational activities. The concept of evidence based practice (EBP) was originally called 'evidence based medicine' –a clinical term relating to information focussing directly on the patient's own health-related scenarios (Booth in Booth & Walton eds, 2000). Originally endorsed as a means to address 'unexplained wide variations in clinical practice patterns" (Walshe & Rundall, 2001: 430) the term has been borrowed and adapted to suit the varying needs of other allied health and public health professionals. Today, a broader range of evidences is now drawn on that aim to articulate non-clinical, and more population health based aspects to health care. The dominant use of and reliance on quantitative experimental research methods is now being questioned as the rapid and widespread diffusion and interpretation of the term grows (Walshe & Rundall, 2001: 435). Urquhart (2000) further argues that greater consumer interest in healthcare and "the trend towards more self-care affect not only the type of information required by health professionals and consumers, but also the power relationships implicated in communicating and sharing health information" (Urquhart in Booth & Walton, 2000: 15). Knowledge production between a health care provider and an active participant aiming to 'self-care' requires more participatory educational processes that challenge the role of the clinician as the knower. The term has now spread to fields beyond health care with evidence-based practice initiatives in education, social care and criminal justice (Davies, Nutley & Smith 1999; Walshe & Rundall, 2001).

Evidence-based health care –the idea that "the care that health professionals provide should be based as closely as possible on evidence from well-conducted research" (Walshe & Rundall, 2001:

431), is an increasingly complex and problematic model that informs professional learning and development traditions in public health. Walshe & Rundall (2001) argue that "because of the volume of research evidence that exists, the speed with which new evidence is produced, the complexity of large health care organisations, and the many practical difficulties of changing clinical practice…major reform of the whole process of knowledge management in health care systems" is needed (Walshe & Rundall, 2001: 431). The other difficulty in generalising the model of evidence-based practice to both clinicians and health service managers (or community workers for that matter) is the great differences in how professional cultures speak about evidence and the kinds of evidence deemed legitimate. Walshe & Rundall (2001) contrast the health service managers' reliance on observational methods, qualitative research and greater focus on theoretical development than on empirical theory testing with the biomedical background of the clinician:

> Overall, the tightly defined, well-organised, highly quantitative, and relatively generalisable research base for many clinical professions provides a strong and secure foundation for evidence-based practice and lends itself to a systematic process of review and synthesis and to the production of guidelines and protocols. In contrast, the loosely defined, methodologically heterogeneous, widely distributed, and hard-to-generalise research base for health care management is much more difficult to use in the same way.
> (Walshe & Rundall, 2001: 444)

Raphael (2000) argues for a need to adopt a pluralist approach when seeking to generate evidence-based knowledge in the broad public health field. She states that evidence-based approaches "emphasize experimental methods, quantitative data collection and analysis, and identification of linear cause and effect relationships" (Raphael, 1990: 358). 'Evidence-based' knowledge "does not extend to non-traditional methods associated with naturalist, ethnographic or critical approaches" (Raphael, 2000: 358). Objective truths (such as the presentation of facts arising from a scientific study) are presented as factual benchmarks that are developed to guide practices. Raphael (2000) highlights some of the tensions building from researchers and practitioners about the primacy of such evidence. She cites Macdonald and Davies (1998) in Quality, Evidence, and Effectiveness in Health Promotion:

> This traditional biomedical approach to evaluation has received a great deal of criticism in recent years and a consensus is undoubtedly emerging that an over emphasis on outcome measures and indeed on quantitative data is an outmoded and inappropriate way to measure the effectiveness of health promotion programs and interventions
> [Macdonald & Davies, 1998 in Raphael, 2000: 11].

They argue for greater pluralism when considering the nature of evidence and outline the weaknesses of the bio-medical hierarchy of research evidence:

> Its underlying ideology is expert-drive, authoritarian and dis-empowering, seeking evidence through narrow clinically based methods and short-term quantitative outcomes measures" [Macdonald & Davies, 1998 in Raphael, 2000: 12].

As in many contemporary studies on broad and multi-disciplinary workforces, the workplace, industry demands and methods of "providing the best information" (Hewlett in Booth & Walton, 2000: 64) in public health are rapidly changing to align with market demands (Kavanagh, Spence, Wilson & Crow, 2002; Roche, 2002). In his review of the changing professional landscape of health service information providers, Hewlett (2000) espouses the need for a mix of contemporary human resource development approaches in coordination with learning the 'right evidence'. In this example, 'the right evidence' relates to professionally targeted research databases and, where relevant, clinical patient data. The notion of professionally targeted sources of evidence, and in particular, an acknowledgement of the need to adhere broadly to the higher status of bio-medical research evidence is included in contemporary human resource narratives aiming to guide public health practices:

> Health service information providers, whether serving healthcare professionals, educators and students, industry or commerce or the general public, work in a world, which is rapidly changing. Technology is advancing, user expectations are expanding, and the structure and infrastructure of the work environment changes almost daily.
> In this context it is necessary to keep our skills updated and, if possible, move our skills forward in advance of the market. Professionally we need to keep our information services modern and dependable so as to provide the best information, the fastest service, [and] the right evidence for our users…
> (Hewlett in Booth & Walton, 2000: 64)

Here, the educational emphasis is on teaching or providing the right kinds of evidence to the health professional. The learner is primarily a passive recipient of the knowledge and rarely referred to beyond his or her professional affiliation. The dominant conception of education used by most health journals places an emphasis on teaching rather than on producing more competent and flexible learners. The evidence or knowledge transferred to the learners is produced as value-free and indisputable. Other forms of knowledge, namely those generated through participation, experience and reflection are rarely referred to. Clinical education and, to a large degree, public health education follows positivist principles: a reliance on imparting objective truths as facts and adopting reductionist approaches that identify and capitalise on a lack of information as the key target of teaching.

A British Medical Journal review undertaken by a professor of clinical epidemiology and biostatistics entitled "Research in medical education: Three decades of progress" describes a key turning point in clinical education under the sub-heading "Basic research in the acquisition of expertise":

> In the early 70s basic research into the nature of clinical reasoning pursued the hypothesis that expert clinicians were distinguished by the possession of general "clinical problem

> solving" skills. This was wrong; what emerged was that expertise lay predominantly in the knowledge, both formal and experiential, that the expert brought to the problem.
>
> This finding resulted in a new direction of inquiry, and a new generation of researchers attempted to uncover the ways that expert clinicians organise medical knowledge in their minds, using research strategies derived from cognitive psychology. Although the fruits of these labours are not yet ripe, the research has moved from purely descriptive research to experimental studies directed at a better understanding of the process and theory based interventions that promise to improve the effectiveness of instruction.
> (Norman, 2002: 1560)

Here, the key turning point for improved "effectiveness of instruction" in clinical education was an explicit valuing and reliance on experimental methods of research that "informed our understanding of learning, teaching and assessment in medicine" (Norman, 2002: 1560). Also contained in the summary is an explicit de-valuing of "descriptive research" and its capacity to generate legitimate evidence in educational research. This review is highlighted to demonstrate how a positivist, scientific agenda in educational research is validated. Empirical theory testing is concluded as the key methodology for conducting sound educational research for clinicians: "Real improvement in education, just like real improvements in medical treatments, will only result when we combine better the understanding of basic science with the experimental interventions." (Norman, 2002: 1562). This example is extreme and there are of course, multiple traditions within this broad field of public health. From a practitioner stand-point however, much of my work has involved a reliance on partnership approaches with clinical experts. Even in non-clinical fields of public health, clinical qualifications and expertise are valued qualities in educational work. As a result, modules and training programs become negotiated and assembled with varied experiential and didactic approaches.

Norman's (2002) key strategy that values "effectiveness of instruction" is aligned with Paulo Freire's banking concept of education (Freire, 1970: 53). Here, emphasis is placed on 'effectiveness of instruction' where learners are conceptualised as empty containers to be filled with knowledge by the expert (senior clinician). Freire summarises the shortcomings of this approach with respect to the kinds of learners it produces and the power imbalances it sustains between the learner and the knower:

> Education thus becomes an act of depositing, in which the students are the depositories and the teacher is the depositor. Instead of communicating, the teacher issues communiques and makes deposits, which the students patiently receive, memorize, and repeat…
> In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing…the more students work at storing the deposits entrusted to them, the less they develop the critical consciousness which would result from their intervention in the world as transformers of that world. The more completely they accept the passive role imposed on them, the more

> they tend simply to adapt to the world as it is and to the fragmented view of reality deposited in them.
> (Freire, 1970: 53 – 55)

In most cases in public health, with perhaps the greatest exceptions being from programs drawing from community development or community capacity building frameworks, learning and development programs do not aim to achieve praxis: "reflection and action upon the world in order to transform it" (Freire, 1970: 33). The goals are much less to do with transformational learning, critical consciousness-raising or liberation. Knowledge is not generated through dialogue, "re-invention" or "hopeful inquiry" (Freire, 1970: 53) but bestowed by senior clinicians. Put simply, knowledge within most public health learning and development programs is presented as indisputable for at least one of two reasons: the evidence or knowledge derives from scientific methods and is therefore unquestionable; and/or the teacher / senior clinician speaks from the position of scientific authority endorsed through their specialist qualifications. Knowledge is perceived as an artefact that is primarily transmitted, not generated.

Freire also argues that by conceptualising knowledge as a banking note, it is fixed and indisputable. Knowledge is not interpreted or re-invented by learners but passively accepted as truth:

> The teacher's task is to organize a process, which already occurs spontaneously, to "fill" the students by making deposits of information, which he or she considers to constitute true knowledge.
> (Freire, 1970: 57)

The relationship between clinical specialist / teacher and the "patient, listening objects" (the students) (Freire, 1970: 53) is hierarchical and well defined in public health. Imparting 'evidence based knowledge' appropriate to particular clinical professions is a technology that sustains the knower as (clinical) expert. Education serves to indoctrinate professional identities rather than facilitate the development of critical thinkers and collective action. Freire describes this form of education as a process of "indoctrinating [learners] to adapt to the world of oppression" (Freire, 1970: 59). In Norman's (2002) article outlining "three decades of progress", education is not transformative but merely a process of 'organising medical knowledge' to advance clinical best practice and to better define clinical expertise.

Nevertheless, evidence-based health care is now a key concept informing the management of health care organisations, the delivery of health care services and the ongoing development of health policy albeit with very different research bases and informed by multiple, interrelated and often competing professional traditions (Walshe & Rundall, 2001: 436). Public health education that purports to be evidence-based also remains vulnerable to multiple, interrelated and often competing ideas about what constitutes legitimate evidence.

## The broadening public health workforce

Defining the public health workforce is a predictably crude task when considering the multiple theories, approaches, professions and settings that public health occurs in. In 1995, the Commonwealth Department of Human Services and Health released a study that, among other workforce planning issues, sought to determine who constituted this workforce (Dept of Human Services and Health: 1995). This report began by defining the public health workforce as including "people who are involved in protecting, promoting and/or restoring the collective health of whole or specific populations (as distinct from activities directed to the care of individuals)" (Dept of Human Services and Health, 1995: 5). The study characterised the workforce as diverse and complex –acknowledging the many professions and activities that contribute to building public health:

> The findings do not point to any one group within the Public Health Workforce as a group of "public health specialists". Instead the findings suggest a workforce composed, as is any workforce operating in a service field characterised by diversity and complexity, of personnel from a range of professional/occupational backgrounds, most performing one major function but generally also involved in a number of other functions, each of which calls for the exercise of some specific expertise not always associated with that person's primary occupational designation or training.
> (Dept of Human Services and Health, 1995: 5)

Public health expertise can be informed by professional or occupational roles but is not restricted to these: "One of the main findings from the Study is the multi-skilled nature of the Public Health Workforce and the level of multiple functions performed." (Dept of Human Services and Health, 1995: 7). Public health practice reaches beyond narrowly defined professional and/or clinical roles. In fact, the study found that the majority of the Public Health Workforce sits outside of health and health-related occupational classifications and concluded: "the Public Health Workforce is more likely to be made up of members who do no classify themselves within the traditional professional groupings associated with clinical health care (Dept of Human Services and Health, 1995: 6). This professionally ambiguous profile is consistent with the broader profile of emerging workforces described in contemporary management and organisation literature (Foley, 2001; Matthews & Candy, 1999; Senge, 1990). Here, workforces are multi-disciplinary, multi-skilled and are increasingly working in ways that are collaborative, participatory and organisationally flatter:

> Multi-skilled, information-integrated workplaces require fewer levels of organisational hierarchy and lower formalisation to manage employees. In turn, flatter, more responsive organisational structures provide not only more rapid response capacities in the organisation to environmental change, but also employees with opportunities in which they can exercise new forms of skill, knowledge, responsibility and commitment.
> (Casey in Boud & Garrick eds, 1999: 22)

Multi-skilled and multi-disciplinary learning relationships convened through engagement in numerous and often overlapping, collaborative programs is now identified as a key (and often hidden) professional development process in workplaces (Solomon in Boud & Garrick eds, 1999: 130). Through dialogue and negotiation, public health programs –including learning and development programs, are increasingly based on principles of partnership that extend well beyond traditional health fields. Walshe & Rundall (2001) distinguish between the "disciplinary coherence" of the clinical workforce, which enables greater compliance with evidence-based practice through a shared professional culture; and the ill-defined and "highly diverse" health care management workforce which values "the application of ideas [as opposed to research] into practice" (Walshe & Rundall, 2001: 441). They argue that the professionally heterogeneous category of non-clinical staff "comes from academic disciplines in which observational methods are used, qualitative research is more accepted and may even be the norm, and there is perhaps a greater focus on theoretical development than on empirical theory testing" (Walshe & Rundall, 100: 442). Strategies for learning and teaching best practices are far less confined to those within the clinical culture of scientific research and knowledge.

Notions of professionalism are changing as well (Bloom & Clayton, 2002) whereby professional behaviour rather than the attainment of a professional qualification is increasingly understood as the mark of a professional (Cram, 1995). This behaviour is not disciplinary or fixed, but rather it's characterised by flexibility, collegiality and a willingness to collaborate. Harris et al (2002) describe this new professionalism as being predicated on practitioners being empowered by those changes which can be seen as opportunities, at the same time refusing to be disempowered by those which are seen as challenges to previously constructed identities (Harris, Simons, Symons & Clayton; 2002). Increasingly, worker identities are less bound by the attainment of disciplinary qualifications and increasingly recognised as a behavioural and in particular, adaptive and collaborative approach to work. In the context of worker identities, the convergence of interpersonal skills and a new professionalism blurs a coherent and fixed working definition of both.

## Towards multiple notions of best practice

What is considered 'best practice' in particular domains of public health has undergone significant changes. Among these is a greater recognition in the ways in which organisational structures and workplace-learning opportunities are valued (O'Connor-Flemming & Parker, 2001). More broadly, the term "the new public health" defined by Baum (2002) recognises the expanding terrain of public health activities in non-traditional health settings. These involve a greater range of interdisciplinary and multi-sectoral approaches and recognise the necessity for involving greater community input in the design, delivery and evaluation of health programs:

> The new public health is the totality of the activities organised by societies collectively… to protect people from disease and to promote their health. It seeks to do this in a way that promotes equity between different groups in society. New public health activities occur in all sectors and will include the option of policies which support health. They will also ensure that social, physical, economic and natural environments promote health. The new public health is based on a belief that the participation of communities in activities to promote health is as essential to the success of those activities as is the participation of experts.
> (Baum, 2002: 531)

According to Baum (2002), the new public health aims to "alter the socio-economic and physical environments in which we live…so that quality of life, well-being and health are enhanced" (Baum, 2002: 388). In practice this means involving a greater range of interest groups, and recognising the diversity in their roles and organisational cultures as well as the complex relationships between different sectors in society. Modern approaches to public health are, to a lesser extent, determined solely by traditional players in health (Baum, 2002). Now targeted settings such as local councils, schools, police, neighbourhood centres and corporations are invited early into the program planning phases when determining the process and outcomes for public health interventions.

### Change within a field of public health: Health promotion

The field of health promotion is one of these domains undergoing considerable change and expansion in theoretical models, program approaches and emerging vocational education and training packages (CSH Industry Skills Council, 2004: 4). Health promotion is a particularly relevant field in public health education because it has its roots in individualistic, behavioural approaches to health education (NSW Health, 2003: 28). This focus on behavioural risk factors is also reflected in the program management structures and resource allocations that frame the work of health promotion practitioners (NSW Health, 2003: 4). Like the new public health, health promotion is undergoing an expansion in theories, approaches and people (both government, private and community) involved in health promoting activities or programs (NSW Health, 2003). In NSW, the organisational structures within which health promotion is managed are reorienting to combine health promotion and public health services within Divisions of Population health (NSW Health, 2003: 3). Growing from its once limited focus on changing individual behaviours (Baum, 2002: 532; NSW Health, 2003), health promotion activity now embraces a much more sophisticated and holistic set of variables recognised for their roles in affecting well-being:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

(WHO, cited Aug 21, 2003 http://www.who.int/hpr/archive/docs/ottawa.html)

With a growing national health policy focus on "healthy ageing strategies and prevention and management of lifestyle and/or chronic diseases (CSH Industry Skills Council, 2004: 4), health promotion is a field where an increasingly diverse range of professional and community groups participate. Its three main approaches of medical, behavioural and socio-economic (Baum, 2002: 311) provide room for a broad spectrum of educational models, interventions and inter-disciplinary approaches. Educational activities in this field are often embedded in the language of program planning and evaluation. Often referred to as 'social interventions' (Eager, Garrett & Lin, 2001: 240), rather than explicitly educational, health promotion programs embrace a broad and variable array of educational models and approaches:

> Program planning for health promotion occurs in a wide range of settings –workplaces, schools, hospitals–and can be locally, regionally or nationally based. A program can emphasise personal skill development, self-help actions, developing support in a community/group or community action, and advocating for policy change. The target group can be universal (the whole population) or selective…A program can be 'imposed from above' …it can derive from a local needs assessment [or] it can be 'imposed' through the interests and skills of a particular health worker…A program can be firmly situated within a health service or it can operate intersectorally.
> (Eager et al, 2001: 240)

In a recently published discussion document entitled "Strengthening health promotion in NSW; a map of the work and implications for workforce planning and development" (NSW Health, 2003), this re-orientation towards a broader, more holistic and inter-sectoral approach to working poses particular challenges to a workforce who has traditionally worked within a narrower health framework that focuses primarily on risk behaviours:

> Considerable policy and infrastructure support will be needed to support the reorientation of the workforce to achieve a greater balance between action on the major causes of morbidity and mortality and associated behavioural determinants; and wider social and environmental determinants of health.
> (NSW Health, 2003: 4)

The table below from Baum (2002) provides a key example of how different approaches to program design and education in the broad field of health promotion can influence the work practices, worker identities and the relationships needed to form productive partnerships among colleagues.

Table 1 A parison of behaviorally driven health promotion and organisational approaches

| BEHAVIOURALLY DRIVEN HEALTH PROMOTION | ORGANISATIONAL APPROACHES |
|---|---|
| Strategy is individual behaviour change and only relates to individual users or employees | Aspects of the activities of the organisation and its relationship with the community are seen as part of health promotion mandate |
| Optional health and safety and physical risk factors for most. Does not take account of broader impacts on health. | Is based on broader conception of health akin to Labonte's Basic environmental perspective. Takes account of the wide range of moral, social and economic factors. |
| Is not based on participative principles | Encourages active participation of all groups of people associated with the organisation as central to health promotion. |
| Optional health services are concerned with screening and disease prevention | Optional health services are seen as having a broader role, including health education implementing health policies and practices, environmental improvements. |
| The organisation operates in relative isolation | The organisation establishes alliances and networks to assist with the task of health promotion. |

*Edited table (Baum, 2002: 381)*
*A comparison of behaviourally driven health promotion and organisational approaches*

Using a health-promoting organisational or 'settings-based' approach in public health requires the adoption of particular sets of organisational learning-related skills:

> The new directions point to the need to ensure that the health promotion workforce, in particular, is highly skilled in core areas such as the development of strong partnerships and in community capacity building, consultation and advocacy for the development and implementation of health and public policy.
> (NSW Health, 2003: 5)

The workplace health promotion approach targets individuals by the organisations they work in and work with but also considers the structural factors within these organisations. The rationale for this approach is that by working at an organisational or 'systems' level in everyday settings such as schools and workplaces, program outcomes will be more sustainable (Harris, et al, 1999: 51). Using this model, health promotion practitioners adopt the role of a facilitator of organisational change (Nutbeam & Harris, 1998: 56) that involves influencing people's behaviour as well as activities and policies of other organisations. Educational methods move from that of individual instruction to that of facilitating group dialogue. Outcomes are measured through a broader repertoire of both individual and organisational activities. The role of the educator moves from that of an instructor (clinical specialist) to that of a negotiator or leader who is able to articulate program

visions or aims and is capable of motivating disparate professional groups to work towards common goals. Within organisations, the facilitation of learning is often articulated through participatory and collaborative management practices. Matthews and Candy (1999) describe the role of management as increasingly having to facilitate multi-disciplinary learning within organisational frameworks. Management practice is "a complex and subtle process of developing learning opportunities and facilitating flows of information" (Matthews & Candy in Boud & Garrick eds, 1999: 53).

Goodman, Steckler and Kegler (1997) describe more challenges that arise for health promotion practitioners' using this framework:

> Organisations are layered. Their strata range from the surrounding environment at the broadest level, to the overall organisational structure, to the management within, to work groups, to each individual member. Change may be influenced at each of these strata, and health promotion strategies that are directed at several layers simultaneously may be most durable in producing the desired results. The health professional who understands the ecology of organisations and who can apply appropriate strategies has a powerful tool for change.
> (Goodman, Steckler & Kegler, 1997 in Nutbeam & Harris, 1998: 56)

To address a range of health-related issues at the workplace, including environmental issues, this approach requires strategies that seek to target ways in which the culture of the organisation moves to that of a learning organisation. The work practices of health promotion practitioners who adopt this public health approach require different planning indicators and outcomes for their work. These outcomes would include working towards supporting the development of a learning culture in which

- Risk taking is encouraged and it is okay to make mistakes
- Change is seen as a learning opportunity
- There are common goals, and progress towards them is regularly and openly reviewed
- There is acceptance that people have differing views and that these need to be heard
- Information is sought from outside the organisation and acted on, even if it challenges the organisation's direction; information is shared with other organisations
- The organisation has formal and informal structures and processes that enable it to respond to changes

(Auer, Repin & Roe, 1993 in Baum, 2002: 383)

Re-orienting the skills, knowledge and relationships needed for the health promotion workforce to adopt this broader, inter-sectoral approach poses great challenges –particularly with respect to the way in which workers have historically identified in terms of being 'content' experts on discreet health topics. The NSW Health (2003) report on implications for workforce planning in this sector highlights this tension:

> The work has demanded that the workforce be comprised, largely, of individuals with specialist 'competence' to develop interventions to address specific public health problems…Workers may be reluctant to move away from [these] specialist areas where they have invested considerable energy developing a high level of 'content' knowledge. (NSW Health, 2003: 20)

The report recommends an educationally ambiguous strategy to support the workforce in reorienting their work practices, skills and relationships: "It will be necessary to ensure that the highest quality education and training is available to support building of knowledge and skills in these emerging areas" (NSW Health, 2003: 5). Again, what constitutes 'highest quality' education within such an expanding, multi-disciplinary workforce is not explicit. Instead, sustainable systems for ongoing 'workforce development' in this field are recommended. These include the need for an active performance management system and the need for active management support and encouragement (NSW Health, 2003: 6). Basing the 'highest quality education' on evidence in this field is also problematic as there is "little formal evidence that might be termed 'good or best practice' to guide action (NSW Health, 2003: 22). Currently the rhetoric for this new way of working, namely the principles and philosophy of inter-sectoral health promotion, lags behind a comprehensive set of programming, educational and evaluation practices or frameworks.

With the broadening scope of health promotion; the multiple professions involved in planning health promotion activities; the traditional skills sets and pools of content expertise; the dominant use of program planning and management language that obscures specific references to educational approaches; and the flexibility of the model to embrace both top down approaches ('imposed from above') or community driven ones makes the field of health promotion an educationally broad yet ambiguous one.

## Guiding frameworks: Capacity building and the rhetoric of partnerships

NSW Health Department has also produced a range of policy and service planning documents that aim to guide public health practitioners, clinicians, health service managers and educators in this approach. The capacity building or human resource management framework advocates for the need to take a much broader approach to the facilitation of learning –one that involves groups of multi-disciplinary professionals and takes into account organisational and community contexts. Here learning is viewed as:

> …a process initiated within organisations and communities, in response to the identified strategic priorities of the system, to help ensure that people working within these systems have the abilities and commitment to contribute to organisational and community goals (NSW Health, 2000: 12).

"A framework for Building Capacity to Improve Health" (NSW Health 2000) is a NSW Health departmental document aiming to guide the development of effective capacity building practices within health promotion activities (NSW Health, 2000: 1). It outlines the overall rationale for such an approach:

> Building capacity to improve health is an important element of effective health promotion practice. It increases the range of people, organisations and communities who are able to address health problems, and in particular, problems that arise out of social inequity and social exclusion.
> (NSW Health, 2000:1)

The framework lists a range of principles, strategies and key action areas to guide work in this area. These include respecting and valuing pre-existing capacities (for people and organisations); developing trust, being responsive to context, avoiding pre-packaged ideas and strategies and developing well planned and integrated strategies (NSW Health, 2000: 5 – 7). A series of program planning and evaluation indicators for such work is listed.

However, this organisational approach to health promotion is one of many concurrently endorsed frameworks that guide the broad public health workforce in their educational and clinical work. Today most program evaluation frameworks within the public health field of learning and development still tend to honour a positivist approach (Adams, Amos & Munro, 2002) with indicators generated around behavioural learning outcomes, skills assessment indicators and even the measure of the number of learners attending training programs. The last factor is largely an accountability mechanism, but remains a significant form of evidence for program funding providers.

The health belief model for example, is a prominent and frequently sited health education theory that assumes that individual behaviour is the primary outcome of interest for educators. Accordingly, if the educator aims to modify beliefs, "they can change the perceptions of benefits and costs of preventive health behaviour and therefore contribute to changes in behaviour" (Freudenberg, Eng, Flay, Parcel, Rogers & Wallerstein, 1995: 293). The focus is on changing individual behaviour rather than organisational capacity. The curriculums, role of the educator and assessment instruments are tailored to fit this behavioural learning theory. Skills in facilitating critical thinking that will lead to collective action; or to initiate changes that are then diffused through existing channels of communication (Freudenberg et al, 1995: 294) would infrequently be utilised under this broad health education theory.

Learning programs such as these rarely provide useful, critical feedback that can assist learning and development practitioners to reflect on how they may better understand the changing contexts of their work. What counts as legitimate educational evidence in my changing professional field remains a contested issue. However the notion (and rhetoric) of 'evidence-based' knowledge and program design is a common and often ambiguous phrase used to describe and defend the legitimacy of our work.

The public health field is a very broad one consisting of people from community groups, clinicians, epidemiologists, health promotion practitioners, midwives, counsellors and arguably, any paid or volunteer practitioner who is involved in 'promoting' particular public health agendas. Each group of public health practitioners become inducted into particular educational models and traditions. For instance, community-based health educators work primarily within educational traditions of community development and radical educational frameworks (Amos in Adams, Amos & Munro eds, 2002: 62). Learning is socially constructed in that individuals interact with and interpret their environments. Professional clinical update training packages tend to honour a behavioural approach to learning programs (such as those informed by the health belief model) whereby pre and post-test examinations are used to determine the extent of learning or behaviour change. Teaching is predominantly expert-driven and learning is assessed by the attainment of specified behavioural learning outcomes. This approach is commonly used in nurse training or through statewide NSW Health funded training providers.

The goals, strategies and philosophies of what constitutes legitimate education vary among professional groups. Adams et al (2002) argue that professional divisions within public health hamper not only multi-disciplinary approaches to learning and knowledge development but that they can promote professional competitiveness and mistrust:

> The idea of improving health through democracy, participation, equality or accountability is barely grasped. One related issue is that of professional division and isolation. Different understandings of health and how to promote it have resulted in competing and sometimes mutually suspicious professional groups…
> (Adams et al, 2002: 180)

Despite this, public health learning and development practitioners are increasingly directed to engage in intersectoral collaboration (O'Connor-Flemming & Parker: 2001:40). The first National Health Workforce Strategic Framework (Australian Government, Dept. Health and Aging, 2004) was released in 2004 to "guide national health workforce policy and planning throughout the decade" (Australian Government, Dept Health and Aging, 2004: 2). Beyond stating a key principle of "ensuring the health workforce is always skilled and competent" (Australian Government, Dept Health and Aging, 2004: 2) the Framework describes and advocates for intersectoral cooperation and coordination in program delivery:

> It is expected that stakeholders will work with much more cohesion and that actions will be better coordinated across jurisdictions, service settings, professional groups, consumer and carer organisations and the education, training, regulation and industrial sectors to maximise the nation's investment in its health workforce and our ability to improve the health and well being of the Australian Community.
> (http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-mediarel-yr2004-jointcom-jc004.htm, cited 17 January 2004)

The 'partnership approach' is also a common element underpinning most national and state blood borne virus strategies (Commonwealth Department of Health and Aged Care, 2000: 9; Commonwealth Department of Health and Aged Care, 2000: 12). State and National strategies are broad governmental frameworks designed to provide directions for the prevention, treatment, management and surveillance of particular health issues. A partnership approach is a common guiding principle now informing many public health strategies. A partnership approach in the Australian National HIV/AIDS Strategy, for example, is defined as:

> …an effective, cooperative effort between all levels of government, community organisations, the medical, health care and scientific communities and people living with or affected by HIV/AIDS, all working together to control the spread of HIV and to minimise the social and personal impacts of the disease. It is based on a commitment to consultation and joint decision -making in all aspects of the response….
> (Commonwealth Department of Health and Aged Care, 2000: 9)

This partnership principle is further echoed in most local public health business planning strategies. In NSW control of communicable diseases is locally managed through multi-disciplinary networks of public health practitioners:

> In New South Wales, communicable disease prevention is coordinated primarily through the public health network of local public health units, and the NSW Department of

> Health's Centre for Health Protection, in partnership with diagnostic laboratories and clinicians. At a local level, public health units work closely with other employees of the area health services, providers of primary and specialist health care, other governmental and non-government agencies, and the community, to ensure that control programs are successfully implemented….The control of communicable diseases depends on the coordination and effective functioning of a network of public health practitioners.
> (NSW Public Health Bulletin 2003; 14(9): 200)

More broadly, public health partnership approaches have been widely endorsed as a means to promote health across sectors (Baum, 2000: 513). The National Public Health Partnership (NPHP) provides a formal structure for the Commonwealth, States and Territory governments to come together to develop a joint Australian intergovernmental agenda for public health.
The Objectives for the NPHP are to:

a. identify and develop strategic and integrated responses to public health priorities to guide and support governments and service providers;
b. establish two-way exchange with key stakeholders on the development of national public health priorities and strategies;
c. develop better coordination and increased sustainability of public health strategies; and
d. strengthen public health infrastructure and capacity nationally.

