It isn't necessary to convince all potential partners at the outset of the value of joining the partnership. Some groups might resist or not be in a stage of readiness for such a commitment. It is important, however, to have the support of an "avante garde" of groups and organisations in the area of the problem or issue. Eventually, resisting organisations are brought on board by the sheer momentum created.

While the midwife and initiating organisation needs to ensure that all potential partners have a voice and equal opportunity to participate, they must also exercise caution that the partnership group does not become so big that it becomes unworkable. Partnerships are maintained, in part, when there are definable roles and responsibilities for all partnering groups.

Managing the Context

Changes valued by partners can be assisted or hindered by (unexpected) developments elsewhere in the system, especially changes in power relations between different groups and organisations. Some ongoing surveillance by partners of this larger environment is necessary. It allows the partnership to identify partnership opportunities (e.g. changes in media coverage or public perceptions, new organisations or groups to recruit for membership, funding) and threats (e.g. competing groups, changes in political agendas) that might arise.

The midwife needs to expose partnership members to the actual constituents (those benefitting through the partnership's activities) and the workplace setting at the coalface (where the activities take place). Otherwise there is a tendency for partnerships to devote all of their attention to the policy, funding or political environment, or to look inward to their own interorganisational processes, at the expense of the actual activities, programs and services for which they originally partnered.

Managing the Process

Initially, a lack of formal structure to the partnership can facilitate creation of a common vision and definition of a superordinate goal. However, as a partnership develops and grows, its work, importance and credibility can be inhibited by the lack of formal structure. A formal structure should document agreements over such matters as:

- decision-making (styles, authority)
- commitments from member groups (expectations)
- managing power relations within and between member groups
- evaluation criteria and methods
- monitoring
- delineation of new partners' roles
- terms for leaving the partnership
- conditions when the partnership should be dissolved

Introducing new partners, or letting go of old ones, is sometimes necessary to ensure the ongoing relevance of partnership activities to its constituent members or the citizen groups it is trying to serve.

Power, knowledge and authority on the part of some partners should not be used to dominate other voices and restrict their ability to contribute. As part of ensuring effective group processes, each partnering group should be given the opportunity to have equal input into developing the ground rules or terms of reference, aims, objectives and targets for the partnership.

Effective communication is an essential part in developing partnerships. The process of communication needs to be flexible, and to give particular attention to people from diverse ethnocultural or social class backgrounds. Effective communication helps to build relationships between partners which depend, in turn, on a sophisticated appreciation by all partner groups of the assumptions and values of one another.

Some degree of intergroup conflict should be expected even in effectively functioning partnerships. Conflict can best be managed by the midwife and initiating organisation through attention to potential differences between partners, particularly in their needs for power and control. Even large organisations, however, are capable of devolving power. There are numerous ways in which an organisation might "signal" a willingness to change the power balance, such as informal meetings, clear resource transfer guidelines and use of external advisers and reviewers for organisational policy change. Effective partnerships, however, may not necessarily lead to broader power changes between stakeholders.

A maturing partnership will be characterised by:

- willingness to put certain objectives on hold or modify them in recognition of the value of the partnership;
- an understanding among the parties that injuring other parties is not in their own best interests; and
- some respect and understanding for the feelings, views and positions of the parties for one another.

Finally, it is important to be able to walk away from un-useful or distracting partnerships. Thus, it is important at the beginning of partnership development that it is understood that, if certain partners are no longer working towards the same vision, they should leave, or the partnership should dissolve.

Making the Time and Resource Commitments

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. It takes time for skills training and supervision in conflict management for key workers and personnel (midwives and the initiating organisation). Partnerships may have more chance of being successful if a reasonable length of time is allowed

for their development. (Comment: The need for time to develop partnerships was a loud and recurring theme in all of the stories and theory notes. No specific time-table was offered, and a caution is added that some partnerships can become bogged down in process at the expense of activity, so judgement calls about how much time must be made. But the prevailing sentiment is that partnerships are currently seen as a cheaper way of doing the same things, rather than a means to accomplish more profound changes in health status by, in part, changing the flow of power and resources through society. Moreover, any partnership development consumes time and resources, and this may be greater than presumed efficiencies in service delivery. Thus, there is a need for those organisations promoting the idea of partnerships to be clear on their assumptions for why partnerships are helpful; and for partnering organisations and midwives to do the same.)

Empowering Full Participation

The partnership should remain open and actively identify whether any important groups or organisations have been overlooked. Invitations to participate should be extended to such groups, although some organisations may require more than an invitation. They may require the removal of specific barriers (e.g. opportunity costs) and the development of specific policies and supports that allow them to participate as equal partners. This "special attention" to initially less powerful partnering groups demands that more powerful partners are willing to examine the bases of their own power, and to share power more equitably among all groups and organisations.

