

A story/dialogue method for health promotion knowledge development and evaluation

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Abstract

Arguments have been made in favour of a constructivist or postpositivist approach to health promotion knowledge development and program evaluation, but little has been articulated about what such an approach would look like. This article describes a ‘story/dialogue method’ that 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. 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. While intended for practitioner training, organizational development and evaluation, the method to date has been used primarily for training purposes. This article describes the method, provides an example of its application, and discusses its strengths, weaknesses and relevance to health promotion.

Introduction

There is growing argument that conventional (positivist) science norms are insufficient to make sense of what health promotion is and how its effects

should be evaluated (Dixon and Sindall, 1994; Baum, 1995; Dixon, 1995; Fawcett *et al.*, 1995; Labonte and Robertson, 1996). At the same time, health promotion has been challenged as more ideological than theoretical, often little more than a series of normative claims (Labonte and Robertson, 1996). This article describes a ‘story/dialogue method’ (S/D-M) that attempts to bridge the gap between descriptive stories and rigorous explanation, and so points towards accountability norms that are more in keeping with what health promotion practice attempts to accomplish. The S/D-M was developed in a partnership between practitioners and researchers who were frustrated equally with researchers whose positivist assumptions (e.g. ‘objective’ truth) and methods (e.g. randomized controlled trials or quasi-experimental designs) often did not fit the ‘reality’ of practice, and with practitioners who risked losing resources for their work by failing to articulate better practice-based theory. Lewin’s famous aphorism, “there’s nothing so practical as a good theory”, can be turned on its head; “there’s nothing so theoretical as a good practice”. The development of the S/D-M was prompted by a desire to assist practitioners to make explicit their assumptions (theories) about their work and to subject them to some critically respectful scrutiny with their peers. The product of this scrutiny is a generalized description of what health promotion is and seeks to accomplish, useful for and usable by other health promoters in other practice situations. Rather than generalized theory being privileged over particular experiences, particular experiences become the necessary components in the continual development of generalized theory.

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This article begins with a discussion of why interest in the use of stories or narratives for knowledge development has increased in recent years. The S/D-M is then described briefly and illustrated with examples from some of the uses to which it has been put (a more detailed account of the method can be found in Labonte and Feather, 1996). This article focuses on the method's use in knowledge development, as other method applications are still underway and not yet properly documented.

Background to S/D-M

The systematic use of stories in program planning and evaluation first began in international development work. Aid workers realized that they needed to respect the oral culture of many poor communities, and discovered that local people had an amazing knowledge about their lives and their environments that conventional (positivist) research was unable to tap (Slim and Thompson, 1995). Because researchers were not members of that community, they often did not know the right questions to ask, the right way to ask them or how to use the results. The contemporary women's movement was another impetus for renewed scholarly interest in the use of stories to create knowledge and for similar reasons. Feminists criticized many of the theories about human behaviour because the science that generated them had ignored women's voices (Gilligan, 1982; Tronto, 1993). Early consciousness-raising circles emphasized the value of women speaking from their own experience. This emphasis on personal experience and voice is also found in empowering approaches to education, including health education (Wallerstein and Bernstein, 1988). As Freire and Macedo (1987) argue, the first act of power people can take in managing their own lives is 'speaking the world', naming their experiences in their own words under conditions where their stories are listened to and respected by others. As stories are shared between people, they become 'generative themes' for group reflection, analysis and action planning. Stories, in the form of personal narratives,

traditionally have formed an important data base for qualitative studies. While some qualitative researchers claim the same objectivity and detachment as conventional researchers (Labonte and Robertson, 1996), many align more closely with action research tenets (Argyris *et al.*, 1985), and their emphasis on contingent and practical knowledge. Such researchers maintain that only in analyzing with people how they 'speak their world' can they, and the people with whom they research or evaluate, understand the practical significance of their experiences (Guba and Lincoln, 1989). It is precisely this element of reflection on meaning that is absent from most conventional scientific research. In many of the social sciences, there is renewed interest 'in narratives, on the telling of stories' as an important means of understanding this meaning-saturated quality of social life (Kvale, 1995).