(http://hna.ffh.vic.gov.au/nphp/about/tor.htm, cited: 31 March 2004).

### Knowledge development through multi-disciplinary and multi-sectoral collaboration

The enhancement of public health professional practices was initially a primary focus of the Partnership in response to the recognition of the growing complexity and interconnectedness of public health issues. Cooperation and collaboration across sectors is viewed as a key professional practice strategy to address increasingly complex health and environmental issues (Baum, 2000: 513). With a growing emphasis on more collaborative and multi-sectorial approaches to public health practice –endorsed in national and state policies, public health planning frameworks and increases in short-term collaborative projects, the public health workforce is undergoing significant changes in the ways in which knowledge, work, and professional identities are continuously shaped. The learning required to undertake partnership programs now requires an increasingly "social and dynamic" (Matthews & Candy, in Boud & Garrick, 1999: 54) approach:

> No longer are the pools of knowledge and expertise acquired in initial education sufficient for 'the new work order'. What is now required are abilities to put that knowledge and expertise to use in unfamiliar circumstances, and so we find demands for 'flexibility', 'communication skills', 'teamwork' and so on.
> (Casey in Boud & Garrick, 1999: 4)

As public health interventions become increasingly oriented towards a multi-disciplinary and multi-sectorial project management approach, professional expertise increasingly becomes a commodity that contributes to "process-oriented, collective and pragmatic" (Barnett in Garrick & Rhodes, 2000: 23) working knowledge. In other words, public health practice, whether it's clinical, population health focussed or educational requires a greater emphasis on collective discussion and collaborative knowledge development in action, rather than a reliance on any one professional body of expertise.

Despite the dominant, positivist definitions and methodologies that become known as public health, I argue that within this field, there are a number of interrelated models of educational work at play being enacted by a broad ranging and disparate group of public health practitioners who undertake learning and development activities. These models are at times, supported by emerging planning frameworks such as through capacity building approaches or by principles of collaboration and partnership that are espoused in key governmental policy and planning documents. Professional and community groups come with different experiences and pedagogical traditions and often very different ideas about what constitutes legitimate evidence. As one of these practitioners, I argue that these competing and often overlapping models of education and evaluation have led to a great deal of conceptual confusion about what constitutes legitimate work practices, skills and knowledge in this field as well as the ways in which we, as learning and development practitioners identify at work.

The next chapter provides a case study for my professional work and where possible, makes specific reference to emerging frameworks and principles that inform and change my practice. The rationale for this history is to illustrate in more detail, the changing nature of work, learning and worker identities. It also describes very different forms of work that sought different outcomes requiring changed relationships with colleagues and other learners. It is through these professional shifts that I came about developing my standpoint of investigation.

# Chapter 3

# Mapping My Professional Histories:
## A case study in changing pedagogical traditions

Having identified some of the concurrent pedagogical approaches to the broad field of public health education along with an acknowledgement of the expanding list of people who develop educational interventions (including both government and community, professional and volunteer workforces), I will now map my own public health educational work, highlighting the divergent theoretical frameworks, work practices and relationships that evolved with both the learners and my colleagues. The rationale for mapping my professional experiences in public health is to demonstrate how my participation with particular pedagogical traditions directly influences and shapes my skills, relationships and my shifting worker identities. It is these experiences of change that prompted me to take a broader look at how others in the field manage multiple approaches and develop a shared and coherent understanding of the educational work they're currently undertaking. This chapter concludes with an analysis of how particular health policies and planning frameworks align with emerging aspects of organisational and interdisciplinary learning activities that encourage less traditional and more interdisciplinary approaches to educational work. In particular, I draw on the rhetoric of partnerships, the continued need for increased professional integration and continuous learning to promote current program approaches that produce situationally (workplace) relevant learning outcomes through group participation. Lastly, I highlight this recurring theme of facilitating knowledge production through professional practice networks, or 'communities of practice' to support my rationale for using these networks as units of analysis for my investigation.

The areas in which I've been employed to facilitate learning include HIV/AIDS and related discrimination; alcohol and other drugs and hepatitis C including a range of related public health topics, health promotion frameworks and, more recently, generic group problem-solving and workplace-based learning programs. These health issues continue to disproportionately affect people from disadvantaged or marginalised social networks and communities.

### HIV/AIDS Community Development and Peer Education Officer

Earlier in my work, as a community development officer based at a non-government HIV/AIDS agency, peer education and community development frameworks informed most of the learning activities I facilitated. The majority of educational efforts targeted gay and other homosexually

active men during the late 1980's and throughout the 1990's in Australia. These have been through State and Territory AIDS Councils (Commonwealth Dept, 1998: 51) which are non-governmental gay community-based agencies. The HIV epidemic in Australia has had the greatest impact on gay men with over 80% of those tested positive to the virus (where exposure category is known) being homosexually active men (Commonwealth Dept, 1998: 1). Emerging in 1983 as an action committee of gay men to respond to the HIV/AIDS, the AIDS Council of NSW (ACON) worked primarily with gay men to fight the epidemic and to influence a health system to develop non-discriminatory public health prevention programs targeting gay men. Many of the workers and volunteers within HIV/AIDS Councils had extensive experience in gay activism and/or gay health since the early 1980s (Dowsett, 1996: 68). Educational activities during the late 1980's to mid-1990's were characterised by peer-based prevention programs focussing largely on reducing high-risk behaviours to prevent HIV transmission among gay and homosexually active men (Dowsett, 1996: 37). Peer education was often defined in training facilitator's manuals and in health department guidelines using behavioural terminology

> …a set of specific education strategies devised and implemented by members of a subculture, community or group of people for their peers … where the desired outcome is that peer support and the culture of the target group is utilised to effect and sustain the change in behaviour.
> (ACON, 1996: 4)

This peer framework to education capitalised strongly on "an existing culture of considerable open discussion on sex among gay men" (Dowsett, 1996: 69)

> …in relation to the Rural Project, this means gathering rural gay men together to talk with each other, share information, skills and mutual support around the issue of HIV/AIDS…having similar experiences or characteristics means peers can often appear more credible and have a strong influence on each other's attitudes, values and behaviours.
> (ACON, 1996: 4)

This approach was largely successful in the early stages of the epidemics, however, many of these types of prevention programs lacked a consistent and detailed approach to program evaluation. Prevention education was done 'on the run', with little time for determining programmatic measures for success and very little scope for reflecting on the efficacy of different educational methods

> …the lack of documentation of the inputs to and the outcomes achieved by the activities that have formed the core of Australia's education of gay and other homosexually active men has hampered the development of benchmarks of good practice in relation to different educational methods.
> (Commonwealth Dept, 1998: 44)

HIV prevention education programs in Australia have largely targeted the specific behaviours that place people at risk for HIV infection.

> The framework being utilised in HIV/AIDS politics and public-health patois was of a simplistic modification in 'behaviour', akin to giving up nicotine, alcohol or chocolate. (Dowsett, 1996: 73)

## Radical education within a community development program

The Rural Project was a small, community development project I worked on based in a state-wide non-government HIV/AIDS agency that aimed to raise awareness of HIV/AIDS and contextually appropriate prevention strategies among rural gay men and to address HIV/AIDS-related discrimination and homophobia. The model of education adopted reflected a social transformationist (or radical) philosophy of education. The goals were emancipatory and adopted learning strategies that drew from participants' life histories, engaging them in critical dialogue and ultimately supporting them as Foley (1995) argues by "chang[ing] the learners' perception of the world from a given they must fatalistically accept to a world upon which they could act in order to bring about change" (Foley, 1995: 73). This approach assists participants to acquire skills specific to their own stories and social contexts and encourages the learners to use these contexts as a basis for understanding and analysis. Here, education is not 'objective' learning, but is firmly rooted in and relevant to the everyday lives of the learners (Shor & Freire, 1987).

At this agency, community development was the driving framework that informed most of our learning activities. It is a process "through which community members take collective action to generate solutions to reaching common goals" (Dureau & Winterford, 2003: 3). Empowerment education programs called, for instance, Peer Educator Training Workshops were developed and facilitated for rural gay men on issues of self-esteem, HIV/AIDS awareness, HIV/AIDS discrimination and homophobia, and skill-based curriculum on lobbying local councils, convening meetings, and other community mobilising activities. Informed by the writings of Paulo Freire, these workshops aimed to involve community groups, and in this case, gay men, in group efforts to "identify their problems, to critically assess social and historical roots of problems, to envision a healthier society, and to develop strategies to overcome obstacles in achieving their goals" (Wallerstein & Bernstein, 1988: 380). Contextual learning is located within a social constructivist approach to the facilitation of learning in that "individuals learn by constructing meaning through interacting with and interpreting their environments" (Imel, 2000: 3). Here learning is recognised as a social, collective and generative process rather than one in which is based in an individual cognitive-behavioural learning approach. The learning activities sought to create change on a personal, interpersonal and political level (Gutierrez & Lewis, 1995 in Minkler & Wallerstein, 1997: 251). For instance, the Peer Education Training workshops were designed in the first instance, to raise a sense of individual self-esteem and to reduce internalised homophobia among participants. Activities were implemented that sought to capitise on both good and bad experiences of growing up as a gay man in a rural context. Methods used included Freire's listening-dialogue-action

approach (Freire, 1970) whereby rural gay men's experiences were shared and broad generative themes were identified so that participants "jointly construct a shared reality of themselves as individuals in their social context" (Minkler & Wallerstein, 2003: 42). The aim of the process was both of individual self-esteem raising (psychological empowerment) and of a broader critical consciousness raising among members of the group to affect systemic change. The frequently used concept of empowerment was often sited by participants as a anticipated outcome of the workshops : a social-action process through which individuals, communities and organisations gain mastery over their lives in the context of changing their social and political environment to improve equity and quality of life (Rappaport, 1984 in Minkler & Wallerstein, 1997: 251). Therefore, the learning that occurred in these workshops was a process of social-action in that these men were "not objects or recipients of political and educational projects, but actors in history, able to name their problems and their solutions to transform themselves in the process of changing oppressive circumstances" (Wallerstein & Bernstein, 1994: 142).

There is a great deal of health education and prevention literature that support the case that empowerment education is an effective health education and prevention model used to affect personal and social change (Bersgma, 2004: 153). This is particularly relevant to marginalised, disadvantaged or vulnerable population groups (Harris et al, 1999; Kendall, 1998; Wallerstein, 1992, 2002).

The Project embedded principles of community development in its evaluation frameworks in an attempt to measure its worth and, importantly, to generate evidence to support its continued funding. Again, outcome measures such as listing contacts gay men have made with rural HIV/AIDS-related health professionals and local council members (increased access to bargaining power); monitoring the frequency of and attendance at gay and lesbian social and education events (increase in frequency of community events); monitoring any increases in funding to HIV/AIDS services in regional areas (increased access to resources) and even documenting participation in urban gay and lesbian cultural events were deemed as appropriate indicators of success. Another important but crude program evaluation indicator was the number of peer-based support initiatives (also called occasions of service) rural gay men were able to undertake with each other as a result of the workshop.

Programmatically, outcomes were measured simplistically and creatively to align with both program planning guidelines (and program reporting requirements) and community development principles. Interactive evaluation principles were selectively used to support the project aim of self and community empowerment. Owen and Rogers (1999) describe the position of the evaluator or program manager using this framework: "If outsiders are involved they are involved on the terms set by providers –that is, outsiders are not there to hand down knowledge" (Owen & Rogers, 1999:

220). The community development officers had multiple roles using this framework that included secretariat and administrative support, facilitation, project management and social marketing specialists. Input and support rather than strategic direction and assessment were key roles for the Rural Project community development officers. The evaluation framework sought to capitalise on emerging themes stemming from life experiences of participants and the resulting activities participants initiated to address these themes.

> The model is thus predicated on the adequacy of local expertise to deal with local problems and to recognise the need for outside assistance when it is needed. In such a scenario, there is an assumption that external knowledge – and in particular accumulated research-based knowledge – is of lesser relevance then 'local' knowledge.
> (Owen & Rogers, 1999: 220)

The skills required for the development and facilitation of these workshops included active listening, language sensitivity, diplomacy, facilitation, and the ability to mobilise resources (Dureau & Winterford, 2003: 8-9). The role of the community development officer in these workshops was that of facilitating the naming of the problems (through shared dialogue) and solutions for themselves and to create the conditions for professionals and communities to engage in empowering practices together. The intended program outcomes were in some ways, partially known or predictable: improve self esteem, share problems, identify themes (homophobia) and develop linked community and public health strategies. However, the collective knowledge and awareness common among these men was produced by the group sharing activities. Freire's philosophy of learner-as-subject loosely directed the facilitation of a 5-step questioning strategy: (1) participants describe what they see, feel and hear (2) as a group they define the problems (3) they share similar experiences and examples (4) they question why this occurs (5) they develop action plans (Wallerstein & Bernstein, 1988: 383). Later, I will draw similarities between this process of facilitating 'authentic dialogue' with community groups, and processes of facilitating action learning circles among multi-disciplinary teams of health workers in health service settings.

### The significance of gay identity within HIV/AIDS education

Sexual identity politics also played a large role for me as a community development officer working in a community-based organisation developed primarily by gay men for gay men. For gay men collectively fighting homophobia and HIV-related discrimination in Australia in the early 1990s, identity politics was an effective group-based movement to build learning relationships and trust with gay peers, and to use experiences of exclusion or powerlessness on the basis of sexual orientation as a common starting point for men to begin to transform their political circumstances – usually through collective action. For the purposes of this community development project, identity politics was

> …a demand for recognition on the basis of the very grounds on which recognition has previously been denied…The demand is not for inclusion within the fold of "universal humankind" on the basis of shared human attributes; nor is it for respect "in spite of" one's differences. Rather, what is demanded is respect for oneself as different. (Kruks, 2000: 85).

It was by articulating this difference –through structured activities whereby gay men recounted experiences of exclusion, violence and public health neglect, that collective starting points for action could occur. According to Freire (1970) it is this process of describing oppressive circumstances in their own words and using their own experiences which leads to "transforming action": The more the people unveil this challenging reality which is to be the object of their transforming action, the more critically they enter that reality …and through praxis commit themselves to its transformation (Freire, 1970: 35 - 36). Transformation in this instance was articulated as better access to HIV-related information, prevention and health services; anti-homophobia strategies and campaigns; lobbying tools for working with local councils and health services; and a network of rural gay men for peer-based support and partnership activities.

My identity as a gay man contributed significantly to the legitimacy I needed to facilitate these peer led activities. Key skills or traits needed to facilitate these groups included: the ability to identify as a peer / gay man where possible; empathise and to take an informal, and at times, personal approach to leading group discussion. Often my own experiences were used as a prompt for discussion points with the group. Core skills in advocacy, facilitation and opportunistic interventions (brief episodes of counselling) were also required. The boundary between the personal and the professional was blurred –a frequent occurrence in community-based organisations (Duran & Wallerstein in Minkler & Wallerstein, 2003; Eager, Garret & Lin, 2001). My relationship with clients (rural gay men) was often spoken of in terms of being a community resource or advocate rather than as a professional educator or trainer. The division between trainer and learner within this Project was intentionally blurred. Memberships to the group, an identification with and empathy for the lived experiences of the community and core skills in advocacy, facilitation and program planning were key characteristics of this work. In later job roles, the skill sets and relationships have needed to shift to match more organisational and business planning goals rather than specific community-based ones.

### Professional Development Officer

A few years later I was employed as a professional development officer for a statewide government training organisation targeting alcohol and other drug workers in government and community-based organisations across the state. The job title clearly reflected the competencies for the position: the development of training-based calendar courses employing, for the most part, individual behavioural learning outcomes as key assessment benchmarks. The position was training-

room focussed and the distinction between trainer and learner was clear. The curriculum was essentially the same each time a course was offered and learners were offered to volunteer workplace examples to demonstrate the foundations of a public health framework or related issue. The training primarily targeted alcohol and other drug workers in both community and government settings, with frequent participation of related workforces such as those working in hepatitis C, HIV and sexual health fields. This 'off-the-job' training approach relied heavily on: skills in presentation; curriculum design informed by experts in the field; the development of assessments based on individual behavioural learning outcomes; and the development of training modules and texts that explicitly direct the learner to attain these outcomes. Content expertise was central to the delivery of this training. The professional development officers who provided training were from a range of clinical, health promotion and community-based backgrounds. The curriculum, although assessed primarily through the application of behavioural benchmarks, was broad and informed by multiple professional perspectives. For example, the HIV/AIDS Orientation Course for Alcohol and Other Drug Workers had a mix of didactic public health, epidemiological and clinical overviews, but also incorporated group problem solving tasks and activities to assist practitioners to examine their values and attitudes towards issues of sexuality, HIV and health access.

The professional skills required for this job were in curriculum design, presentation, facilitation, program evaluation and a range of informal and formal liaison and professional consultation activities. As a Professional Development Officer, skills were recognised via professional disciplines. That is, it was the professional skills (rather than personal affiliations or identifications with community) that were recognised. For instance, counsellors and rehabilitation workers would provide skill-development workshops on counselling and opportunistic interventions with clients. Knowledge too was primarily viewed within a highly segmented professionalism. Clinical specialists would speak on medical conditions and pharmacology to workers in the field. Again, the transmission model of learning was a particularly strong feature of this training program – particularly on topics that were closely aligned with clinical knowledge and skills. Despite this, the curriculum had a mix of educational approaches – much of this due to the broad mix of Professional Development Officers bringing with them their diverse experiences. It would be too reductionist to conclude that the training provided through this work solely aligned itself with behavioural learning theories and that all training was didactic, mechanistic and framed solely through professional areas of expertise. Indeed, many clinical specialists actively drew on the experiences of the learners in their workshops. Some even ventured into facilitating games and simulations to stimulate problem-based learning and to draw cautiously on some of the personal experiences of the learners, particularly when addressing issues of values and attitudes in public health. Reflection on current practices, dialogue and problem-solving through collaboratively developed case studies were frequently used educational approaches. In many cases the curriculum was supplemented by the trainers ability to engage with, motivate and support the learners.

However, the calendar of courses offered gradually received fewer enrolments and a governmental restructure saw the closure of this statewide education agency. As well, funding allocations to sustain the provision of these training courses became threatened at a time when 'training' as the primary solution to addressing learning needs of a broad workforce came into question by research centres such as the National Centre for Education and Training on Addiction. In her paper entitled "Workforce Development; Our national dilemma" (Roche, 2002), Roche critiques the sustainability of training-based interventions for the AOD workforce by highlighting a recent paper by Simpson (2002) that measured transfer of knowledge 'provided' by training to workplace settings

> Traditional training approaches are fraught with difficulty and most common training methods are associated with levels of transfer failure in the range of 80 – 90%, that is in 80 – 90% of cases the content of the training programs is not translated into professional practice (Simpson, 2002 in Roche, 2002: 14)

Roche (2002) proposes that the directions needed for the development of the AOD workforce have 'parallels' with more systemic and holistic public health frameworks such as the Ottawa Charter for Health Promotion. The Charter was a product from the first International Conference on Health Promotion and proposes key areas of action to achieve 'health for all' globally.

### Training versus a broader workforce development agenda

Roche (2002) argues that the Charter "provides a useful springboard" (Roche, 2002: 14) to assist learning and development practitioners to think more broadly about the factors that affect individual learning as well as more systemic responses and strategic approaches to workforce development. Roche outlines the five components of the Ottawa Charter and proposes parallel activities for workforce development:

| OTTAWA CHARTER FOR HEALTH PROMOTION | AOD WORKFORCE DEVELOPMENT PARALLELS |
|---|---|
| 1 Build policies which support health | 1 Develop policies that support workforce development |
| 2 Create supportive environments. | 2 Create supportive work and management environments. |
| 3 Strengthen community actions | 3 Strengthen community involvement |
| 4 Develop personal skills | 4 Develop professional skills. |
| 5 Reorient health services | 5 Reorient health and welfare services to better support clients. |

(Roche, 2002)

Roche (2002) argues that a multifaceted approach to workforce development is required to facilitate and sustain the AOD workforce: "Unlike more traditional approaches, it is broad and

comprehensive, and incorporates more than just education and training of individual frontline workers. The primary aim is to facilitate and sustain the AOD workforce. It does this at different levels, targeting individual, organisational and structural factors" (Roche, 2002: 9). The language for this model of education borrows explicitly from health promotion theory, but also from organisational capacity building approaches that focus on learning goals articulated by identified strategic priorities. Learners become 'workforces' to sustain. Learning outcomes become strategic priorities. And training becomes a somewhat generic term that brings workers together to learn using a broad range of pedagogical approaches.

As a Professional Development Officer, skills in curriculum design, training, facilitation and program evaluation were explicitly called for in the essential and desirable criteria for the job. All Professional Development Officers working in the centre also had a specialised area of expertise – usually defined through a professional body of knowledge. Therefore, the Professional Development Officers who were social workers or counsellors (either in the past or as consultants) usually had carriage of curriculum and training relating to psycho-social aspects of alcohol and other drugs. Those Officers who have nursing as a profession (again, either in the past or as contract or agency nurses) would have carriage of more clinical or pharmacological components of the curriculum. The Professional Development Officers' relationship with learners however, matched with the more traditional notions of student and teacher/trainer particularly when the learning required assessment.

The temporary contract I had with this training provider expired after a year and my professional work continued in the same but broad field of workforce development in the health sector.

### Hepatitis C Workforce Development Project Officer

As mainstream health and social services continue to attempt to meet the public health needs of targeted population health groups, my work in developing adult learning activities has shifted to a range of settings within the government health sector. My target groups shifted from those individuals affected by hepatitis C or HIV to the broad range of clinical and allied health professionals involved in developing care and treatment strategies, prevention education programs and harm minimisation programs (such as methadone services and Needle Syringe Programs) for people living with blood borne viruses. Historically, government and non-government services targeting the health needs of at risk population groups have suffered from limited funding allocations, limited management development support, high staff turnover and a politically fragile environment that jeopardises the viability of harm reduction programs. The bulk of public health-related interventions aim at reducing behaviours that may lead to infection and re-infection (sharing of injecting drug use equipment) and in non-clinical care and treatment strategies (such as programs

aimed at reducing binge drinking). Importantly, there is no new infrastructure to be developed within the national health system specifically set up to address hepatitis C-related issues. Education, brief interventions, referrals and other coordinated care strategies are to be incorporated into generalist health workers core duties. Those workers disproportionately affected will be those working in such areas as alcohol and other drugs, sexual health, HIV/AIDS, youth health services, multicultural services and community services.

### Learning through participatory management development approaches

In 1999 I was contracted by the Hepatitis C Council of NSW to write a learning strategy for health workers on hepatitis C (Wilkins, 1999) that used an action learning framework and incorporated principles of team planning and participatory management development. The product, named "The NSW Health Care Worker Hepatitis C Education Strategy" was primarily developed in response to needs highlighted among health workers at a forum that was held in July 1998 that aimed to map current hepatitis C-related educational opportunities, gaps and barriers with the aim of developing recommendations for improving health care worker education in NSW. The key recommendations or educational comments were:

- There will be increasing demand for education services; however as resources may not increase significantly, education of health workers will need to use existing infrastructures where possible.
- There is a need to tailor education, based on the role and experience of health care workers.
- Existing education and learning opportunities are not always appropriate and relevant, and are not accessible to all health care workers, particularly in rural areas.
- Education and learning related to hepatitis C need to be integrated with other health workers education processes, and draw on the experience and diverse needs of people living with hepatitis C.

(Hepatitis C Council of NSW, 1998 Forum Proceedings)

A project proposal was then developed and informed by the above statements and funded jointly, between NSW Health and the Commonwealth Department of Health and Aged Care and was based at the Hepatitis C Council of NSW. The Council is an independent, charitable, community-based membership organisation offering assistance to people affected by the hepatitis C virus. The Council is frequently asked to provide education to health workers across the state. This temporary project "The NSW Health Care Worker Hepatitis C Education Strategy" project was planned with the objectives to

- increase coordination of information and knowledge sharing among health care workers
- identify health care worker roles and learning needs
- establish effective partnerships and alliances between education institutions and relevant organisations
- facilitate greater involvement of people living with hepatitis C in the development of education and learning strategies

(Hepatitis C Council of NSW, 1999 Project Description)

The learning strategy was fairly simple and void of any specialist clinical content. Key elements of the strategy were borrowed and adapted from an action learning based project in Western Australia that targeted non-specialist alcohol and other drug (AOD) organisations to incorporate AOD issues into clinical and other practices as they related to the agencies core business (Rose & Gallagher, 1999: 2). This approach recognised the significant role of the organisation as a key context in which learning needs and ultimately, program outcomes are shaped. It also aimed to capitalise on the knowledge and skills of the multi-disciplinary teams of health workers who worked within these organisations. The implementation of the learning strategy relied on the facilitation of action learning focus groups within these organisations. The action learning methodology for this strategy was primarily chosen for its cost-effectiveness (eg no costly expert specialist required for training) and its settings-based approach that capitalised on local organisational settings and workers' existing knowledge that could be drawn on to inform new or emerging work practices and service enhancements.

### Action learning with multi-disciplinary teams

The action learning focus groups proposed in this document require a commitment to organisational behaviour that encourages group dialogue and collaborative program planning processes among all staff. The processes support health workers to contribute beyond their traditional functional roles (Casey, 1999) by supporting group problem solving processes that make use of existing skills and knowledge. The group dialogue also contributes to team based participative decision making (ANTA, 1996). In this way the outcomes developed are more organisationally integrated (Casey, 1999) and sustainable and less fixed on individual expertise. (Wilkins, 1999:5)

The learning strategy argued that action learning has been adopted in the workplace as a viable approach to experiential management education and development and is an important element of a training and development strategy (Vince & Martin, 1993). The process of group problem solving using focus groups was a relatively new and challenging process for many participants. It challenged the concept of professional expertise for some (such as senior clinicians), and for others it provided them with adequate space to voice their opinions and to contribute to the problem solving process. What was unique in this approach to professional education in the NSW Health government system was the shift from targeting individuals by their professional categories (social workers, nursing staff for example), to targeting multidisciplinary groups of workers in the settings in which they worked. The education sessions were workplace-based and were facilitated during team meetings or hospital changeover periods.

The focus group educational process began with the facilitator clarifying the purpose and goal of the meeting. A time frame is negotiated with participants. Depending on the number of people, the process can take approximately one to two hours. The facilitator poses open ended, yet directed questions to participants to encourage discussion (Lydecker, 1986). The facilitator then capitalises on the communication among participants to stimulate reflection and group deliberation. The funnel format of questioning sequence is used to move general introductory questions to more specific and complex questions over the course of the group discussion (Frey et al 1991).

> Emerging themes and more detailed data highlighting organisational and individual characteristics are recorded on the tools developed for this project. The final stage is the shift from problem solving to developing a coherent individual and/or organisational action plan detailing how the organisation will respond to the hepatitis C-related needs of their clients.
> (Wilkins, 1999: 8)

The facilitator may also need to pose additional questions to encourage workers to become critical of what they do and why they do it. Tailoring the process to local needs can provide a much more robust organisational action plan:

> Learning will be lower, and resistance higher, if change techniques are prepackaged and tightly prescribed. Often, it is the process of struggle and experimentation, and not the change technique itself, which brings the most benefit. (Field and Ford, 1996: 49 in Wilkins, 1999: 10)

The action-learning approach had a key program goal in mind: to enhance public health responses to people living with and affected by hepatitis C. The problem was broad and in almost all situations required the problematising of professional and organisational partnerships in developing responses. This was a framework that aimed to offer "multiple models of action, knowledge, reasoning and reflection, together with opportunities for the [practitioners] to challenge, evaluate and interrogate…" (Saving-Baden, 2003: 23). It was a collective process for developing innovative program ideas requiring service enhancements and shifts in worker roles without significant funding enhancements. In short, workers were encouraged to think outside the square when problem-solving common public health challenges such as ensuring health services are accessible, responsive and coordinated. It was also a process that aimed to accommodate or fulfil organisational requirements and variations in the development of public health activities. The settings-based approach was also an emerging public health planning phrase echoed in a number of state-wide blood-borne virus health strategies and in government planning documents such as "A Framework for Building Capacity to Improve Health" (NSW Health, 2001). Within this framework, the valuing of program contexts is instrumental in understanding and mobilising collaborative partnerships:

> Context refers to the range of physical, economic, political, organisational and cultural environments within which a program sits. 'Context' is often thought about as the environmental constraints on a program that are generally not amenable to change. Programs never exist in isolation…Practitioners need to be aware of and be ready to respond to changes in context.
> (NSW Health, 2001: 6)

Implicit in this acknowledgement of the importance of program contexts and various organisational settings is the awareness that as a facilitator (rather than a trainer), I have little local knowledge to contribute to the group learning process. My role was to be aware of broad content issues such as basic epidemiology, best practices in prevention education and broad planning principles that inform local service delivery. The goals of these action-learning sessions focussed primarily on ways to mobilise local resources, skills and knowledge drawing primarily on the expertise of workers in specific settings. What counted as valid knowledge was much less clear to me as a facilitator. Local politics, organisational anomalies or differences; and the pre-existing professional relationships among practitioners would challenge static notions of curriculum on best-practices in program planning and service coordination. As discussed later in this chapter, the critically successful component of this action-learning framework was a recognition of the importance of drawing from these less predictable and tangible contexts when facilitating problem-solving sessions.

