

There were points of similarity between several of these values:

HEART HEALTH	MANAGEMENT	UNION
prolong life decrease disease	demonstrate a concern for workers' health, satisfaction and comfort	ensure a safe, healthy workplace
BUT THERE WERE ALSO POINTS OF CONFLICT:		
non-smokers' rights	maintain workplace harmony	worker solidarity, represent all workers' interests
(choosing one side)	(striking a balance)	(striking a balance)
no exposure to ETS	minimise control costs	maximise benefits, workers' choices
(outright ban)	(outright ban)	(separately vented areas)
		ensure a safe, healthy workplace
		(why focus only on ETS?)

After lengthy discussions, a re-framed superordinate goal was established, one that was different from the values (goals) of each individual stakeholder group, required their cooperation in achieving and did not violate any of their particular values or interests: Ensure that the air quality in the workplace contained no serious health hazards, including no known human carcinogens.

In reaching this accord, each side had to give a little. The heart health coalition had to agree to support other efforts at workplace toxics control. The union had to agree to drop its demand for separately vented smoking areas throughout the workplace (the cost was prohibitive). Management had to agree to divert saved funds from such smoking areas into an overhaul of the indoor ventilation system, and a thorough analysis of all other potential atmospheric pollutants that were linked to cancer or respiratory ailments.

MOVING FROM PARTICIPATION TO PARTNERSHIPS

The themes of power and participation build towards the goal of creating health-promoting partnerships, that is, partnerships that not only focus on health promotion work, but are themselves internally health-promoting. Practice stories form the basis for an analysis of what such partnerships look like, and how they can be created. These stories, the methodology used to develop and analyse them and the lessons they generated are topics for the next two Chapters. As a bridge into these topics, we might consider briefly what some of the literature on building partnerships tells us.

Barbara Gray (1989) provides a comprehensive partnership model which she describes as “collaboration.” Language becomes tricky here, for another meaning of collaboration is cooperation with the enemy! This is not what Gray means. Rather, successful intergroup collaboration is “a mutual search for information and solutions,” and has several features which characterise the process-as-outcome (Table 6).

Table 6: The Three Phases of Collaboration

PHASE 1: PROBLEM-SETTING

- common definition of problem
- commitment to collaboration
- identification of stakeholders
- legitimacy of stakeholders
- convener characteristics
- identification of resources

PHASE 2: DIRECTION-SETTING

- establishing ground rules
- agenda setting
- organising subgroups
- joint information search
- exploring options
- reaching agreement and closing the deal

PHASE 3: IMPLEMENTATION

- dealing with constituencies
- building external support
- structuring
- monitoring the agreement and ensuring compliance

Effective collaborating requires the efforts of persons Gray labels “midwives,” the community developers of organisations-as-communities. These midwives (non-vested facilitators who are functionally distant from all of the stakeholders) work with the stakeholders before they come to the table, seeking to find the “superordinate goal” around which agreements can be made, tasks undertaken and power relations transformed.

Another story helps to ground these points. It concerns a failed attempt to establish a collaborative environmental forum in an industrial suburb called Pitchfork (not its real name).

Pitchfork suffered from citizen perceptions of poor water quality and pollution-related diseases. Two community groups had formed although both groups were waning: One because its leader had moved, another because its leader became ill. A public health association, intrigued by the concept of Round Tables on Environment and Economy, approached Pitchfork’s local council, the industry and the two community groups and urged them to develop a joint partnership to reduce water pollution and improve environmental health (their superordinate goals). Eight months later, community group participation on the collaborative committee was moribund, the committee appeared to function more as apologist to industry than as a true collaborative forum and no action was occurring on water pollution levels. The committee, claiming industry-acting-in-good-faith, was not even calling for release of industry data on toxic emission levels (Labonte 1993b).

There are many ways one might construe this failure in collaboration, but there are a few important ones.

First, in the absence of strong community groups, the consensus-oriented collaborative forum became the reference group for the environmental representatives. This reduced conflict between industry and the community groups as the different stakeholders sought to be “nice” to each other. But this niceness may be shortlived, since conflict reduction relied on a folding of the environmental groups’ interests into the “niceness” interests of industry and local council, and not on any genuine reduction in the conditions (water pollution) that lead initially to the conflict.

Second, the collaborative forum’s meetings occurred over socialising events (dinners, recreational activities) that built interpersonal bonds but failed to emphasise group interdependency. That is, the forum emphasised participation software to the exclusion of participation hardware.

