INSIGHTS FROM THE INSIDE: PRACTITIONER PERSPECTIVES ON PLANNING

by

Christine Harumi Lewis
B.A. Queen's University, 1969
M.A. The University of Hawaii, 1973
M.S.W. The University of Toronto, 1978

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Department of Educational Studies

The University of British Columbia
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ABSTRACT

This interpretive study was designed to learn more about program planning from the practitioner's perspective, to understand how those directly involved in planning make sense of their work. Of particular interest was practitioner experience in non-formal educational settings where education is not the primary purpose. Six practitioners responsible for planning health promotion programs in hospitals and public health departments participated in three in-depth interviews. Findings in three thematic areas were analyzed using insights from two frame perspectives (Elgström & Riis, 1992; Schön & Rein, 1994):

Language and metaphors of practice: Practitioners' comments reflected more the uncertain, dynamic environment of planning, and the people-orientation of their work, and less the technical-rational approach to planning. Practitioner metaphors embed organizational and societal values. As metaphors both reflect and shape practice, we begin to understand how we socially and politically frame and construct our experiences.

Factors influencing practice: Practitioners identified three key frame factors: the understanding of the program concept itself, in this case, health promotion; senior management commitment and direction; and the support and involvement of colleagues. These factors may be viewed as negotiable or non-negotiable depending on the individual practitioner.

Professional performance: Practitioner roles and strategies reflected the people-work of practice: communicating, coordinating, negotiating to maintain support for the program. Skills in such areas as group process, conflict resolution and consensus-building are key to effective practice. Situated frame reflection with colleagues within the immediate context of practice and at different levels of action frames (program, organizational and societal) may broaden the practitioner's awareness of the assumptions and implications of planning.

The study affirms the social interactive nature of program planning currently portrayed in the literature and points out several key implications. By attending to how practitioners frame and act on planning challenges, by expanding the language of planning to reflect practitioner experience, by developing relevant curriculum for the interpersonal people work of practice, and by examining the ethical base of practice and its micro-macro level implications-- we may work toward development of planning theories which better reflect the richness and complexity of practice.

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CHAPTER I

INTRODUCTION

Over many years of involvement in program planning in social services, mental health and education, in both community and government sectors, I have repeatedly been impressed by two realities of practice. The first is the clearly evident impact of planners and their individual style on the planning process and the resulting program. Notwithstanding the power of politics and the usual considerations of organizational culture and available resources, individuals directly responsible for the planning of programs have played an extremely influential role in directing the planning process and in shaping programs. I have also been particularly struck by how the individual planner's underlying values, beliefs, priorities, assumptions (sometimes made explicit, more often not) about the planning process, the program to be planned, and the planning environment, have affected program development and outcomes. The second reality of the work world is the gap between the conventional, rational planning models in the literature and the unpredictable, often chaotic, complex reality of practice. The planning process invariably does not follow the models with their well-delineated stages and phases proposed in the literature.

The influence of those planners is even more evident when the programs have been new initiatives: that is, when the organization adopts a new program area and attempts to implement it into tangible program activities. Typically, the program area centres on a popular social issue-oriented concept which has not yet been clearly defined in operational terms such as "de-institutionalization of services," "healthy communities," and "parent involvement in education." Such interesting but vague concepts allow for considerable variation in program

design and activities. And when the persons responsible for planning changes, there is often a corresponding shift in planning activities and program design. As I have long been intrigued by the planning process, particularly as it is experienced by the practitioner, I wanted to know more about how practitioners understand and make sense of the planning process in practice.

Because of my own experience in the human service field, my area of interest is in organizations with a primary mandate to provide social or health services to their consumers. Such organizations are called non-formal educational settings in the adult education field. While they are not formal educational institutions with a primary goal of education, they do provide important educational activities. From my perspective as a practitioner, as services and programs continue to expand outside the formal educational system, a better understanding of program planning in these non-formal educational settings is needed.

The literature on program planning in adult education also supports the need to further explore practitioner experience. Professionals shape their problems and thereby have considerable influence on the direction of problem-solving (Cervero & Wilson, 1991; Schön, 1987). Therefore, it is timely that more attention be paid to professional planners in adult education (Cervero & Wilson, 1994; Sork & Buskey, 1986); such attention to the practitioner in situ is congruent with the current recognition of value-based practice in the literature. This study can be viewed as exploratory (Marshall & Rossman, 1989) as it further investigates the phenomenon of planning from the practitioner's perspective. Although this area has been researched extensively in the teacher-as-curriculum-developer literature (Feiman-Nemser, 1986; Shulman, 1986), it is an area that has received less attention in adult education planning. Chapter I has served to introduce this study of practitioner understanding of program planning in practice. The remainder of the chapter

attends to the refinement of the research focus and approach and provides a rationale for its undertaking.

Refining the Research Focus and Approach

Focusing on Practitioners in Health Promotion

Having established the practitioner's perspective on the program planning experience in non-formal educational settings as the general area of study, the focus can now be further refined. I sought a situation in which practitioners were taking on the challenge of planning a new program for their organization which would result in tangible program activities. Practitioners in the midst of building a new initiative area for their organization were less likely to be bound by past tradition or rigid program definitions and design. The new program concept had the possibility of being operationalized in a flexible manner, and could be interpreted in multiple ways resulting in a variety of concrete program activities. Health promotion programs in health care organizational settings met these requirements.

Health promotion with its embedded assumptions about the role of adult learning in changing health attitudes and behaviour is an appropriate subject for adult education. Health promotion when understood as prevention has itself had a long history, whereas health promotion as a means of empowerment and community development is relatively recent. This newly popularized concept has been operationalized in a variety of ways, for example, mass media campaigns, public relations, individual life style, and community development (Green & Kreuter, 1991). Therefore, health promotion programs essentially represent a larger category of education programs, which constitute new initiatives for an organization, which are not yet clearly defined

and which may result in any variety of tangible program activities depending on the planning and implementation directions undertaken. Other examples of this category of programs might be "client empowerment," "consumer involvement," and "family values preservation."

Health promotion programs are growing in number in health care settings such as hospitals and health departments (Kar, 1989; Rootman, 1988). Health care organizations are considered non-formal educational settings because their primary purpose is the provision of health care, not education. Therefore, the parameters of this study can be further delimited to practitioners in health care organizations who are responsible for health promotion planning. Having narrowed the focus, the approach to be undertaken in this study can be clarified.