Health promoters themselves recognize the importance of stories in researching, learning, evaluating and planning their work (Community Development In Health, 1993; Dixon, 1995; Feather and Labonte, 1995). Many health promoters, however, feel defensive because stories do not fit into the conventional scientific method. Dixon (1995) argues that a distinction should be made between conventional methods for institutional evaluations and 'community stories' for community-controlled evaluations, although this still risks institutional funders demanding evaluation using methodologies inappropriate to community-based programs. Even when stories are used in knowledge development and evaluation, an important issue remains of using stories more rigorously. Stories are not accepted simply as presented, but are used as a grounding base against which probing questions can be asked about what was done, why it was done and what it accomplished.

S/D-M

There are different ways to use stories in knowledge work. One method is simply to listen to a story and reflect upon it personally, which is the way

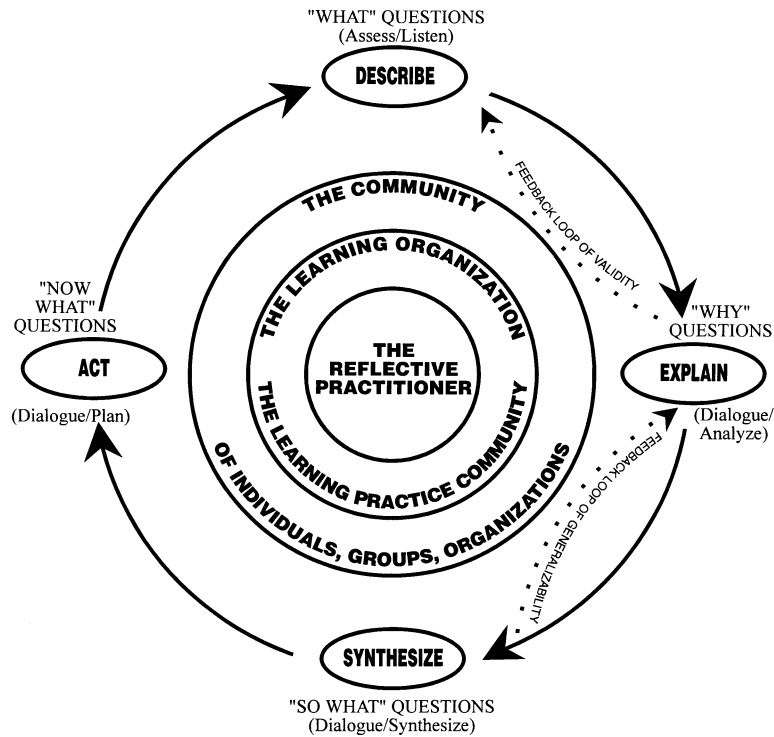


Fig. 1. Story/dialogue method.

most people read stories or enjoy the oral craft of story-tellers. Another way is to engage with others, including the story-teller, in a dialogue about the story, which is how the S/D-M works (see Figure 1). At the heart of this method is the reflective practitioner—the story-teller and those participating in the dialogue. At every stage in the method, participants are encouraged to reflect on how what they hear and learn from others has meaning for them personally. This requires organizational commitments to this type of inquiry (the learning organization) and supportive peer relationships (the learning practice community) (Labonte, 1996).

The notion of reflective practice derives from Schon's (1983, 1990) work, in which he proposes a 'transformative' option to the adversarial construction of the professional/client relationship. In a 'reflective contract' the professional slowly gives up an initial claim to authority and begins to negotiate a shared understanding with the person

or group with whom she or he is working. The professional's unconscious assumptions about what is effective in his or her own work become conscious and negotiable. In health promotion and community development, this is often characterized as a 'problem-posing' approach to program work, in which neither the issues nor their resolution are taken for granted but are analyzed against a repertoire of experience and knowledge from both professionals and community members.