Third, past struggles between industry and environmentalists in Pitchfork had been insufficient for the two community groups to create a strong identity for themselves, or to establish themselves as legitimate stakeholders. This is an important point, for less powerful groups usually seek to “level the playing field” by limiting the power other groups have over them, which often involves periods of opposition to or conflict with groups that are more powerful than themselves.



This dynamic has been at the base of the confrontational approach to community organising favoured by Saul Alinsky and his adherents (Alinsky 1971, Kling and Posner 1990), and which has been used successfully to create communities from the seemingly intractable conditions of isolation and apathy (Ward 1987, Labonte 1993b). Even Gray (1989) acknowledges that collaboration usually requires a period when less powerful groups establish their legitimacy through conflictual relations with more powerful groups. And so, in Pitchfork, and in the absence of a strong environmental group identity, citizens sitting on the collaborative committee became absorbed within the more powerful identity of industry representatives.

Fourth, members of the collaborative committee were recruited as citizens and not as organisational representatives. The collaborative committee could not be truly collaborative; no formal intergroup agreements could exist because participants were not collaborating as group representatives.

Fifth, no midwife had been present in the collaborative forum's birth, and no pre-negotiation stage for "problem-naming" had occurred.

Sixth, the condition of unilateral action by one of the stakeholders (industry) had not yet been removed through successful conflictual challenges by the environmental groups.

The public health association that sponsored this project is now attempting to locate (discreetly) a few environmentalists within Pitchfork who would be willing to initiate a "challenge" to the legitimacy of the collaborative forum. This challenge would recommence the task of creating an environmental group identity separate from that of the "consensual tyranny" of the prematurely constituted collaborative committee.

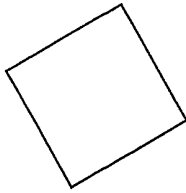
What Can We Conclude Makes for the Effective and Authentic Partnerships Community Development Creates?

The six lessons learned from this case-story might be considered preliminary terms for effective partnership. Panet-Raymond (1992) frames these terms more specifically, based upon insights gleaned from the attempts to forge relations between community health and social service centres and neighbourhood volunteer centres in Quebec. Merging the two sets of conclusions, we might say that partnerships only exist when:

1. All partners have established their own power and legitimacy. This often requires a period of conflict, and some enduring strain between powerful and powerless groups. Providing resources to these groups is one facet of community development work, provided such resources remain in the autonomous control of the groups.
2. All partners have well defined mission statements; they have a clear sense of their purpose and organisational goals.
3. All partners respect each other's organisational autonomy by finding that visionary goal that is larger than any one of their independent goals. This requires extensive "midwifing" work, to set the shared agenda. Achieving this shared agenda is another facet of community development work.

4. Community group partners are well rooted in the locality; they have a constituency to which they are accountable.
5. Institutional partners have a commitment to partnership approaches in work with community groups.
6. Clear objectives and expectations of the partners are developed. The partners create a commitment amongst themselves to jointly "manage the problem domain."
7. Written agreements are made clarifying objectives, responsibilities, means and norms; regular evaluation allows adjustments to these agreements.
8. Community workers have clear mandates to support community group partners without attempting to get them to "buy into" the institutional partner's mandate and goal. This distinguishes community development from community-based approaches to work.
9. All partners strive for and nurture the human qualities of open mindedness, patience, respect and sensitivity to the experiences of persons in all partnering organisations.





CHAPTER 5:

A Story/Dialogue Method for Health Promotion Knowledge Development and Evaluation

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INTRODUCTION

Even if there is agreement that health promotion should emphasize more changes in risk conditions and psychosocial risk factors than in behavioural risk factors (Chapter One), there are still disagreements over how health promotion should account for its effects. Are improvements in morbidity and mortality rates the “bottom line,” especially in a tight fiscal environment where “evidence-based decision-making” is the new rhetoric driving government health “investments” (Federal, Provincial and Territorial Advisory Committee on Population Health 1994, Health Australia 1995, Labonte 1995)? Is health promotion concerned primarily with people’s subjective experiences of “positive health” (Antonovsky 1980, Labonte 1993b) or quality of life (Renwick, Brown and Nagler 1996)? Are these more distant outcomes, questions for health promotion research to sort through, while programs should demonstrate that they have achieved proximate changes in lifestyles, empowerment or community capacity?