Adopting an Interpretive Approach

Paradigms "represent belief systems that attach the user to a particular world view" (Denzin & Lincoln, 1994, p. 2). The inquirer's world view will then influence the many choices that must be made (Lincoln, 1990, Schwandt, 1994). Therefore, as I understand the world from an interpretivist perspective, it then follows that the design of this study will be approached in a manner congruent with the tenets of this paradigm. Some initial comments about the interpretivist approach follow; however, a more in-depth discussion of the particular ontology, epistemology and methodology of this paradigm and their implications for the design of the research is undertaken in Chapter III.

Central to interpretivism is the premise that individuals in the context of their social relations construct their own realities (Berger & Luckman, 1967). In this sense, there are no external objective realities, no universal social laws to be discovered in social and educational inquiry. Reality is comprised of mental constructs around which individuals have created a degree

of consensus at a certain time and place, and are subject to changing conditions (Smith, 1993). It is this reality, grounded in the experiences of humans, that is most significant as we increase our knowledge about social phenomena.

An interpretivist inquiry seeks to understand better the individual's experience of the phenomenon under study. The inquiry focuses on those key individuals, the practitioners, who are responsible for the design of programs and who actually participate in planning. Such a social interactionist view assumes that individuals are reflective and are able to share their experiences. Through speaking with selected individuals about their lived experience of program planning, their mental constructs of the planning process and practical knowledge can be drawn out to broaden and enrich our understanding of the nature of this phenomenon.

Language is a critical component of this study as practitioners use words, craft metaphors and images to depict their experience. The use of expressive language and the presence of voice serve not only to "display our signatures" indicating that human beings, not machines, exist behind the words, but also serve to further human understanding (Eisner, 1991, p. 36). My interest is in the everyday life experience of practitioners planning programs, and in the meanings they associate with this activity. By examining the "invisibility of everyday life" we need to make the familiar strange and interesting again (Erickson, 1986, p. 120). Refining this interest into a formal inquiry has resulted in the narrowing of the focus to practitioners responsible for planning new health promotion programs in health care organizations. The interpretivist approach centres on the practitioner's understanding of the planning process in non-formal educational settings. The research focus and approach can now be translated into the research question central to this study.

Research Question

From the above research focus and approach regarding practitioner perceptions of planning health promotion programs, one major research question can be formulated:

What is the nature of planning from the perspective of practitioners ?

The following subquestions flow from this general question:

i) What language and metaphors do practitioners use to describe their planning experience?

ii) What factors do practitioners identify as influencing their planning experience?

iii) What roles, responsibilities, strategies and actions do practitioners engage in?

Some inquirers may feel that the formulation of subquestions overstructures the inquiry and contradicts the spirit of allowing themes to emerge from the data. I contend that the inquirer participates in the construction of meanings in interaction with the practitioners, and that acknowledging inquirer values, biases, assumptions is an important component (Janesick, 1994). As I consider the issues of practitioner language and metaphors, identification of influencing factors, choice of roles and strategies as key to an enriched understanding of planning, I propose that these subquestions are appropriate to this study.

Further, the concepts identified in the subquestions such as factors, organizational context, roles, and responsibilities can be viewed as "local interpretive resources - recognizable categories, familiar vocabularies, organizational missions, professional orientations, group cultures and other existing frameworks for assigning meaning to matters under consideration" (Holstein & Gubrium, 1994, p. 266). Practitioners do not create reality "from scratch," but are familiar with and use these local resources in combination with "artful practice" to make sense of and get on with the business at hand.

Rationale for the Study

The literature on program planning published over the past decade has recognized the limitations of the traditional, technical-rational perspective of planning models and promotes the need to move to an understanding of planning which values a more interactive, value-driven orientation. A study of the literature also points up the need for more empirically-based (i.e., grounded in experience) studies, particularly in non-formal settings, of what does occur in practice. The tendency of writers in this area well into the 1980s has been towards normative models of what should take place in effective planning. This study, therefore, addresses the two stated concerns of involving attention to the practitioner, and the need for practice-based studies by proposing an exploration of the real life experience of planning as understood and expressed by practitioners, those individuals directly engaged in this activity.

By recognizing the limitations of technical-rational planning models, and positing that persons in interaction with others create their own constructions of planning, the interpretivist anticipates a variety of interpretations which reflect the diverse and complex actors and contexts of planning. The significance of the study lies in its potential contribution to an expanded understanding of the nature and dynamics of the planning process, particularly in the realm of planning programs in non-formal educational settings. In Forester's (1993) words: "Any new empirical account of planning practice ought to lead to new research questions, new data to collect, new patterns of action to explore - all of which may inform the effectiveness, efficiency and morality of planning practice" (p. 17). Given the current and future emphasis on lifelong learning, non-formal education organizations will increasingly offer community adult education programs and growing numbers of practitioners will be involved in planning. It may also help to

lessen the gap between theory and practice in planning often discussed in the literature by examining practice from the practitioner's perspective. As has been frequently noted in the recent literature, we are reminded that it is people, not theories, who plan programs (Cervero & Wilson, 1994; Forester, 1993). Thus, a better understanding of the practitioner's experience of planning in practice may assist in developing theory, thereby attempting to bring congruence between the two areas.

Clarification of Key Terms

Recognizing that, "All definitions, regardless of how abstract and wide-ranging they may appear, are crafted within a specific ideology of practice" (Courtney, 1989, p. 23), I offer the following understandings of some key terms as a starting point and common reference for this particular study.

Adult Education: Understanding this term to include both adult and continuing education, adult education is "an intervention into the ordinary business of life - an intervention whose immediate goal is change, in knowledge or in competence" (Courtney, 1989, p. 24).

Health Promotion: The process of enabling individuals, groups and communities to increase control over the determinants of their physical, mental and social well-being, thereby improving this well-being (World Health Organization definition).

Interpretivism: The world view that posits that reality is socially constructed by humans in interaction. These constructions are influenced by changing conditions of actors in time, and space, and therefore are constantly evolving. Interpretivism is the foundational paradigm of this study.

Non-formal Education: Any purposeful, organized, sustained activity to transmit knowledge, attitudes, values or skills, which is carried on outside the framework of the formal institutional schooling system. A non-formal educational setting is one in which adult education is secondary to other primary functions of the organization (Coombs, 1985; Galbraith, 1990). In this study, such settings include hospitals and public health departments.