Particular consideration must be given to the voices in the community with whom we are in partnership. People being served by the partnership's activities are also partners. Often times, they need to be provided with opportunities to develop and use skills that, in turn, will allow them to play a more active and powerful role in the partnership structure itself.

Evaluating from the Start

In developing partnerships, recognition at the outset should be given to both the tangible (activity-oriented) and intangible (process-oriented) outcomes. Different partners will likely have different views of what constitutes "success," and just coming to some mutual agreement on this comprises a successful accomplishment of an otherwise "intangible" outcome!

All partners should participate in evaluation, in order to ensure that the outcomes are meaningful for the groups involved, and for the ongoing partnership process. Criteria for partnership success and how this will be evaluated needs to be agreed upon and documented. These criteria should include realistic short and long term goals, both of which are necessary to ensure sustainability of the partnerships' activities. Internally, partnership activities need to build upon successes to maintain local cohesion and sustainability. Externally, partnerships need to promote their successes to the broader community to further community and political support.

It is important to use evaluation methodology appropriate to the goals of the partnership, and acceptable to all of its members. Particular attention should be paid to methods that take into account the diverse forms of understanding that exist across different social classes, ethnoracial communities and age groups.

Finally, a partnership can only function within an open process of communication, in which both successes and failures are acknowledged and utilised constructively to reorient the implementation process.

Building in Sustainability

Partnerships are likely to be most successful where they are enduring and long term. The most sustainable partnerships are those that begin with a commitment by partners to long term sustainability. However, this is not always possible. Also, not all partnerships are productive or should last beyond a limited time-frame. But the sustainability of the partnership, and particularly of its new activities, should always be considered early on in partnership development. This consideration is driven primarily by an ethical concern: If the new activities are important and needed by a broader community of citizens, and if the partnership does not survive beyond a certain funded period, what is to happen to the activities and to the citizens?

Conclusion
Dr. Elizabeth Reid, Director, HIV & Development Program, UNDP

Let us return to the questions I posed in the introduction and reflect on what insights the use of stories has provided which could help make health promotion a transformative practice.

How can health promotion be a transformative practice?

How, and from whom, does one learn how to answer that question?

How can one give an account of knowledge, and of morality, that retains continuity with daily experience?

What is the role of the professional, the outsider, in bringing about these transformations?

How can transformative practices be monitored and evaluated?

The way of looking at power, participation and partnerships for health promotion embedded in the methodology and approaches of this book are dissonant with much of the current practices, rhetoric and values of health practice and funding. Glimpses of the way this dissonance works itself out in a particular setting can be gleaned from the stories. Those concerned to ground health promotion practice in the complexity and cussedness of daily experience, so that its practice can transform from within, may find themselves living in a way that rationalism has long made extinct: within overlapping contradictory systems.

Let me illustrate this with a story. A Zairean friend, a university graduate, owned three cows back in his village, a significant investment and relatively unusual for someone of his age and education. He had been allocated some grazing land by the responsible chief; family members tended them. One day, he arrived at my house upset and worried. He had just heard that all the cows were dead, of Brucellosis. We talked at some length about what that would mean for him and his family socially, economically and in terms of his future.

About six months later, when we had grown to know each other better, we were together in a different setting, working in villages near his own. One day he started talking again about his cattle. He explained that they had wandered off his grazing land onto that of someone else and that person had become angry, gone to a sorcerer and asked him for a fetish to put a spell on the cattle. When my friend realised what had happened, he too sought out a sorcerer to put a protective, counteracting spell to keep them well and alive. However, sadly, his sorcerer was not as powerful as the other one and so his cattle died.

My friend believed and acted on both accounts of what happened, both world views. They were not linked - he did not believe his cattle died of Brucellosis because the sorcerer had put a spell on them - rather they were co-existing world views. Both explanatory systems co-existed for him with equal validity.

We are not quite so lucky. The contradiction within which we are struggling to function as professionals is between contradictory accounts of the relationships between theory and practice, between experience and knowledge, and of the basis of validation, proof and evaluation. We draft proposals, seek funding, are appraised and held accountable in a system of theory construction, knowledge generation, program design and evaluation that has a tendency to set aside or dilute human interaction and interrelationships, the lived experience of people. A system which assures that numbers can prove facts; a system of pre-defined categories and dichotomies which so shape our thinking as to lead us to believe that the world presents itself to us in this way.

But life is rarely that simple; experience does not come dichotomised. And so there is a tension, a discomfort because this system and its derived practices obscures the complexity of experience. It is not grounded and does not capture what we are living through. It repudiates and discredits the methodological approach of the stories methodology. But why should the emotional impact of what we do not be considered a fitting subject of discussion and practice? Why should we only draw on certain things and not others as a legitimate basis for knowledge or theory construction?