The two action learning focus group frameworks listed in Appendix i, were used most frequently and tended to generate the greatest amount of critical discussion among participants. They were also the two frameworks that generated the most detailed organisational and individual action plans informed directly by the group discussion.

The second key component of the focus group process (see Appendix ii) marked a shift from problem mapping to the development of a coherent individual and/or organisational action plan detailing how the organisation would respond to the hepatitis C-related needs of their clients by building on the existing knowledge and skills of its staff and capitalise on the organisational assets of their workplaces. Organisational assets (or context) included such things as mission statements, management structures and activities, team meetings, staff expertise and workers' professional relationships both within and outside the organisation. The funnel format of questioning used in the focus groups provided a transparent method of documenting the rationale for the workplace goals. The rationale for this process is described below. The template for documenting individual and organisational solutions to these problems follows this.

In all the trial sites the processes of participation and group discussion formed the foundation of the learning both on an individual and organisational level. The focus group method provided an ideal context for critical discussion to take place. In particular, this relatively simple process

promoted group problem-solving that took into account the structures, skills and resources of the local setting. Learning outcomes were measured primarily through the attainment of completed team learning contracts.

### Evaluating action learning through participatory methods: How do we know what works?

The Program Evaluation Continuum (Owen, 1999) framework was applied to map the critical success factors involved in the implementation of this project. Briefly, the Program Evaluation Continuum (PEC) highlights the need for evaluation to contribute to decision-making at every key point in program design. Since participation of learners is a paramount principle in the piloting of this action-learning project, input was sought from those learners, as well as steering committee members and other key stakeholders at various stages of the project's life. Focus group questions were refined as a result of this input as well as the more practical applications of project management such as session time allocations, facilitation skill refinement etc.

Three months after the individual and organisational work plans were negotiated through the focus group method, an independent contract evaluator conducted a series of phone administered interviews from a sample of organisations within each arm of the pilot project. The evaluator emphasised at the beginning of each phone interview that the evaluation would look at a range of individual learning outcomes as well as broader organisational outcomes (formal programs, diversity in services, relationships with clients or other health services) from the pilot project. Coordination or information and knowledge sharing was highlighted as a key outcome stemming from this intervention. Particular reference was made to the effectiveness of the participatory methodology used to generate workplace goals:

> - Sitting down and working out a plan has been a very significant step. There had already been plans to do something but these were vague and had not been formalised. There is a much sharper focus now.
> - At an area level, we are always being told what to do but it didn't feel like that. It felt very inclusive.
> - It was relaxed, non-confrontational and very productive.
>
> (Wilkins, 1999: 25)

The project was also evaluated using a Nominal Group Process, which is a group process that combines individual and group activities in order to reach a ranked series of opinions concerning the worth of the project. The Nominal Groups Process was originally developed as a problem solving strategy to be used where groups are disparate, and there is a desire to have the decisions reflect a wide range of perspectives. The strategy begins by considering individual responses to a defined problem. In this case the questions were:

1. What do you see as the most significant, relevant and positive aspects of the project?
2. What do you see as the least significant, relevant and positive aspects of the project?

Key project strengths highlighted by participants in the nominal group evaluation process were its ability to use existing infrastructures and, in particular, the existing skills and knowledge of health workers; its simple and transparent methodology to support a broad range of problem solving on a range of client specific and broader organisational issues, and its focus on locally driven solutions.

### Facilitating problem-based learning: A shift in worker identity

A dominant theme that potentially threatens sustainable outcomes was an acknowledgement that this framework is incongruous with the hierarchical nature of the current expert driven education and development framework predominantly used in this health service. In other words, most training programs assume an expert driven transmission of information model: one that is structured on the linear process of imparting professionally based expertise to the learners without much consultation about individual learning needs preceding the training. Facilitating problem-based learning in an organisational culture that predominantly relies on clinically expert-driven training poses challenges not only to my professional identity, skills and knowledge but also to those of the learners (in this case, hepatitis C-related public health workers). The tensions arising when shifting from lecturer to facilitator is described by Savin-Baden (2003):

> For many staff engaged in problem-based learning, the transition from lecturer to facilitator demands revising their assumptions about what it means to be a teacher … This is a challenge to many, since it invariably demands recognition of a loss of power and control when moving towards being a facilitator. …for many…it involves letting go of decisions about what students should learn, trusting students to learn for themselves and accepting that students will learn even if they have not been supplied with a lecture or handout. The conflict for many staff is in allowing students to manage knowledge for themselves, when in previous roles and relationships with students they have invariably been the controllers and patrollers of knowledge.
> (Savin-Baden, 2003: 35)

Shifting from a trainer to a project manager who undertakes facilitation required that I focus less on content and more on encouraging the participation of a diversity of perspectives. It also meant that I had to learn to work with uncertainty about the particular learning goals, program outcomes and overall control of the educational session. According to Savin-Baden (2003), "Facilitation invariably demands that we make personal shifts away from long-held beliefs about the nature of knowledge and notions of learning" (Savin-Baden, 2003: 3). My personal shift required an uneasy transition from that of a holder of discreet forms of knowledge (usually delivered through training) to that of an ambiguous professional identity, which sought to support learning in a number of apparently non-direct, non-clinical and non-content oriented ways. My daily professional skills of consultation and collaboration with service managers and departmental policy analysts, required a greater accountability to achieving learning outcomes in line with organisational and broader policy

goals. Heron (1993) in Savin-Baden (2003) suggests that facilitator authority is paradoxical "because of the way in which the facilitator has to pass on to the students some body of knowledge and skill through a process of learning that promotes and affirms the autonomy of the learner" (Heron, 1993 in Savin-Baden, 2003: 70). Consequently, my professional identity shifts from that of the tangible and easily identifiable public health trainer (or professional development officer) to that of the ambiguous Project Officer who undertakes facilitation, planning and a range of informal administrative and individual relationship building activities.

Furthermore, there exists bureaucratic divisions between and within Area Health Services that could and frequently do hamper collaborative processes and partnerships (especially partnerships between Area Health Services). Despite this framework attempting to operationalise many of the guiding principals within both the state and national blood borne virus strategies (namely Partnerships and Enabling Environments), the realities of competition for limited financial resources and ownership of intellectual / professional knowledge (expertise) were considered key barriers to the continued uptake of workplace based, action learning programs. Individual technical expertise is valued over group problem solving processes. Participants would often express frustration about having to spend time problem solving rather than receiving information. Learning, particularly in hospital ward or community health settings was voiced as a luxury that would have to be squeezed in between the daily chores of getting work done. Learning and work were still perceived as two distinct and qualitatively different activities. Traditional conceptions of knowledge: in this case knowledge that's professionally owned and technical in quality was viewed by many health practitioners involved in the nominal process evaluation as the most important, useful and legitimate form of knowledge. It is this type of knowledge that is collectively viewed, as Ronald Barnett describes in his paper entitled Working Knowledge as "natural and indisputable". (Barnett in Garrick & Rhodes, 2000: 16) But Barnett argues that we are facing a fundamental epistemological transition about what constitutes legitimate knowledge: "Crudely put, it is a shift from knowledge understood as a matter of what one knows, to knowledge understood as a matter of what one can do." (Barnett in Garrick & Rhodes: 2000: 16). Barnet references Gibbons (Gibbons et al, 1994) "this transition is not a matter of academic knowledge being applied to domains of action: it is rather the recognition that knowledge is generated in action" (Barnett in Garrick & Rhodes, 2000: 16). It is this knowledge generated in action that is apparently the "most highly prized in the modern world," and that "[it] is produced in situ in the domain of work that is, in settings that are systematic, collective, often large scale and oriented towards production, profit and growth (Barnet in Garrick & Rhodes, 2000: 16). Yet it is this very form of knowledge production that was viewed by key stakeholders within the health department as the most vulnerable aspect of the project. Professional hierarchies (or ownership of professionally shaped

intellectual properties) were seen as obstacles to the ongoing development of the collaborative learning processes and partnerships fostered in the action learning focus groups.

Lastly, this framework relied heavily on the use of existing organisational resources such as staff, staff meetings, participatory management practices and a willingness to be critically reflective about the work people do and the program outcomes that result. If an organisation has a predominance of casual or contract staff; has infrequent or non-existent staff meetings and/or limited opportunities for group learning facilitated through management practices, then this framework was perceived to have limited applicability beyond the life of the pilot project.

### Workforce Development Senior Project Manager

This healthcare worker education strategy provided program evidence that informed the development of a proposal for another broader workforce development project: The NSW Hepatitis C Workforce Development Project. It adopted Solomon's (1999) description of learning as 'repertoire':

> Learning in the workplace, where flexibility and difference in terms of roles, tasks, processes and people are the norm, may best be achieved by understanding learning as a concept of 'repertoire' rather than as a developmental concept. This signifies a shift from understanding learning as a vertical climb to a specific ideal goal towards a horizontal model where learning is an expanding broadening experience that draws upon and adds to employees' prior life and work experiences.
> (Solomon in Boud & Garrick, 1999: 130).

### Horizontal learning: Facilitating collaborative learning relationships

Like the previous project, the educational approaches from this project drew from group-based, interdisciplinary problem-based learning frameworks. The notion of the knowledge 'expert' was directly challenged using Solomon's language of learning as "repertoire" (Solomon in Boud & Garrick, 1999: 130). This quote was frequently used at the beginning of workshops and planning forums to highlight the key programmatic strategy of capitalising on a range of professional and prior life experiences in the development of learning outcomes for the program. Again, it draws from a social constructivist approach to learning in that "learning is a process of constructing meaning from experience" (Imel, 2000: 3) that takes place in a range of varied contexts. This is also congruent with principals of contextual learning in that "the meaning of what individuals learn is coupled with their life experiences and contexts [and] is constructed by the learners … and [importantly] is anchored in the context of real-life situations and problems (Dirkx, Amey & Haston, 1999 in Imel, 2000: 3).

Accordingly, this project adopted and promoted learning strategies that aimed to generate collaborative learning relationships and non-expert based (and non-vertical) learning activities. These included action learning forums and focus groups, interagency forums known as Practicums and experiential learning activities such as work placements and site visits. The project also sought to highlight and document opportunities where the more tacit forms of informal and incidental workplace learning occurs with the aim of incorporating these activities in the projects repertoire of learning activities. This approach stemmed from a need to work with existing capacities within the health care workforce in the range of settings. The project adopted Billet's (2001) key premise of workplace learning: "It needs to be founded on the contributions and circumstances afforded by workplace environments" (Billet, 2001: 6) Specific project objectives aimed:

- to support the development of enhanced and coordinated service delivery at an Area Health Service level
- to facilitate workforce learning and development within organisations (or networks of organisations) that is consistent with their core business and local planning processes
- to foster the effective use of partnerships within and among Area Health Services and related non-government agencies
- to optimise health outcomes by building the capacity of Area Health Services in their response to local needs within existing resource allocations

Much of the focus of the NSW Hepatitis C Workforce Development Project was to foster organisational and inter-organisational learning relationships. A particularly successful strategy for the project was the Practicum series. Practicums aimed to bring together workers from a range of disciplines to demonstrate the practical foundation of a theory or topic and to share information and strategies on its application. Each Practicum focussed on planning ways to effectively incorporate session outcomes into participants' workplace programs. The series evaluated well in relation to:

- highlighting how links between theories, principles and frameworks can inform work practices
- reinforcing the need for ongoing partnerships with local services
- demonstrating how transferable elements of successful past programs can be applied in different work settings to different issues, and
- illuminating a need for management support for learning activities and relationship building within and outside health services

The evaluation also highlighted other strengths of the Project. Among them a recognition that the learning topic was understood and applied in the context of current workplace skills and programs; that the workplace learning framework directly assists client-driven program planning cycles and that the processes of participation in the learning activities addressed both individual and organisational learning needs.

Yet despite localised successes in supporting group problem solving and workplace-based action learning activities, this Project faced the same broader challenges as other programs attempting to foster sustainable workplace learning practices. Among these are concerns that workplaces provide only piecemeal and situationally specific learning outcomes that lack the coherence of programs offered by traditional education institutions (Billet, 2001: 15). The challenge for this project was therefore perceived to be in the facilitation of a more integrated and expanded network of workplace learners by fostering the development of learning partnerships with people and agencies beyond the immediate work setting.

This raised a range of professional issues for myself as the project manager for a state-wide workforce development program: the identification and development of new skills relating to project management and facilitation; a need to surrender particular forms of knowledge (ie clinical or technical) in my daily work to make way for skill building in core areas such as supporting the development of partnerships, community and organisational capacity building approaches and broader program management support.

### Public health policy and discourses of learning as organisational performativity

Although this project and the learning strategy that informed its development can easily be located within social constructivist learning theory, contextual learning and a range of organisational and management development perspectives, the overall rationale for such an approach was based on its performativity within a particular set of policy, resource and economic circumstances. The pilot project that supported the funding of the new statewide workforce development project was recognised for its ability to produce tangible, workplace based program outcomes. Usher and Edwards (2000) acknowledge that contemporary social research is increasingly influenced by "demands of relevance" (Usher & Edwards, 2000: 254):

> Knowledge production is no longer, if indeed it ever was, a leisurely 'curiosity-driven' conversation confined exclusively to academic communities of practice; the need for results (or outcomes that 'perform') is greater and more urgent.
> (Usher & Edwards, 2000: 254)

Importantly, I did not model this project on situated learning theory or on the uptake of communities of practice as a unit of analysis but later located these as useful academic tools to accompany my project evaluation outcomes. The project merely recognised the applied value of learning activities that took advantage of processes of participation among these groups of people and later found a theory of learning that supported this targeting. Indeed, if it were not for the

program outcomes resulting from these activities the project would most likely not have been granted continued funding.

The rationale from such an approach is therefore an essentially pragmatic one but was also informed by both state and national hepatitis C health policies. The NSW Health Hepatitis C Strategy 2000 – 2003 states:

> ...any strategic response must be flexible, in order to adapt to new information, knowledge or developments regarding the disease. The response to hepatitis C will seek to harness existing infrastructure where possible. (NSW Health, 2000: 3).

Similarly, the National Hepatitis C Strategy states:

> By situating this Strategy within a broader communicable diseases framework we create the opportunity to ensure that the overall health outcomes achieved are greater than the sum of the individual parts. It is the links between, and the integration of, these responses that will ensure both sustainability and maximum population health impact.
> (Commonwealth of Australia, 2000: iv)

The language in both of these policy frameworks makes strong emphasis on new practice models of care that value and are built on "integrated, clinical teams of knowledge workers", (Kaiser, 1991), all of whom are involved in decision-making and problem-solving. Here the competent worker (and health service organisation) is aligned with contemporary (and popular) principals used in learning organisation literature and management development theories. The "fostering of organizational [or group] learning as opposed to individual skill formation" (Johnston, 2001: 3) further emphasizes the value of shared learning activities as a key dimension of organizational activity and "a driver of organizational competitiveness" (Johnston, 2001: 3).

The policy framing document entitled "New Directions for Public Health in New South Wales (NSW Health Department, 2000) was developed to provide a framework within which the organisations that make up the public health system in New South Wales can plan their activities over the next five years. The rhetoric of organisational and group partnerships is used frequently along with phrases such as intersectoral communication, partnering skills and repeated references to continual learning processes. A key challenge however, is to be able to operationalise this rhetoric within funded learning and development programs and to be able to demonstrate the worth of this repertoire of activities beyond individual knowledge and skill assessments to a broader model that adopts notions of learning through professional practice networks or communities of practice.

## Facilitating knowledge production through professional practice networks

The activities used in both the radical education programs facilitated earlier within community-based contexts and the workplace-based learning activities I co-ordinated within work settings have clear similarities. Both are rooted in constructivist learning theory in that the activities aim to construct meaning from lived and/or professional experiences and contexts. Both conceptualise learning as a process of group participation (Lave & Wenger, 1991 in Matthews & Candy, 1999: 51) rather than as an individual and passive transfer of knowledge. Lave & Wenger's (1991) theory of 'situated learning' "takes as its focus the relationship between learning and the social situations [including organisational] in which it occurs (Lave & Wenger, 1991: 14). Again, learning is conceptualised as a social and situated series of relationships rather than as a singular cognitive process: "Rather than asking what kinds of cognitive processes and conceptual structures are involved, they ask what kinds of social engagements provide the proper context for learning to take place." (Hanks in Lave & Wenger, 1991: 14). Similarly Freire, with his philosophy of radical education, proposes a structured dialogical problem-posing process whereby community members or members of social networks meet, discuss common problems, look for root problems and the interconnections among them and devise strategies to transform their current social, economic or political conditions. Again, the learning process is a social and generative collective process. Lastly, the concept of empowerment, "an enabling process through which individuals or communities take control over their lives and their environment" (Minkler & Wallerstein in Glanz et al (eds), 1997: 241) is an overlapping theme. Freire's central premise about education was that it should be libratory and bring about conscientization that comes through the social analysis of conditions and peoples' role in changing those conditions. Conscientization is "a key ingredient to maintaining a broader vision and sustaining community-organising efforts over time and is one of the links between individual psychological empowerment and community empowerment" (Minkler & Wallerstein in Glanz et al (eds), 1997: 252). Herbert (2000) describes how the rhetoric of action learning programs in the 1990's among Australian Vocational Educators "claimed that individuals would be empowered to direct their own learning, collaborating with others to question taken-for-granted knowledge norms, and… implement workable solutions to problems identified from practice situations (Herbert, 2000: 391). Bellman (2000) in her action research study on creating an integrated organisational culture of working and learning in a large NHS Trust hospital in London described this workplace based action learning programs as "…an emancipatory form of social research [that] implies that as human beings become active in constructing reality, they can also act to change it for the better. Both the process and outcome should be an empowering experience for participants" (Bellman, 2000: 3).

Despite these similarities and the many policy frameworks espousing increased integration, collaboration and multi-disciplinary and transdisciplinary knowledge teams, the NSW Health

Department remains a large, highly hierarchical bureaucracy. Like most large organisations, there remains a traditional hierarchical framework of management and clinical expertise that favours a reliance on experts to provide information and to solve problems. Learning activities are largely training room based and offered on a fee for service basis through Learning and Development Centres throughout the state.

Although the horizontal learning model used by this government funded workforce development project has gained notional acceptance in NSW Health via a solid funding allocation, the question of how such a model can co-exist within a broader system that operates from a relationally opposite learning paradigm remains.

My research question began with an observation of the effectiveness of a range of informal and formal learning activities conducted among various professional practice networks or communities of practice –a term introduced in the early 1990s by Jean Lave and Etienne Wenger in the book *Situated Learning* (Lave & Wenger, 1991). With this recent acknowledgement of different modes of learning comes an acknowledgement of the different forms of and changes in 'knowledge production' in the contemporary workplace and indeed, contemporary society.

Gibbons et al (1994) introduces two heuristic modes of knowledge production: Mode 1 and Mode 2. Gibbons explains that the primary purpose of describing the attributes is to show that these attributes possess sufficient coherence to be called a new mode of production. In an effort to describe and distinguish between the attributes of each, Gibbons generates descriptive and applied profiles for each. In short, Mode 1 knowledge production traditionally refers to what is known as the discipline of science. Mode 1 problems "are set and solved in a context governed by the largely academic, interests of a specific community" (Gibbons et al, 1994: 3) whereas Mode 2 is described as being transdisciplinary, heterogeneous, heterarchical and transient (Gibbons et al, 1994: 3). Gibbons further describes Mode 2 as being "more socially accountable and reflexive. It includes a wider, more temporary and heterogeneous set of practitioners, collaborating on a problem defined in a specific and localized context" (Gibbons et al, 1994: 3). Mode 2 is produced by continuous negotiation with the interests of various people from a range of disciplines being included and is dynamic (Gibbons et al, 1994: 5) and involves processes of group participation and problem solving for specific and often transient applications. Importantly, Mode 2 knowledge production is social and this has particular implications for the ways in which the informal, incidental and previously unacknowledged and invisible forms of knowledge production occur:

> But the socially distributed nature of Mode 2 knowledge production is above all embodied in people and the ways they are interacting socially organised forms. Hence, the emphasis

> on the tacit components of knowledge which we see as taking precedence of the codified components
> (Gibbons et al, 1994: 17).

The learning activities developed by these last two projects are clearly aligned with that of Gibbons' Mode 2 of knowledge production. Within the context of my professional work, it is the "continuous negotiation with the interests of various people from a range of disciplines" (Gibbons et al, 1994: 3) that forms the predominant character of the professional learning activities developed.

The learning activities are aimed to include multidisciplinary health teams working in specific health settings, temporarily formed professional interest groups and multidisciplinary working groups formed to address a particular health issue. The project recognised and capitalised on learning that is situated in these forms of social co participation (Hanks in Lave & Wenger, 1991: 14). In this way, the project drew on situated learning theory in that the learning activities capitalise on the everyday physical and the social contexts participants live and work in (such as workplaces or professional networks). The project recognised learning as a process of participation and negotiation among people in particular situations rather than a traditionally located individual – cognitive process (lacking a social context or situatedness). Learning is active rather than receptive (Lave & Wenger, 1991: 33). Lave and Wenger (1991) describe these often multi-disciplinary groups of people involved in a shared practice as communities of practice. This unit of analysis helps to focus attention on specific practices members engage in when participating in shared activities (Fox, 2000: 854). More, importantly, the term helps us to understand the processes in which these individual and/or collective practices can emerge within particular settings. Wenger (1996) describes how the emergence of these practices can result over time:

> As people pursue any shared enterprise over time, they develop a common practice, that is, shared ways of doing things and relating to one another that allow them to achieve their joint purpose. Over time, the resulting practice becomes a recognizable bond among those involved.
> (Wenger, 1996 in Capra, 2002: 94).

In his book, *The Hidden Connections* (2002), Capra describes the importance of these social networks as being living social systems that are integral to the adaptability, and sustainability of modern corporations (Capra, 2002: 92-93): "These are informal networks –alliances and friendships, informal channels of communication (the 'grapevine') and other tangled webs of relationships –that continually grow, change and adapt to new situations." (Capra, 2002: 95).

It was through the experiences of piloting activities that capitalised on these pre-existing interdisciplinary networks, situated in particular workplace (or health service) setting that produced more reflexive, social and generative learning outcomes. More importantly, the learning outcomes tended to fit more neatly within concrete service or program planning documentation. The shift from Mode 1 to Mode 2 form of knowledge production in my work posed not only new challenges for the ways in which I developed ongoing relationships with peers and learners as an involved subject and learner, but provided insight into how current public health policy rhetoric of partnerships, increased integration, collaboration and multi-disciplinary knowledge production can support program approaches that capitalise heavily on learning through multidisciplinary professional practice networks.

The next chapter identifies literature relating to collaborative learning that occurs through professional practice networks or communities of practice. In particular, this review of the literature highlights how ongoing work-based learning relationships develop into temporary and informal networks with shared characteristics and broadly shared standpoints and goals. These professional practice networks are described through Lave (1993) and Lave & Wenger's (1991) literature on "communities of practice" and adapted for use as a unit for analysis (or participant group) in the Story-Dialogue Method (S/D-M) workshops. The chapter describes features of the three professional practice networks participating in this research and will outline the stages of structured group dialogue required for the S/D-M. The purpose of the activity is to explicate the kinds of knowledge, skills and relationships that networks of practitioners use when speaking of their ongoing educational work.

# Chapter 4

# Methodological Framework

Having identified some of the concurrent pedagogical approaches to the broad field of public health education along with an acknowledgement of the expanding list of people who collaboratively develop educational interventions (including both government and community, professional and volunteer workforces), I now describe the rationale for drawing on Lave (1993) and Lave and Wenger's (1991) term of Communities of Practice as a unit of analysis for the three Story-Dialogue Method (S/D-M) Workshops. Often called interagencies, working groups, or networks, these groups of public health practitioners commonly work, learn and educate in partnership with each other. The joint enterprise or purpose of the group, engagement strategies and shared repertoire of communal resources are shared characteristics that can assist in building critical analysis from a shared standpoint (ie a public health message, a disease, a profession). The idea of capitalising on pre-existing professional relationships also honours the expanding literature acknowledging the high prevalence of informal and incidental learning that continually occurs among colleagues:

> ...it is now recognised that by far the greatest proportion –perhaps as much as 90 per cent – of organisational learning actually occurs incidentally and adventitiously, including through exposure to the opinions and practices of others also working in the same context. (Matthews & Candy in Boud & Garrick, 1999: 49)

This chapter then outlines the aim, generative theme and stages of structured group dialogue required from the three professional practice networks participating in the S/D-M.

The S/D-M was developed by Feather and Labonte (1996) as a means to structure and facilitate group reflection and the creation of generalised knowledge through an analysis of professional stories and experiences in the public health sector. This participatory methodology will draw, in the first instance, directly from the Generative Theme statement that serves to outline a broad professional practice tension that is relevant to all three professional practice networks. The Generative Theme in this research is a concise acknowledgement of the varied and often competing approaches to public health education I have experienced as an education practitioner over time. The Generative theme therefore, directly reflects my own standpoint of professional experiences and observations. The Theme suggests that working with multiple models and changing learner expectations poses challenges for the ways in which practitioners negotiate their range of skills,

knowledge and learning relationships. It is through a structured series of analytic group dialogues that knowledge and theories about what works in education in their sector, are elucidated.

### Professional practice networks as a unit of analysis

There has been renewed interest in Australia and overseas about recognising the applied value of working with "groups of people bound together by shared expertise and passion for a joint enterprise" (Wenger & Snyder, 2000: 139). Cohen and Prusak (2001) argue that sets of relationships within professional settings ultimately contribute to the development of social capital in organisations, that is, "the company's stock of human connections such as trust, personal networks and a sense of community" (Cohen & Prusak, 2001 in Mitchell, 2002: 6). This 'social capital' within workplaces is thematically similar to those articulated by Freire in the processes of community conscientization described earlier. Both see experiential group based learning programs among networks or communities as having the potential to be liberating. Although Freire's political work reaches well beyond the articulation of ways to nurture the learning that occurs in corporate groups (empowerment aims to enable people to take control over their lives and environment well beyond the restrictive capitalist confines of modern organisations), it does emphasise the need to situate learning within the daily realities, activities and politics of the learners and to capitalise on the processes of participation and problem solving in order to meet their learning needs and, more importantly, to transform aspects of their social, economic and at times, political conditions.

Gonczi (2001) recognises the challenges this focus on professional practice networks brings to common calendar based, training programs:

> The challenge is to shift the focus of professional education from training the individual mind, to the social settings in which the individual becomes part of the community of practice; from facts and rules stored in the brain until the need to use them, to enacting knowledge through activity; from a conception of humanity centred exclusively on the brain to a wider conception where humans are seen as embodied creatures embedded in the world.
> (Gonczi, 2000: 5).

Here, Gonczi acknowledges the need for a radical re-think of the way in which we train or learn from professionals predominantly by way of their professional association. Acknowledging that people relate to each other at work in ways that reach beyond their narrow professional roles, brings increased opportunity to investigate ways to produce knowledge through dialogue, negotiation and activity with multi-disciplinary groups.

Wenger (1998) explains:

> Workers organise their lives with their immediate colleagues and customers to get their jobs done. In doing so, they develop or preserve a sense of themselves they can live with,

> have some fun, and fulfil the requirements of their employers and clients. No matter what their official job description may be, they create a practice to do what needs to be done. Although workers may be contractually employed by a large institution, in day-to-day practice they work with –and, in a sense, for – a much smaller set of people and communities.
> (Wenger, 1998: 6)

### Drawing from communities of practice

According to Lave (1993) and Lave and Wenger's (1991), analysis of learning within organisations must focus on nests of practices (Fox, 2000: 858) rather than focussing broadly on the larger organisation. Within each organisation there can be numerous and overlapping communities of practice (Fox, 2000: 855). Similarly, Stronach et al (2002) describe the mix of practitioner experiences, beliefs and practices drawn on in the facilitation of learning as ecologies of practice. These ecologies relate "largely to the kinds of knowledge that are essentially intuitive or tacit and encompass particular ideologies that may be personally held, but in the main are held by a particular profession" (Savin-Baden, 2003: 53). This notion of knowledge that is intuitive or tacit and that is embedded within professional practice networks is particularly relevant to my research. By structuring dialogue and analysis among these networks, this research is aiming to explicate the kinds of productive relationships, approaches and skills that define their work.

Capra (2002) believes the benefits of acknowledging and working with communities of practice within corporations can go beyond a mere understanding of how concrete practices develop:

> Within every organisation, there is a cluster of interconnected communities of practice. The more people are engaged in these informal networks, and the more developed and sophisticated the networks are, the better will the organisation be able to learn, respond creatively to unexpected new circumstances, change and evolve. In other words, the organisation's aliveness resides in its communities of practice.
> (Capra, 2002: 96)

Wenger argues that although the term is historically new, the informal and dynamic processes of group learning over time have appeared throughout history and continue to evolve in a range of professional settings and community-based activities:

> Since the beginning of history, human beings have formed communities that accumulate collective learning into social practices—communities of practice. Tribes are an early example. More recent instances include the guilds of the Middle Ages that took on the stewardship of a trade, and scientific communities that collectively define what counts as valid knowledge in a specific area of investigation. Less obvious cases could be your local magician club, nurses in a ward, a street gang or a group of software engineers meeting regularly in the cafeteria to share tips. Such communities do not take knowledge in their specialty to be an object; it is a living part of their practice even when they document it. Knowing is an act of participation.
> (http://www.ewenger.com/ewthemes.html, March 2003)

The term Communities of Practice has recently gained widespread use and endorsement as a tool to assist vocational education and training (VET) professionals and organisations to implement the national training system in Australia. Through a national staff development and change management program called 'Reframing the Future" funded by the Australian National Training Authority (ANTA) over 200 innovative 'Reframing the Future' projects were piloted to enable enhanced implementation of the National Training Framework (NTF). The NTF is the system of vocational education and training that applies nationally. It is made up of the Australian Quality Training Framework (AQTF) and nationally endorsed training packages (ANTA, 2002: iv). The report entitled "110 Ways to Implement the National Training System" (ANTA, 2002) outlines some of the innovative approaches VET professionals are using to meet the new challenges encountered under the national training system utilising the concept of Communities of Practice.