S/D-M workshops

As of February 1997, over 1700 practitioners, researchers and program managers in six countries have participated in workshops on the method. Most of these workshops have emphasized knowledge development, although some post-workshop applications include staff and organizational development, program planning, and program and policy

evaluation. Workshops vary in size from 20 to over 200 participants and range from 1 to 3 days in length. While most participants are ‘front-line’ health agency staff (e.g. health promoters, community health nurses, social workers), many workshops attract academic researchers, policy workers and government program managers interested in the method as an approach to research and evaluation. S/D-M workshops always have two goals: training in the method itself, including some discussion of other uses of stories in health promotion (e.g. stories as testimony in advocacy work or as means to create solidarity within self-help groups), and application of the method to specific problems or issues important to participants attending the workshop. All workshops include at least one full day in which small *story groups* of five to nine participants analyze two or more *case stories* constructed around a *generative theme* using a *structured dialogue* intended to assist participants in creating generalizable knowledge, or *theory notes*, about practice. (*Italicized* terms are explained later in this article.) Longer workshops use theory notes to develop evaluation indicators or logic models of practice, or to identify skills training needs. The different steps and applications of the method are outlined in Figure 2 and a typical 1 day workshop is outlined in Table I.

The generative theme

An S/D-M workshop begins with determining one or more generative themes. A good theme is one that identifies ‘tensions’ or strained relations that exist within and between the people who are part of it. A generative theme speaks to power relations in health promotion practice (e.g. between practitioners and community members, state institutions and community groups, front-line workers and senior managers), rather than to content issues of health promotion work (e.g. heart health, tobacco, injury prevention). An assumption behind the S/D-M is that an important element of health promotion work is empowerment, in which power relations between different actors and groups involved in activities around a specific issue

become more equitable. (For discussions on the relationship between power, empowerment and health, see Wallerstein, 1992; Wallerstein and Bernstein, 1994; Labonte, 1997.) Generative themes are selected by workshop organizers (usually a health department, health non-governmental organization or university), based upon their knowledge of important practice tensions experienced by health promoters in their area. Themes are written up in paragraph form and distributed in advance to all workshop participants (see Appendix 1).

Case stories

Workshop participants are invited to prepare a case story around the generative theme. In longer workshops, all participants have an opportunity to be story-tellers, where their experience becomes a ‘trigger’ for a deeper analysis of the theme. More commonly, and depending on the number attending a workshop, about one-third of participants will prepare case stories in advance. A case story describes the practitioner’s experience with the tensions summarized in the generative theme. It is 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. Story-tellers, who are provided with briefing notes to help them prepare case stories, are encouraged to problem-pose their experience, rather than problem-solve it. Story-tellers are also encouraged to write down their story in narrative or point form, which typically run 1–3 pages in length (see Appendix 1)

Workshop evaluations indicate that the more reflective time the practitioner takes in preparing a case story, and the more the story poses the tension rather than resolves it, the richer becomes the structured dialogue around it. Many persons who have been story-tellers in these workshops also comment that:

- The process of preparing the story itself led them towards new insights about their practice.
- Reflecting on their practice is rarely encouraged