These questions embody a view of health promotion that is different from its framing as social engineering; that is, as a system whose set of principles and interventions can be applied to change human conduct and health institutions.

It is clear that the crafting of the story is critical to the effectiveness of the methodology and approach discussed in this book. If this methodology is to give an account of knowledge and allow the possibility of theory construction, the stories must be grounded in the storyteller's own experience and told from her or his perspective. This allows the teller and the listener to understand complexity and structures from within, for the storyteller, at least, has been there. It is lived experience.

This imperative makes essential that the voice of the story be the first person "I" or "we", not "you" or "they". This structure contributes an important insight on the role of the health professional or outsiders in bringing about changes in health practice: the professional's story is just one story which can be told of a particular experience. All other actors have a first person story to tell. In this approach, health professionals cannot tell anybody else's story, only their own. Other participants tell their own stories and out of the emerging whole, all involved can learn as well as share.

Because the outsiders, the health professional too, has a story to tell, she or he is present as a full partner, not just as a cipher to facilitate somebody else's reflection and action. Yet because the outsider's story is only one of many, he or she is not interacting as an expert that determines the questions and provides the answers. Rather, the outsider is one of the contributors, adding one set of experiences, insights and knowledge to the processes of change. Thus the answer to the question "whose reality counts?" must be: that of all involved.

The crafting of a story is the creating of a "thick description", as the stories told illustrate. The simplicity of the crafting instructions allow and create a complex understanding and the possibility of encompassing complexity in the necessary simplicity of practice. In Denzin's words, a thick description presents not only facts and surface appearances but also context, emotion and the web of social relationships that join persons to one another.

Thus the crafter of the story will be constantly faced with the need for judgement about what to include. For these judgements to be made responsibly and for the insights to have value requires a capacity to observe sensitively, to reflect imaginatively and to assess relevance and significance. The stories need to be perceptive as well as thick. In this way, they become stories we can live by and learn from.

The crafting methodology must also build in safeguards against the reproduction in, and reinforcement through, the act of storytelling of vested patterns of dominance and marginalisation, of gender, ethnic or class stereotypes and of unreflective experience. Its use also presupposes an autobiographical tradition and capacity. Many cultures rely on others, the elders, the peer group, the praise singers, etc., to tell the stories. The autobiographical "I" does not exist. For many people, especially women, in any culture, the confessional, reflective "I" is very difficult.

By their nature, stories are cluttered, rich, multifaceted, often ambiguous, the very antithesis of the analytical methodologies that give rise to simple sets of dictums. The methodology rejects the dichotomising of fact and value, of objective and subjective, of premise and conclusion, upon which scientific method and other forms of rationalism are built and validates the potential relevance of emotions, beliefs, insights, feelings, failures, tensions, intuitions and values, along with rational deliberation, facts, axioms and validation.

Thus first person stories provide a kind of access to a situation not traditionally regarded relevant or appropriate for epistemological or moral consideration or for theory construction.

But for this methodology to work, stories must not only be crafted and told, they must also be heard. The experience of listening seriously and empathetically closes the gap between theory and practice, between bureaucracies and those they are created to serve, between power and its exercise.

The sharing of stories creates a space from which insight and change can emerge. Like all interactive endeavours, it presupposes openness and receptivity and requires trust and respect. The more diversity in and differences of perspective in the group, the more the outcome will be grounded in the complexity of reality and the more likely that the ensuing changes will be sustained.

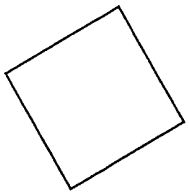
Yet it must be acknowledged that sustaining such transformations, both of insight and of practice, is difficult, even when many are involved. All of us who have worked in the women's movement have been concerned not only to sustain its energy but to pass on the experience of transformation within and across generations. Our transformative practices have stimulated a desire for transformation in others, but we have much to learn about how, systematically, these transformative experiences can be stimulated in other contexts.

The stories told within these spaces may be different perspectives on the same situation or they may be different stories about similar experiences or practices, for example, different experiences of participatory evaluation. The stories make us more aware of our connectedness. They create a sense of relatedness and responsibility. They nudge us away from a view of the world as objects towards one of the world as performance, interaction and interpretation.

Moral understanding is seen as arising from understanding principles internal to the stories, rather than from the application of rules derived externally. Such an interactive interpretative account of morality requires that we understand people in the context of the relationships, communities and cultures that shape us all and give our lives meaning.

Thus, the story telling methodology provides different processes for the creation of knowledge and theory, assigns a different place to professionals, and challenges us to find ways of evaluating the relevance and impact of transformative experiences. It shifts the balance of social power by mediating it through solidarity, dissent and imagination and exercising it in activism, empathy and respectful interaction, with all involved as co-contributors and agents of change.