Based on interviews with trial participants and an analysis on the communities' report, Mitchell, Wood and Young (2001) argue that:

> Communities of Practice have the potential to reshape professional practice and to improve organisational productivity. Practitioners and organisations within the VET sector will benefit from the development and maintenance of such communities, particularly as a tool to assist in the implementation of the National Training Framework, with its emphasis on networking with industry and developing new ways of training. Communities of Practice are also valuable in encouraging further innovative professional practices amongst VET practitioners across Australia.
> (Mitchell et al, 2001: 15)

Fostering Communities of Practice in a range of settings using different methods, the report highlighted critical success factors, limitations and process-oriented observations as to the impact and suitability of drawing from this framework. Mitchel et al (2002) conclude that:

> The major theme emerging from this evaluation study is that Communities of Practice in the vocational education and training (VET) sector in Australia have the potential to accelerate, intensity, enrich and enhance the implementation of the national training system.
> (Mitchel et al, 2002: 5)

This research will draw from the learning that occurs within these communities or professional practice networks participating in the S/D-M workshops.

### Participatory action research and the S/D-M

The methodological framework adopted draws in part from Participatory Action Research (PAR). PAR is "commonly defined as a form of collaborative, reflective enquiry carried out by practitioners on their own practice, in order to find ways of improving that practice" (Kemmis & McTaggart, 1988 in Sanguinetti, 2000: 232). Furthermore,

> Through action research people can come to understand their social and educational practices more richly by locating their practices, as concretely and precisely as possible, in the particular material, social and historical circumstances within which their practices were produced, developed and evolved –so that their real practices become accessible to reflection, discussion and reconstruction as products of past circumstances which are capable of being modified in and for present and future circumstances.
> (Atweh et al, 1998: 25)

The principles of PAR include an emphasis on participation, discussion, problem solving, the development of collaborative learning relationships, and are recursive in that the research aims to help people to investigate reality in order to change it. The structured group dialogue processes of the S/D-M aim to encourage group participation and reflective analysis of ourselves and our changing conditions of work.

Because those participating in the S/D-M workshops come from a broad and diverse range of professional and community-based employment conditions, I will adopt Sanguinetti's (2000) postmodern approach to action research activities "to facilitate more complex and historically informed understandings" (Sanguinetti, 2000 in Garrick & Rhodes, 2000: 233) of how this workforce struggles to develop dynamic learning arrangements in a particular context. The S/D-M is a collaborative learning process, based on the lived experiences of the participants. The method is structured to facilitate reflection on historically specific occasions and to build a shared and broadened understanding of our work and ourselves.

In her research on adult literacy teachers facing neo-liberalist reforms, Sanguinetti (2000) describes the rationale for adopting a postmodern action research methodology:

> I saw action research as a process of collaborative learning which would provide a structure and a 'space' for examining the contending discourses of practice which structure the work of adult literacy teachers and constitute their personal and professional subjectivities…. Foucault's concept of power as productive and dispersed throughout society widens the scope of action research from an emancipatory meta-narrative of 'them' and 'us' to a deliberate investigation of discourses which construct our understandings of ourselves and our social situations. This becomes a focus on the practices, techniques and procedures by which power operates.
> (Sanguinetti, 2000 in Rhodes & Garrick, 2000: 237)

The action research participants (including myself and the three professional practice networks) are "conceived as complex, multiply-positioned and shaped by a multitude of historical, psychological and social forces" (Sanguinetti, 2000 in Rhodes & Garrick, 2000: 237). Analysis and reflection would therefore include how participants are "implicated in the structures and practices we are trying to change" (Sanguinetti, 2000 in Rhodes & Garrick, 2000: 237). Furthermore, by drawing on a social theory of learning among communities of practice, learning "is seen as the outcome of a

process of a local [multi-faceted] struggle" (Fox, 2000: 860). The processes of structured dialogue within the S/D-M require participants to problem-pose, share diverse professional experiences and to negotiate how these inform broader understandings of their work, relationships and professional identities.

As a point of departure from the emerging bodies of literature on learning at work, this research will employ a social-constructivist approach to knowledge development. The Story-Dialogue Method (S/D-M) was created "with and for practitioners in response to their concerns that much of their practice did not lend itself to a positivist, or conventional methodology." (Labonte, Feather & Hills, 1999: 39). It will draw on structured group dialogue of practitioners to explicate the kinds of knowledge, skills and relationships that assist them to work in a changing field. By drawing exclusively from participants written case stories I intend to "open up text for multiple readings; to de-centre authors as authority figures and to involve participants, readers and audiences in the production of the research" (Putnam, 1996 in Rhodes, 2001: 4). The S/D-M is a group process that "honours the lived experience of individuals through storytelling while developing a deeper theoretical understanding of an issue" (Beneteau, 2003: 4). The method was developed initially to assist public health practitioners to analyse their experiences in order to learn more about their practice. It aligns itself with Freire's (1970) description of problem-posing education where;

> …people develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality, but as a reality in process, in transformation.
> (Freire, 1970: 64)

The process begins and ends with individual and group analysis of practice experiences with a view to not only identify themes, but to take action as a result of their analysis: "A deepened consciousness of their situation leads people to apprehend that situation as an historical reality susceptible of transformation" (Freire, 1970: 66).

### Professional practice networks - Recruitment

The following professional practice networks participated in a two-hour Story-Dialogue workshop:

#### HepLink – steering committee

The HepLink steering committee is part of a broader multi-disciplinary interagency (including clinical, health promotion, and community-based practitioners) addressing hepatitis C-related public health issues. Steering Committee members rotate their membership on an annual basis and contribute to the development of a series of professional development forums throughout the year. The content and format of the

forums are negotiated through members of the Interagency. The aim of HepLink is to share information, resources and support.

HepLink offers members:

- professional connectivity
- support
- information sharing
- networking
- a forum to discuss and address issues of common concern

(Hepatitis C Council of NSW, cited 7 Oct 2004: http://www.hepatitisc.org.au/education&development_site/heplink.htm)

10 members of the steering committee participated in the HepLink Story-Dialogue workshop.

### Network of Alcohol and other Drug Agencies Inc (NADA)

The Network of Alcohol and Drug Agencies (NADA) contributes to the ongoing development of a multi-disciplinary interagency (including clinical, health promotion and community-based practitioners) addressing a broad range of health-related issues relating to alcohol and other drugs. The interagency is auspiced by the Network of Alcohol and Drug Agencies Inc (NADA) - the peak organisation for the alcohol and drug non-government sector throughout NSW. Through its Workforce Development Project, it provides organisational development support and staff training and development strategies to its target agencies.

The NADA interagency is multi-disciplinary, comprised of experienced trainers in alcohol and other drugs (AOD), professional development officers, clinicians such as clinical nurse consultants, allied health professionals such as social workers and community-based practitioners. Participants from this network are members of NADA and regularly come together for professional development or collaborative program planning activities.

8 members of the network participated in the NADA Workforce Development Story-Dialogue workshop.

### Network of Practice Development Midwives

The Network of Practice Development Midwives is a single profession interagency addressing a specific health-related issue: midwifery practice development. This is a local network of midwives who work together to advance midwifery practice through advocating for continuity of care models for women –a key public health access strategy. The midwives in this network include those directly involved in midwifery practice with

mothers and who also work as health service managers, Area administrators or directors, clinical educators and researchers.

8 members of the Network participated in the Practice Development Midwives Story-Dialogue workshop.

In preparation for the three workshops, participants were invited to participate through an explanatory letter that outlined the aims, method and relevance of this research to their ongoing work. Because the methodology for the Story-Dialogue Method is highly structured and demands increased participation and problem-solving as the workshop progresses, a methodological overview was also provided to all participants 2 weeks prior to the workshops. Consent forms outlining the research aim, parameters of participant involvement and confidentiality were signed by all participants prior to each workshop. Ethical issues relating to the research were described to and approved by the UTS Human Research Ethics Committee and the South East Health Human Research Ethics Committee (Southern Section). Potentially adverse affects to subjects were highlighted in relation to the need for participants to engage in a "critically respectful scrutiny with their peers" (Labonte et al, 1999). In order to maintain respectful participation, participants were provided with another overview of the process, highlighting any potential pitfalls immediately prior to the workshop. This overview also included the development of a collaboratively negotiated and verbally agreed upon group contract. The contract aimed to make explicit, the rules of participation and included words and phrases that demonstrated mutual respect. The S/D-M workshops did not begin until all members of the groups were clear about the meaning of the contact and agreed to participate under the terms, words and phrases articulated in each group contract. Each of the three workshops were approximately two hours in duration.

Participants from each workshop were provided with a written summary that identified the Insights and Theory Notes relating to their two professional practice case stories and the critical group dialogue.

### The Story-Dialogue Method

The S/D-M has been used broadly as a method for developing theory grounded in practice experiences. The methodology is rooted in program planning and evaluation methods in international development work because researchers recognised the importance of oral culture as a central component of the way in which people understand their lives and their environments (Labonte, Feather & Hills, 1999: 40). It draws from a range of historically situated political movements that capitalised on the use of stories to create knowledge that has been overlooked or

suppressed. Labonte and Feather (1996) highlight how feminist discourses "criticised many of the theories about human behaviour because the science that generated them had ignored women's voices (Gilligan, 1982, in Labonte & Feather, 1996: 40). The S/D-M emerges from a particular world view, or paradigm known as 'constructivisim'. It focuses on people's lived experiences located in a particular sociohistorical context (Labonte & Robertson, 1996: 434). From a constructivist paradigm, realities are socially constructed, local and specific -in other words, they are ungoverned by universal laws. Labonte and Robertson (1996) describe what a constructivist research approach looks like:

> In a constructivist epistemology, the researcher is part of the reality that is being researched, such that the research findings area a creation of the inquiry process itself rather than a collection of external, already existing "facts". It's methodology…is interpretive and dialectic in that it involves a constant comparison of differing interpretations. It is a process of iteration, analysis, critique, reiteration, reanalysis, synthesis, and so on.
> (Labonte & Robertson, 1996: 434)

I have chosen this constructivist methodological approach, where "individuals learn by constructing meaning through interacting with and interpreting their environments" (Imel, S, 2000: 3), due largely to a recognition that my relationships with peers in so many disparate professional and community-based contexts have profoundly shaped the ways in which I work, learn and change –all of which are "located in a particular sociohistorical context" (Labonte & Robertson, 1996: 434). Labonte argues that in public health, "it is precisely this element of reflection on meaning that is absent from most conventional scientific research" (Labonte et al 1999: 40). The S/D-M provides an opportunity to build theory from these experiences:

> Rather than generalized theory being privileged over particular experiences, particular experiences become the necessary components in the continual development of generalized theory.
> (Labonte, Feather et al, 1999: 39).

The S/D-M was further refined in a later conference by practitioners who were interested in using stories to build stronger, more effective practice. The methodology has been encouraged in "health-promotion settings of all kinds – in the community, in clinics and health centres and hospitals, in government and non-government agencies and organisations concerned with improving health or the underlying conditions affecting health" (Labonte & Feather, 1996: 2). The intention of developing and using this model in a range of settings among health promotion practitioners was to "help practitioners of all kinds to take a critical look at their own work, learn from the experience of their peers, and build an even stronger base of knowledge and skills to meet the health promotion challenges of the future" (Labonte & Feather, 1996: 2). Similarly, this model can be undertaken by groups of learning and development professionals within a particular health sector to help meet the 'challenges of the future' relevant to their professional practices.

The goals of the S/D-M can vary according to what practitioners or community members want to learn (Labonte & Feather, 1996: 11) but generally has been developed with these goals in mind:

1. to tap into the knowledge practitioners and community members gain through reflection on their own practice experiences;
2. to help practitioners and community members share their practice knowledge with one another more effectively
3. to create more generalised knowledge about practice, from practice, for practice;
4. to incorporate practice knowledge in project evaluations

(Labonte & Feather, 1996: 11)

In this case, I modify Labonte and Feather's fourth goal to a much broader research goal: one that aims to make explicit the shared meanings and themes that inform our work, so that we, as learning and development practitioners, may improve our work.

The Story-Dialogue workshop begins with the telling of a generative theme. In this case, the generative theme is a brief statement outlining a broad practice tension that is relevant to all three professional practice networks and will serve as a starting-point for critical analysis. For the purposes of the S/D-M, a good theme is one that "identifies 'tensions' or strained relations that exist within and between the people who are part of it…[and] speaks to power relations in [public health] practice rather than to content issues of work" (Labonte et al, 1999: 42). The generative theme in this application is a concise acknowledgment of the competing and often overlapping models of education and program evaluation undertaken by a range of professionals within the broad field of public health. The theme aims to direct participants to reflect on and articulate how they approach education (eg the theories, frameworks, skills, knowledge and relationships) within their professional discipline and, with other public health professionals and community groups in a changing professional and public health landscape.

Two participants from each workshop prepare a case story, which "describes the practitioner's experience with the tensions summarized in the generative theme" (Labonte et al, 1999: 42). The case story consists of "a first-person account of how the practitioner dealt with the tensions, what was happening in the context of his or her practice and what happened as a result of the actions taken" (Labonte et al, 1999: 42). Furthermore, "Story-tellers…are encouraged to problem-pose their experience, rather than problem-solve it" (Labonte et al, 1999: 42). This notion of problem-posing allows the story-teller to focus on the telling of their story without having to prematurely and individually problem-solve their experiences in front of their peers.

After the telling of the first case story, participants reflect on how that case story relates to them and the work they do. Next, a structured dialogue is facilitated that asks questions of the group that grounds the dialogue in their own experiences (ie How is the story I have just heard also my practice story? How are the issues in this story similar to or different from my own experiences?). This process is developed to "assist practitioners to make explicit their assumptions (theories) about their work and to subject them to some critically respectful scrutiny with their peers." (Labonte et al, 1999: 39). The social-constructivist roots of the S/D-M include the researcher "as part of the reality that is being researched, such that the research findings are a creation of the inquiry process itself rather than a collection of external, already existing facts" (Labonte & Robertson, 1996: 434). My role as facilitator of the S/D-M workshops involves me in the inquiry process. Insights are mutually identified, negotiated and adapted through a group discussion that, at times includes the voice of the researcher.

These insights are then recorded on Insight Cards and are used as key points of discussion or ideas that arose from the structured dialogue. The telling of the second Case Story occurs, followed again by a brief reflection circle, the structured dialogue process and the development of insights. Participants then group the Insight Cards into thematic categories –such as relationship building or evaluating practice for example. The categories are refined and at times, Insight Cards are duplicated when they match with multiple categories.

Theory Notes are then drafted under each category in an attempt to consolidate and identify some key lessons learned about their educational work. Theory Notes 'relate to a range of key points arising from the story that members of the group think are significant enough to be shared with other practitioners (Labonte et al, 1999: 45). These key points could relate to articulating characteristics of professionally productive partnerships; engagement strategies with learners or key stakeholders working in other areas of public health; or educational frameworks which assist with and validate their educational work. The S/D-M is used to create generalised knowledge and understanding using particular practice experiences (Labonte & Feather, 1996: 29) through group critical reflection. It is this group process of critical reflection that the S/D-M uses to "bridge the gap between descriptive stories and rigorous explanation" (Labonte et al, 1999: 39).

The Story-Dialogue process is summarised in the table below and adapted from Labonte and Feather (1996) *Handbook on Using Stories in Health Promotion Practice.*

**Methodological overview**

1 A generative theme is one that identifies practice tensions among networks of people and aims to create discussion. The Case Stories are based on the following theme

**The Generative Theme**:

| |
|---|
| Public health is a broad field where competing and often overlapping models of education and program evaluation has lead to a great deal of conceptual confusion around determining what constitutes best practice.<br><br>Doing education and practice development work in public health often requires that educators, clinicians, service managers and others need to adapt to the different learning needs, expectations and capacity of their target groups. It also means working with different educational frameworks. Some projects require a more organisational approach to build the capacity of particular services. Others may require a more training-based approach that is based on assessing behavioural learning outcomes. And others may work on a community development or peer-based model of education.<br><br>Working with various models and changing learner expectations poses ongoing dilemmas for the ways in which public health practitioners negotiate our range of skills, knowledge, and learning relationships in order to adapt and change with the demands of this field. |

**2. Telling of the Case Story**

A Case Story is a personalised account related to the Generative Theme. It describes the practitioners experience with the tensions described. The Story-tellers who write the Case Stories are encouraged to problem-pose their experiences rather than problem-solve. "It focuses on particular events in your practice experience that were difficult, puzzling or especially instructive for you" (Labonte & Feather, 1996). The Case Story can run for about a page.

**3. Reflection Circle**

A Reflection Circle occurs when other group members speak one at a time and without dialogue on how the story and the issues it raises are similar to (or different from) their own experiences. It has proven useful in shifting analysis from descriptive content of a Case Story towards the organisational and social contexts in which we work. This is a brief process.

**4. Structured Dialogue**

According to Labonte & Feather (1996) the Structured Dialogue is "how we create a deeper, shared understanding of the themes around which a Case Story is prepared" (Labonte & Feather, 1996). Four categories of questions generate the Structured Dialogue:

1. What do you see happening here? (Description)
2. Why do you think it happens? (Explanation)
3. So what have we learned from our own experience (theory and hypothesis)
4. Now what can we do about it? (Action)

It is not necessary to answer all the questions in the order they appear. Keep the focus on that Case Story

5 **Insight Cards**

Following the Structured Dialogue process, Insight Cards are developed that identify key points from discussion. Insights are written as 'I' statements and are meant to express generalisable lessons. Often

they arise for the "So what" and "Now what" questions. The statements need to have meaning on their own (in other words, they are worth sharing with other people beyond the story group).

6 **Repeat Process** with next case story (reflection circle, structured dialogue, Insight Cards)

7 **Make Categories with Insight Cards** – Look for themes or categories allowing for the consolidation of lessons from a range of stories.

8 **Theory Notes**
Theory notes are then developed based on these categories. They are descriptive statements that link with the statements from the insight cards. "This theory note is an attempt to explain what lessons the category of insights holds for other practitioners who may be in other practice situations" (Labonte & Feather, 1996).

use as a guide for discussion. These can be asked in any order.

| | |
|---|---|
| What do you see happening here? | ▸ What's the need, problem or issue? |
| Description questions | ▸ What did we do?<br>▸ What was our plan?<br>▸ What were our successes?<br>▸ What were our problems? |
| Why do you think it happens? | ▸ Why did you take the actions you did? |
| Explanation questions | ▸ Why do you think it worked?<br>▸ Why did you get the results you did?<br>▸ Why did some actions go smoother than others? |
| So what? | ▸ What have we learned? |
| Synthesis questions | ▸ What remains confusing about our practice?<br>▸ How have people changed through the process?<br>▸ How have organisations changed through the process?<br>▸ How did relationships between people and organisations change? |
| Now what? | ▸ What will we do differently next time? |
| Action Questions | ▸ Action planning |

*Adapted from* Labonte and Feather (1996)

The second stage of analysis explores the various categories, insights and theory notes that have been produced and an analysis of other texts participants bring to the process (eg strategic planning documents, Mission statements). The audio taped scripts will also be used to record any discussion that is not included in the insight cards or theory notes but that substantially contribute to the development of practice-based theory statements.

From the audiotape transcriptions and texts I identify and group themes in relation to changing knowledge, skills, relationships and worker identities but not limited to these. An analysis of these texts identifies how practitioners speak of and shift through particular educational models and worker identities.

The following analysis and grouping of Insights and Themes arose from the telling of two case stories for each of the three S-D/M workshop. The resulting Case Stories, Insights and Theory Notes are contained in Appendices iii-v.

# Chapter 5

# Analysis

To provide context for this analysis, the following Generative Theme aimed to identify practice tensions and to create discussion. This Theme directly informed the development and telling of all Case Stories and was read at the beginning of all three Story-Dialogue Method workshops:

> Public health is a broad field where competing and often overlapping models of education and program evaluation has led to a great deal of conceptual confusion around determining what constitutes best practice.
>
> Doing education and practice development work in public health often requires that educators, clinicians, service managers and others need to adapt to the different learning needs, expectations and capacity of their target groups. It also means working with different educational frameworks. Some projects require a more organisational approach to build the capacity of particular services. Others may require a more training-based approach that is based on assessing behavioural learning outcomes. And others may work on a community development or peer-based model of education.
>
> Working with various models and changing learner expectations poses ongoing dilemmas for the ways in which public health practitioners negotiate our range of skills, knowledge, and learning relationships in order to adapt and change with the demands of this field.

All three professional practice networks, and in particular, the two Case Story writers for each workshop wrote of concrete examples where professional tensions arose through new or multiple ways of working. Although the contexts, professional groupings and educational approaches differed among the three networks, recurrent themes, insights and theories were developed addressing how public health practitioners conceptualise their educational work and their changing roles.

The six Case Stories, Insights and resulting Theory notes for all S/D-M workshops are contained in Appendix iii – v. This analysis focuses particularly on Insights that generated the most discussion and that lead to the development of Theory Notes –descriptive statements about lessons learned through group discussion.

The analysis of data from the three story-dialogue workshops is structured from the Case Stories prepared by two participants in each network; the Insight Cards that arose through the structured-

dialogue component of the activity, and the Theory notes that aim to explain or summarise key themes that arose through the workshop. The analysis is organised by the themes participants generated while grouping theory notes. Particular attention is given to the ways in which the three groups speak of their skills, knowledge, relationships and worker identities in relation to their professional experiences.

### HepLink Story-Dialogue Method Workshop

Both Case Stories for the HepLink Story-Dialogue Workshop described the planning, facilitation and evaluation of an educational intervention targeting a specific workforce within public health. The stories made frequent reference for the need to plan for and assess learning needs; establish relevance of the topic; value a mix of pedagogical approaches (ie lecture style, games and simulations, action learning focus groups); to work within organisational and capacity building frameworks; and to provide creative evaluation strategies to assist with describing learning outcomes related to individual, organisational or sector-wide issues. Both stories demonstrated participants' unease with attempts to combine contemporary adult learning principles such as the need to establish relevance; to motivate learners to become critical problem-solvers; to support learners to reflect on how their values affect work practices and programs; and their current repertoire of skills and knowledge, with more organisational or business planning mechanisms (where individual and organisational contexts inform the curriculum and processes used). Both Case Stories make reference to the need to build on existing skills and knowledge of the learners and to 'build their capacity' or to move the learning achieved 'into action'. In other words, both Case Story tellers described the tensions arising when trying to shift the learning from that of a disciplinary-based form of knowledge production, involving the presentation of scientific and epidemiological facts, along with a defined body of skills crudely grouped as 'best practices' to more "socially accountable and reflexive" (Gibbons et al, 1994: 3) collaborative problem-based learning programs that focus on individual and group action in localised contexts.

Heplink's Case Story 1 describes the tensions arising when attempting to accommodate both the learner preferences for clinical information or as is phrased in the Case Story, 'the real stuff" (Case Story 1, para 9) and the educator's own educational goals that include more reflexive and collaborative forms of knowledge production:

> Usually…in the get-to-know-you section, participants state they want 'information', often about transmission, so we hope that by starting with this basic section, we satisfy that need first up. If we ever do try to jump straight into being interactive and drawing from their experience, participants seem impatient to get to what they perceive to be the 'real stuff' – the information.
> (HepLink Case Story 1, para 9)

Through formal evaluations learners indicated they valued clinical and epidemiological information over activities that involved group problem-solving despite educator observations of 'livened discussion' during those times. On reflection, the Case Story author writes:

> Reflecting on this session now, it stands out as one of our best -mainly because there was a lot of interaction among the diverse participants. They seemed to learn from each other as much as from us.
> (Heplink Case Story 1, para 13)

Despite formalised evidence from program evaluations, the educators, through their own participant observation recognised the value of facilitating more group based problem-solving activities that drew on their existing professional skills and experiences and related these to concrete workplace settings. Learning outcomes from these participatory sessions were observed to produce more "concrete suggestions" (HepLink Case Story 1, para 13) aligned with observable program or service outcomes. In other words, the learning that occurred was seen to have more application to workers' skills, relationships and programs than the learning that occurred through the provision of clinical and epidemiological information on hepatitis C. It is the learning that applies to people's lived work experiences that were deemed to have more meaning and application to the educational interventions.

Both practitioners who wrote Case Stories highlighted the complexity and ambiguity of working with multiple models, approaches and learner expectations -at times described as informal 'behind the scenes workforce development work' (HepLinkCase Story 1). This work was articulated as partnership building activities and the broad ranging work required to facilitate "organisational strategic development" (HepLink Case Story 1). Both Case Story authors describe the tensions arising in adapting this mix of approaches and multiple learner expectations with educationally rigorous evaluation strategies as well as working with individuals, teams and varying organisational contexts.

Working with practitioner values and attitudes towards people who inject drugs illicitly, or as in HepLink Case Story 2, building interpersonal, professional and organisational trust to ensure continuity of care and access to health services for people living with hepatitis C, required creative but uncertain benchmarking approaches to measuring program outcomes and to guide their own professional knowledge and skills in this evolving work:

> We need to think about evaluating more than increasing knowledge. We need to evaluate our partnerships. This requires a shift in what we traditionally value in education. This shift could move towards validating our broader workforce development activities.
> (Heplink Theory Note)

The following analysis is organised by the categories generated through the S/D-M. The resulting Insight Cards and Theory Notes under each category aim to make explicit the shared meanings and

themes that inform and challenge educational work in public health among these professional practice networks. Together these categories, Insights and theories were generated as a result of the structured-dialogue process for Heplink and are used as analytic devices to examine how particular practice networks speak of their work, skills, knowledge, relationships and identities.

### The practice of relationship building

Individual and organisational relationship building was a recurrent theme articulated in all three story-dialogue workshops. In the context of HepLink dialogues, the quality of relationship building was valued primarily as an informal process that worked towards building trust and receptivity on the part of the individual learners or organisations. The informality of relationship building was articulated as a critical component to the development of organisational partnerships:

> Personal relationships and informal partnerships between workers are as important as formal organisational level partnerships
> (Heplink Theory Note)

Many participants described the process of relationship building as a series of informal and tacit activities that aim to build reliability and to demonstrate relevance:

> Building trust requires that we offer a range of timely and tangible activities
> (Heplink Insight Card)

> This work occurred within a framework of service trust
> (Heplink Case Story 2)

Here, an expanded notion of education is identified –one that includes a range of organisational planning and informal relationship building activities and a desire to match the individual or organisational learning needs with 'tangible activities' such as education sessions or program partnerships:

> …That is, we aim to build not only the skills and knowledge base of individual workers, but also their ability to put these into action. This means that we aim to focus not only on education, but also on development partnerships, networks, access to resources, organisational support etc…
> (Heplink Case Story 1)

Promoting organisational capacity building or 'settings-based' approaches in public health education requires the adoption of particular sets of terms, theories and a range of activities that rarely become formalised in program evaluations or course plans. For example, as in Case Story 1 the educator observed that she facilitated the production of more reflective and workplace-relevant skills and knowledge among learners despite program evaluations indicating the worth of clinical information provision.

Within the broad 'settings-based' approach the notion of education is articulated as 'workforce development' –a term defined by the NSW Health Department (2001) as "a process initiated within

organisations and communities, in response to the identified strategic priorities of the system, to help ensure that the people working with these systems have the abilities and commitment to contribute to organisational and community goals" (NSW Health, 2001: 12). The language of this definition poses particular obstacles for the development of informal partnerships and trust:

> The concept of workforce development is not an easy one to promote or evaluate…on our first rural visit we did not include or offer education sessions, but instead focussed on networking, meetings and resource distribution. However, I got the feeling that people wondered what we were doing there.
> (Heplink Case Story 1)

The terminology of capacity building or 'settings-based' approaches to public health education was used by both story-tellers. The principles and activities within these two broad frameworks were achieved through a series of often administrative work practices, informal relationship building activities and a desire to be viewed as relevant and useful.

Although the notion of relationship building was regularly highlighted as a key strategy to achieve trust and ultimately desirable health service outcomes, it requires a mix of interpersonal, informal and ongoing activities that are not commonly viewed as professional practices within a more traditional pedagogical view. In other words, the experiences of planning and facilitating education was described by both Case Story tellers as an inherently messy process yet an important one as it supports enhanced service or programming outcomes as well as individual learning outcomes:

> Good education leads to trust, leads to partnerships, and may lead to capacity being built.
> (HepLink Theory Note)

> We have a constant need to produce tangible products but much of our learning theories are fuzzy and difficult to identify in our work outcomes.
> (HepLink Insight Card)

In both Case Stories, the goal of organisational performativity, that is, the ability to document concrete program or health service outcomes as a result of an educational or workforce development intervention were described as being crucial:

> …the education and development team was established with the aim of developing the hepatitis C workforce in the broadest sense, that is, we aim to build not only the skills and knowledge base of individual workers but also their ability to put these into action.
> (HepLink Case Story 1)

> …a Service Agreement is currently being negotiated between [these two services] in order to formalise and support these agency level activities
> (HepLink Case Story 2)

Relationship building was articulated as an important, ongoing component of educational practice. Using both informal, personalised relationship building activities as well as more formalised, organisational approaches (through the development of Service Agreements as part of their

educational work for example), Heplink practitioners place great importance on the development of trust to build receptivity to new ideas and to facilitate organisationally relevant service outcomes.