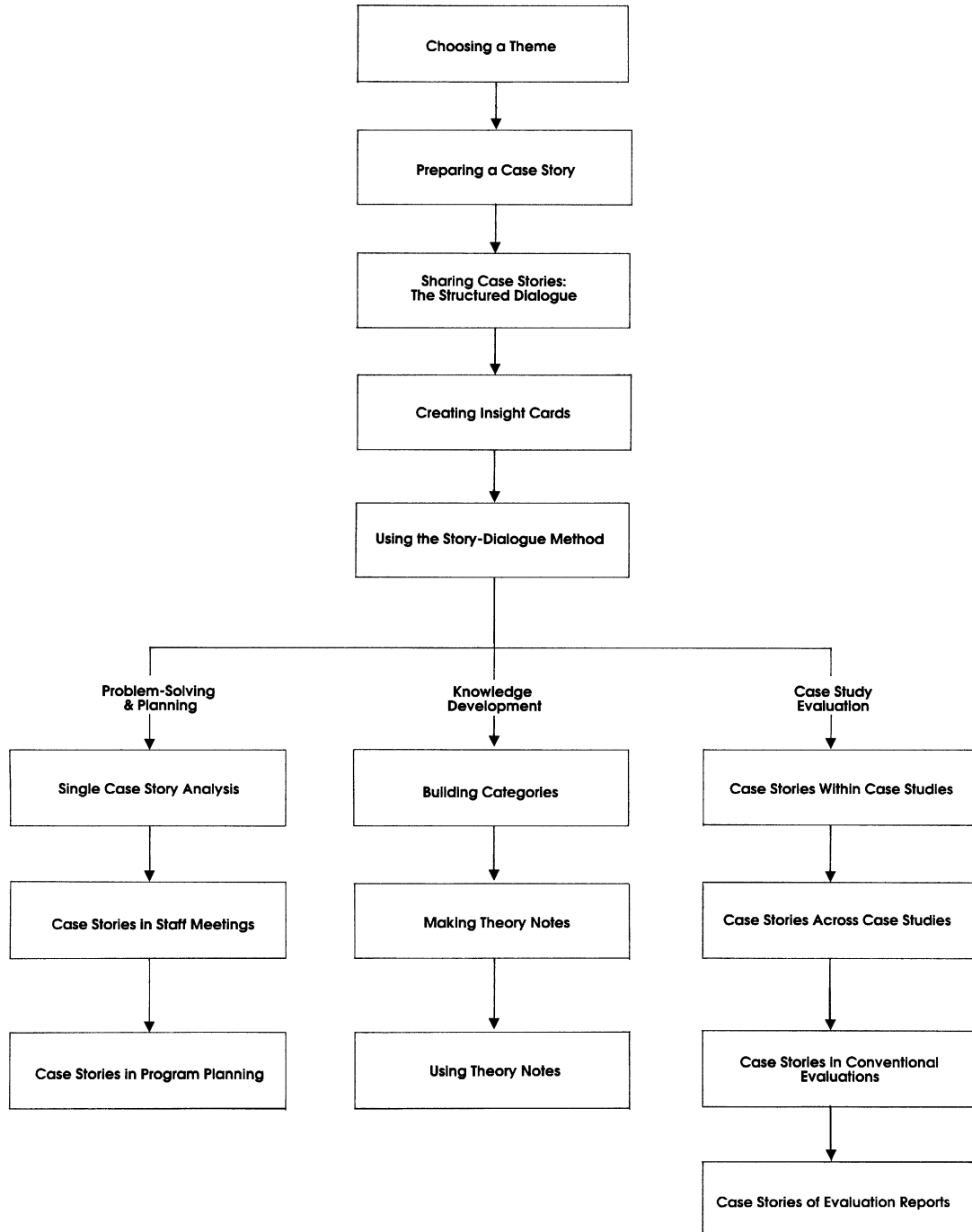


Fig. 2. Steps in the S/D-M and its uses.

Table I. *One-day workshop on the S/D-M*

Steps	Time (min)
Overview of the method	60
First round of stories	
story-teller	15
reflection circle	5
structured dialogue	55
insight cards	45
Second round of stories	
story-teller	15
reflection circle	5
structured dialogue	55
insight cards	45
Making categories	45
Making theory notes	45
Closing evaluation circle	30

or supported in their own workplaces (but could be).

- Preparing ‘good’ case stories was a new skill that could be developed with practice.

Story groups

Once in the workshop setting, participants form story groups. Story groups typically average five to nine participants, who work through two or three separate rounds of story-telling, each round lasting between 90 min and 2 h. In each round, one person is a story-teller, four persons volunteer for the dual role of story-recorders/story-listeners and the rest are story-listeners. Story-recorders are asked to listen for significant comments in the dialogue made under each of the four question categories (described below) and to note them in point form. The purpose of recording the dialogue in this way is 2-fold: to provide participants with a practice opportunity in a participant/observation technique and to ensure that the dialogue remains the data base for later ‘second level synthesis’ (also described below). Workshop evaluations indicate that when participants have responsibility for recording key dialogue points, the quality of their listening becomes more intense and they understand better the distinctions between descriptive and explanatory modes of questioning. Story

groups begin with a verbal telling of the story. This is followed by a ‘reflection circle’, in which other group members, one at a time and without dialogue, reflect upon and speak to how the story and the issues it addresses are similar to (or different from) their own experience. These reflection circles have proved useful in shifting story group members’ thinking away from the descriptive content of the story-teller’s experience, and towards the organizational and social contexts in which health promoters work, which constitute the terrain in which empowerment occurs.