Planning: Future-directed intentional action in which humans have the capacities to act purposively and to form and execute plans (Bratman, 1987). Activities in program planning theory in adult education literature have generally included needs assessment, content selection, formulating methods, managing and evaluating the program (Cervero & Wilson, in press; Sork & Caffarella, 1989).

Practitioner/Planner: Individual/s directly responsible for the design and delivery of the organization's health promotion program. The position title will vary with the organization.

Program: The overall collection at the organizational level of specific activities, projects and events. In this case, reference is made to the health promotion program at the organizational level which may encompass single, specific projects such as heart health, nutrition classes or stop-smoking campaigns.

Theory: A coherent group of general propositions used as principles of explanation for a class of phenomena (Random House Dictionary of the English Language, 1973, p. 1471).

Summary

Chapter I has introduced the purpose of this study, to increase our understanding of program planning in non-formal education settings from the perspective of practitioners directly

involved in this planning activity. Interest in this topic has evolved out of my own experience as a practitioner and from the literature which recognizes the need for more empirically-based research to go beyond the technical-rational models of planning. There is a call to explore more expanded meanings of this phenomenon called program planning by redirecting attention back to practitioners, and the constructs they make and the meanings they hold from their lived experience of practice.

This study focuses on the planning of a certain type of program in non-formal education settings; namely, a category of programs considered new initiatives for the organization. Unrestricted by tradition or rigid program guidelines, practitioners have flexibility in the interpretation and operationalization of the new initiative, which may result in a variety of planning activities. Health promotion programs in health care settings were selected, as they are representative of this category of new program areas being introduced in non-formal education settings.

Based on the premise that social reality is constructed by humans in interaction, as they assign meaning to their own thoughts and behaviour and that of others, the interpretivist inquiry attends to the everyday lived experiences of people. Therefore, practitioners planning health promotion programs in health care settings were key to the study. It was anticipated that practitioners' multiple understandings of the planning process would contribute to a broadened and enriched body of knowledge about the complex nature of planning practice in non-formal education settings. The significance of the study, therefore, lies in its potential to generate thoughts about alternative frameworks or theories for understanding the practice of planning.

CHAPTER II

REVIEW OF THE LITERATURE

In Chapter II selected literature is reviewed on program planning published in adult education over the past four decades. The review provides an historical perspective on the development of program planning from its roots in formal schooling curriculum design in the 1950s, through the growth of adult education and the emergence of systematic, rational planning models from the 1960s into the 1980s, to the recent major shift toward more interactive, interpretive explanations of program planning appearing in the mid 1980s and 1990s. The changing assumptions underlying planning, recent critiques of traditional planning models and the current challenge to develop alternate understandings of the planning process are included in this review. The chapter concludes with a discussion of current critical issues which underpin the need for further research in the area of practitioner experience of the planning process.

This research addresses practitioner perceptions of the planning process of health promotion programs in the non-formal educational settings of hospitals and health departments. Planning cannot be studied in isolation from its content and context, as the nature of the mission and the setting in which is occurs clearly affect the perception of the planning experience. However, in determining the boundaries of the literature review, it should be reiterated that planning is the main focus; therefore, discussion on the content of health promotion and organization context literature will be more limited.

Historical Origins of Program Planning

Tyler's Curriculum Design Model

Formal program planning in education can be traced back to Tyler's systematic curriculum design model developed in the 1930s and 1940s within the K-12 educational institutional context (Tyler, 1949). This classical "educational effectiveness" approach to program planning involves answering four basic questions:

i) What educational purposes (objectives) should the organization seek to attain?

ii) How can learning experiences be selected that are useful in attaining these objectives?

iii) How can the selected learning experiences be organized for effective instruction?

iv) How can the effectiveness of these learning experiences be evaluated?

During the 1940s and 1950s the behavioural orientation to learning further reinforced the use and popularity of this systematic, objectives-driven model. In the 1960s with substantial growth in educational programs in the United States under Johnson's Great Society initiative, this model became increasingly influential. However, the terminology shifted from curriculum design to program planning and evaluation activities that were often of nation-wide scope incorporating many sub-projects. Notions of social engineering and the solving of social problems through the use of expert professionals was a major theme in social and educational programs through this period (Worthern & Sanders, 1987).

Tyler's (1949) curriculum design model fit well not only with the behaviourist orientation from psychology which dominated education into the 1970s, but also the positivist tradition in social research which had established a stronghold well into the 1970s. These influences together reinforced a systematic approach to program planning. Tyler's model has made a major

contribution to the field of program planning (Knowles, 1980). "Many of the program planning models devised by theoreticians of adult education have flowed directly or indirectly from his rationale" (Houle, 1972, p. 15). The impact of Tyler on current program planning models continues to be acknowledged through the 1980s and 1990s (Apple, 1990; Boyle, 1981; Griffin, 1983), with the four basic elements of systematic planning still appearing (Hanson, 1991).

Assumptions of the Curriculum Design Model

Given the impact of Tyler's (1949) model, it is useful to make more explicit the assumptions on which it is based. Tyler's approach was based on a "logico-deductive rationalist tradition" (Boone, 1985) which Apple more critically referred to as the "administrative model" (1990) and Posner (1988) called the "technical production perspective." The following assumptions may be drawn from Tyler's (1949) four basic questions of curriculum development:

- *Primary purpose of education:* The primary concern of the organization is to provide education as an end in itself and not as a means to other purposes.
- *Organizational control:* The organization controls objectives, process and content of the educational experience. The organization has the expertise (the professionals) and resources internally who set out the objectives, select and sequence appropriate learning experiences, and then evaluate those experiences.
- *Behavioural approach to learning:* Learners can be motivated, manipulated or controlled to go through these sequenced learning experiences. Individual learning outcomes can be translated into observable behavioural outcomes and can be measured to determine the effectiveness of the learning experience.

- *Rational approach to planning:* Planning occurs in an institutional, linear approach (Kowalski 1988), which assumes an orderly world in which the model can be applied (Brookfield, 1984).

Given that Tyler developed his curriculum model for the formal K-12 educational system, these assumptions seem congruent with an environment that promotes purposeful, organized, sustained activity. Tyler's model was able to dominate curriculum planning because his assumptions were congruent with our assumptions about schooling and curriculum planning, and generally unquestioned (Posner, 1988).