One of the difficulties in answering these questions is that health promotion practice exists primarily within institutions whose underpinning explanatory framework for health is biomedical (Labonte 1995). This explanatory framework rests upon the knowledge assumptions of positivist or “conventional” (Guba and Lincoln 1989, Labonte and Robertson 1996), which attempts to understand complex relations by reducing them to specific variables that can be subjected to experimental manipulations. Conventional research or evaluation emphasises “objectivity” through use of randomised control or quasi-experimental designs, quantitative data and repeat intervention trials. While an important source of knowledge for health promotion practice, this methodology often runs into difficulties when it is used to study people and their relationships, e.g. making people subjects of researchers’ questions rather than subjects of their own lives (NYCHPRU 1993, Kort 1990, Labonte 1993b, Goodman, Steckler, Hoover, and Schwartz 1993), assuming that numbers are “hard,” “objective” data, while people’s stories of their own lives are “soft,” “subjective” opinions (Labonte 1996a) and interpreting the findings using assumptions that may not be shared by the research subjects (Eng and Parker 1994, Labonte and Robertson 1996). There is growing argument in the practice and research communities that conventional science norms are insufficient to make sense of what health promotion is, and how its effects should be evaluated (Baum 1995, Labonte and Robertson 1996, Fawcett et al 1995, Dixon 1995, Dixon and Sindall 1994). Yet there are important counter-challenges from the research community that health promotion practice is more ideological than theoretical, often little more than a series of normative claims.



This Chapter describes a “story/dialogue method” that attempts to bridge the chasm between descriptive stories and rigorous explanation, and so point towards accountability norms that are more in keeping with what health promotion practice attempts to accomplish.

Epistemologically, the method is based on the knowledge paradigm Lincoln and Guba (1989) characterise as “constructivist” because its ontology holds that realities are socially constructed, local in meaning and ungoverned by universal laws. In a constructivist epistemology, the researcher is part of the reality which is being researched, such that the research findings are a creation of the inquiry process itself rather than a collection of external pre-existing “facts.” Its methodology is interpretive and dialectic, a process of iteration, analysis, critique, reiteration, reanalysis, synthesis and so on (for a detailed discussion of the constructivist paradigm applied to health promotion, see Labonte and Robertson 1996). The story/dialogue method was developed in a partnership between practitioners and researchers who were frustrated equally with researchers whose more conventional methods and assumptions 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.

The Chapter begins with a discussion of the history and theoretical underpinnings of the story/dialogue method. The method is then described and illustrated with examples from some of the uses to which it has been put. (To date, over 1,500 practitioners have participated in thirteen different applications of the method.) The Chapter concludes with a discussion of its strengths and weaknesses, and its particular relevance to health promotion evaluation.

HOW STORIES BECOME USEFUL KNOWLEDGE

Stories are about people and what they do. They touch listeners in ways that theoretical arguments and statistical data do not and cannot. They “hit us at a feeling level, as well as a thinking level...what’s powerful about stories is the personal connection” (Labonte and Feather 1996)². The systematic use of stories in program planning and evaluation first began in international development work. Aid workers realised 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 research could not tap into (Slim and Thompson 1995). Because conventional researchers were not members of that community, they 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. Feminists criticised 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 emphasised the value of women speaking from their own experience. Story-telling also has become an important tool in education. Paulo Freire writes about the power of language in shaping our thoughts and our actions. The first act of power people can take in managing their own lives is “speaking the world” (Freire 1968, Freire and Macedo 1987), 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 and analysis.

Stories, or narratives, traditionally have formed the 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, Putnam and McLain-Smith 1985) and their emphasis on contingent and practical knowledge. Such researchers maintain that only in analysing 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 conventional scientific research. Indeed, the academic community has re-engaged in debates about the role meaning plays in generating scientific knowledge (e.g. Kuhn 1970, Giddens 1984, Bloor 1986). Much science, and certainly social science, no longer seeks universal truths as it once did in the 18th and 19th century. Today, as Kvale (1995) writes, there is “an interest in narratives, on the telling of stories” as an important means of understanding social life, in which increased emphasis is placed on “communication and the impact of a message upon the audience.”