The structured dialogue

After the reflection circle, story group members begin a structured dialogue around the story. A structured dialogue is intentionally designed to move discussion from a description of what happened, to one or more explanations for why it happened, a synthesis of key lessons derived from the case story and similar experiences and some articulation of new actions. The structured dialogue, and its use, are fashioned after Habermas’ (1984) notion of “ideal speech situations”. Habermas’ complex theory of power relations in society hinges on the role communication plays in maintaining or transforming social systems of dominance. Transformative communication occurs under ideal speech situations, in which participants search for a better understanding of particular events in the world. The rules for ideal speech are that people’s claims are ‘comprehensible’ (understandable to others), ‘true’ (they are not logically or rationally false and can be defended by argument or data), ‘appropriate’ (justified by a shared purpose among participants) and ‘sincere’ (people state what they mean). Truth and appropriateness can only be defended in open dialogue. An open dialogue, in turn, is facilitated by using open questions which invite reflection. Four categories of open questions are used to generate a structured dialogue:

- (1) *What* do you see happening here? (Description). What questions invite people to describe

what is happening in their case story from their own vantage point. They ground the explanation in experience.

- (2) *Why* do you think it happens? (Explanation). Why questions invite a discussion on causes, where participants begin to interpret or make sense of what has been described.
- (3) So what have we learned from our own experiences? (Synthesis). So what questions invite a synthesis, or distillation, of new knowledge.
- (4) *Now what* can we do about it? (Action) (adapted from Vella, 1989; Wallerstein and Sanchez-Merki, 1994). Now what questions translates this new knowledge into normative claims of what health promotion practice ought to do.

A number of prompts exist for each question category and are often tailored to the specific generative theme. Although the four questions and their prompts are not intended to be used in a linear fashion, providing time for each question category helps to prevent discussion from bogging down in description. While some practitioners initially find the structure awkward, workshop evaluations note its importance in moving practitioners to a deeper understanding of their work experiences. Story-tellers frequently note that the structure of the questioning surfaces a different and more generalized quality of insights about practice than they normally encounter in peer exchanges or conference presentations. Often, case stories shared in the same story group concern quite different health 'content', e.g. one story on environmental activism, another on smoking control programs, a third on community gardens, causing some initial scepticism among participants about what they might learn from one another. However, as was expressed in a recent workshop, "we were surprised by how much our work had in common, once we got beneath the superficial differences of the issues themselves".

Each story-telling round concludes with the generation of insight cards. Insights represent key points taken from the structured dialogue on the story that story group members think are significant

enough to be shared with other practitioners. Insights are written as full statements, naming an actor and an action, e.g. "the leader needs to be able to unpack the differing agendas of the partners" (an insight card from the case story in Appendix 1). This is the point where story-recorders' notes play a role, to obviate the risk of some persons reaching personal conclusions ungrounded in discussion points on the actual case story experience. Between 10 and 15 insight cards are generated for each story and posted on a wall.

Validity and generalizability

An important issue in using the S/D-M is the validity of the knowledge gained through analysis of the story. Validity here does not mean that the method generates 'truth' in a universal sense, but that its findings have 'the quality of being well-founded' on experience (Heron, 1988) and represent a diversity of opinions that create 'saturated' categories (Strauss, 1987) that are 'grounded' in the description of actual events (Glaser and Strauss, 1967). Validity means that a good explanation is understandable, and that it reflects what happened and not just what practitioners wanted to see happen (Razack, 1993). In the S/D-M, this requires a return to the description of the story: what more details are needed to know that the explanations, or generalized lessons, are valid ones? Does the explanation cover all of the story details or has it selected those that fit well and ignored others that do not? Validity is of particular concern when the S/D-M is used for case study or evaluation purposes. In one application currently underway, validity is being addressed by incorporating data from project records and files, individual interviews, and case stories from many persons involved in the project during S/D-M workshops, thus triangulating data sources and practitioner perspectives.