Program Planning in Adult Education

Emerging Adult Education Context

Using Tyler (1949) as a foundation, the field of program planning in adult education has moved forward since his work (Houle, 1972). However, the context has also changed, with the growth of adult education as a profession and a distinct field of practice from the 1950s onward. Adult education began seeking an identity separate from the formalized K-12 system as it expanded outside educational institutions. With this development came discussions in the 1960s and 1970s about the differences between *curriculum* and *program* and a growing recognition that Tylerian models of curriculum design geared to the formal K-12 schooling system were limited in their application to adult education.

The literature reveals differences between the two terms, curriculum and program, based on a variety of criteria such as:

- age of the learner: curriculum for K-12 system intended for children and program for the post secondary system for adult learners;
- degree of flexibility of content: curriculum connotes a more rigid form of content subject to institutional standards, while program is more flexible, designed to meet the needs and interests of participants (London, 1960);
- part or whole: curriculum development constitutes one component or subpart in the larger program planning process, and is essentially instructional design referring to the selection and sequencing of the learning experience while program is much broader and includes additional facets, such as budgeting, marketing and evaluation (Kowalski, 1988, p.87).

The major discussion over the differences between curriculum and program appears to have taken place in the 1960s and 1970s (London, 1960; Schroeder, 1970). With the advent of adult education and expansion of educational activities outside the formal K-12 system, and the growing distinction of adult education as a professional field, the term program planning has generally replaced curriculum development in adult education. Yet despite recognized differences between program and curriculum related to the different approaches of adult education and the K-12 school system, program planning models in adult education still continued to reflect Tyler's framework of curriculum design (Posner, 1988).

Major Planning Models of the 1970s and 1980s

Literature on planning educational programs began emerging in the 1950s and the next four decades saw about one hundred pieces of writing on how to plan programs (Sork & Buskey, 1986). I turn now to a closer examination of the major adult education program planning models

of the 1970s and 1980s. Despite recognition of the limitations of the curriculum design model, it continued to have its effect on planning models.

> Most of the theories (on program planning) were offered on the premise that the curriculum theories used in schools were inappropriate for the situations faced by the educators of adults. Nevertheless, the curriculum development framework presented in Tyler's (1949) classic book [Basic] Principles of Curriculum and Instruction, undergird most program planning theories in adult education...Tyler's four questions have been translated into the prescriptive steps of the program planning process as described in nearly all theories. (Cervero & Wilson, 1991, p. 39)

Thus, the program planning process has generally been portrayed as a systematic rational decision-making process which assists in minimizing uncertainty and in maximizing the fulfilment of educational objectives (Sork & Buskey 1986; Boyle, 1981).

The development of models in adult education has been useful as, "models do make the underlying logic of a planning process explicit and provide verbal or graphic cues to help practitioners systematize their work" (Sork & Caffarella, 1989, p. 234). While Tyler's model emphasized course content, Houle (1972) shifted attention to context and learner needs by identifying four general groups of learning situations where planning of education for adults may occur: individual learning, learning in group activities, institutions/associations/organizations and mass education. These four groups were further subdivided into a total of 11 categories of possible learning situations. Having established the specific learning situation, a basic program design decision-making framework was applied. The elements of Houle's framework were clearly spelled out: identifying possible educational activity, deciding to proceed, identifying and refining objectives, developing the format, and measuring and appraising results (pp.131-183). While Houle contributed to clarifying the variety of adult learning settings, his approach is still one of a rational decision-making perspective.

Boyle (1981) approached planning from the perspective of program purpose. He offered three frameworks for developing programs depending on program purpose: developmental, institutional and informational. A developmental program defines and solves individual, group or community problems. The institutional program promotes growth of the individual learner's abilities, skills or knowledge. The informational program provides for an exchange of information. Each type of program has different goals with concomitant implications for the design of learning opportunities, the resources needed and the role of programmer in the process (pp. 6-7). Boyle listed 15 specific concepts important to the development of effective educational programs which reflected process tasks to be completed such as situational analysis of problems and needs, involvement of potential clientele, and recognition of institutional and individual constraints (p. 56). Further, the practitioner was reactive and restricted to the appropriate role as determined by program type. Boyle's model also reflected an expert-driven rational approach.

Langenbach (1988) also focused on the purpose of planning. One of the few adult education authors who preferred the term curriculum to program, Langenbach concluded that "one comprehensive model...for all that is considered curriculum development in adult education would be an imprudent proposition" (1988, p. 217). Therefore, he proposed four different categories of models of development: single-purpose model, multi-purpose model, self-directed learning model and generic model; a classification which seemed to be based on a mix of content focus (e.g. adult basic education) and method (e.g. self-directed learning). Rather than focus on the learning situation and the learner (Houle, 1972), or on program purpose (Boyle, 1985; Langenbach, 1988), Boone (1985) targeted the three major subprocesses: planning, design and implementation, and evaluation. While Tyler (1949) did not explicitly outline formal process

stages of educational programming, Boone found Tyler's general approach appropriate and adaptable for adult education program development (Boone, 1985, p. 31).

Sork and Caffarella (1989) presented a model of the six basic elements of planning which they considered to reflect the most common planning logic found in the literature. Their model was also used to organize identification and discussion of contentious issues which relate to each of these six major steps of planning: analyze planning context and client system, assess needs, develop program objectives, formulate instructional plan, formulate administrative plan and design a program evaluation plan (pp. 234-244). Although the stages were presented sequentially, the authors emphasized the interactive nature of the stages, and the point of entry at any step.

Adult education in the past has focused on program planning within school-like settings, secondary and post-secondary (Kowalski, 1988). With the spread of adult education to such locales as private industry, unions, churches, and libraries Kowalski focused on the importance of adult education in the non-school organizational context and contended that program planning was essentially an administrative responsibility involving leadership of knowing what should be done, and management, knowing how to do it (p. 5). His model of program planning was oriented to an organizational context and emphasized environmental diversity of different organizational contexts, the relevance of organizational theory, and the basic elements of program planning. Therefore, the essential rational model of planning was also seen to be applicable to non-formal education settings.