### Educational frameworks and professional practice

This category refers to a range of contemporary adult learning theories or business planning frameworks that guide the work of the practitioners and the implications this framework has on professional practice. Both Case Stories explicitly framed the descriptions of their work using a range of organisational capacity building, and in particular, workforce development-related terms. The "fostering of organizational learning as opposed to individual skill formation" (Johnston, 2001: 3) was a common goal underlying both Stories. However, tensions arose when participants spoke of the need to shift from an individual, training-based model of education, to a broader more organisationally focussed notion of workforce development. This shift requires a new range of professional practices not conventionally recognised as educational ones:

> …we know that best practice in workforce development isn't just offering education but opportunities for us to give more than just education sessions. …You know theory versus what we can actually do. People aren't really buying theory.
> (HepLink Insight)

> …workforce development –is not just around training but around education and workforce development more broadly and that this is a lot of de-centralised fuzzy-wuzzy activities that often don't count in people's expectations about what education is.
> (HepLink Insight)

The resulting Insights from the structured dialogue highlight a key tension arising from a need to employ a range of contemporary adult learning theories, business planning frameworks and formal and informal interventions on one hand, and a difficulty in articulating and documenting how their range of activities fit within such overlapping frameworks:

> We have a constant need to produce tangible products but much of our learning theories are fuzzy and difficult to identify in our work outcomes
> (HepLink Insight)

> What about all this stuff that's telling us that we learn incidentally and informally all the time in multi-disciplinary settings with multiple strategies. I think this makes a lot of theoretical sense but I also think it creates a lot of methodological hiccups…
> (HepLink Insight)

There remains an ongoing concern about the quality and availability of evidence that supports the use informal, relationship-building work practices. With several pedagogical approaches being employed within one 'workforce development' intervention, participants acknowledged the worth of informally drawing on a range of skills or 'tools.' This range of approaches is informed by the professional traditions of the learners and the educators and the type of health service or organisation:

> We don't have enough evidence to say with certainty that the more informal, creative processes necessarily yield results in this context.
> (HepLink Theory Note)

> Educational practice requires a range of tools that can be drawn on quickly. The tools used by the educator depend on their professional experience.
> (HepLink Theory Note)

While working with multi-disciplinary teams of health workers, participants identified the use of informal, interpersonal relationship building activities to best encourage collaborative learning in the workplace:

> In some cases we need to rethink what education is. Sometimes we see education as a process of facilitating dialogue.
> (HepLink Insight)

> …people will learn in a multi-disciplinary setting if they operate in a multi-disciplinary setting. That relates to the workplace. I think if people work well in multi-disciplinary settings they learn skills about how to relate to other professional groups….
> (Heplink Insight)

Organisational capacity building approaches, such as NSW Health (2001) "A Framework for Building Capacity to Improve Health" provide a range of planning principles and indicators that require the practitioner to engage with learners on interpersonal, organisational and inter-sectoral levels. Methodologically, this poses challenges for educators in defining their practices and attributes beyond a range of informal, inter-personal approaches.

### Assessing learner needs

The shift from assessing individual to organisational learning needs was acknowledged as a newly emerging and complex process requiring 'creative' and adaptive methods:

> Assessing learner needs now requires a broader, more organisational focus. We have to know how the education topic fits in with organisational goals and we have to be creative in our methods of adapting to different organisational contexts.
> (HepLink Theory Note)

The skill of assessing organisational motivation to learn and to engage in a particular issue was identified as crucial when undertaking a capacity building approach to education:

> Assessing learner needs is much more than assessing content or knowledge gaps, it should be relevant to work culture, motivation and partnership development.
> (HepLink Theory Note)

By building flexibility into the curriculum, educators can take into account the complexities of drawing together an integrated and mutually agreed upon curriculum for multi-disciplinary teams of workers. The assessment process then becomes something negotiated through dialogue with a range of key stakeholders:

> …in this case we only had contact with the Coordinator, who … gave us their impression of who might be attending and what their learning needs and experiences…might be. So we assumed that there would be a lot we would not know in relation to their learning needs until we asked them on the day…For this reason, we build flexibility into our programs. (Heplink Case Story 1)

For both Case Stories, the skills involved in assessing learner needs (including individual, multi-disciplinary teams and organisational) were undertaken 'on the run' despite an explicit references to a capacity building framework. 'Building flexibility' into educational programs requires skills in facilitation and action-learning in addition to providing clinical, epidemiological and prevention information. By targeting workforce development or educational interventions by organisations (as opposed to professional groups within public health such as nursing staff), the educator is required to address the learning needs of a range of health care professionals in the contexts of an organisation or local region. The planning processes of assessing these varying learning needs among multi-disciplinary staff along with the need to ensure programming outcomes are strategically aligned with service or regional business plans makes the process of assessing learner needs complex and difficult to articulate:

> Through our discussion, there seemed to be things coming up like the problems with the need to know what the audience expects. And what they're learning needs are and what the culture of the participant's workplace is and to know all that stuff inside and out to try and make your education session as relevant as possible now.
> (HepLink Insight)

### Worker identities and learner expectations

While drawing from various contemporary adult learning theories or business planning frameworks to guide their work, participants highlighted the tensions that arose between learners' expectations (often aligned with more traditional pedagogical approaches) and their own changing professional roles. Working with multiple educational or program planning frameworks; embedding problem solving within the context of individual, professional and organisational contexts; and managing often divergent views about what constitutes legitimate or evidence based workforce development practices were key tensions arising for HepLink practitioners. Casey's (1999) description of the 'knowledge worker', where 'workers must be willing and able to learn and perform new tasks, take on different roles and be easily redeployed" (Casey in Boud & Garrick,. 1999: 18) reflects the transient and changing professional identities described by participants:

> The other thing … which resonated with me, was that when we're trying to do other workforce development activities, people don't see if you're doing networking or hosting a meeting, people don't value it alone. You need something else. You need the education sessions otherwise people don't think you're doing anything. That's really frustrating.
> (HepLink Insight)

The need to 'balance expectations' beyond those of the individual learner to a broader collection of organisations and funding bodies was identified as an ongoing challenge requiring 'a flexible

approach' as well as 'careful planning [and] appropriate data collection' (HepLink Theory Note). The process of balancing expectations is a methodologically vague process of negotiation that participants referred to when attempting to assess learner needs and in offering a flexible and organisationally relevant curriculum:

> Our own identities are less relevant than managing expectations. We need to balance expectations of participants, ourselves and our funding bodies reporting expectations. We need to be conscious of these often conflicting needs and expectations in program planning. They can all be met with careful planning, appropriate data collection and a flexible approach.
> (HepLink Theory note)

Varying and frequently competing learner expectations (including their expectations of their own work) require the practitioner to assess through negotiation, and action-planning type practices rather than through a more traditional and insular process of assessing individual, behaviour learning needs. The ongoing processes of negotiation and consultation at different organisational levels and with an expanding, multi-disciplinary workforce of learners requires a flexible notion of worker identity. Worker identities are in part shaped by the multiple roles negotiated through ongoing program activities across various work settings:

> Sometimes we're trainers, facilitators, problem posers, HR persons –there's a lot of different sorts of expectations about who you are when you go into the training."
> (HepLink Insight).

### Evaluating our practice

Determining the evaluated worth of various educational interventions was a common point of discussion. HepLink practitioners acknowledged the range of traditional evaluation indicators available to them such as assessing behaviour learning outcomes, attendance records, and a range of empirical tools and scales that can align with organisational or business planning frameworks. Participants also identified that such empirical approaches to evaluation do not provide the kind of meaningful, reflexive feedback needed to inform their own practice development:

> I think we're talking about ways of analysing our practices so 9.2 may be a good reporting tool and maybe a very impressive business planning thing but it doesn't actually do too much in terms of specifically guiding our work practices. It makes us feel good. It says that we probably did something right. But I think the point around the observations was that we have lots of tools and rating things but we often underestimate our own observations about how we think it went – through gut feelings, through observations and participant comments.
> (HepLink Theory Note)

HepLink Practitioners identified an awareness of and desire for a greater recognition of broader and more dynamic forms of knowledge production in their everyday education. Shifting from "knowledge understood as a matter of what one knows, to knowledge understood as a matter of what one can do" (Barnett in Garrick & Rhodes, 2000: 16) can require an adherence to traditional

mechanisms for program evaluation and more creative, reflexive and participatory methods that assist with their individual skills development:

> Longer term success is often about bringing people together and networking although often people undervalue that networking stuff and emphasise the content-oriented sessions (HepLink Insight)

> Creative evaluation strategies can tell us more about what participants may do with the knowledge and can be more reflective and personally illuminating (eg Photolanguage, learning contracts, observations)
> (HepLink Insight)

Creative group evaluation strategies such as the use of Photolanguage have provided some Heplink participants with the kind of knowledge production described earlier by Gibbons et al (1994). Mode 2 of knowledge production is produced by continuous negotiation with the interests of various people from a range of disciplines being included with key elements of group participation and problem solving to its production (Gibbons et al, 1994: 5). Participants identified the need for employing a mix of evaluation strategies. While adhering to the use of more traditional, Mode 1 forms of knowledge production (usually based on the assessment of skills or the use of behavioural learning or program outcomes) participants also described their experiences with, and desire for using more reflexive and group-based methods to guide their practices. These methods provided participants with more meaningful yet difficult to articulate impressions about facilitating group learning in varying organisational contexts:

> I mean why do we use numbers to evaluate? They make us feel good. Do they actually help us? They're never low. What do they tell us anyway?
> (HepLink Insight)

> …somehow I get more out of the subjective stuff than I do out of the objective stuff.
> (HepLink Insight)

> But ultimately it's a lot easier to go with numbers and so we evaluate with numbers and I suspect that most people are less inclined to give really low scores, generally. … So do we go for the cheap and cheerful way because ultimately at the end of the day, while people are scribbling away, in terms of meaning, what meaning can we really get from that process? Because we have to work with this structure and we like to think we base our practice on evaluation so we incorporate it but we don't actually incorporate it in a meaningful way.
> (HepLink Insight)

### HepLink summary

The structured dialogue process highlighted the tensions arising when HepLink practitioners negotiate broad shifts in their professional practices -from more traditional pedagogical approaches based on disciplinary-based forms of knowledge to those of more dynamic group-based activities informed by organisational and business planning frameworks. The skills, knowledge and

relationships required to achieve broader program outcomes required a tacit mix of 'behind the scenes' (HepLink Case Story 1) work that relied on interpersonal and informal practices aiming to build trust and to assess learning needs: "we facilitated some get-to-know-you activities which gave us an idea of their roles and experiences and what they want to find out…" (HepLink Case Story 1). Working with multiple models, flexible approaches and varying learner expectations highlighted a concern for the quality and availability of evidence that can inform their work. Drawing from a mix of both empirical and reflexive group methods of evaluation was viewed as necessary both for the documentation of program outcomes and for the development of individual practitioner skills. HepLink participants described the ongoing need to negotiate their work roles and methods in a range of organisationally varied settings. Again, Casey's (1999) description of the 'knowledge worker' is closely aligned with the principles of flexibility, the need to adapt to different organisational contexts and the ability to draw from a range of pedagogical approaches. Recognition of the continued need to build trust through personal relationships and informal partnerships also reflects the increased attention brought to the interpersonal characteristics or attributes of the worker rather than their more traditional discipline-based forms of knowledge.

### Network of Alcohol and Other Drug Agencies (NADA) Story-Dialogue Method Workshop

The Network of Alcohol and Other Drug Agencies (NADA) Case Stories highlighted a range of critical success factors and ongoing challenges related to working with business planning and capacity building models of education. Both stories articulated a need to employ a range of organisational learning strategies along with a need to adapt or "manipulate" (NADA Case Story 2) contemporary health promotion or health education models. While naming their professional approaches and underlying key principles involved in business planning and organisational relationship building, both Case Story tellers again emphasised the need for ongoing interpersonal trust and relationship building activities. By first assessing "how services do business" (NADA Case Story 1), both Story Tellers described a range of interpersonal or "practical strategies" (NADA Case Story 1) that assist them to "refine and continually develop their relationships" (NADA Case Story 2). Working within broader business planning and organisational approaches to education required that education practitioners negotiate their roles with the learners, and at times, offer more traditional pedagogical interventions (such as providing on-site training) to align learner expectations with the broader goals of the practitioner.

### The practice of relationship building

Informal and formal relationship building activities were key to the broader programming successes of both Case Story tellers. Again, a mix of interpersonal and organisational approaches was used. Both storytellers described the procedurally messy processes involved in building trust between themselves and their target agency before they aimed at building trust among groups of agencies.

Through a mix of "face to face" (NADA Case Story 1) consultations and by offering a range of organisationally relevant but smaller scale incentives, practitioners were able to build the trust needed to work with and influence the business of other agencies:

> In its simplest terms- its organisational based –in its simplest terms it's a process of building relationships between myself, [this NGO] and key people in different Area Health Services –one Area at a time.
> (NADA Case Story 1)

> …and it's almost like an informal thing…it doesn't seem like a professional way to work…it's like having to trade on the personal
> (NADA Insight)

> …much more time, resources and energy has gone into pre-training or setting up training in an effort to try and change or optimise the learner environment. And I guess that has been through building of trust and relationships.
> (NADA Insight)

### Educational frameworks and professional practice

Case Story 1 described the educational work using business planning and at times, capacity building terms. The assessment of learning needs was described as "examin[ing] how services do business' (NADA Case Story 1) and interventions were described as a range of organisationally relevant 'practical strategies" (NADA Case Story 1). In Case Story 2, the storyteller described a desire to adapt successful models in HIV/AIDS peer education among gay men, to youth using contemporary health promotion models. Both approaches to education work highlighted a need to both name the educational framework and formal professional practices associated with this and to describe a range of smaller and flexible, interpersonal relationship building strategies articulated by the workshop participants as "ongoing, creative approaches" (NADA Insight).

> So you're kind of setting an agenda and supporting them to make decisions about strategies –so that's a lot about facilitation.
> (NADA Insight)

> And so it's encouraging people to look at the skills, experience, expertise, relationship building and thinking "How can we link all that together and reorient what we do?" Which isn't actually, necessarily requiring major steps but it's that creativity and permission giving at a whole lot of levels to do that's the middle, manager, the senior executive and so forth.
> (NADA Insight)

> So we also have to work with what comes up in the day I think that's our thing –to be very, very flexible. That the agenda is merely an outline.
> (NADA Insight)

The structured dialogue process arising form the telling of the second Case Story, acknowledged the 'implicit conflict' (NADA Theory note) between the social and generative processes used in contemporary adult learning and organisational development frameworks and those which are "are set and solved in a context governed by the largely academic, interests of a specific community."

(Gibbons et al, 1994: 3) In this case, the specific community referred to is the medical community, which, as highlighted earlier, traditionally values scientific evidence and knowledge derived through empirical research. The processes of assessing learning needs of multi-disciplinary groups requires "more socially accountable and reflexive" (Gibbons et al, 1994: 3) forms of knowledge. The ability to respond creatively to a variety of organisational contexts and with multi-disciplinary groups of people requires a series of tacit and informal relationship building activities, flexibility and an ability to negotiate mutual program benefits. These practices are at odds with traditional pedagogical approaches, which emphasize 'effectiveness of instruction' (Freire, 1970: 53) that draws from a professionally specific body of clinical knowledge. The divergent views of what constitutes legitimate educational practices poses ongoing challenges for the ways in which more contemporary and heterogeneous approaches are valued within public health:

> Our work context is often dominated by a medical paradigm. There's an implicit conflict between this model and underlying principles of health promotion and adult learning. Much of our workforce development activities (such as assessing learning needs of multi-disciplinary groups; working with multiple organisations including those in other sectors; negotiating mutual program benefits; facilitating dialogue) are not viewed as legitimate educational practices.
> (NADA Theory Note)

### Organisational development as education

Working with business planning or organisational development frameworks requires consultation and assessment at both an individual and organisational level. The processes for working with organisations need to be flexible to take into account a variety of organisational structures, relationships and business planning frameworks. Assessing 'how services do business' is often complex and relies on the development of interpersonal relationships with key individuals (ie service managers).

Nevertheless, the language of education becomes firmly rooted within business planning models. Educational outcomes are measured through the attainment of program objectives or changes in work practices.

> …so the first goal is to examine how services do business –How the culture of the service supports access and equity principles and policy for people who are culturally and linguistically diverse with alcohol and other drug problems. And secondly, once we've done that – how to improve the access and equity through relationships and practical strategies that are using Area resources.
> (NADA Insight)

> One of the big things is the sign off, it is the high-end endorsement we seem to need now to do education with this organisational framework.
> (NADA Insight)

> You're certainly advocating on an issue: access and equity. You have an idea there and you're trying to push it through in lots of different ways in different organisational settings which is again a little bit different from the usual way we perceive education.

(NADA Insight)

> Increasingly our educational work is becoming more organisationally focussed. This means that we often have to assess not only individual learner needs, but the various organisational structures and goals. We try to "sell" our value before engaging in training. We're now asking people to demonstrate changes in work practices or program outcomes. Those are high benchmarks to achieve.
> (NADA Theory Note)

> We are increasingly working within a business-planning framework. We 'do business' with other services and are explicit about using this rhetoric in our work. Learning outcomes become business outcomes. It's one way of validating our educational work.
> (NADA Theory Note)

### Assessing learner needs

Assessing learner needs using business planning approaches was acknowledged as a complex and varied task that required a broad range of formal activities (as demonstrated through this NADA Theory Note: 'meeting people on their space and working with them on what they want, connecting key agencies and sectors', for example) and interpersonal alliance building strategies. Participants described the processes of assessing learning needs, as a means to building organisational trust and interpersonally 'aligning' (NADA Insight) themselves with individuals. As well, assessments were undertaken on a 'systemic level' (NADA Insight) requiring increased consideration for the ways in which strategic planning documents, organisational relationships and boards of management influence their educational activities and program outcomes:

> All that stuff about being aware of relationships at a systemic level but also a personal level...what a huge impact both of those things have on the way your day pans out or how the project works and so on.
> (NADA Insight)

> I'm just saying if you want this information it might be something you use. And I can actually see the pressure coming off them. They come in like this and sort of go –ah right. So I work on aligning myself.
> (NADA Insight)

> Working for change in AOD organisations has to recognise the particular idiosyncrasies of workers as well as the agendas of other players — the organisation, its board of management, the funders.
> (NADA Theory Note)

> There is a range of other things we have to accomplish (key relationships, meeting people on their space and working with them on what they want; connecting key agencies and sectors, empowerment strategies, etc)…with training and workforce development programs.
> (NADA Theory Note)

Through strategies of interpersonal 'aligning' and 'trad[ing] on the personal', NADA practitioners, like HepLink relied on their characteristics and attributes when assessing learning needs and negotiating their roles across varied settings.

### Worker identities and learner expectations

Working with organisational development and business planning frameworks requires that different forms of participation occur with multiple networks of people. Much discussion focussed on the amount of informal, behind the scenes work required to build mutually beneficial partnerships. One participant described her work as "selling something" (NADA Insight) to promote individual practice or organisational change. Another described his work as doing organisational "advocacy" (NADA Insight) to encourage engagement with the educational topic. Both Case Stories and the resulting Insights and Theory Notes emphasise again the methodologically vague planning processes required to build both individual and organisational trust. Often working on multiple collaborative projects, participants described their need to take on different roles that are negotiated in multiple settings. Casey's (1999) notion of the 'knowledge worker' aligns with many of the Insights and Theory Notes generated in the workshop relating to these multiple ways of working and learning. Their work was often being measured through documented changes in work practices or, more broadly, "re-orienting what [people] do." (NADA Insight) which suggests that notions of organisational performativity rather than individual skill formation are more common benchmarks of success for their educational work.

> I guess one of the things that struck me is that you're out there selling something that's really, really important [and] that there are no resources to support. And so what you're also doing is asking for them to think really creatively about a whole lot of levels about re-orienting what they do.
> (NADA Insight)

> …the amount of different types of skills required to do the organisational relationship building stuff is intensive. There's lots of face to face; a lot of time is spent assessing and asking people to do a lot of different things -not just learn stuff but act on some of the things.
> (NADA Insight)

> A lot of our work is advocacy. We advocate for organisations and workers to become engaged with our particular health topics.
> (NADA Theory Note)

### NADA summary

The NADA Story-Dialogue workshop identified the need for and ability to draw on a range of business planning frameworks, contemporary health promotion theories, and a variety of pedagogical and interpersonal approaches to do educational work. The process of building relationships with individuals and organisations was viewed as central to the task of developing

organisationally relevant incentives to learners. A flexible, interpersonal approach to assessing learning needs was commonly used to accommodate a variety of organisational contexts and again, to build trust. An emphasis on changing or "optimis[ing] the learner environment" (NADA Insight) by taking into account organisational factors such as strategic goals, relationships and the influence of boards of management was viewed as integral to assessing learner needs on a 'systemic level' (Nada Insight). No longer is the identification of individual learning outcomes on their own a 'valid' educational outcome. Participants described the need to "demonstrate changes in work practices or program outcomes" (NADA Theory Note) as a result of their workforce development approaches. To achieve these aims, practitioners described the need to "sell" (NADA Theory Note) their educational goals through a series of consultations and by developing "practical strategies" (NADA Case story) and organisationally relevant activities. Using business planning terminology was viewed as a way of "validating … educational work" (NADA Theory Note) despite acknowledging that often the tasks required to undertake this work are rarely perceived by the learners as "legitimate educational practices" (NADA Theory Note). Employing a range of flexible approaches that are not readily viewed as specifically professional but more interpersonal in appearance, poses challenges to the ways in which NADA practitioners professionally identify and are viewed by their peers.

### Midwifery Story Dialogue Method Workshop

The categories for the Midwifery S/D-M are significantly different to those developed by HepLink and NADA practitioners. The Case Stories and structured dialogue focussed less on pedagogical practice or guiding frameworks, and more on midwifery practice development as part of an ongoing historico-political movement.

The two midwifery Case Stories spoke of different forms of "organis[ing] influence" (NADA Case Story 1) or "challenging" barriers to accessible or non-discriminatory midwifery care. Both stories spoke of ways in which midwives mobilise change in the public health system. The resulting Insight Cards and Theory Notes point towards more feminist and radical goals that reach beyond organisational capacity building or individual knowledge production. Formal education programs and informal one-to-one educational encounters are regularly informed by a historico-political movement that places women's empowerment and improved access to public midwifery services as long-term visions. A key distinction between the practice development midwives workshop outcomes and the outcomes from the other two groups is the ways in which gender power relations and dominant medical paradigms are questioned, and at times changed, through educational interventions. Education was frequently articulated as an opportunity for ongoing activism within a historically marginalised political movement of women. The Philosophy Statement from the Australian College of Midwives Incorporated (2004), an organization whose role includes the

provision of "a unified political voice for the midwifery profession" (ACMI, 2004: http://www.acmi.org.au/text/whois/whois_009.html) provides a useful summary of politically specific principles and strategies that inform their ongoing work. It is also a philosophy that directly informed the telling of both Midwifery Case Stories:

> **Philosophy Statement**
> Midwife means 'with woman'. This meaning shapes midwifery's philosophy, work and relationships. Midwifery is founded on respect for women and on a strong belief in the value of women's work of bearing and rearing each generation. Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman's life. These events are also seen as inherently important to society as a whole. Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society.
> Midwifery is a woman centred, political, primary health care discipline founded on the relationships between women and their midwives.
> (ACMI, 2004: Cited 27 03 05:
> http://www.acmi.org.au/text/corporate_documents/position.htm)

The democratic relationship between a woman and her midwife informs the radicalist aims and often coercive strategies that seek to address the power imbalances existing between the women and the broader public health system. Leap (2000) describes this unique relationship between a woman and her midwife:

> …the relationship between a woman and her midwife is based on mutual respect, trust and the potential for both parties to learn from each other as they engage in partnership.
> (Leap in Kirkham, 2000: 3)

Peer-based empowerment principles of "trust", "motivation" and "care" (Midwifery Insights) are central to the transformational aims of midwifery education to women. Leap (2000) further describes characteristics of midwifery educational interventions that seek to empower women:

> Slowly, over the years, a different underlying philosophy of care emerged as I had the privilege of working in the relatively untrammelled world of independent practice. I learnt about the potential for the empowerment of women through an approach that:
> - minimises disturbance, direction, authority and intervention
> - maximises the potential for physiology, common sense and instinctive behaviour to prevail
> - places trust in the expertise of the childbearing woman
> - shifts power towards the woman
>
> (Leap in Kirkham, 2000: 2)

Education to other sectors of the public health system was viewed by many as an ongoing act of personal and political "persuasion" (Midwifery Insight). Advocacy for women; the identification of social and historical roots of problems; drawing from experiences of these and using a series of formal and interpersonal approaches to overcome structural obstacles are fundamental aspects of midwifery education and political activism within the profession.

### Describing midwifery as a historical / political movement

Educational interventions are spoken of and situated within a series of historico-political movements that seek to empower women and challenge the accepted primacy of medical knowledge and public health service provision. It is a well-documented struggle that, like HIV-related education among gay men, emerges through political activism. The educational goals draw on the past political achievements of a movement that seeks specifically of ways to reorient a health system to incorporate principles of access, equity and continuity of midwifery care:

> Well I suppose all of us are involved in development different models of midwifery continuity of care. That's why these people are here because that is our major focus on the work we're doing at the moment is trying to change the system.
> (Midwifery Insight)

> Any institutional work in health is not nurtured. When a threat comes –it's the politics of oppressed people. You know? Because midwives have been so oppressed. Oppressed by obstetricians, oppressed by nurses, and used.
> (Midwifery Insight)

> Midwifery is political. Midwifery is about changing the status quo. It involves change at national and local levels. Midwifery change agents have incredible passion –it drives them to make a difference to the experiences of childbearing women in Australia. To come together to share experiences and stories with laughter, nurtures the support and ignites the passion and drive.
> (Midwifery Theory Note)

> Talking about the history (herstory) is a means to engage people and bring them along on the journey. Talking about history makes us realise how far we have come and gives energy to keep going.
> (Midwifery Theory Note)

Midwifery work therefore is explicitly located beyond a professional field and brings into light past political struggles and achievements to directly inform their ongoing educational work both within the profession and to organise influence beyond it.

### Midwifery practice development through role modelling

The telling of both Case Stories repeatedly generated a series of Insights and Theory Notes relating to the practical and politically important processes of Role Modelling within the profession. Role modelling was viewed as practical way of "inspiring" (Midwifery Insight) new midwives to "challeng[e] them" (Midwifery Insight) and to "encourag[e] them to question" (Midwifery Insight). This peer-based support approach is politically central to the broader political struggle of women's empowerment because it "encourages them to be their own individuals" (Midwifery Insight) and to "spread the word" (Midwifery Insight) of what it means to be "with women" (Midwifery Insight). Peer approaches such as these draw on life experiences and employ a range of ongoing interpersonal approaches to support the development of critical dialogue that aim to bring about

change. The language and educational approaches reflect that of a social transformationalist (or radical) philosophy of education. Peer-based role modelling within the profession is a fundamental educational approach used to guide the professional development and political awareness raising of new midwives:

> But also you need those inspiring role models and if you don't find them then you'll lose them. So you need that inspiration and passion around you to keep that momentum going. Until you feel mature enough to just do it on your own.
> (Midwifery Insight)

> It's hard to describe what we do isn't it? Really. I think what I do is try to encourage individuality in midwives. I try and make them buck the system and not to go with the sheep. Like "Don't wear a uniform. Why are you wearing a uniform? Why do you need to wear a uniform?" You know, try to encourage them to be their own individuals and thereby seeing that the women are individuals as well. So that's sort of a fundamental thing.
> (Midwifery Insight)

> …role modelling, mentoring, being an inspiration for young midwives, challenging them and encouraging them to question.
> (Midwifery Insight)

> …That's what I hope to do in my job is for other midwives see how I'm with women and they learn from that. So that's role modelling.
> (Midwifery Insight)

> The dominant culture is so pervasive for the midwives, isn't it? It's all most people know. Sure we're giving the students a vision of what might be but most midwives aren't that political. We could probably tell you who we were I think. We'd know in each hospital there are probably only on one hand you'd count the amount of midwives who are motivated, passionate enough to spread the word, speak at conferences, do things that they're not paid for, develop resources, strategies to deal with that and there's not a lot of us.
> (Midwifery Insight)

The Theory Notes relating to how midwives employ a range of role modelling techniques within their profession further articulate it as a way of "harnessing our passion into political action" (Midwifery Theory Note). Peer based role modelling is part of an emancipatory educational approach that seeks to raise critical awareness among women within the profession in order to "build a strong, autonomous profession" (Midwifery Theory Note):

> Awareness of who we are in the world is linked to building a strong, autonomous profession
> (Midwifery Theory Note)

> Midwifery is about harnessing our passion into political action that improves things for women
> (Midwifery Theory Note)

> Role models are an essential component on bringing about change
> (Midwifery Theory Note)

> Practice development is about building supportive networks and mechanisms
> (Midwifery Theory Note)

> No matter what the industry the mentor and the role model can never be understated. The student never forgets this form of learning, the woman never forgets the midwife who supports her. The concern in midwifery is that there are not enough good role models to go around. But one really good one can be so dynamic.
> (Midwifery Theory Note)

### Midwifery relationship building through persuasion

"Persuasion is an important strategy within midwifery" (Midwifery Theory Note) to influence public health workforces outside their profession. Again, the broad ranging approach of persuasion is directly linked to a clear political vision of continuity of midwifery care and professional practice development:

> We do a lot of explaining it. Explaining, what and why. Talking it up. I suppose providing the rationale… I think we spend out lives persuading people that it's a good thing. That's what the cause is all about really. So we write about it, we get up there on platforms and talk about it even if we don't like doing that. It's for the cause you know.
> (Midwifery Insight)

> Persuasion is an important strategy in midwifery
> (Midwifery Theory Note)

The activities relating to persuasion draw heavily on the "interpersonal skills" (Midwifery Insight) of individual midwives to then "challenge a whole lot of systems and organisational practices" (Midwifery Insight). One-to-one educational interventions that not only attempt to challenge "old practice" (Midwifery Theory Note) but to encourage the learner to reflect or "challenge her even a little bit more and unsettle her" (Midwifery Insight) reflect transformational learning processes of critical thinking and awareness raising:

> So it was challenging to a whole lot of systems and organisational practices going on within her unit. And she kind of knew that once I got in there and started looking at what was going on that I would ask a whole lot more questions. And perhaps challenge her even a little bit more and unsettle her and unsettle her staff. So it's kind of playing the game at all sorts of levels to bring about change. And that's just one example of bringing about a little change…
> (Midwifery Insight)

> Communication and interpersonal skills are essential for building collaborative relationships and partnerships
> (Midwifery Theory Note)

> So coming back to persuasion you know I think we do a hell of a lot. You might give them choice but there is persuasion behind that choice.
> (Midwifery Insight)

The discipline of midwifery within the ACMI's (2004) Philosophy Statement "is informed by scientific evidence, by collective and individual experience and by intuition" (ACMI, 2004). This holistic view of public health evidence is consistent with what Baum (2002) earlier referred to as being a key feature of the new public health - one that is "multidisciplinary and holistic" (Baum,

2002: xv). By drawing from a range of evidence including empirical and qualitative research-based evidence as well as from personal experience, the notion of evidence as a tool for persuasion is highly valued:

> Midwifery is also about forming workable relationships with peers who do not have the same 'philosophy' as ourselves. So how this is done can take many forms. Midwives demonstrate the evidence and so the benefits to women cannot be disputed. The evidence informs our practice and so we can challenge the old practice and provide the best care to women.
> (Midwifery Theory Note)

### Midwifery – "with woman" (worker learner identities)

The definition of midwifery is one that reaches well beyond notions of professionalism. Being with woman is the meaning of midwifery and a fundamental characteristic of the ACMI's (2004) Philosophy Statement: "the focus is on the woman, not on the institutions or the professionals involved" (ACMI, 2004). The forms of participation among these midwives are firmly embedded in social activism and explicitly relate to past midwifery historico-political movements and the empowerment of women. This politically-driven identity is often at odds with that of "the institution" (Midwifery Insight) or the "medical fraternity" (Midwifery Insight) because its "allegiance" (Midwifery Insight) and political identity stems from "the struggle of midwives to support women within [these] institutions" (Midwifery Theory Note).