Heron (1988) argues that postpositivist research findings should be generalizable or replicable. He does not mean this in the positivist sense, in which the same actions should be transferable to other

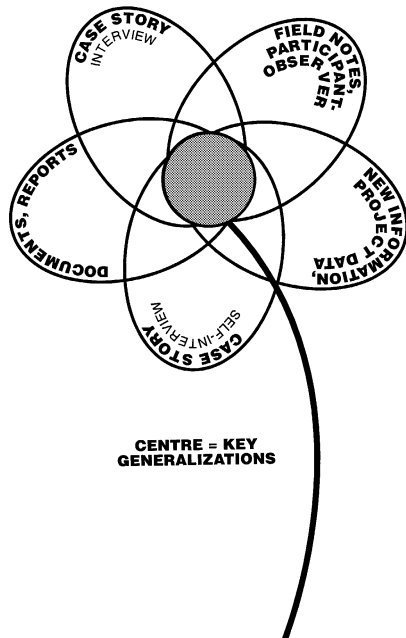


Fig. 3. Case stories in case study evaluation.

locales with similar results. Rather, he argues for a 'creative metamorphosis', in which the underlying 'wisdom' gained is shared with persons facing similar situations. This requires the knowledge claims to be of sufficient depth (specificity) and abstraction (generalized statements) that others in similar situations can make use of them. The S/D-M is designed to provide both. It begins with specific practice experiences (the individual case story) and ensures that efforts are made to extract important lessons for all practitioners from the particular case, 'an in depth-analysis of an experience', as was expressed at one recent workshop. Generalizability is strengthened by analyzing two or three different stories on the same theme in each story group during an S/D-M workshop (see Figure 3). If the method is used in peer group meetings, in which instance the peer group becomes the story group, such stories can be analyzed over a series of meetings. Participants in the story group then work up the results to a more abstract or second-level synthesis of practice.

A second-level synthesis

To move from insights from a particular story, to more generalized lessons derived from several stories, a second-level synthesis of the insight cards occurs. There are two steps involved in a second-level synthesis, building categories from the insight cards and writing theory notes based on the categories. Categories allow participants to consolidate lessons from a range of stories. After the categories have been made, story groups write up a descriptive statement that links the statements on the insight cards, in effect writing a more abstract, or generalized, 'story' of the lessons learned from the particular case stories they have been analyzing. 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. As one workshop participant stated, "the theory notes allowed me to see how the case story was made useful". After theory notes are written for each category, they are structured or linked together into a composite theory note (see Appendix 1).

Composite theory notes generally have a normative quality to them. The structure of the S/D-M leads to theory notes being written in an imperative mode, in which the subtleties of explanation and context present in the dialogue around the story are removed. This is intentional. People do not live as if each situation they encounter is completely novel. They bring to it a repertoire of analytical devices, strategies and other forms of knowledge built up from previous experiences. The same applies to health promotion work. The S/D-M is designed to make this health promotion repertoire more explicit and open to peer analysis. Resulting theory notes speak to practitioners in particular work contexts. These notes are not theory in the 'grand' sense in which some transhistorical understanding or statement of causal relations is sought (Giddens, 1984), but neither are they simply the ungrounded ideological claims for which health promotion has been criticized. The difference lies in their connection to a group analysis of actual practice experience.

A theory note derived from a single case story

may fail to identify lessons pertinent to a wider range of health promotion practice concerns. For this reason the S/D-M encourages the triangulation of at least two or more case stories in any given story group. In some instances, case stories and theory notes are published alongside one another following an S/D-M workshop, together with a synthesis of all of the different story groups' theory notes (e.g. Labonte, 1997). This provides more contextual richness to the generalized lessons contained in the theory notes and a more robust account of these lessons by drawing from a wider range of case stories.

Using theory notes

Theory notes are used by S/D-M workshop participants in a number of ways. In shorter workshops, they are often used to identify new practice tensions that become the focus for later workshops or peer group meetings. In longer workshops, theory notes have been used to develop 'benchmarks' for good practice. Workshop participants examine their theory notes, extracting from them those actions or outcomes for which they believe health promoters should hold themselves accountable (see Appendix 1). Once these benchmarks are established, workshop participants develop an argument why achieving them will improve health. This additional reflexive step in S/D-M workshops returns practitioners to the larger issue: how does their work contribute to improved health?