The planning models during this period reflected a technical production, rational decision-making orientation and focused on the external "objective realities" such as different learning situations (Houle, 1972), program purpose (Boyle, 1981), planning subprocesses (Boone, 1985) and organizational contexts (Kowalski. 1988). It was assumed that planning was based on

objective, accumulated knowledge and methods which if not universally applicable required "minimal situation adaptation" (p. 14). The underlying assumption of rationality reasoned that once the process was logically laid out in a cause-effect relationship, any intelligent warm body could follow the steps. Because of this assumption, research has focused more on the overt activities, behaviours and decisions of planners with less attention to the subjective interpretations and judgments of the planner.

This generalized rational approach to planning also acknowledged the complexity of planning, and models were put forth as guidelines planners might apply in making sense of tasks and the environment. Such models have been useful in guiding practitioners in practice; however, they did not explore the subjective interpretations of planners in any significant way. These models tended to minimize the practitioner's thoughts about or experience with the planning process.

Critique of the Technical Perspective

A major shift in thinking about program planning began to emerge in the mid-1980s. Writings on program planning over the past decade have addressed the need for alternatives to the educational effectiveness model. The positivist tradition with its objective reality and one truth came to be challenged in the late 1960s and into the 1970s along with an increasing scepticism of the capacity of science to effectively address social problems (Schön, 1983, 1987). The social construction of reality (Berger & Luckman, 1967) posited the idea of multiple realities and contended that truth was, in fact, social agreement or consensus of the individuals involved. At the same time, the idea of research as reflecting the value-laden biases of the researcher gained currency (Burgess, 1982; Eisner, 1988).

Our understanding of the term "program planning" has been influenced by the positivist tradition, construed as an orderly sequence of steps toward some clearly delineated goal. We do not have the words, or the language to describe planning other than in the usual positivist terms. Language is inextricably linked with the notion of symbolic interaction and social construction of knowledge. Smith (1993), Eisner (1991), Soltis (1968) and others have emphasized the impact of our linguistic framework on our reality. Therefore, we must examine the linguistic framework of our profession as adult educators and the use of terms frequently used in planning such as needs assessment, objective setting, and administrative tasks to understand their impact on how we construe the planning process.

Brookfield (1984) was very critical of the current "mechanistic, techniques-orientated" approach to program development and its assumption that this decision-making process can be easily replicated in a number of different settings. This position ignores the "professional workaday" reality and the many contextual variables which require educators "to develop idiosyncratic, situationally-specific styles of professional performance" (p. 199). The technical-rational perspective reflected in the logic of Tyler's framework has become known as the classical viewpoint in adult education (Apps, 1979; Brookfield, 1984; Cervero and Wilson, 1994). The classical viewpoint of planning is normative in nature, providing a model of what planners should do, not what they actually do; therefore, this gap between theory and practice should not be surprising.

Adams (1991) presented two social paradigms of planning, interactive and rational, and placed them at opposite ends of a subjective/objective axis respectively. He located planning models on this axis, stating that the dominant models sit at the objective end of the continuum and fall into the rational category. In contrast, adult educators increasingly appreciate the subjective

interpretations of reality, and are moving toward the interactive category which mixes fact, attitude, observation and values. Adams suggested that all planning models contained both elements of rationality as well as elements of interaction; however, interactive planning models with an interpretive view of the world were potentially more valuable for educational planning than rational planning models with their scientific tenets. Such rational models have been oversold in the field of educational planning.

> Despite the general acknowledgment that education systems are soft, which suggests interactive models would be more efficient, rational models continue to be the planning processes of choice for many educational planners. Clearly, the notion that planning can be sequential, observable and measurable is a powerful one...[H]owever, much educational planning cannot and does not fit into the objective-rational system. (p. 15)

Focus on Practitioners and Process

The critique of the technical-rational model has led to a refocusing on the process and the actors in the process, the practitioners. Planning presupposes intentional activity; however, the process also involves a more free-floating movement, an iterative, integrative, back and forth exchange in context, allowing for greater flexibility. This process is further complicated by the unique individuals involved, as no two planning participants interpret the key concepts in the same way (Kochen & Barr, 1986, p. 80).

Adult education, as in other fields, has increasingly recognized the influence of the values of the planner, the institution, and the general political and cultural environment on planning (Brookfield, 1984). "Value-laden choices are evident at all levels of planning" (Kochen and Barr, 1986, p. 81). Bratman (1987), from a more philosophical orientation, described humans as planning agents with the capacity to act purposively and form and execute plans. Posner (1988) reiterated this thought through his concept of critical conscience built on Freire's (1985) critical

consciousness and the need for planners to identify and question the assumptions underlying their work.

Associated with criticism of the technical-rational model is the declining credibility of professionals as master technicians. It is timely to reconsider the concept of professionalism and re-examine the nature of skilful professional practice through a reflective process. The importance of values and consensus building is consistent with Schön's work (1983, 1987) on the limits of rational technical interpretation of professionalism. Schön argued that much can be learned from examining the individual practitioner's reflection in and on action to better understand effective professional practice. Recent work based on practitioner perceptions of successful and unsuccessful programs appears to signal a new tradition in acknowledging the practical knowledge possessed by practitioners and their influence on determining the shape of programs (Lewis & Dunlop, 1991).

In the policy field, the term policy implementation is understood to include the stages of planning, operationalizing and evaluating (Schneider, 1982). Writers in this field acknowledge that only 10% of the work is done when a policy has been set and that the remaining 90% is left in the realm of interpretation (Williams, 1982). Policies do not implement themselves; implementors interpret policies and make decisions that affect the shape of programs representing the policy. Therefore, implementors (including planners) are not merely technicians, but can have a substantial effect on the planning and the product. Successful implementation of policies into programs is rooted in the heads of people who administer and implement "vague policies" and it is this knowledge of these agents that must be mobilized (Elmore & McLaughlin, 1982). It is time to shift the focus from the delivery system to the actual deliverer (McLaughlin, 1976).

Ottoson's study (1984) of policy examined analytically the question of how ideas became manifest in behaviour. In thinking about how "good ideas" change in their interaction with the concrete world, four factors were identified which shape implementation: policy, host organization, politics, and surrounding environment. Ottoson suggested the further examination of the educator's understanding of the policy implementation process, as there appeared to be a number of roles educators play in policy implementation: that of the concept developer, the administrator, the implementor and the evaluator. This interest in practitioner roles is congruent with the shift to interpretive meanings and social construction of reality occurring in other fields.