"To be in partnership with women and in partnership with midwives" (Midwifery Theory Note) reflects non-hierarchical power relations among the educators and between the educators and the learners (the women). Learning, advocacy and women's empowerment are overlapping goals negotiated through participation, critical dialogue, and the targeted use of evidence and peer support strategies. These activities along with the "partnership with" (Midwifery Insight) and "allegiance to" the learner (the woman) reflect the transformational or radical philosophy of midwifery education:

> From the outset, [the educator] must coincide with those of the students to engage in critical thinking and the question for mutual humanisation. [Her] efforts must be imbued with a profound trust in people and their creative power. To achieve this, they must be partners of the students in their relations with them.
> (Freire, 1970: 56)

The partnership with women among midwives is a defining characteristic of midwifery identity. It is an identity articulated through social-activism and interpersonally driven educational approaches that reflect elements of feminist critical theory that include a woman-centred vision for social change:

> I mean we talk about leadership and stuff but it's different. It's being alongside midwives with a passion… It's about that thing about relationships with women, it's all about the partnerships, the relationships and how you are with women. You know, midwives…

means "With Woman" so the whole kind of philosophy of midwifery is built on that notion of partnership with women.
(Midwifery Insight)

the people around this table –we're trying to develop models of care that are –for women and midwives – totally different to what the nursing culture has been
(Midwifery Insight)

It's about getting midwives together in teams or groups to provide women with continuity of care and working across the interface of hospitals and community services.
(Midwifery Insight)

It requires a shift in allegiance from the institution to the woman that's been described in the literature. When midwives work in the context of continuity of care there is that shift. - So that you care about the woman.
(Midwifery Insight)

How we are in partnership with women makes a difference. The shifting allegiance from the institution to the woman is a result of continuity of care
(Midwifery Theory Note)

To be in partnership with women and in partnership with midwives in a continuity of care model-is the best practice for all concerned. The politics of the institutions do not see it this way. The medical fraternity do not value the idea of relationship with women or midwife for that matter. They often will not change their own practice, even in the light of the evidence. They prefer to have the upper hand -it's about power and control. So "with woman" is the essence of midwifery and the struggle of midwives to support women within institutions.
(Midwifery Theory Note)

### Midwifery summary

The Midwifery S/D-M workshop produced categories, Insights and Theory Notes unlike those produced in the other two workshops. Aside from a recurrent emphasis on the need for ongoing relationship building both within and beyond the profession, the Midwifery S/D-M outcomes related primarily to interventions that stemmed from their past historico-political struggles. The ACMI Philosophy Statement is explicitly political and states that midwifery is always an "emancipatory" relationship with women. This politicised identity is apparent in the peer-based strategies of role modelling used within the profession and more broadly, being "with woman" beyond conventional clinical care roles. Throughout this workshop, midwifery education was always articulated as being embedded in activities that organise influence or that unsettle through persuasion or one-to-one relationship building. Their educational work was transformational in that it sought to raise a critical consciousness with individuals and professional groups to "bring about change" (Midwifery Insight) for and with women.

## Summary of contrasting themes within three professional practice networks

The analysis of how these three professional practice networks speak of their educational work has been structured by their categories of Insights, the Case Stories and the resulting Theory Notes. All

three networks have spoken of the need to develop interpersonal and organisational relationships with their learners and to draw on a range of pedagogical approaches, educational principles and planning frameworks to help guide and at times, legitimise their work. Despite these similarities, there were clear differences in how these networks spoke of their changing educational work and the traditions that inform their practices and goals.

HepLink practitioners focussed on learner-centred approaches, evaluating their pedagogical practices and tensions arising when trying to move towards more group-based activities informed by organisational and capacity building frameworks. This shift posed challenges to the ways in which practitioners evaluated their work –not so much in terms of relying on indicators or benchmarks developed as part of these frameworks, but in terms of valuing "more reflective and personally illuminating" (HepLink Insight) evaluation indicators. HepLink practitioners frequently spoke of their need to adhere to more empirical indicators but to use these as program reporting benchmarks for funders that indicate such things as behavioural outcomes along with numbers of learners attending and any program enhancements or practice improvements recorded as a result of the educational intervention. This rarely provided practitioners with meaningful, reflexive feedback required when evaluating particular pedagogical approaches such as those required to address values and attitudes or issues of public health access and equity. These sessions, usually led through experiential activities requiring dialogue, problem solving and negotiation are often deemed as "undervalued" (HepLink Insight) by practitioners and require a stronger reliance on "gut feelings through observations" (HepLink Insight) to measure their worth. Changing attitudes and identifying and overcoming barriers to service provision requires at times, transformational learning through the facilitation of ideas and opinions in multi-disciplinary settings. HepLink learning and development practitioners continue to rely on both "creative evaluation strategies" (HepLink Insight) as well as more traditional approaches to guide their educational programs. The dialogues focussed on their ongoing need and abilities to draw personally illuminating observations to inform their professional practices.

NADA practitioners however, emphasised the need to employ a flexible range of educational options guided and negotiated "at a whole lot of [organisational] levels" (NADA Insight) as a means to produce broader, "systemic level" (NADA Insight) outcomes. Their practice tensions focussed on ways to produce mutually agreed upon "business outcomes" (NADA Theory Note) through enhanced organisational relationships. Unlike HepLink practitioners, these dialogues remained firmly rooted in business planning and organisational development frameworks. "Trad[ing] on the personal" (NADA Theory Note), "selling" (NADA Insight) and "advocating" (NADA Insight) were terms used to describe their educational approaches. Importantly, this business planning terminology was viewed as a means to "validat[e] our educational work" (NADA Theory Note).

The practice development midwives spoke of education as part of a historico-political movement seeking to affect change for women within the public health system but not limited to this. Here education was less concerned with the achievement of individual learning or strategic organisational outcomes and more concerned with the empowerment of women and the broader public health goal of continuity of care. Although ongoing relationship building was also a fundamental component to their educational work, it was used in specific ways to affect change both within and outside of the profession. In other words, relationships were spoken of more as a historically informed and legitimate part of their overall educational approach. The Australian College of Midwives Inc. (2005) describes midwifery practice as a "woman centred" discipline that is "founded on relationships between women and their midwives" (ACMI, 2004). The woman centred philosophy of care is a central relationship that serves as a fundamental principle of midwifery identity. It is an explicitly framed relationship that serves to advance midwifery practice development by describing roles and relationships with women. Unlike HepLink and NADA practitioners, the Midwives' educational philosophy was explicitly radical and their practices, goals and language were closely aligned with this vision.

Emerging from this analysis are recurrent themes of relationship building at both individual and organisational levels, challenges in assessing learning needs in diverse organisational settings, employing skills in negotiation, relying heavily on their own interpersonal attributes and characteristics and often aligning their work with endorsed business planning and organisational development frameworks to help clarify their roles with learners and to guide their approaches. The Midwifery S/D-M differed significantly from the other two professional practice networks in the ways in which they spoke of the long recognised importance and acceptance of using personal and professional relationship building activities (either through role modelling or persuasion) as a primarily strategy to affect change. Although the HepLink and NADA networks spoke of the importance of building relationships, their methodologies for doing so were less clearly articulated and confident. They spoke more of their concerns when having to "trad[e] on the personal" (NADA Insight) and were at times prompted to "rethink what education is" (HepLink Insight). Relationship building with multi-disciplinary groups of practitioners was a newly emerging professional practice required to assess learning needs but more importantly, to develop a mutually agreed upon learning curriculum. Relationship building for the network of midwives was a much more historically informed professional practice endorsed through philosophy statements of midwifery professional associations and demonstrated through their explicit emphasis on and competence in interpersonal relationship building activities with women.

### Skills, knowledge, relationships and worker identities

Points of commonality and difference are now examined in relation to how practitioners spoke in particular, of their skills, relationships and worker identities.

## Skills

The strong reliance on and use of interpersonal skills was a fundamental feature of all three Story Dialogue workshop outcomes. A range of interpersonal approaches was used in the planning, implementation and in the follow up or evaluation of learning activities. Interpersonal skills were drawn on to build trust, assess individual and organisational learning needs, to build partnerships, to encourage collaborative learning and to motivate learners. All groups spoke of a continued need to negotiate, build flexibility into, or balance expectations of their educational approaches and their program goals. Interpersonal skills were drawn on by HepLink participants to build trust and to develop "a range of timely and tangible activities" (Heplink Insight) often not recognised as legitimate educational interventions. The Midwifery practice experiences relied heavily on interpersonal skills for role modelling within the profession and for persuasion to other public health workforces. In all three professional practice networks, the use of interpersonal skills was fundamental to establishing engagement with the individual or organisation.

Using interpersonal skills was tacitly described as informal "behind the scenes" work (HepLink Case Story 1); or work that "trades on the personal" (Nada Insight). All groups referred to the methodologically vague and situationally specific interpersonal activities used to build trust, organisational partnerships and mutually beneficial learning or program outcomes. This reliance on personal skills and characteristics in all three workshops was a strong theme that contributed to workers ongoing development of professional identity. It is particularly useful when working in multiple workplaces, on collaborative programs with multi-disciplinary groups. In these settings, workers capitalised more on their personal attributes to engage learners and to build trust and less on discipline-based bodies of knowledge or professional roles.

Those Case Stories that explicitly referenced organisational or business planning frameworks, such as capacity building, also relied heavily on the use of interpersonal skills. These were used to describe or explain their educational role; to adapt to different organisational contexts, to build trust and to assess learning needs in the context of multi-disciplinary teams or workers. The frequent need to "build flexibility" (HepLink Case Story 1) into daily work, required a strong reliance on interpersonal skills and at times, the personal attributes of the worker.

Skills relating to more traditional pedagogical approaches including training or public speaking, developing individual learning assessment tools, designing program evaluation frameworks and in group planning and facilitation were also described as integral to their ongoing work.

### Knowledge

Participants in all three professional practice networks described emerging areas of knowledge required for them to undertake educational activities. Discipline-based knowledge was a relatively small component compared with knowledge required of organisational or business planning frameworks, multi-disciplinary group learning and planning processes, corporate or governance roles within services, and individuals and key stakeholders to negotiate with and to develop the trust of. Importantly, all three professional practice networks spoke of their need to know how to build trust and to effect change within the field. This knowledge was often embedded in descriptions of personal attributes or through interpersonal exchanges rather than through more traditional, discipline-based forms of knowledge.

In the case of the midwifery dialogues, knowledge of broader historico-political movements and a coherent and explicitly political vision of midwifery practice development were underpinning principles that guided their educational work. The knowledge required to be a role model for new midwives and to persuade those outside the profession relied heavily on an historical awareness of midwifery activism and a political agenda that shifts power towards the woman. The knowledge valued among participants in this group reached beyond discipline-based knowledge to include, for example, knowledge about techniques of persuasion and drew explicitly from past struggles, successes and an awareness of how to effect change within a large bureaucracy.

HepLink participants in particular, spoke of a need to emphasise "what participants will do with the knowledge" (HepLink Insight) as an evaluation indicator that was increasingly relevant to their work.: "…we aim to build not only the skills and knowledge base of individual workers, but also their ability to put these into action" (HepLink Case Story 1). All professional practice networks spoke of the need to develop knowledge in action by way of working towards mutually agreed upon program outcomes, health service enhancements, changes in work practices, better coordination of services and in the case of midwifery practice development, greater continuity of care for women. This understanding of knowledge aligns with Barnett's (2000) framing of knowledge, described earlier as one that is "understood as a matter of what one can do" (Barnett in Garrick & Rhodes, 2000: 16). This mode involves the participation of groups of multi-disciplinary workers "collaborating on a problem defined in a specific and localized context" (Gibbons et al, 1994: 3). Reflecting Gibbons' (1994) model of Mode 2 knowledge production, HepLink participants describe their need to embed their educational interventions with program outcomes, service enhancements

and changes in work practices. The tacit components of knowledge production, namely activities negotiated through group participation and problem solving that are organisationally specific are emphasised in the work of HepLink participants: "In some cases we need to rethink what education is. Sometimes we see education as a process of facilitating dialogues" (HepLink Insight).

Similarly, NADA participants emphasised their need to generate organisationally relevant 'practical strategies' (NADA Case Story) through activities that "optimise the learner environment…through building trust and relationships" (NADA Insight). Again, the notion of knowledge in action is a fundamental characteristic of educational work. The more tacit components of this form of knowledge production are frequently embedded in organisational and business planning terminology such as: negotiating agendas, mutual program benefits and gaining "high-end endorsement" (NADA Insight). Educational processes such as these are described as organisationally driven products whereby "…Learning outcomes become business outcomes" (NADA Theory Note). NADA participants describe the adoption of business planning terminology as "one way of validating" (NADA Theory Note) their educational work. However, like the other two networks, NADA participants also drew heavily on a combination of personal and professional attributes to establish trust and to negotiate the parameters of their varied programs. Knowledge of how to build relationships was a fundamental part of all three professional practice networks.

### Relationships

Individual and organisational relationship building was a strong, recurrent theme arising from all S/D-M workshops. The processes of building relationships were firstly spoken of as informal "behind the scenes work" (HepLink Case Story 1) or "peacemaking" (Midwifery Insight) activities that aim to build trust, assess learning needs and to develop mutually beneficial learning or program outcomes. Those practitioners that spoke of employing organisational or business planning frameworks also referred to relationship or partnership building as an explicit benchmark to their work. For example, HepLink practitioners described their education as workforce development, occurring within the framework of organisational capacity building. In this approach the principles of respecting pre-existing capacities and the need to develop trust underpin capacity building practices (NSW Health, 2001). Relationship building was no longer an intuitively driven, informal goal, but rather a valid series of professional practices named within a broader planning framework.

Relationship building was also employed as a means to "persuade" (Midwifery Insight) or "organise influence" (NADA Case Story) with other public health practitioners. The Midwifery dialogues articulated education as opportunities to mobilise change towards greater continuity of care for women. Through a series of interpersonal, one-to-one approaches, midwives aimed to "challenge" and "unsettle" (Midwifery Insight) other public health experts once a "workable relationship"

(Midwifery Theory Note) was established. Relationship building here is viewed as a political strategy for affecting individual, organisational and broader political change.

The notion of relationships within the discipline of midwifery is unique compared with other public health professions. Being "with woman" (Midwifery Theory Note; ACMI, 2004) directly informs midwifery philosophy, work and relationships (ACMI, 2004). It is founded on "respect for women" (ACMI, 2004) and is explicitly political. Using peer-based role modelling within the profession and peer-based empowerment strategies that aim to shift power towards the mother, midwives seek to guide their professional development, advocate for women more broadly and continue to work towards continuity of care. The notion of equity in relationships within the profession and between midwives and mothers is central to and part of their broader historico-political struggle. Relationships within midwifery practice are central to notions of midwifery identity.

### Worker identities

> Sometimes we're trainers, facilitators, problem posers, HR persons –there's a lot of different sorts of expectations about who you are…
> (HepLink Insight)

The concept of identity was described and problematised throughout all Story-Dialogue workshops. As "a process that involves a construction of sameness that is continually evolving and incomplete" (Chappell, Rhodes et al, 2003: 28) participants spoke of notions of identity as a changing construct negotiated through time, multiple settings and different forms of work. HepLink and NADA workshops highlighted the tensions that arise for practitioners when negotiating shifts away from traditional curriculum packaging and pedagogical approaches to more multi-disciplinary, "socially accountable and reflexive" (Gibbons et al, 1994: 3) forms of knowledge production. In particular, new forms of worker identities were described that were negotiated through activities of relationship building and the temporary forms of work required. Negotiation was required to manage divergent views about what constitutes legitimate education or workforce development; to assess the learning needs of multi-disciplinary groups and to embed notions of flexibility in their pedagogical approaches in order to align with organisational or business planning frameworks. Professional identities were largely described through the description of tasks or through accounts of building "workable relationships with peers" (Midwifery Theory Note). These accounts of identity align with the transient qualities of Casey's (1999) term "knowledge worker," where identity is described temporarily through a worker's ability to learn and perform new tasks and to adapt to a range of different roles. It is through processes of negotiation and the resulting descriptions of varied and temporary forms of worker relationships that characterise identity beyond static notions of professionalism or discipline-based knowledge.

These discourses of multiple, temporary and ongoing forms of worker identities are located in a changing professional landscape where discipline-based knowledge production gives way to a more "distributed nature of both knowledge production and learning practices [that occur] within and across various learning and work sites" (Solomon, 2003: 1). This distributed nature includes a reliance on personal characteristics and interpersonal skills that are conducive to building trust and mutually productive relationships.

This chapter aimed to explore how three professional practice networks speak of challenges to their educational work in a field where multiple pedagogical traditions and educational approaches exist. The Case Stories, Insight Cards and Theory Notes generated from the three Story-dialogue workshops highlighted how different sectors within public health drew from a divergent range of philosophical, theoretical and methodological traditions in education. Despite these differences, all professional practice networks emphasised the need to rely on their use of interpersonal skills and personal attributes to negotiate program parameters and their roles within these. Even when specific organisational planning or capacity building frameworks were used, participants continued to rely on their interpersonal skills to describe their educational role, to adapt to different organisational contexts, to build trust and to assess learning needs. Knowledge of a range of pedagogical traditions was raised in the context of needing to shift from one educational approach to another –depending on the type of educational program or the learner expectations. Discipline-based knowledge was secondary to the expressed need to be aware of a range of multi-disciplinary group learning and planning processes as well as key relationships required for the program to generate mutually beneficial outcomes. The development and maintenance of individual and organisational relationships were key components to all educational work among the three professional practice networks. Guided by both formalised planning frameworks (ie capacity building frameworks) and by a series of informal and interpersonally driven notions of what works, relationships with colleagues and learners were pivotal but often ill-defined attributes of successful work. Lastly, the notion of worker identities as something that is continually negotiated through multiple relationships and varying program parameters has implications for the ways in which we value and are aware of the varied pedagogical traditions associated with particular public health disciplines and professions. All three professional practice networks emphasised their need to rely heavily on their interpersonal attributes and characteristics rather than their professionally based body of knowledge and skills.

# Chapter 6

# Conclusions

This research began from my own standpoint as a practitioner employed in the broad field of public health. Over time I've undertaken a range of educational roles through varied professional categories and settings. Through these experiences I became increasingly aware of the disparities between the narrowly defined or undefined notions of best professional practices that arise through formal discourses of government policy and endorsed frameworks and those of my own changing professional practices and opinions carried out in the field. Educational work is a dispersed and often buried activity conducted formally and informally by most workers, called different things and carried out regardless of their professional identification or community affiliation. The notion of the 'educator' as a fixed professional identity remains in small professional instances such as those employed as "Hepatitis C Educators" or "Asthma Educators" but for the majority of public health practitioners, regardless of our job titles, education is an implicit part of our ongoing work. Called project management, organisational advocacy, business planning, capacity building, workforce development, persuasion or alliance building, educational practice has many names and is supported by a mix of pedagogical theories, discipline-based traditions and professional and personal experiences and opinions about what works for us at the moment.

This research aimed to make explicit, the ways in which three professional interagencies or networks of public health practitioners construct and negotiate worker identities over time by exploring skills, knowledge and relationships in a changing field. Skills were often articulated vaguely (apart from the Practice Development Midwives' explicit references to principles of being in partnership with women) and summarised as a series of situationally specific interpersonal activities used to build trust, organisational partnerships and mutually beneficial learning or program outcomes. These skills, alongside the ability to negotiate with a range of key stakeholders were frequently drawn upon. In particular, the ability to negotiate jointly agreed upon pedagogical approaches, organisationally relevant curricula and a series of smaller process-oriented activities not traditionally viewed as educational practices were named. The attribute of flexibility and a desire to be viewed as relevant and motivational to learners from various disciplines were also described as necessary stages in collaborative and increasingly multi-disciplinary approaches to the development of educational programs.

Discipline-based forms of knowledge were a relatively small spoken component of their educational work compared with the increased valuing of more reflexive knowledge generated through collaborative processes of inquiry, partnership building and negotiation. Notions of professional expertise were embedded in this form of working knowledge, reflected in Barnett's (2000) framing of it as "process-oriented, collective and pragmatic" (Barnett in Garrick & Rhodes, 2000: 23). Participants also spoke of the need to emphasise "what participants will do with knowledge" (HepLink Insight) as an emerging evaluation indicator or aim of their work. This is particularly relevant when drawing from business planning or workforce development models that aim to produce explicit program or staff activity outcomes as opposed to behavioural learning outcomes, for example. Learning outcomes become measured with a mix of program planning, relationship building and other more intuitive and personally illuminating factors.

A changed or increased focus on "the fostering of organisational learning as opposed to individual skills formation" (Johnston, 2001: 3) requires changed relationships or forms of participation with colleagues and can bring about unclear expectations about what constitute legitimate pedagogical practices. The processes used to shift learner expectations from that of a disciplinary-based form of knowledge production (often involving the presentation of scientific, clinical, epidemiological facts) to that of a more collaborative, "socially accountable and reflexive" (Gibbons et al, 1994: 3) form of knowledge production were varied and often difficult to articulate. Spoken of as both "behind the scenes work" (HepLink Case Story 1), practitioners described a range of interpersonal engagement strategies as well as offering what learners once described as "the real stuff –the information" (HepLink Case Story 1) before facilitating more organisationally focussed, group problem-solving type activities as a means to shift learner expectations. Participants described these strategies as a means to "persuade" (Midwifery Insight) or "organise influence" (NADA Case Story), with the learners. These practices also served to build individual and organisational relationships with groups of learners and were often articulated as benchmarks to contemporary educational work.

Described as a workforce "characterised by a diversity and complexity" (Dept of Human Services and Health, 1995: 5) who's functions evolve or quickly change in response to multiple program activities and whose teams of peers change accordingly, our notions of worker identity become less fixed on traditional discipline-based professions to one of a changing construct negotiated through time in varied settings under different program parameters. A reliance on describing interpersonal characteristics or attributes of the worker was a recurrent theme that arose particularly when participants spoke of the need to assess learning needs both individually and organisationally, establish rapport, build trust and to negotiate their continued roles in new settings. For all three interagencies participating in this research, educational practice was an adaptive and flexible process informed by multiple and often conflicting pedagogical expectations.

Notions of skill, knowledge and relationships were factors that required ongoing negotiation – through a series of one-to-one informal encounters to more formalised organisational agreements and collaborative working arrangements, all of which closely contribute to the production of temporary worker identities. As reflected in Casey's (1999) term "knowledge worker," whereby identity is described temporarily through a worker's ability to learn and perform new tasks and to adapt to range of different roles, these participants spoke of their work more as a negotiated, collaborative process. As witnessed in all three S/D-M workshops, participants described methodologically vague and adaptive approaches to their work using advocacy and persuasion at times and drawing on a range of theories, business-planning frameworks and the skills and knowledge of multi-disciplinary teams of workers.

Having varied goals and educational approaches these three networks also drew from multiple evidence bases and professional traditions to inform their current work. Contemporary adult and organisational learning theories, business planning frameworks, mission and philosophy statements, historico-political movements, professional or discipline-based traditions, "intuition" (ACMI, 2004), and past program successes all informed their current educational practices. A reliance on one form of evidence was not a strong theme that informed professional practice. This closely aligns with Walshe and Rundall's (2001) acknowledgement of the great differences in how professional cultures speak about evidence and the types of evidence each deem to be legitimate or relevant. In all three S-D/M workshops, participants acknowledged competing pedagogical traditions informed by different forms of evidence among their colleagues and their learners. The growing body of theoretically informed evidence pertaining to contemporary adult learning theories provided practitioners with a range of 'tools' to opportunistically draw from rather than a singular, evidence-based methodology. However, Heplink participants described this range of evidence as often "creat[ing] a lot of methodological hiccups" (HepLink Insight) in educational practice rather than serving as a unifying evidence-base to guide that practice.

Generalising an overall model of evidence-based practice in public health education would require, as Raphael (2000) argued earlier, a pluralist approach –one that recognises the interplay among these influences as well as the increased participation and contribution of different forms of evidence by communities and other non-traditional players in public health. As public health literature continues to espouse principles of intersectoral collaboration, partnerships and community participation in our work we will need to expand our awareness of, and where possible be explicit about, our use of different models, theories and traditions of education along with the varied notions of evidence that support or inform our work.

### Implications for future practitioner-led research

Participation with my colleagues over time led to my initial inquiry. This participation is ongoing and the inquiry that resulted from that also continues in many forms, by my colleagues and I. Practitioner-led research such as this, continues through such things as our dialogues, negotiated and collaborative program activities as well as our informal encounters. Exploration into group processes that assist with explicating varied pedagogical traditions and assumptions among multiple workforces could assist with our ongoing need to negotiate and come to mutually agreed on roles and approaches.

Future research that draws from the participation of communities, and the multiple workforces that promote health can build a broader base of evidence that supports the vision for a new public health. Characterised by Baum (2002) as "the totality of the activities organised by societies collectively" (Baum, 2002: 531), new public health requires multiple perspectives, research traditions and other, less heard of forms of inquiry "to ensure that social, physical, economic and natural environments promote health" (Baum, 2002: 531).

### Implications for my professional practice

Most of the Insights and Theory Notes generated by the three professional interagencies spoke of tensions and opportunistic strategies that resonated with my ongoing work and sense of professional self. Whether the work was based in a small community-based organisation, a branch of the health department or a project worker in an Area Health Service, educational practice has always been an adaptive and negotiated activity. Over time, particular trends in educational approaches, such as behaviourism or organisational capacity building frameworks for example, emerge. With multiple educational programs operating concurrently, often drawing from different pedagogical traditions or planning frameworks, my colleagues and I come to know each other through our changing roles, informal observations and 'on the run' strategies.

Our professional identities become defined through such things as our participation in program activities; through our achievements, professional practice 'hiccups' and through our interpersonal reputations. Notions of professionalism are not fixed, through vocational job titles for example, but are negotiated through our changing forms of participation with our colleagues, our learners and other organisations. This transient form of identity sits uncomfortably within a broader public health bureaucracy that traditionally values a positivist, bio-medical perspective and a clinically dominating hierarchy of professions within it. As one NADA workshop participant described: "…it doesn't seem like a professional way to work…it's like having to trade on the personal" (NADA Insight). With such a transient professional identity also comes a sense of professional

vulnerability. Public health education, with its varied methodologies and pedagogical traditions can become an adjunct to the primacy of clinical or vocational professions. Yet, within these classifications comes the ongoing demand for multi-disciplinary and collaborative work –often involving members of communities outside of the traditional public health field. Each profession or community member brings his or her own culture and beliefs about what constitutes legitimate educational practice. In a field that traditionally values instruction through "experimental methods, quantitative data collection and analysis, and identification of linear cause and effect relationships" (Raphael, 1990: 358), the ability to negotiate more reflexive and dynamic group educational approaches occurs on an uneven professional playing field. This could explain the strong reliance often expressed by participants on describing their informal approaches and interpersonal attributes as a means to persuade and develop mutually beneficial educational approaches.

Although evidence-based practice is a term commonly and often enthusiastically used by colleagues, and more formally in public health policy, the notion of having tools to draw from was a more useful and varied element that informs our practices. Tools in group facilitation, planning and evaluation for example, are commonly exchanged among colleagues and myself. If the tool produces the desired outcome such as increased group cohesion, goal clarification or a means to explore values and attitudes, then it is often stored and adapted for use in our own repertoire of professional resources. Our tools gained through wide ranging experiences, methodologies and settings form our eclectic mix of evidences.

Evidence-based practice is a contested term, broad in scope and drawing from multiple theoretical and, in the field of public health educational work, pedagogical traditions. What counts as evidence or best practice is often blurred by generic usage of the phrase or a narrowly defined or stagnant view of what constitutes public health evidence. As a practitioner involved in these ongoing debates, making slippages from one theory to the next, drawing from various approaches, and always negotiating as we go along, doing educational best practice in public health becomes a collaborative and negotiated endeavour.