Strengths and weaknesses of the method

The examples provided in Appendix 1 of results from the S/D-M come from workshops that were also training in the method itself. The potential usefulness of the method lies in its more continuous application and refinement within practice settings. 'One-off' S/D-M workshops generate some useful lessons, but the limitations of workshop settings

preclude assuming that these lessons, in the absence of further reflection and analysis, represent 'good' practice-based theory. Rather, the lessons point the way towards such theory and the S/D-M provides practitioners with a tool for participating actively in its generation. Triangulating several different stories on the same case increases the validity of the theory notes (conclusions) reached by story group members, while triangulating several different cases on the same generative theme increases their generalizability.

Evaluations of S/D-M workshops indicate that the method's appeal to practitioners lies in the power of sharing stories, grounding the stories in first-person experiences, affirming that practitioners and community members have important knowledge, the story group process that, in one participant's words, "helped to make everyone work together as equals", and the logic of the structured dialogue. Weaknesses in the method do exist, and pertain primarily to differences in the ease with which practitioners are able to prepare 'good and revealing stories' (Feather and Labonte, 1995), to move from the concreteness of description to the abstraction of explanation, to 'discover' or articulate insights and to search for patterns when creating categories. When practitioners encounter difficulties in these areas, there is a tendency to retreat into the personal stories and problem-solve the particular, rather than to move on into assessing and analyzing the generalized knowledge the stories help to create.

The ability to document revealing experiences, to analyze and explain these experiences, to synthesize the analysis, and to search for patterns and abstract from the particular to the general are all skills that can be acquired with practice. The S/D-M has evolved to assist practitioners in acquiring these skills, notably through briefing and support of story-tellers prior to their crafting of the case story, use of briefed facilitators in each story group, creation of a detailed handbook on the method and development of additional stages, such as 'benchmarking,' that return the abstract theory notes to the particulars of practice.

Conclusion: the method's relevance to health promotion knowledge development and evaluation

The S/D-M is one of many approaches to knowledge development, program planning and evaluation. It is not intended to replace other methods nor does the group approach to story analysis, synthesis and generalization preclude the more traditional qualitative analysis of such 'texts' undertaken by individual researchers. The logic of the method—the structure of the dialogue, generation of practice-based theory and application of theory to the creation of evaluation indicators—represents one technique for postpositivist research that can be, and is being, adapted to a range of program evaluation questions. It is particularly suited to analysis of health promotion strategies and activities, whether from the vantage of practitioners, their agencies or community members.

Expert knowledge in theorizing and evaluating health promotion practice is important, but often has overshadowed the knowledge of practitioners and community members. The S/D-M, by basing itself on the day to day experiences of these groups, moving from their particulars to a statement of more generalized or abstract knowledge, and applying that knowledge to specific program evaluations, can create a better balance between the knowledge and power of institutions and professionals, and the knowledge and power of communities.

Acknowledgements

The hundreds of health promotion practitioners who have participated in the various iterations of the method. Marcia Hills and Nina Wallerstein who worked with Ronald Labonte in several applications of the method. The project team which piloted the method: Nicole Dedobbeleer, Marcia Hills, Nancy Kotani, Heather Maclean, Karen Parent and Irving Rootman. Health Canada, for funding various stages in the development of the method, and Nancy Hamilton of Health Canada for her support and insights. Patricia Williams, Edmee Korsberg and Carmelle Thibodeau, who

reviewed drafts of the handbook (Labonte and Feather, 1996) on use of the method. Bonnie Sproat, who designed and produced many of the documents and graphics used in applications of the method.

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Received on September 10, 1996; accepted on September 15, 1997

Appendix 1: Examples of a generative theme, case story, theory note and benchmarks

The following examples are taken from 2 day workshop in Melbourne, Australia (August 1996) on the topic 'Creating Partnerships for Health Promotion'.

Generative theme

Everyone talks about the need to develop new partnerships or intersectoral collaboration. Our work should lead us beyond ourselves, to partnerships with like-minded groups, organizations, sectors. However, territoriality, competition over resources, different language and concepts, different accounting structures and priorities all seem to get in the way. Power differences/inequalities between partners are often large and are rarely talked about so that they might be resolved. This is particularly true in partnerships involving community people and groups, whose participation is often token, largely because the terms of participation remain largely with institutions. Despite recognition that supports for citizen participation are essential they are often meagre or lacking. There is also a general participation exhaustion with everyone running from one consultation meeting to another in the hopes of not missing something that just might be important, but often is not.