A parallel move from a focus on the rational approach to a more interpretive approach can be seen in the research on teaching. The more behavioural-oriented approach popular into the 1970s has given way over the past two decades to a research focus on teacher cognition. This shift emphasizes the subjective world of teachers and the importance of their practical knowledge to the field of teaching (Feiman-Nemser,1986; Shulman, 1986). Perhaps we are beginning to see a similar shift in greater interest in the subjective world of planners and the value of tapping their practical knowledge by listening to their stories and experience. That is, we may benefit from a closer scrutiny of the perceptions of the planner and contribute to a more holistic rounded view of planning.

New Metaphors/Frameworks for Planning

A metaphor is "the application of a word or phrase to an object or concept which it does not literally denote, in order to suggest a comparison with another object or concept" (Random House Dictionary of the English Language, 1973, p. 901). The search for meaningful concepts which may emerge from new metaphors is an important strategy for the development of

knowledge. In policy implementation, implementation is metaphorically referred to as "evolution," as "mutual adaptation," as "learning" (Pressman & Wildavsky, 1984). In the field of evaluation, insights from unusual metaphors in such areas as geography, investigative reporting, literary criticism have brought new understanding and methodology.

The use of new metaphors and frameworks is also occurring in adult education, with alternative characterizations of planning beginning to emerge which reflect the complex and iterative nature of the planning process. The portrayal of planning as "negotiation of personal and organizational interests" (Cervero and Wilson, 1994), as "communicative action" (Forester, 1993, 1985), as an "educative process," as a "political or bureaucratic process" (Rivera, 1987) are broadening our conceptions of planning and recognizing the role of human beings in the planning process. A variety of metaphors and frameworks also raises the prospect of a possible overlapping of metaphors, that is, planning conceptualized as using several metaphors reflecting different types of processes occurring simultaneously. The metaphors we choose focus our attention. A construction or project management framework emphasizes products and timelines, a gradual building on in some orderly fashion. The conversation or negotiation metaphor highlights the process and the give and take in the shaping of a plan. Central to our use of metaphors is the critical awareness of how language frames our realities and what we pay attention to (Eisner, 1991).

In distancing themselves from the classical viewpoint of program planning, Cervero & Wilson (1994) discussed the *critical* viewpoint premised on the political and ethical nature of program planning. Planners must learn to "read" complex environments and negotiate economic, political and social interests in their commitment to the development of "a substantively democratic planning process" (pp. 153-154). Negotiation of interests occurring in highly

politicized environments can constitute unstructured problems and are best dealt with by an interactive versus a rational model of program planning which builds consensus and shared values (Adams, 1988). This shift towards what Forester (1985) referred to as the symbolic interaction model of planning calls attention to the importance of human beings as they socially construct their reality.

Aware of the planner's potential impact on planning, Forester's (1985, 1989, 1993) metaphor of planning as communicative action is grounded in a critical theory perspective. By challenging professionals to question their role in the planning process, Forester held that they will become more aware of their ethical commitment to the role of education in bringing about social change. In this way micro level studies about planning can be related to macro level discussions about social change; the personal is the political. He also made the point that policy shapes personal experiences and learning and that policy analysts (and he includes planners in this category) have a responsibility to ensure opportunities for "domination-free discourse" where citizens can engage in true and not manipulated learning (1985, p. 272). The planning model selected by the planner dictates to a large extent, the rules of the game in making planning decisions (Adams, 1991, p. 13).

To briefly summarize the discussion thus far, on the historical origins and dominant models of program planning in the adult education literature, the growing field of adult education in the 1950s and 1960s led to the popularity of the term program replacing curriculum, and the recognition of differences between adult education programs and K-12 curriculum. Yet, despite this awareness, adult education planning continued to be based on Tyler's curriculum model. These models all reflected what came to be known as the technical-rational perspective. However, critiques of the technical-rational models began to emerge, consistent with the broader trend of

criticism of the positivist tradition. Calls for more interpretive, interactive approaches began to appear in the 1980s, along with new metaphors and frameworks for understanding program planning. The discussion thus far has mainly focused on planning in formal educational settings. A more concentrated attention on non-formal educational settings is now in order.

Program Planning in Non-Formal Educational Settings

Growth of Community Programs

Up until the last decade, much of the research on program planning has taken place within "formal" educational settings as opposed to what Coombs (1985) referred to as "informal" (natural learning), and "non-formal" (outside of formal systems) educational settings. Studies conducted in formal educational organizations have tended to focus on more traditional educational content -- continuing professional development, vocational training, literacy -- fairly structured programs with specific curricula and individually-oriented learning outcomes. While this type of content is appropriate for traditional formal areas of adult education, research is needed on program planning in all aspects of adult education, including the non-formal and informal settings (Lawson, 1985). Recently, we have seen a visible increase in research in the non-formal areas (Cervero & Wilson, in press).

My interest has been in planning programs in the more non-traditional educational content areas, that is, around issues that involve education at the broader community level such as health promotion, multiculturalism, family violence, AIDS, and the environment. Adult education may be assumed to be an important component of these community issues. When these more social issue-oriented concepts are turned into programs in non-formal educational settings under the

auspices of a variety of organizations, they may appear in different formats with only the most general objectives. These issues present themselves as new initiatives, new program areas adopted by organizations to be translated into specific program activities for the community.

Brookfield (1984) has attempted to sort out the conceptual ambiguity in community adult education by developing a typology of: adult education for the community in which an adult educator produces programs which are based on identified needs and desires of adults (consumer-oriented approach); adult education in the community with the use of locations and resources in natural social settings; and adult education of the community where adult educators hold a strong responsibility for determining normative needs of the community (pp. 87-89). By Brookfield's analysis, any of the broader social issues mentioned above can be considered adult education *for*, *in*, and *of* the community.

Using the broad definition of adult education as "an intervention into the ordinary business of life - an intervention whose immediate goal is change, in knowledge or in competence" (Courtney, 1989, p. 24), allows for a diverse array of activities to be included, expanding well beyond the borders of educational institutions into the community and larger society. With the growth of the concept of lifelong education, the demands of a better-educated population and the many social issues now requiring public education, more and more non-formal education organizations in the community are engaging in adult education programs. Galbraith (1990) highlighted this growing awareness of adult education through community organizations such as libraries, museums, religious institutions, human service agencies, business and industry.