> Knowledge changes. That is a commonplace. Less understood and less remarked upon is the point that what counts as knowledge also changes.
> (Barnett in Garrick & Rhodes eds, 2000: 15)

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## Appendices

| **Tool** | **Vision and planning exercise** |
|---|---|
| **Process** | For Group |
| **Target Group** | All staff within an organisation (including reception and casual staff)<br>Key stakeholder staff within a sector of an area health service |
| **Purpose** | • To clarify key features of a hepatitis C related program<br>• To highlight the applicability of existing skills and knowledge to develop new or enhanced hepatitis C related services<br>• To operationalise partnerships both within the organisation and with other related organisations |
| **Rationale** | This tool is designed to highlight key principles in the development of hepatitis C related programs. After discussing the rationale for such principles (the Why question) the generic program planning stages should be highlighted to illustrate how existing skills, knowledge and cultural expertise can be applied to new issues.<br><br>The later part of this exercise is to assist team members to operationalise how partnerships both within the organisation and with other related organisations can assist with continued coordinated program planning. |

## Vision and planning

**1. What could an effective hepatitis C program look like? Why could this be effective?**

**2. What would you need to do within or outside your workplace to enhance hepatitis C services?**

| Tool | **Vision and action exercise** |
|---|---|
| **Process** | For Group |
| **Target Group** | All staff within an organisation (including reception and casual staff) |
| **Purpose** | • To brainstorm a range of potential hepatitis C related service options for the organisation (vision exercise)<br>• To appraise current (if any) hepatitis C related service options<br>• To explore the issues and factors associated with the discrepancies between the visions and the current range of services |
| **Rationale** | This tool is designed to generate group discussion to clarify why hepatitis C is relevant to the work of the organisation. These series of questions are a useful if there are values and attitudes among staff which may prevent them from undertaking learning and participating in service enhancement related to hepatitis C. |

## Vision and Action

1. **What is supposed to be happening for your clients with regard to hepatitis C?** *Describe the ideal situation in your organisation as outlined in the strategic or corporate plan, constitution or policy; or as described by your manager, supervisor, management committee or funder.*

| |
|---|
| |

2. **What is the actual situation? How does your organisation currently respond to the needs of its clients?**

| |
|---|
| |

3. **What explains the difference between the ideal situation and the current situation?** *List the causes or factors contributing to these differences*.

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|---|
| |

Adapted from Rothwell, 1994

*A Worksheet to Answer the Question "Is It a Training Problem?"*

| **Tool** | **Finding gaps, barriers and opportunities** |
|---|---|
| **Process** | For Group |
| **Target Group** | All staff within an organisation (including reception and casual staff)<br>Key stakeholder staff within a sector of an area health service |
| **Purpose** | • To establish individual and organisational relevance of hepatitis C and related issues<br>• To identify and map gaps, barriers and opportunities in developing a hepatitis C related programming to vary elements of the organisations infrastructure: Individual (learnings/skills development) and Organisational (structures/processes)<br>  • To support the development of individual and workplace action plans by highlighting key features of the organisations infrastructure |
| **Rationale** | This tool builds on all of the previous activity tools and is the next phase of the action learning for group. The process and key components within the organisation affecting the size, scope and sustainability of the resulting hepatitis C related organisational action plan.<br><br>Although the five components that need to be considered to ensure the development of a comprehensive approach to capacity building are not explicit in this table, they can be used as prompts to assist the team to build a more comprehensive table.<br><br>The table also assists teams to recognise features within their organisation of the five components of a capacity building framework:<br>Partnerships<br>Organisational development<br>Leadership<br>Workforce development<br>Resources<br><br>If any of these components cannot be featured in the table, then they are to be listed in the Gaps and Barriers' cells of the table. |

## HepLink Case Story 1

At the Hepatitis C Trust, the education and development team was established with the aim of developing the hepatitis C workforce in the broadest sense. That is, we aim to build not only the skills and knowledge base of individual workers, but also their ability to put these into action. This means that we aim to focus not only on education, but also on developing partnerships, networks, access to resources, organisational support, etc.

We do a lot of this behind the scenes' workforce development work, such as building partnerships and facilitating organisational strategic development, but overall most of what we end up doing is short training sessions. The longest we do is a one day session – about 6 hours.

In late 2002 a colleague and I facilitated a one day session for workers in a regional centre.

To organise the session, we pointed it to the HIV/HCV Coordinator in that area, offering a free one day session for any interested workers in the region, in return for their help in booking the room, providing catering, promoting the training and registering participants.

Ideally we would be aware of the learning needs of our participants when designing the training workshop. However, in this case (as usually happens) we only had contact with the Coordinator, who, through discussions and completing our standard booking form, gave us their impression of who might be attending and what their learning needs and experience working with HCV might be. So we assumed that there would be a lot we would not know in relation to their learning needs until we asked them on the day.

For this reason, we build flexibility in to our programs. We have a basic outline of a standard one day session program which we alter depending on the above feedback, and depending on the kind and size of group we expect. Our basic program allows for a lot of discussion and participant input of their experiences and issues. We used a variation on this program on the day in question, which had 12 participants from a range of departments of the local hospital, for the GUM, sexual health centre, infection control unit and others.

So, the day started with a quiz that participants completed on their own (and don't hand in for correction'). This aimed to get participants in the mindset for the day, and perhaps clarify what it was they want to find out. It also filled in time as participants trickled in.

Then we facilitated some get-to-know-you activities which gave us an idea of their roles and experiences are and what they want to find out about hepatitis C, and if possibly why they want to know this.

Then, we ran through the basics of hepatitis C at a population level. This was delivered as kind of a lecture' style. Usually (and in this case) in the get-to-know-you section, participants state that they want information', often about transmission, so we hope that by starting with this basics section, we satisfy that need first. If we however do try to just go straight into being interactive and drawing for their experience, participants seem impatient to get to what they perceive to be the real stuff – the information. That is just a sense we get, of course.

After they were feeling more comfortable, and we had proven that we were a source of information they can respect (that we have presented ourselves as experts' on the matter) we started to make the day more practical and incorporate their experiences so as to keep it relevant to their working and local situation.

So, we facilitated a game around the issue of transmission that is quite interactive and generated some laughter, but which we hope also clarified and reinforced the issues we had just covered. I like this part. It's fun to facilitate and seems to provide a good opportunity for participants to bring in an informal setting, all those myths and hazy out situations in which people have heard of or worry about transmission occurring (e.g. kissing after eating corn chips). The way/s the game means that the answers which people give regarding the levels of risk of different activities are anonymous. I think it helps people to feel free to take guesses, have their questions answered, and make mistakes without being singled out.

Then, we facilitated an activity which aimed to keep the content of the day relevant to their client group and their experience working with their client group. We asked them to develop a hypothetical client with hepatitis C, define their characteristics, and then we outlined details about how hepatitis C affects people – physically, psychologically and socially – relating it back to their imaginary person all the time. This bit can be hard, because sometimes the group – or someone within the group – wants to make this a really difficult' client, and this can make the activity unrealistic, or can highlight some possible pitfalls (e.g. racism, such as that this imaginary client is an unemployed Aboriginal man from Redfern who has been in and out of jail and has a wife and girlfriend on the side who drinks heavily). Nonetheless, it seems to work really well. However they make it lively, it gives the discussion, gives us an insight into the group's values and attitudes, and gives us a base to start to address them, as well as the health issues for the client.

We then facilitated an activity with the specific aim of addressing values and attitudes around injecting drug use. We discussed drug use, the concept of harm minimisation and showed a video about injecting drug use, followed by discussion. As much as possible, we tried to get members of the group to respond to and challenge each other on the issues, and we never told them what they 'should' think, just how clients would like to be treated, or what the policies of the government are, for example.

Also in the day were sections on disclosure, discrimination, psychosocial issues relating to hepatitis C, and treatment and management issues. These sections were a combination of talking heads' presentations and quotes from people living with hepatitis C.

In the last major section of the day we aimed to prompt some thinking about action they or others can take to address hepatitis C. We used a 'photolanguage' activity to do this. This involved displaying a set of symbolic photographs (for example, train tracks, a cow, a sad person, a spider web, etc), and asked participants to select ones which represented (1) what their service is like to work in, and (2) how their clients with hepatitis C might perceive their service. We then asked them to discuss, in small groups, how they can build on their strengths in both these areas and begin to address the weaknesses. This seemed to generate some interesting thoughts and potential action points for participants. This is also the section where we took on government policies and strategies, and Hepatitis C Council services.

Then, we asked participants to write a contract to themselves' which is confidential, and which we post to them three months later. On this, we ask them to list three things they hope to have achieved in that time.

After that, we discussed available services and resources which could support their work. We ended by asking participants to complete short written evaluation forms about the day.

This workshop was evaluated very highly by participants. It was rated overall by participants on a scale of not useful (1) to very useful (10) as an average of 8.9 out of 10. When asked what they found most useful, the most common response related information based parts of the day (2) and more specifically mentioned information about treatment and/or transmission. A few also mentioned the resources (2) one person mentioned networking.

Three months later, we posted all participants their contract to self, along with some other material, and a follow up evaluation form. Only two participants returned this form. These two both rated the session highly in retrospect (an average of 8.5 out of 10).

After the session, and after collating participants' evaluation, we facilitators reflected that it would have been great to have Seen & Heard speakers at these sessions to provide a personal perspective, but this was not possible as the Seen & Heard service does not extend to rural areas. This session was one of our most highly rated (although only by a margin). It was not substantially different from other one-day sessions. The main differences were the diversity of participants', and our use of the photolanguage activity which we don't usually use. None of these aspects were mentioned by the participants specifically although we did note at the time that this was the first time someone had mentioned 'networking' on evaluation forms in a while, and we wondered if the photolanguage had helped this.

Reflecting on this session now, it stands out as one of our best. Mainly because there was a lot of interaction among the diverse participants - they seemed to learn from each other as much as from us - particularly in relation to harm minimisation - and because participants seem to engage in the section on workplace issues (photolanguage activity) more than in other sessions, and there were more concrete suggestions arising out of this discussion than in any other one-day hepatitis C session I've facilitated.

The concept of workforce development is not an easy one to promote or evaluate. Once when we went on our first rural visit, we did not include formal education sessions, but instead focused on networking, meetings and resource distribution. However, I got the feeling that people wondered what we were doing there, and feared we were playing a 'watchdog' role. When we offer education sessions, it provides a 'hook' to get invited out there and allowed, and enables us to then meet people and build partnerships for ongoing workforce development work.

Evaluating workforce development is extremely difficult, particularly with limited resources. Even measuring the learning which occurs as a result of an education session is very difficult. How do we know what because the discussion went well, that any long term learning has been achieved? How do we know what the information they stated was useful for them will be retained? And even if it is, how do we know if the workplace is supporting them to keep up to date, and/or put any new ideas or skills they have developed into practice? How do we know if we have influenced their attitudes, or at least their approach to working with clients?

## HepLink Case Story 2

### Context

Northern Sydney Health provides a range of blood borne virus health education and health promotion activities targeting specific population groups. These services are provided by a number of agencies, primarily Hepatitis Link, RHS and the Liver Clinic.

This case study will describe an educational intervention developed by Hepatitis Link and RHS which targets clients of drug and alcohol services. Drug and Alcohol services have a significant number of hepatitis positive clients and provide what amounts to a captive audience for educational interventions.

### Background

In addition to pharmacotherapy and outpatient counseling programs, there is a 14 bed detoxification unit at Herbert Street Clinic. Over a period of approximately 8 years, the local needle and syringe program (now called RHS) have been running a weekly blood borne prevention group for detox inpatients. This group is part of a health education approach which supports individual clients in their detoxification. One of the features of this interservice arrangement is the degree of trust shown towards the RHS team. The presence of a harm reduction based educational program within a 21 step abstinence based detox is fairly unique and is seen as a valuable strength.

2 years ago, as part of the Hepatitis Link project, a program was developed to assist Drug and Alcohol agencies build their capacity to address the hepatitis C related needs of their clients.

### Process

Following a number of focus groups with staff of the Herbert Street detox, and discussions with group facilitators from RHS, an opportunity was identified to review the weekly blood borne virus prevention group. While this group had been in place for a number of years, the content area had recently expanded to include hepatitis C treatment and care issues. In addition, the group had been facilitated by a small number of RHS staff. With a broadening of the facilitator group to include new staff it was felt that there was a need to review the content and delivery of the group.

Also, despite a number of attempts to involve detox staff in the facilitation of the group, there had been no consistent attendance at the group by detox staff.

The fact that the timing of the group was during shift handover, and that a number of the staff felt that the RHS group offered some time away for the clients, acted as perceived disincentives to change.

In relation to the content expanding to include treatment and care of Hep C, the RHS group facilitators expressed some confidence in addressing these issues. However, they felt that the primary objective of Prevention needed to be maintained. In addition, recent developments in the Liver Clinic had resulted in hepatology nursing expertise being available for client focussed education.

Following a series of informal discussions which sought to gauge the willingness of key individuals within the involved services, a time limited working group was brought together to explore options. This group consisted of representatives from Hepatitis Link, RHS, detox and the Liver Clinic.

Following discussion and anecdotal review, the following structure was developed to guide the group program:

**3 month pilot intervention**

- Weekly education group focusing on blood awareness and Blood Borne Virus prevention, facilitated by RHS staff
- Weekly education group focusing on maintenance of general liver health, including alcohol related liver damage, facilitated by Hepatology CNS

### Pre Implementation Activities

To ensure the appropriateness of the planned group, the following planning strategies were undertaken:

- review of existing BBV prevention Group (undertaken by Morris and Rob)
- focus group X2 held with detox staff to discuss overall HCV related educational needs (Jonathan)
- participant observation of BBV prevention Group by detox staff member and Hepatology CNS

**Evaluation Activities**

| OBJECTIVES | METHODS |
|---|---|
| Measure client satisfaction with content and style of groups | Post group survey to all participants during pilot period |
| Measure levels of client anxiety as a result of participating in group | Post group discussion between participants and case workers |
| Measure staff satisfaction with group content and outcomes | Focus group with Project staff and group facilitators |
| Qualitative analysis of group process and quality | Observation of random groups by independent observer |

**Outcome**

- The pilot educational groups were conducted for 3 months and successfully evaluated. Results of evaluation feedback are below
- The 2 groups ran for a period of approximately 1 year, and appeared to strengthen the relationships between the involved services. Approx 16 clients were accessed.
- Following a number of staff changes and other organisational issues, the Liver Health group was discontinued after 12 months.
- The BBV group was restructured to incorporate Liver Health material and there is now a weekly BBV group which is facilitated by a RHS worker and Liver Clinic worker.
- A service agreement is currently being negotiated between RHS and CDAT and Alcohol Services in order to formalise and support these agency level activities.

**Reflection points**

- This work occurred within a framework of service trust
- The key individuals involved were generally co-operative and willing to participate in group processes
- The value of building partnerships was openly valued
- There was an established history of productive work across the services
- The Hep C Service had a tangible product to offer BBV services, with an current need of BBV
- The information gathering processes were tailored to gather information from a number of sources in a variety of different ways
- The planning and organisational support of Hep Plus enabled the clinical and educational staff to focus on their areas of expertise

**Challenges**

- How do we embed positive developments within service culture, as opposed to relying on champions (or nice people)?
- The relationship between the services in essentially one way. Hep C gives and BBV takes. How can this become a more equal partnership?
- Could high level management involvement support or interfere with worker level action?

**Can you give me your understanding of the groups and what they address?**

- "education around HIV, HCV and the Liver"
- "what services are available"
- Only 1 staff member had attended both groups as an observer. Staff have been rostered to attend but

onflicting demands had resulted in not all staff having first hand knowledge of the group and their content.

**BBV group: any feedback in terms of client comments, actions and general impressions?**

- Positive feedback for clients
- Clients have quoted information for group
- A small number of clients have "stressed out" following the group mainly as a result of information relating to transmission routes, eg infection risk for tourniquets. Staff felt that this was to be expected due to the nature of the group and staff felt confident in managing such issues.
- The group was not seen to generate undue anxiety in clients and did not compromise clients detox program
- The group facilitator was viewed as being very experienced and sensitive to the overall aims of the detox program
- "This group is important"
- There has been an increase in the number of HepB vaccinations as a result of client requests following the group

**Liver health group: any feedback in terms of client comments, actions and general impressions?**

- Overall, positive feedback for clients
- "clients have been talking about liver function following the group"
- 3 clients have left the group although staff felt this was due to pre-existing anxiety rather than the group content
- Staff felt that this group is an important component of overall detox program
- Client feedback that facilitator establishes a good rapport during group and generates an enjoyable group

**What do think of the current pilot programme?**

- "Wouldn't want to lose them"
- "It gives staff a break and the clients benefit"
- "It helps to dispel some myths for clients, eg, being afraid of people with hepC"
- Staff felt that the group presented an "essential message" as part of a wider, intense program
- Staff felt it allowed clients to confront issues relating to past behaviours.

## HepLink Story Dialogue Method – Outcomes

### a. The practice of relationship building

***Insights:***

- *Capacity Building is about helping to make the links and know where to call for expertise. However, informal relationships and agreements can be eroded by formalising them through such things as MoU's at times.*
- *A key element in the support of networking and partnership development is human contact.*
- *Building trust requires that we offer a range of timely and tangible activities.*
- *Trust and therefore partnerships develop through an understanding of the experiences by the facilitator / coordinator of the group or service they are presenting to.*
- *It's so important to have a physical presence for developing and continuing partnerships (eg Gary's office next door, Mark visiting AOD service, rural visits)*
- *The relationships developed during the process of implementing education sessions is just as important as the learning objectives achieved by the participants.*

***Theory Notes:***

- *Good education leads to trust, leads to partnerships, which may lead to capacity being built.*
- *Personal relationships and informal partnerships between workers are as important as formal organisational level partnerships.*

## b. Educational Frameworks and Professional Practice

***Insights:***

- *In some cases we need to rethink what education is. Sometimes we see education as a process of facilitating dialogues.*
- *We have a constant need to produce tangible products but much of our learning theories are fuzzy and difficult to identify in our work outcomes.*
- *There is value at looking at different educational methods for specific professional groups. Their professional cultures have an impact on how we work with them.*
- *Educational groups evolve within a session and over time between facilitators and clients and also between the organisations involved*
- *You can have something that we describe as creative, that's very involved, multi-faceted, you did follow-up, planned it. You did a whole range of creative activities with a lot of energy that went into it and you achieved good results. Is it possible to get the same results by being simplistic and not creative. Is there a risk that we spend a lot of time doing a lot of that?*
- *Sometimes we just misjudge the vibe, or there's people in the group who are very critical or aggressive. I can usually be worked out by being a bit flexible. You can swop it around a bit and do all the didactic stuff first and wait for them to be ready to talk or skim through the stuff*
- *What about all this stuff that's telling us that we learn incidentally and informally all the time in multi-disciplinary settings with multiple strategies. I think this makes a lot of theoretical sense but I also think it creates a lot of methodological hiccups because how many times have we ran a workshop where there's been a grumpy old GP at the back and everything is going well and then he cuts you down in two seconds by saying something superior and discouraging*
- *…people will learn in a multi-disciplinary setting if they operate in a multi-disciplinary setting. That relates to the workplace. I think if people work well in multi-disciplinary setting they learn skills about how to relate to other professional groups. In very hierarchical professions, like consultant doctors find it really difficult to talk to social workers because they use a different language.*
- *The other thing … which resonated with me, was that when we're trying to do other workforce development activities, people don't see if you're doing networking or hosting a meeting, people don't value it alone. You need something else. You need the education sessions otherwise people don't think you're doing anything. That's really frustrating.*
- *…we know that best practice in workforce development isn't just offering education but opportunities for us to give more than just education sessions. …you know theory versus what we can actually do. People aren't really buying theory.*
- *…we can all roll in and do a training session on hep C but the theories says we need to assess the learning needs first and develop a flexible curriculum package and all that, when often you go in and they just want to sit there and get the info*
- *It's like expectations versus needs. We know that 'theory says' that the interactive stuff fosters more learning and yet people expect just to get lots of information so, how do you balance that?*
- *And there's a tensions between this notion of workforce development and education. We're talking about matching educational theory with training packages. We're trying to do all these things that are part of this idea of workforce development, but we often end up being recognised for the training that we do.*
- *workforce development –is not just around training but around education and workforce development more broadly and that this is a lot of de-centralised fuzzy-wuzzy activities that often don't count in people's expectations about what education is.*

***Theory Notes:***

- *We don't have enough evidence to say with certainty that the more informal, creative processes necessarily yield results in this context.*
- *Educational practice requires a range of tools that can be drawn on quickly. The tools used by the educator depend on their professional experience.*
- *Education is an important part of Workforce Development and can be a springboard for further work or learning as well as a self-contained activity.*
- *People see workforce development essentially as education. But it is also about building capacity to enable people to understand why they're doing the work that they're doing. Workforce*

*Development, like education can be in various shapes and forms. The most important thing is that people are learning.*

## c. Assessing learner needs

***Insights:***

- *It's about assessing motivation rather than assessing learning needs*
- *And that's an issue that comes up sometimes. Not having a chance to consult with the people about what they want. Then evaluation at the end it's always hard to get it and what it means. I find sometimes people fill it in so fast and you might as well just forget it.*
- *I think the watchdog thing comes in …is education the right answer to the problem? And yet it's the only thing we can offer where people don't feel they're being judged as much.*
- *Through our discussion, there seemed to be things coming up like the problems with the need to know what the audience expects. And what they're learning needs are and what the culture of the participant's workplace is and to know all that stuff inside out to try and make your education session as relevant as possible now.*

***Theory Notes:***

- *Assessing learner needs is much more than assessing content or knowledge gaps, it should be relevant to work culture, motivation and partnership development.*
- *Assessing learner needs now requires a broader, more organisational focus. We have to know how the education topic fits in with organisational goals and we have to be creative in our methods of adapting to different organisational contexts.*

## d. Worker Identities and learner expectations

***Insights:***

- *Sometimes we're trainers, facilitators, problem posers, HR person- and there's lots of different sorts of expectations about who you are when you go into the training.*
- *And there's a tensions between this notion of workforce development and education. We're talking about matching educational theory with training packages. We're trying to do all these things that are part of this idea of workforce development, but we often end up being recognised for the training that we do.*
- *The other thing … which resonated with me, was that when we're trying to do other workforce development activities, people don't see if you're doing networking or hosting a meeting, people don't value it alone. You need something else. You need the education sessions otherwise people don't think you're doing anything. That's really frustrating.*

***Theory Notes:***

- *Our own identities are less relevant than managing expectations. We need to balance expectations of participants, ourselves and our funding bodies reporting expectations. We need to be conscious of these often conflicting needs and expectations in program planning. They can all be met with careful planning, appropriate data collection and a flexible approach.*
- *Workforce development often isn't recognised unless there's education.*

## e. Evaluating our practice

***Insights:***

- *I mean why do we use numbers to evaluate? They make us feel good. Do they actually help us? They're never low. What do they tell us anyway?*
- *…the networking is one of the main things and this isn't often mentioned in evaluations –it's not recorded. People I don't feel are conscious of it's impact. Sometimes I think that's a massive factor*

- *Observing participants in education sessions and recording these observations along with the facilitators reflections on the session can be useful for us in guiding our own work.*
- *But ultimately it's a lot easier to go with numbers and so we evaluate with numbers and I suspect that most people are less inclined to give really low scores, generally. … So do we go for the cheap and cheerful way because ultimately at the end of the day, while people are scribbling away, in terms of meaning, what meaning can we really get from that process? Because we have to work with this structure and we like to think we base our practice on evaluation so we incorporate it but we don't actually incorporate it in a meaningful way.*
- *Creative evaluation strategies can tell us more about what participants may do with the knowledge; and can be more reflective and personally illuminating. (eg photolanguage, learning contracts, observations)*
- *Longer term success is often about bringing people together and networking although often people undervalue that networking stuff and emphasise the content-oriented sessions.*
- *And that gets highlighted when we talk about what action should be done on hep C and then we always say well who needs to take that action and it's very… there's very little things that they identify that need to be done that they have power over.*
- *I think we're talking about ways of analysing our practices so 9.2 may be a good reporting tool and maybe a very impressive business planning thing but it doesn't actually do too much in terms of specifically guiding our work practices. It makes us feel good. It says that we probably did something right. But I think the point around the observations was that we have lots of tools and rating things but we often underestimate our own observations about how we think it went – through gut feelings, through observations and participants comments.*
- *Observing the participants and recording these observations and reflections from facilitators can be useful alongside other evaluation techniques.*
- *…somehow I get more out of the subjective stuff than I do out of the objective stuff*
- *We need to reflect on our own awareness of the structural and power limitations of individual or groups or learners. Are we expecting the most disadvantaged or devalued workers to affect change beyond their means?*

***Theory Notes:***

- We need to *think about evaluating more than increases in knowledge. We need to evaluate our partnerships. This requires a shift in what we traditionally value in education. This shift could more towards validating our broader workforce development activities.*
- *Although participant evaluation forms can be useful, practitioners need to be aware of the validity of subjective forms of evaluation and use these in conjunction with traditional forms of evaluation.*

## *NADA Case Story 1*

I guess just to put this into context, my background is in drug and alcohol counselling and group work in Sydney and the United Kingdom for many years in HIV and drug and alcohol. So I have no formal qualifications in education. I'm doing my Cert IV with TAFE so my language is very sort of basic. It's not based in any sort of academia.

I've been with [this DHS] for six years and for the last few years I have attempted to run a project with different Area Health Services. And if I think back to the first one that I did which was a few years ago, I'm very different, they're very different and the way I run it is quite different.

In it's simplest terms – it's organisational based – in it's simplest terms it's a process of building relationships between myself [this DHS] and key people in different Area Health services – one Area Health Service at a time. To get them to participate in a one day forum around how they do business currently and how they could possibly do business a little bit differently perhaps, so that the amount of people from culturally and linguistically diverse backgrounds, and by that I mean [DHS] access either a bed, a counselling session, a preventative service – whatever. So it's about getting drug and alcohol services, [DHS] and health, mainstream health, ethnospecific services and what we also call natural systems. To get them to come together for one day to look at how they can build relationships and how they can work together in a more effective way so they can increase access and equity. I guess that's it in a nutshell.

What I have learnt upon reflecting on the different kind of groups that we've done over the last few years is that – I can remember doing some training in the UK and this guy wrote up on a white board and in the middle he had something called 'effort', on the outside of that ring there was something called 'risk" and on the outside of that there was 'panic' and he said "Let them move into risk, try and shift them out of effort, but don't let them sit in panic for too long." And I think that people sit in panic for drug and alcohol at times when it comes to giving them another level to look at. So, it's difficult because there is legislation around access and equity and it's very specific to [People of Non-English Speaking Background] and about people participating and being able to access and utilise services that are available to all people in NSW or Australia. I've sort of made some notes before I came in – not on the project itself – but just on what I thought might be going through the minds of the people who are participating in this project. Usually they're forced to be there I suppose. They've been told to attend. They probably need to be somewhere else. They may have closed down a clinical service to be there. They may be pissed off. They're sometimes very enthusiastic. So you want to try and hang on and nurture that a bit. And they can sometimes be fear based: Are you going to take me do something different? I don't know why I have to do it? Why do I have to do it? I'm full. I have a waiting list. This is ridiculous. Do you have any money? (laughs) the reality is that no' [this DHS] doesn't have any money to either run this project or to give people to build their capacity. So it's very much looking at the resources that are in the area and for people to see each other as a resource.

I guess what I've learnt is that the relationship building between two groups starts with (emphasis) relationship with the two groups. And I have to be very careful about making sure it's face to face especially with the ethnospecific agencies – it must be face to face. It's quite time consuming to get people there. It's not like doing a mailout and we'll see who turns out that's fantastic. You need key people there or it doesn't work and you need to meet with them face to face or it doesn't work. So I was taken down a peg or two by the two directors about my assumptions about how they are already working and that that might be incorrect. So, I now am very careful about having the first meeting and this is so vital – have the first meeting with the two directors and get them to literally sign off on having a commitment to having this one day. I can say that the best response I have had in every Area Health Service has been from the Director. Who have been quite enthusiastic and also very willing to participate in the running and owning of the processes of the day, and then we start to look at who, geographically lives in the Area. Often this is a surprise to services – they don't actually know who lives in their backyard and who they service.

So the first goal is to examine how services do business - How the culture of the service supports access and equity principles and policy for people who are culturally and linguistically diverse with alcohol and other drug problems. And secondly once we've done that – how to improve the access and equity through relationships and practical strategies that are using Area resources. [this DHS] doesn't have a pot of money [t]also sees a written plan by the end of the process to be a way of ensuring sustainability for the action. For example, a reciprocal training agreement of a Memorandum of Understanding.

The other thing I've learned to acknowledge is that people are there and say they're from "Blah blah" agency but they're actually sitting there, especially some of the [DHS] workers, they're there as an individual. They're there as the organisation. But they're also there as their field of expertise. I have to really defuse the anxiety around trying to make the drug and alcohol workers, cross cultural specialists. Whatever that means. And we're trying to make ethnospecific workers, drug and alcohol therapists – we're not trying to do either.

What gets in the way Area seem to be in constant restructure. Whether that's a new thing or whether people are in acting positions and it's really difficult to get to know who to speak with and for anyone to actually sign off on things. As I've said we have no funding to support new ideas for the process. Resources are not even for the Area. There's often personal politics. How dare to have any part of the day called 'issues around racism'. How dare to go there? The commitment needs to come from the top down. We can have 15 super keen and enthusiastic drug and alcohol workers who really want to work with [DHS] or whatever. If they don't have the power to sign off on stuff to commit for say X's "this is how we're going to change our visiting our job descriptions, our orientation package". It's great for them to be there for the energy level, but it doesn't mean anything at the end of the day. The possible stigma of [DHS] issues amongst ethnic communities. "Who .. sees this as a

priority? So they're some of the tensions that I find while running this.

I think there have been some really successful outcomes. We also don't have a formal evaluation. I normally go in with a set of questions about how people currently do business. I have a look at their data in terms of who is using the service. How many times is the interpreter called. If they do anything specific in terms of being proactive to get a different group of people in. ... So we also have to work with what comes in the door. I think that's our thing - to be very very flexible. That the agenda is merely an outline.

## *NADA Case Story 2*

Case story is an education story. It's about when I went to work for an organization called [ ] as their new director and hired by their board because I had health promotion and campaign expertise for the HIV/AIDS area. And had done that kind of work. They thought that it would be good to have a new director who had a focus on health promotion and education rather than the previous director who had been a clinical person. So they wanted that sort of change.