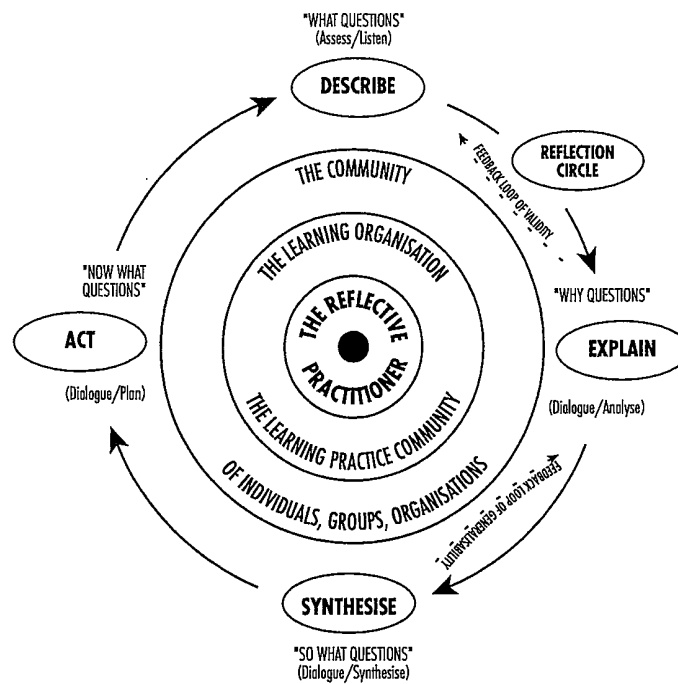
Finally, health promoters themselves recognise the importance of stories in researching, learning, evaluating and planning their work (Feather and Labonte 1995, CDIH 1993, Dixon 1995), although many feel defensive because stories do not fit into the conventional scientific method. Dixon (1995) argues that a distinction should be made between conventional methods for institutional evaluations and “community stories” for community-controlled evaluations. The issue remains, however, of using stories more rigorously, meaning that 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.

STORY-TELLING AND THE STRUCTURED DIALOGUE: THE STORY-DIALOGUE METHOD

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 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 story/dialogue method 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 organisational commitments to this type of inquiry (the learning organisation) and supportive peer relationships (the learning practice community) (Labonte 1996c).

The notion of a reflective practitioner 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.

Figure 1:



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 characterised as a "problem-posing" approach to program work (Labonte 1994), in which neither the issues nor their resolution are taken for granted but are analysed against a repertoire of experience and knowledge from both professionals and community members.

THE CASE STORY

The first element in the method is the story itself. Stories are helpful for knowledge development and evaluation to the extent that:

- They are constructed around a generative theme.
- They come from personal experience.
- They are prepared in advance of the structured dialogue and include some elements of both description and explanation.

Case stories are prepared in point form or as fully written narratives. Practitioners versed in qualitative methods or otherwise prone to "journaling" often use their practice notes of a particular event. Typical story lengths are three to seven pages. Preparing stories is not an easy task. Another approach to the use of stories involved writing workshops for community development practitioners leading to creation of longer, case-study style "reflections" (Dixon 1995). Of 200 participants in the workshops, only 30 completed the task. Yet, with few exceptions, the several hundred practitioners who have prepared case stories for use in workshops on this method have attested to the usefulness of the task.

THE GENERATIVE THEME

Case stories are constructed around a particular theme pertinent to the purposes for generating knowledge, e.g. to help practitioners problem-solve with peers, to help in planning a new action or program, to develop a more critical knowledge of practice, or as part of program evaluation (see Figure 2). Case stories become the starting points for a deeper analysis and understanding of the theme. A good theme is one that identifies “tensions” or strained relations that exist within and between the people who are part of it. A common theme in method workshops has been community development, described as follows:

Community development poses numerous challenges in health promotion practice, such as defining “community,” being explicit about values (the practitioner’s and the community’s), being flexible and responsive to changing community needs, and evaluating the impact of development work. Many practitioners feel that community development is essential in health promotion but that their formal training has not equipped them to be effective. Others struggle to reconcile the policies of their own organisations and the community’s needs (Labonte and Feather 1996).

Case stories are based upon one or two events where the story-tellers experienced the tensions in the theme’s description. (The theme of building partnerships is described in the next Chapter.)

THE STRUCTURED DIALOGUE

A structured dialogue is intentionally designed to move discussion from a description of what happened, to one or more explanations for how it improved health, to a synthesis of key lessons derived from the case-story and similar experiences, to some articulation of new actions based upon the dialogue. 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 conditions he describes as “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. Open questions invite people to reflect upon what the issue or concern (the generative theme) means in their health promotion work. Open questions often begin with what, how and why, in contrast to the closed questions typical of conventional science research, particularly survey research.