Assumptions of Planning In Non-Formal Educational Settings

In adult education the assumptions underpinning program planning in non-formal educational settings differ substantially from Tyler's assumptions of curriculum design in formal educational settings. The assumptions of non-formal program planning follow:

i) Education is not the primary purpose of the organization. Because the organization's primary purpose is in areas other than education, education becomes a lower priority and competes for recognition and limited resources. The community program becomes more marginal and vulnerable. ii) *Educational activities are not controlled by educational experts.* Staff in non-formal organizations assigned to plan community programs may not have the knowledge and training in education. Therefore, the planning, design and control of the learning situation is no longer within the domain of education experts, and tends to involve a wider range of stakeholders. *iii) Learners voluntarily engage in an interactive approach to learning.* Participation in non-formal community programs is voluntary and non-credit. As adults are not a captive audience, more attention needs to be paid to their needs, motivations, interests, and learning styles in order to maintain their involvement.

Given the above assumptions, program planning in non-formal educational settings occurs within different conditions from those in formal settings. This situation, therefore, supports the need to take a new look at how we think about planning in non-formal settings. An important step in reshaping our thinking in this area is to gather information from the field, from the practitioners themselves.

The literature contains prescriptive and descriptive models of planning. The literature has added to our knowledge about the types of decisions made, the tasks and activities involved, and the influence of the context particularly in formal education settings. However, more experienced-

based studies on how planning is done in practice are needed for the development of planning theory to bring it more in line with reality, and thus lessen the gap between current state of theory and practice. In particular, studies of planning in non-formal educational settings are required as they introduce another set of challenges which differ from those of planning in formal educational settings. Further, the critique of the technical-rational perspective of planning has led to the realization that additional studies which focus on practitioner perceptions and their practical knowledge would be instructive. Alternate frameworks and new language beyond the positivist-based rational approach, particularly in planning in non-formal settings, have been emerging in the literature.

Health Promotion Context

The study centres on practitioners involved in planning new health promotion programs in health care settings. Organizational settings are social structures providing ongoing interaction of both formal and informal membership and communication, and thereby serve as mechanisms of influence. Health care settings may be particularly effective in health education/promotion because of their primary objective of improving health, and because of the public perception that health promotion providers are credible sources of health information (Mullen et al. 1995, p. 330). Thus, a review of the literature on health promotion in health care organizations is now in order. However, since the study's intended primary focus is on planning, the review of this literature will be limited to a discussion of the following aspects: health promotion link to adult education, the development of health promotion, the provincial context, and the planning of health promotion programs.

Health Promotion and Adult Education

Green and Kreuter's (1991) understanding of health promotion and the World Health Organization (WHO) definition of health promotion have both emphasized the purpose of health promotion as enabling people to gain greater control over the determinants of their own health (p. 4). Hence, health promotion can be understood as being closely linked to adult education as it is defined as the process of individuals and communities increasing control over the determinants of their social, mental and physical health. This process involves attitude and behaviour change as well as empowerment and social change: core concepts which are also central to adult education. In this respect, health promotion can be perceived as affecting individuals in all aspects of their work and home life. Health promotion introduces learning in more natural work and social settings and is not restricted to more formalized educational settings. Because it is a very loosely defined operationalized concept, health promotion has resulted in a wide array of programs and activities (Canadian Hospitals Association Report, 1987).

Development of Health Promotion

At the international level, in 1946 the World Health Organization (WHO) defined health as "a state of complete physical, mental and social well-being," recognizing a multi-dimensional, more holistic view of the individual. The 1960s and 1970s saw the growth of the self-help and citizen participation movement. "Health education and the budding health promotion movement became tools of the people seeking to take control of their own health and to control the determinants of their own health" (Green and Kreuter, 1991, p. 8). In 1977 a key international milestone was reached with WHO's document Health for All by the Year 2000, which identified the need for individual participation, intersectoral cooperation and primary health care as the basis

of health as a social goal. In 1984, the WHO redefined health promotion as the process of enabling people to increase control over, and to improve, their health - a definition that is widely used today.

At the national level, Canada produced an important document in 1974 known as the Lalonde Report, A New Perspective on the Health of Canadians, which signalled the start of the formal era of health promotion in this country. Its significance lay in identifying a broader base of determinants that influence an individual's health: human biology or genetics, lifestyles, environment, and the health care organization. Canada was seen to be playing a leading role in health promotion. In 1986 the Federal Government's document, Achieving Health for All: A Framework for Health Promotion, outlined three national health challenges: reducing inequities, increasing the prevention effort, and enhancing people's capacity to cope. The challenges were to be met by three health promotion mechanisms: self-care, mutual aid, and healthy environments; and by three implementation strategies: fostering public participation, strengthening community health services and coordinating healthy public policy. This framework was put forth to enable people to increase control over and to improve their health. Canada also hosted the first International Conference on Health Promotion in Ottawa in 1986. The international conference produced a document known as the Ottawa Charter which emphasized the importance of the socio-ecological context of health, recognizing the basic prerequisites for health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.

Provincial Context

At the provincial level British Columbia sponsored Canada's National Symposium on Health Promotion and Disease Prevention in Victoria in 1989 to generate and co-ordinate nation-

wide activity in this province. The federal initiative strongly influenced provincial initiatives, and British Columbia established the Office of Health Promotion within the Ministry of Health in 1989. Its mandate was to improve the health of British Columbians by encouraging the use of health promotion strategies (V. Gruneau, B.C. Office of Health Promotion, personal communication, spring, 1991). The Office offered consultation and seed monies to organizations and communities interested in developing health promotion initiatives. Hospitals and health departments were among the key organizations targeted by the Office. This, then, is the historical context in which health promotion developed a high profile at the international, national and provincial levels and leads us to the more immediate context of hospitals and public health units in the province entering into the development of new health promotion programs for their organizations.

Planning Health Promotion Programs

Despite general agreement on the definition of health promotion as the process of enabling people to gain control over their health, in the practical implementation of the concept, there still remains some confusion over what constitutes appropriate health promotion activities at an operational level. The literature on health promotion (Kar, 1989; Rootman, 1988) opens up discussion on how the different understandings of the concept of health promotion and the various contexts in which health promotion programs are developed result in different planning processes, program purposes and outcomes.