When I got there they had this really crappy phone system and one old Macintosh LC II on the office and I got depressed straight away. I found the workers in the place kind of anxious and agitations - always worried that the funding body was looking at them thinking that they were being measured all the time. We've got to do a lot of stuff. They had to see as many clients as possible. And had to do as many skilled things as possible, otherwise the funders would come down on them.

Also their education people were still called "Prevention Officers" - their focus was on youth and we weren't going to change that because it was the only area and it's good to do stuff around drugs up there. But their approach was more, as a bit old fashioned I thought. And I think the education officers felt the same thing. They were keen for change but no one had actually tested it and they were really happy that a new director was coming in who had a role to help build the prevention and health promotion side of things.
So to start rectifying things, I thought we would need to do a few things first inside the place before we would have anything new and good outside the place. So I identified ways to use unexpended funds that had been there, we got some new computers and some decent software. And we got a computer telephone system that was internal and a proper system as well so that the physical environment and their tools were better.

Then we decided to change the name from Prevention Officers. I said "Well what do you reckon you are" and they said "Well, we're community educators" so that's the name. The positions are now called "Community educator". And then we had a look at what they did and we talked a fair bit about needing to stop panicking about you think the area health service thinks you're doing and if they think you're doing enough of it. So what can we do that's less driven by "We've got to be seen to be doing a lot of stuff" and more driven by "What's going to work." And it was a happy kind of discussion because people identified that prevention workers, the health promotion people were very good at, they understood about health promotion. They were quite skilled women. They were happy and comfortable with looking at research and new models and those sorts of things. So it was mainly the actual structure of the place and the prevailing organisational attitudes that were more blocking for them than they needed to be.

So we decided that also one of the things that we would change to help us do better things outside of the place would be to have some very clear rules and expectations amongst each other. So they were shocked and happy to learn that as the director I actually do prevention work with them I would go and do things with them. Whether it be a change in the approach in the way we wanted to do interactive schools or whether it be physically involved in the delivery of campaigns. That was a new thing as well because the previous director was a clinical person and thought "Well you educators can go off and do whatever. I don't really care. I don't believe in it. It's not clinical work." So we spent time doing that stuff before we did anything else. One of the things that I wanted to do in terms of change was to move away from the event based stuff like running and going into schools and letting to kids or going to a community meeting and providing information about drugs and alcohol to people. And they wanted to get away from that too. And so, what we discussed was let's look at some of the successful models in the HIV/AIDS area around peer education that are built on more diffusion of innovation notions and see if that works with young people. And they were really excited about that stuff. I looked at models for [a State] AIDS project that had been going on a couple of years before on young gay men. We grabbed that model and looked at it and tried to see if we could manipulate it a little bit and see if could be made more palatable to young people on the northern beaches. And then we did things like - they already had good interagency connections but they didn't have actual formal relationships with the services. So we started looking at what we could do to work with and recruit young people to start doing some of this peer ed work and those sorts of processes so I've picked this story because what happened for [this agency] was that it started to develop a name as a leader in being able to work with young people in drug and alcohol through two things: changing it's model to more kind of contemporary health promotion models of peer education realising that that's the same in terms of cultural issues for gay men as for young people, is that drugs and alcohol stuff is taboo. It's not delivered well by somebody in a position of power and authority who might be seen as a discriminator (ie a parent or a teacher) it deals directly with lived experience and lived reality and young people can share each other's stories and experiences and look at issues of concern together around harm minimisation.

So they were keen to implement new models and they were also keen to refine and continually develop their relationship with key things like the youth service provider people, they were also keen to be traditionally still available to the schools. Because the schools in the area and a lot of other services in the area thought that [this agency] was great because it was there, connectable and local. They didn't like the local drug services, because the local drug services are all very clinical based and very closed door and so we decided that even though we would try to do more evidence based stuff around peer ed work, in terms of good harm reductionist interventions for young people, we thought that it was still important to do some of the stuff we know doesn't work like go to schools still because it kept the relationship with the school which was really important. Why? Because that was part of the social ecology of the environment that we worked in.

And generally we found what happened with schools was, as when they really asked you to come out and do a lecture on cannabis, it wasn't because they were thinking, "Oh gee we gotta go to this part of the drug ed program" it was because cannabis

was a problem at school. So in that sense we would go to the school, do the cannabis thing but talk to the teachers and sort of identify a few things. Like, 'You guys might want to link in with these people, and here's a plug for managing a cannabis incident and here's someone else you can talk to"...

I think they've still doing that kind of work and have developed over the years as having a good reputation as having an innovative, youth friendly youth expert group. This agency has been getting funding for the Commonwealth under Community Partnerships; the Area has funded it for that sort of work. So I think that helped and what we've done is helped to make an overall change to improve practice around issues about prevention and health promotion in drugs.

## a. The practice of relationship building

***Insights:***

- *So it's about getting drug and alcohol services, [and a range of other key stakeholders] …to get them to come together for one day to look at how they can build relationships and how they can work together in a more effective way so they can increase access and equity.*
- *it's almost like it's not worth going there unless I get it auspiced by somebody up at the top. So I spend a lot of time building relationships with medical administrators so that they think I'm okay. And it's almost like an informal thing … it doesn't seem like a professional way to work…. it's like having to trade on the personal*
- *I guess what I've learnt is that the relationship building between two groups starts with my (emphasis) relationship with the two groups. And I have to be very careful about making sure it's face to face…It's quite time consuming to get people there. It's not like doing a 500 mail-out and we'll see who turns out-that's fantastic. You need key people there or it doesn't work and you need to meet with them face to face or it doesn't work*
- *I'm just saying if you want this information it might be something you use. And I can actually see the pressure coming off them. They come in like this and sort of go –ah right. So I work on aligning myself.*
- *one of my insights is acknowledging the burden that workers have -we did it with that pilot project … You know going in and spending 5 minutes acknowledging peoples work and that of the organisation.*
- *All that stuff about being aware of relationships at a systemic level but also a personal level..what a huge impact both of those things have on the way your day pans out or how the project works and so on.*
- *much more time, resources and energy has gone into pre-training or setting up training in an effort to try and change or optimise the learner environment. And I guess that has been through building of trust and relationships.*

***Theory Notes:***

- *In order to have lasting relationships that produce useful results in the work context, it is necessary to move beyond the individual or personal level and to develop formal systems and processes at a more systemic level.*
- *Managers in AOD agencies are the most important people for us. They are the gate-keepers, keepers of the learning and development flame…Getting managers and team leaders onside is vital.*

## b. Educational Frameworks and Professional Practice

***Insights:***

- *So the first goal is to examine how services do business - How the culture of the service supports access and equity principles and policy for people who are culturally and linguistically diverse with alcohol and other drug problems. And secondly, once we've done that –how to improve the access and equity through relationships and practical strategies that are using Area resources.*
- *So we also have to work with what comes up in the day I think that's our thing- to be very, very flexible. That the agenda is merely an outline.*

- *So it's almost like people need an opportunity to reflect on the fact that their model doesn't suit all their clients. Because once you really try and pin them down they'll admit it. They'll say "Ah yeh I see what you mean." But it's like there's no room for that in their normal work practices.*
- *The insight part that I reckon is the really difficult change stuff is that concept that I like to use every so often from sociology called 'over determination'. I think that the agency structures and the industry structure in drug and alcohol … is something that almost over-determines the way in which workers or organisational actors behave. I think that's one of the things that we need to keep in our minds.*
- *I think an extension of that is the kind of scientific paradigm or the medical paradigm that makes health promotion and education difficult. And people don't believe in it –education. Because we're in a highly dominant, medical framework.*
- *So you're kind of setting an agenda and supporting them to make decisions about strategies – so that's a lot about facilitation*
- *With no resources to offer, a great amount of creativity is required of us.*
- *We need to follow-up to maintain change. Otherwise, what happens if the facilitator walks away?*
- *And so it's encouraging people to look at the skills, experience, expertise, relationship building and thinking "How can we link all that together and reorient what we do?" Which isn't actually, necessarily requiring major steps but it's that creativity and permission giving at a whole lot of levels to do that's the middle manager, the senior executive and so forth.*
- *…much more time, resources and energy has gone into pre-training or setting up training in an effort to try and change or optimise the learner environment. And I guess that has been through building of trust and relationships.*

***Theory Notes:***

- *Putting together health education activities in our sector requires a range of ongoing creative approaches to support individual workers and organisations in their learning.*
- *Our work context is often dominated by a medical paradigm. There's an implicit conflict between this model and underlying principles of health promotion and adult learning. Much of our workforce development activities (such as assessing learning needs of multi-disciplinary groups; working with multiple organisations including those in other sectors; negotiating mutual program benefits; facilitating dialogue) are not viewed as legitimate educational practices.*

## c. Organisational development as education

***Insights:***

- *[I have some] thoughts on what might be going through the minds of the people who are participating in this project… they can sometimes be fear based: "Are you going to make me do something different? I don't know why I have to do it? Why do I have to do it? I'm full. I have a waiting list. This is ridiculous. Do you have any money?…" So it's very much looking at the resources that are in the area and for people to see each other as a resource.*
- *…the amount of different types of skills required to do the organisational relationship building stuff is intensive. There's lots of face to face; a lot of time is spent assessing and asking people to do a lot of different things –not just learn stuff but act on some of the things.*
- *The industry structure if you like, is something that almost over-determines the way in which workers or organisational actors behave. I think that's one of the things that we need to keep in our minds.*
- *…what came out for me from the story was the remark about NGOs –how they were really willing and active partners. I think that reflects, in terms of systems and cultures stuff, I think that reflects …that NGO's feel freer to make change and to be different and engage than their counter-parts in government. Because the health system is very rigid and hierarchical in comparison*
- *I guess I one of the things that struck me is that you're out there selling something that's really, really important that there are no resources to support. And so what you're also doing is asking for them to think really creatively about a whole lot of levels about re-orienting what they do.*
- *One of the big things is the sign off, is the high-end endorsement we seem to need now to do education with this organisational framework*

- *So it's one thing to come and provide a message about access and equity but it's a huge step when your outcomes are about changing work practices*
- *I've watched […] do this particular model over how many years now, and it's so intensive, the time, because she's on the phone half the day chasing people and then they come to the face-to-face meetings. And in some ways, it's so labour intensive and I don't know many other people who would do this.*
- *You're certainly advocating on an issue: access and equity. You have an idea there and you're trying to push it through in lots of different ways in different organisational settings. Which is again a little bit different from the usual way we perceive education.*
- *What gets in the way: Areas seem to be in constant restructure. Um, whether that's a new thing or whether people are in acting positions and it's really difficult to get to know who to speak with and for anyone to actually sign off on things*

***Theory Notes:***

- *Increasingly our educational work is becoming more organisationally focussed. This means that we often have to assess not only individual learner needs, but the various organisational structures and goals. We try to "sell" our value before engaging in training. We're now asking people to demonstrate changes in work practices or program outcomes. Those are high benchmarks to achieve.*
- *We are increasingly working within a business-planning framework. We 'do business' with other services and are explicit about using this rhetoric in our work. Learning outcomes become business outcomes. It's one way of validating our educational work.*

## d. Assessing learner needs

***Insights:***

- *… what I thought might be going through the minds of the people who are participating in this project. Usually they're forced to be there I suppose. They've been told to attend. They probably need to be somewhere else. They may have closed down a clinical service to be there. They may be pissed off. They're sometimes very enthusiastic. So you want to try and hang on and nurture that a bit. And they can sometimes be fear based: "Are you going to make me do something different? …*
- *All that stuff about being aware of relationships at a systemic level but also a personal level..what a huge impact both of those things have on the way your day pans out or how the project works and so on.*
- *And I think that people sit in panic from drug and alcohol at times when it comes to giving them another level to look at. So, it's difficult because there is legislation around access and equity and it's very specific to NESB and about people participating and being able to access and utilise services that are available to all people in NSW or Australia.*
- *..[there is an] issue about communication and making assumptions about how people are working or bringing people together to talk about how they're working –together or not together…and what relationships exist*
- *We basically go in and map the services and make sure it's going from the top down. If Area directors aren't on board, I don't think it's a successful project at all. And in consultation with the Area find out how they want to run the day and what they want to get out of the day. We suggest that they need to get something in writing and formalise their relationships otherwise it falls away very, very quickly.*
- *I'm just saying if you want this information it might be something you use. And I can actually see the pressure coming off them. They come in like this and sort of go –ah right. So I work on aligning myself.*
  *So what have we gathered from all of these things? You were saying that it's so labour intensive, sussing out the vibe, we used to call that learner centred. But now we have this organisational focus it requires heaps of phone calls, heaps of face to face; heaps of giving out information about what your organisation does, how it's structured, how is theirs structured, what are the opportunities for people or groups of people to work together that make us both look good. I think one of the big issues is the amount of administrative time needed to assess learning needs and all the tasks required to acknowledge and make use of the informal.*

- *There is a great complexity to the need assessment component of the task, which includes, What's in it for me?, What am I going to have to give? ….and that thing about expectations about change..*
- *Drug and Alcohol workers have beliefs about 'what works' that often match with those of their organisations. And we have to work with that.*
- *I try to facilitate a discussion about it that doesn't involve people … tearing each other apart. And I do my best professional guess.*

***Theory Notes:***

- *Working for change in AOD organisations has to recognise the particular idiosyncrasies of workers as well as the agendas of other players — the organisation, its board of management, the funders.*
- *There is a range of other things we have to accomplish (key relationships, meeting people on their space and working with them on what they want; connecting key agencies and sectors, empowerment strategies, etc)…with training and workforce development programs.*

## e. Worker Identities and learner expectations

***Insights:***

- *The think that struck me in your description was the reiteration of the sensitivity of the role that you have as a facilitator, or change agent or stimulus to do things or look at things and then maybe do things differently afterwards. All that stuff about being aware of relationships at a systemic level but also a personal level...what a huge impact both of those things have on the way your day pans out or how the project works and so on. In the same way that you're asking a lot of workers to reflect about why they do, what they do, the way they do it and then maybe change. You're doing that yourself as a facilitator or as a teacher or trainer or whatever –at another level. It's about being aware of all the things that impact on you or your effectiveness or ability to stimulate that change.*
- *I guess I one of the things that struck me is that you're out there selling something that's really, really important that there are no resources to support. And so what you're also doing is asking for them to think really creatively about a whole lot of levels about re-orienting what they do.*
- *…the amount of different types of skills required to do the organisational relationship building stuff is intensive. There's lots of face to face; a lot of time is spent assessing and asking people to do a lot of different things –not just learn stuff but act on some of the things.*
- *You can't depend on a universal acceptance of access and equity principles among learners like we used to. We have to work harder to change attitudes.*
- *I'm just saying if you want this information it might be something you use. And I can actually see the pressure coming off them. They come in like this and sort of go –ah right. So I work on aligning myself.*

***Theory Notes:***

- *In seeking to address the learning needs of workers in the AOD NGO sector there is a specific challenge, which manifests as a blurring between client and worker behaviours — with workers exhibiting such things as learnt helplessness and feelings of inadequacy.*
- *A lot of our work is advocacy. We advocate for organisations and workers to become engaged with our particular health topics.*

## Appendix v Midwives' Case Stories 1 and 2, Insights and Theory Notes

### Midwifery Case Story 1

I'm going to tell two stories and you've all heard them before. The first story is about a group of radical midwives. It's about how they got their act together and organised great influence in midwifery practice development. While going for the weekend with pens and note paper and a bit of red wine we brainstormed our vision for a community based midwifery. We wrote it out in a document called "The Vision" which articulated the basis for a philosophy guided midwifery service. It was to some extent, trying to get what independent midwives were on about into the NHS and that was to make midwifery continuity of care available to all women. Very soon that vision document somehow got incorporated into all the philosophy documents in the UK (New Zealand, Ontario and in NHS documents here in Australia. It's a little success story. And I still go back to it and think "What a beautiful thing that was really".

And another story is kind of a challenge because what's happened since then as you all know is that the notion of choice' has taken over and women should be able to choose anything they want. My story is related to the options for new mothers. Would choose' to hire an independent midwife and spend your own hospital birth but that's not an option most women would even know about. The story is about talking to radio personality Jane Gross at the recent midwives' conference about midwifery as a philosophy health strategy and midwives being based in the community. She responded, My prediction is that midwives will always be there but they'll become a sort of health food shop type option for women who choose a normal birth. But the reality will be that most women will actually go into the hospital system and choose to have an epidural or an elective Caesarean"... and when she said that it sent a shiver down my spine. And I keep thinking of it. It's there in my head a lot of the time when things aren't going well and particularly when trying to get midwives to work according to the vision. I realise that a lot of the time I feel and think that way too. You know that midwives themselves actually think along that line of choice' as opposed to as needing to be part of a broader philosophy health strategy

### Midwifery Case Story 2

My story's [s]oing down about ten years. I suppose from the big picture where are we and what's midwifery to a more practical story about practice development.

In my proper job I write protocols and challenging practice and my wife has been on the postnatal ward so generally I get to see a lot of what's going on and people wandering past and generally have a bit of an idea of what's happening in the unit. And when I first started I was intrigued as to why anyone who had hepatitis B got a single room. I thought it was nice for them that they got a single room but couldn't quite see the rationale behind that. I went and asked the manager because we were writing protocols about blood borne viruses at the time and I went to the manager and asked why and she said, Because they're infectious." Then she said "It's just what we do" and she was quite annoyed about it though because it meant that if a woman who had Hep B was coming around she had to shift the whole ward around so that that woman got a single room. And that everyone made a lot of fuss about wearing gloves with that woman but nobody cared about the rest of the ward – they didn't worry about gloves.

It just didn't make sense to me that this was happening. So we started to challenge this process and the manager on the other ward was very pro challenging these practices because she thought it was discriminatory and also unsafe for practitioners that they felt they were safe because they were gloves in this room but they didn't have to worry about the rest of the place. So we had to ask a lot of people why this was and unfortunately the infection control group had a mandate on making these decisions about who was in single rooms and who wasn't. So we challenged this – tried to write a protocol, looked at the evidence obviously to start with and unless someone was sleeping with the woman in the bed it wasn't going to be a problem. I'd ask people what the problem was and they'd say "There could be blood on the floor" and I'd say "Well, that doesn't happen very often and even so you'd have to be pretty damn unlucky"..

And so we tried to talk to the infection control people and they couldn't play ball. And then finally the other manager and I ended up in a mandatory session on infection control one day [the] other hand and said "Tell me why women with hepatitis B have to be cared for in single rooms" on the post-natal ward" and the clinical nurse consultant infection control – like a senior woman – said "I'll talk to you outside. We will not discuss these issues in public". And she walked up the stairs and she dragged [me] out into the corridor. I was so shocked and I ran after her. And this woman was so defensive and so aggressive that we had dared challenge this practice. We had dared to say "This is not good for women. This is not good for midwives or doctors who work on our unit. And it's not evidence based. We're not going to do it anymore. And she said "I've had complaints over the years and that's why it happens."

So we challenged her about the complaints and after a long conversation there was one complaint five years ago from a woman when somebody dropped blood on the floor and the woman in the next door bed complained that she was sharing a room with somebody who dropped blood on the floor. And so, for that complaint this ridiculous defensive, reactive policy had been policed. And in the end we've changed it...

I guess I'm telling this story because it's an example of engaging with other groups and we had to talk to all the other managers and infection control and all the other medical people involved. Also [the] narrow-mindedness of people astonished me. That one view of how these things should be – no they just didn't want to think any broader about the bigger issues or actually the evidence of what the risk was. Subsequently we do lots of talks with student midwives around blood borne viruses and truly you would think they were going into a war zone the amount of equipment they want to wear. It is so ridiculous. I don't get all of that stuff you know? The shields, and the plastic pinnies I just don't get it. So to change all of that policy is hard work. I think we've done a lot of it. I don't think we've fixed it but

## a. Describing Midwifery as a historical/political movement

***Insights:***

- *Can I just make a comment about midwifery –to me it's like a belief structure that doesn't start when you go to uni … it's about way, way, back in your childhood in your own birth and your belief systems and your mother and the way you were raised. And even though there are some student midwives that may not have had that gift, you can still see the difference and choose to change, you know? They've just got that trust in women, trust in themselves and they can step over, for want of a better word. So and you can pick them out in a group, the students like, you think, "She'll be great." You can just see it. It's a bit like religion and politics. It is something you either totally get or you don't.*
- *Well I suppose all of us are involved in developing different models of midwifery continuity of care. That's why these people are here because that is our major focus on the work we're doing at the moment is trying to change the system.*
- *Sometimes I feel we're at loggerheads to what's actually going on.*
- *Any institutional work in health is not nurtured. When a threat comes –it's the politics of oppressed people. You know? Because midwives have been so oppressed. Oppressed by obstetricians, oppressed by nurses, and used.*
- *Well you're dodging things. You're looking at strategies to get around the next one you know. You're bringing in all sorts of things –your sense of humour. I mean it takes quite special people to be able to do what we do. And that's what saddens me because there's not enough of them. In driving midwifery forward it's a minefield and it's very difficult. It takes a lot of energy and passion and motivation to get through that minefield.*
- *It takes collective action in terms of (pause) I don't know not the traditional sense of collective action but it's the coming together like this and it's the laughter and it's the stories and midwives learning from each other and the reinforcement of the ideology and the passion that makes us feel strong enough to carry on doing it. To carry on doing dodging. And it's laughing at ourselves in the process.*

***Theory Notes:***

- *Life experiences contribute to how we are as midwives*
- *Coming together to reflect, support each other, strategise, learn from stories, is important*
- *Story telling and laughter arise from our passion for midwifery*
- *Midwifery is political. Midwifery is about changing the status quo. It involves change at national and local levels. Midwifery change agents have incredible passion-it drives them to make a difference to the experiences of childbearing women in Australia. To come together to share experiences and stories with laughter, nurtures the support and ignites the passion and drive.*
- *When midwives are passionate about providing women with first-rate care, by working together, learning from each other and sharing experiences…women will be better off.*
- *Collective action and being involved in the political movement of midwifery and health.*
- *Trying to work in a system that is difficult*
- *Talking about the history (herstory) is a means to engage people and bring them along on the journey*
- *Talking about history, makes us realise how far we have come and gives energy to keep going*

## b. Midwifery practice development through Role Modelling

***Insights:***

- *But also you need those inspiring role models and if you don't find them then you'll lose them. So you need that inspiration and passion around you to keep that momentum going. Until you feel mature enough to just do it on your own.*
- *It's hard to describe what we do isn't it? Really. I think what I do is try to encourage individuality in midwives. I try and make them buck the system and not to go with the sheep. Like "Don't where a uniform. Why are you wearing a uniform? Why do you need to where a uniform?" You*

*know, try to encourage them to be their own individuals and thereby seeing that the women are individuals as well. So that's sort of a fundamental thing.*

- *…role modelling, mentoring, being an inspiration for young midwives, challenging them and encouraging them to question.*
- *There's formal stuff that goes on and then there's, I call it "Talking it up" –which is forever playing Pollyanna. Forever talking it up saying "God isn't it fantastic what's happening." Like what we talked about –that doom and gloom stuff –we never do that out there.*
- *A wonderful young woman came up and for her project she said, "I decided that I'm going to be a midwife like [name], she's going to be my role model …" It was great. She's out there on the wards now and she's holding onto it. It's lovely. And she's got it now. She's got it.*
- *[Midwifery is] like a religion. And we also deal with women and families. And a lot of the work we do is based on the relationship we have with women. It might seem un-seen. But it is seen. That's what I hope to do in my job is for other midwives see how I'm with women and they learn from that. So that's role modelling.*
- *I think that's a lot of pressure on the midwife's work within that [Continuity of Care] model because they don't feel so supported...and I worry that they'll burn out. Because they're isolated…and if they don't have somebody who is there to protect them or to mother them I worry that they'll fall apart…and that's what's happened in places.*
- *…and they [midwives] never see any other midwives practice so they just think that what they're doing is safe and the woman's happy … And they just think that's normal because they won't ever step outside …they're so isolated. They never go to a conference ever or keep up with readings because they don't think that's their role. I think that's a problem too –how do you tap into those networks.*
- *The dominant culture is so pervasive for the midwives, isn't it? It's all most people know. Sure we're giving the students a vision of what might be but most midwives aren't that political. We could probably tell you who we were I think. We'd know in each hospital there are probably only on one hand you'd count the amount of midwives who are motivated, passionate enough to spread the word, speak at conferences, do things that they're not paid for, develop resources, strategies to deal with that and there's not a lot of us.*

***Theory Notes:***

- *Awareness of who we are in the world is linked to building a strong, autonomous profession*
- *Midwifery is about harnessing our passion into political action that improves things for women*
- *Role models are an essential component on bringing about change*
- *Role models need to be found and supported*
- *Practice development is about building supportive networks and mechanisms*
- *No matter what the industry the mentor and the role model can never be understated. The student never forgets this form of learning, the woman never forgets the midwife who supports her. The concern in midwifery is that there are not enough good role models to go around. But one really good one can be so dynamic.*
- *Developing the passion and motivation into midwives is the job of passionate and motivated role models*

## c. Midwifery relationship building through persuasion

***Insights:***

- *We've got this fantastic research around in this country and lots of others –saying this is what you should do but in a way that's been for me quite disappointing –that that's not enough. And I suppose that's the way for any intervention –it's not a magic pill. It doesn't go on the front page because it's genome therapy and it's cheap! That's the other problem it's not fancy stuff –so because it's cheap it kind of gets sidelined again. I think that evaluation and that stuff is important but it's actually the politics and the pressure along side of it that makes the difference in the end.*
- *We do a lot of explaining it. Explaining, what and why. Talking it up. I suppose providing the rationale… I think we spend out lives persuading people that it's a good thing. That's what the cause is all about really. So we write about it, we get up there on platforms and talk about it even if we don't like doing that. It's for the cause you know.*

- *I think we build bridges with medical colleagues and that's really important. That sometimes we don't have medical colleagues that we want to put a bridge anywhere near but when we do, for me that has been one of my strategies –is to become friends with my medical colleagues. And do things over coffee that drag people around over long coffee conversations. It's that persuading. But sometimes they won't do it in a public forum because they lose face. So I find doing it one-to-one much safer … And we jolly them along…*
- *I think we engage in their game and we meet them on a level with evidence. I mean evidence based practice has a lot of answer for in certain ways, but we play the game and we get so good at knowing the evidence and we teach our students to be so good because the evidences are ammunition –to use war terminology – it's how we score points. Thank goodness we have the evidence for what we want to do.*
- *…I was just thinking that what this represents to me is that fragmentation …That our hole role as project coordinator for continuity of care is peacemaking with all these people …There are experts in every bloody area that think they're way is the only way –yet they're not with the women. They're not with them all the way through. And it drives me mad –individualising their care … There's no flexibility.*
- *So it was challenging to a whole lot of systems and organisational practices going on within her unit. And she kind of knew that once I got in there and started looking at what was going on that I would ask a whole lot more questions. And perhaps challenge here even a little bit more and unsettle her and unsettle her staff. So it's kind of playing the game at all sorts of levels to bring about change. And that's just one example of bringing about a little change…*
- *what I do now is if something comes up in a meeting or in policy or something I will go and do the interpersonal conversation first so that by the time we get around the table I know that they're sold. That they'll be okay.*
- *So coming back to persuasion you know I think we do a hell of a lot. You might give them choice but there is persuasion behind that choice.*
- *You need the role and the time and space to do it in.*

***Theory Notes***

- *Persuasion is an important strategy in midwifery*
- *Communication and interpersonal skills are essential for building collaborative relationships and partnerships*
- *Midwifery is also about forming workable relationships with peers who do not have the same 'philosophy' as ourselves. So how this is done can take many forms. Midwives demonstrate the evidence and so the benefits to women cannot be disputed. The evidence informs our practise and so we can challenge the old practise and provide the best care to women.*
- *Midwives can be in a powerful position …being clever about "getting our way".*
- *Playing the 'games' to bring about change*
- *Working with others to make them think it was their idea!*

## d. Midwifery – "With woman" (worker learner identities)

***Insights:***

- *I mean we talk about leadership and stuff but it's different. It's being along side midwives with a passion… It's about that thing about relationships with women, it's all about the partnerships, the relationships and how you are with women. You know, midwives … means "With Woman" so the whole kind of philosophy of midwifery is built on that notion of partnership with women.*
- *the people around this table –we're trying to develop models of care that are –for women and midwives - totally different to what the nursing culture has been*
- *It's about getting midwives together in teams or groups to provide women with continuity of care and working across the interface of hospitals and community services.*
- *It requires a shift in allegiance from the institution to the woman that's been described in the literature. When midwives work in the context of continuity of care there is that shift. So that you Persuasion is an important strategy in midwifery*

- *Communication and interpersonal skills are essential for building collaborative relationships and partnerships*
- *Midwifery is also about forming workable relationships with peers who do not have the same 'philosophy' as ourselves. So how this is done can take many forms. Midwives demonstrate the evidence and so the benefits to women cannot be disputed. The evidence informs our practise and so we can challenge the old practise and provide the best care to women.*
- *Midwives can be in a powerful position …being clever about "getting our way".*
- *Playing the 'games' to bring about change*
- *Working with others to make them think it was their idea!*
- *care about the woman.*
- *That's what I hope to do in my job is for other midwives see how I'm with women and they learn from that.*
- *[Midwifery is] like a religion. And we also deal with women and families. And a lot of the work we do is based on the relationship we have with women. It might seem un-seen. But it is seen.*

***Theory Notes:***

- *How we are in partnership with women makes a difference*
- *The shifting allegiance from the institution to the woman is a result of continuity of care*
- *The need to 'get it' in order to bring about 'the revolution'*
- *Demonstrating that midwifery is different and has a role to play*
- *Partnerships with women is what will bring about change*
- *To be in partnership with women and in partnership with midwives in a continuity of care model-is the best practise for all concerned. The politics of the institutions do not see it this way. The medical fraternity do not value the idea of relationship with women or midwife for that matter. They often will not change their own practise, even in the light of the evidence. They prefer to have the upper hand-it's about power and control. So "with woman" is the essence of midwifery and the struggle of midwives to support women within institutions.*
- *The focus of midwifery has shifted to being firstly, with woman and then with colleagues.*