Case story

I am a medical graduate who has had a lifelong interest in involvement in community-based youth activities. I was recruited 5 years ago to establish an adolescent health program—The Centre for Adolescent Health—which was the first clinical academic program in adolescent health to be established in Australia. Those who came together to stimulate this initiative were three hospitals, a university and VicHealth (the Victoria Health Foundation, an Australian health non-governmental organization funded through a special tobacco tax). What quickly became apparent was that these multiple agencies did not share one single vision, had many differing agendas and had chosen me for different reasons. The hospitals' agenda was

largely focussed on improving service delivery to young people in problem areas. The academic agenda was more to do with research excellence and education/training. VicHealth had a more politicized agenda informed by the release of a report on youth homelessness emphasizing outreach and development work with youth in the most severe social circumstances. In a similar fashion the agencies valued me in different ways. The hospitals valued my physician status and my knowledge of health service delivery. The university valued my academic achievements. VicHealth looked towards my non-professional commitment to young people as an indication of my understanding of the importance of a social view of health and the promotion of well-being as integral components of an adolescent health program.

My initial attempts were to try and please the multiple constituencies by attending management meetings, faculty meetings, staff meetings and key committee meetings at all of these agencies. It quickly became apparent that this was not a good strategy. I was not keeping anyone happy and not achieving core objectives. I came to realize that the true constituency for the Centre for Adolescent Health was young people in the community and that addressing their needs was the key outcome. As I worked towards identifying and addressing these needs, I took a pragmatic decision to focus my partnership building attention on two of the agencies only, one hospital and VicHealth. By slowly building on the particular strengths of these agencies, we were able to begin to develop a common vision that helped us to then take on board other partnerships.

The things I learned during this process were, firstly, the need to keep a focus on the big picture and the true constituency for the work of the program; secondly, that there was a need to create a vision around which to rally the partners, rather than to necessarily try and create a hybrid vision from all the different agencies involved; and thirdly, to build on partners' particular strengths and not to try and pursue too many concurrent relationships.

Theory note

Effective partnerships require the establishment of a clear vision of the role of the organization and a definition of what future role the organization will play. Having agreed on the vision,

effective leadership requires working to ensure that the partners have a common goal and a commitment to share in a true partnership. Effective leadership must focus on the common goal for success and not try to please all the partners.

Partners may be pre-determined, self-selected or chosen. As development and management of multiple partnerships is difficult, it is essential to identify key partners to ensure any long-term sustainability for the partnership. Key partners may be those who have certain forms of 'power-over' in relation to the issue, often through their control over funding relationships. Changes with partnerships and the external environment require monitoring of power bases—who has power, who has not and how this changes over time. Introduction of new partners, or termination/repositioning of existing partners, may be needed to ensure their ongoing relevance to the issue around which the partnership formed and their effective contribution to achieving partnership goals.

Good partnerships take time to develop. It takes time to develop a shared common goal, a sense of ownership of the project, and an intellectual and emotional commitment to successful outcomes for the project. To accomplish this, the leader needs to be able to unpack the agendas of different partners (which are often hidden) and to understand fully their individual motivations, interests, goals and expectations. The leader may also need to expose the partners to the constituents (those benefiting through the partnership's activities) and the

setting at the coalface (where the activities take place). The leader needs to develop and nurture current partnerships while recognizing the need to identify potential new partnerships and train future partnership leaders. The leader also needs to be aware of his or her own personal limitations and be prepared to draw on others' skills to supplement his or her own.

Finally, partners from the constituency (those benefiting from the partnership's activities) need to be provided with opportunities to develop and use skills that empower them to play an active role in the project/organization.

Benchmarks

The agendas of each partner are clearly stated and a common agenda reached, through agreement on one or more goals.

- The partners agree to a process that exposes managers of the partnership to 'coalface' experiences.
- Partnerships establish a process to actively skill the constituency (those benefiting from the partners' activities) so that they are empowered to participate actively in the partnership itself.
- Partners agree on mechanisms to enable skilled constituents to participate in the partnership and methods to monitor that participation.
- Partnerships are strategically managed through establishment of a clear, common vision formally documented and agreed to by all of the partners.