For the time being, two different systems, two different approaches to health promotion practice, co-exist simultaneously in our professional world and it is critical that we do not reject one or the other for the sake of the comfort of having a unitary world view. The world *is* complex and recalcitrant and some explanations do have to do with sorcerers and fetishes.



References

Abrams, D. and Hogg, M. (eds.) (1990) *Social Identity Theory: Constructive and Critical Advances*, Harvester/Wheatsheaf.

Adorno, T. (1957) "Sociology and empirical research," in Connerton, P. (ed.) *Critical Sociology* (1976), Markham: Penguin Books.

Alinsky, S. (1971) *Rules for Radicals*, New York: Random House.

Antonovsky, A. (1980) *Health, Stress and Coping*, Washington: Jossey-Bass.

Argyris, C. Putnam, R. McLain-Smith, D. (1985) *Action Science*, San Francisco: Jossey-Bass.

Arnstein, S. (1969) "A ladder of citizen participation," *American Institute of Planners* 35:4.

Auslander, G. (1988) "Social Networks and the Functional Health Status of the Poor: A Secondary Analysis of Data from the National Survey of Personal Health Practices and Consequences," *Journal of Community Health* 13(4).

Baum, F. (1995) "Researching public health: Behind the qualitative-quantitative methodological debate," *Social Science and Medicine* 40(4):459-68.

Berkman, L., (1986) "Social networks, support and health: taking the next step forward," *American Journal of Epidemiology*, 123: 559-61.

Bjaras, G., Haglund, B.J.A, and Rifkin, S. (1991) "A new approach to community participation assessment," *Health Promotion International* 6(3):199-206.

Blane, D., Brunner E. and Wilkinson R. (eds.) (1996) *Health and Social Organisation: Towards a Health Policy for the 21st Century*, New York: Routledge.

Blane, D., White, I. and Morris J. (1996) "Education, social circumstance and mortality," in

Blane, D., Brunner E. and Wilkinson R. (eds.) *Health and Social Organisation: Towards a Health Policy for the 21st Century*, New York: Routledge.

Blaxter, M. (1990) *Health and Lifestyles*, New York: Routledge.

Bloor, D. (1986) *Knowledge and Social Imagery* Chicago: University of Chicago Press.

Body, J. (1985) *Health: Perspectives and Practices*, Palmerston North: Dunmore Press.

Brindley, D.N., (1981) "Regulations of hepatic triacyglycerol synthesis and liprotein metabolism by glucocorticoids," *Clinical Science* 61:129-33.

Brunner, E. (1996) "The social and biological basis of cardiovascular disease in office workers," in Blane, D., Brunner E. and Wilkinson R. (eds.) *Health and Social Organisation: Towards a Health Policy for the 21st Century*, New York: Routledge.

Centre for Development and Initiative in Health (1993) *Case Studies of Community Development in Health*, Melbourne: CDIH.

City of Toronto (1991) *Health Inequalities in the City of Toronto*, Toronto: Department of Public Health.

Cohen, S. and Syme, S.L. (1985) (eds.) *Social Support and Health*, Toronto: Academic Press.

D'Arcy, C. (1989) "Levelling the Playing Field - Toward Equity and Health," Paper presented at the "National Symposium About Families", Regina, Canada.

Daly, H. and Cobb, J. (1989) *For the Common Good*, Boston: Beacon Press.

Dixon, J. (1995) "Community stories and indicators for evaluating community development," *Community Development Journal* 30(4):327-36.

Dixon, J. and Sindall, C. (1994) "Applying the logics of change to the evaluation of community development in health promotion," *Health Promotion International* 9 (4):297-39.

Doyle, R., Mitchell, A., and Orr, J. (1990) *Opportunities for Community Empowerment and Community-Based Planning*, Toronto: Social Planning Council.

Durning, A. (1989) "Mobilising at the grassroots," in Brown, L. et al (eds.) *State of the World 1989*, New York: Norton.

Eng, E. and Parker, E. (1994) "Measuring community competence in the Mississippi Delta: the interface between program evaluation and empowerment," *Health Education Quarterly* 21(2):199-220.

Environment Ontario (1989) *Public Consultation: A Resource Book for Ministry Staff*, Toronto: Environment Ontario.

Environment Ontario (1991) *Towards Improving the Environmental Assessment Program in Ontario*, Toronto: Environment Ontario.

Evans, R.D. and Stoddart, G.L. (1990) "Producing health, consuming health care," *Social Science and Medicine* 31(12):1347-63.

Evans, R., Barer, M. and Marmor, T. (eds.) (1994) *Why Are Some People Healthy and Others Not? The Determinants of the Health of Populations*, New York: Aldine de Gruyter.

Fawcett, S., Paine-Andrews, A., Francisco, V. et al (1995) "Using empowerment theory in collaborative partnership for community health and development," *American Journal of Community Psychology* 23(5):677-698.