Health promotion has been confused with public relations, mass media campaigns, and most consistently with health education. While it incorporates all of these activities, it goes beyond them. Green and Kreuter (1991) offered an alternative definition of health promotion: the

combination of educational and environmental supports for actions and conditions of living conducive to health. The actions may be individual, group or community based and are actions aimed at controlling or influencing the determinants of health. In this definition, health education is central to but only part of health promotion. Therefore, health promotion must address not only educational influences on lifestyle and health, but also social forces (including political, organizational, economic and environmental) as well as the more specific behavioural influences on health that together make up the health promotion concept.

Given the broad scope encompassed by this interpretation of the concept, the diverse range of activities involved in health promotion programs is understandable. Green and Kreuter discussed the vulnerability of health promotion falling prey to the "grab-bag syndrome" (p. 25) because of the extremely wide range of professional, business and commercial personnel who find themselves planning health promotion programs today. Often there is no clear cut rationale for addressing certain health issues or target groups. The selection of some strategy, be it mass media, community organization, or group work, is dependent on the preferences and talents of the individual involved. It is in this situation that an increasing number of public and private organizations (non-formal education settings), including hospitals and health departments, are planning and developing health promotion programs.

A recent and comprehensive review of health education/promotion policy, programs and research (Mullen et al., 1995) noted that, with the exception of continuing medical education, very little attention has been paid to the organizational and communication processes that underlie the planning and implementation of these programs. Given the trend in the literature in adult education towards an interpretation of planning as communicative acts of negotiation, this line of research within the health promotion field appears timely.

Critical Issues

Out of an integrated analysis of the literature on program planning in non-formal education, two critical issues emerge which serve to support the research focus of this study.

Need for Practice-Based Studies in Non-Formal Settings

The first critical issue involves the need for additional empirically-based studies, and by empirical is meant research grounded in experience, particularly of planning in non-formal education organizations. Much of program planning literature in adult education into the 1980s has been prescriptive in nature, that is, authors write about how planning should be carried out based on their own experiences and produce normative models (Boone, 1985; Boyle, 1981; Houle, 1972). The empirical base of the writings had been assumed from the individual's experience but tended not to be documented for the reader to evaluate. There are some limited examples of descriptive research, where authors describe program planning done in specific situations (Mazmanian, 1980; Pennington & Green, 1976). The foci of these studies included the specific activities undertaken by the planners, the sequence of planning activities, and the decision-making styles exhibited. These studies have verified and provided concrete examples of the commonsense knowledge that planning is not a linear, sequential "clean" process, but in fact is highly complex and context dependent (Murk and Galbraith, 1986).

The apparent lack of interest in program planning in non-formal educational settings may be understood from a variety of perspectives. Not only did the marginality of adult education within such organizations minimize its importance, but also people who did write about planning in these settings did so from their own particular discipline (e.g., nursing, psychology, social

work) and perhaps did not view themselves as part of the adult education field. A second possibility may stem from adult education itself, where the educators from formal educational institutions researched what they were interested in, namely formal educational settings.

As our awareness grows of the vast array of public, private and voluntary settings in which program planning takes place (Galbraith, 1990), we can anticipate more empirical research of planning in non-formal educational settings. From the 1980s onward case studies of planning were increasing in number, particularly in the non-formal educational arena (Cervero & Wilson, in press). As discussed previously, the assumptions underlying planning in non-formal settings differ from formal settings. Planning in non-formal organizations where education is a secondary function, with lesser priority and fewer resources poses particular challenges.

Programs with a social issue community focus in such settings are of increasing concern. Health promotion is only one of myriad other new and emerging program areas such as empowerment, anti-racism, and gender equality which carry implications for larger societal change. With a greater appreciation of social concerns being more than the individual's problem but also rooted in societal structures and processes, we can anticipate a growth in more communication and education-oriented programs under the auspices of a variety of non-formal organizations. Such programs are aimed at not only individual learning and change, but also broader societal change. The political nature of planning and the obligation of planners to carry out their role in a socially responsible manner is becoming a recurring theme in the current literature (Cervero & Wilson, 1994; Forester, 1993). Dominant models of program planning into the 1980s have promoted an essentially administrative focus (Griffin, 1983) and have been geared toward maintenance of the status quo. This recent shift to the political and interactive realities of planning offers an opportunity to understand planning in non-formal educational settings from an

alternate perspective, and contribute to increased knowledge of responsible planning of community programs.

Gap between Theory and Practice

The second critical issue is connected to the previous discussion on need for empirical studies and concerns the gap between theory and practice (Burnham, 1988). This gap has long been written about but has been further exacerbated by the lack of success of the theories of professionals as they attempt to solve society's social problems since the 1960s (Schön 1983, 1987). The conventional models in the literature often assume idealized conditions and a generic applicability which do not fit the "messiness" of reality. An important consideration which has contributed to this acknowledged gap has been the limitations of language in talking about planning. The language of the predominant classical viewpoint has shaped how we talk about what we do when we plan (Cervero & Wilson, 1991). Pennington and Green (1976) made the same point twenty years ago, "Planners use the language of the classical model to label their planning actions" (p. 22). We are in a sense entrapped by the language of positivism and systems thinking (Apple, 1990). Language shapes our reality (Smith, 1993). Continued use of words and metaphors grounded in the positivist tradition to describe planning only serve to limit our understanding of the concept. Further, the dominance of one understanding leads to the assumption of the "right" way to do planning, leaving practitioners feeling guilty or inadequate when they are unable to manage the process in the rational, clearcut way reflected in the texts. As will later be discussed in Chapter III under the interpretive paradigm, there is a growing awareness of the challenge of developing new language which emerges out of a naturalist rather than a positivist context (Green, 1990; Lincoln, 1990).

The gap between theory and practice appears to be widening, to the dismay of both academics and practitioners (Brookfield, 1984). More empirical or data-based research on how planners understand the planning process and what they actually do in practice is needed as the basis of further theory development, in order to bridge this gap (Sork & Caffarella, 1989). "A theory of planning practice must not only order data, it must also speak to the working interpretations that planners have of the practical situations and problems they face" (Forester, 1993, p. 17).

Planning theory has also been criticized because the models have been viewed less as theory and more as techniques of planning or "how-to" strategies due to their underlying problem-solving orientation. One asks the question: What is knowledge in this context? If it is to explain a phenomenon, knowledge should provide some understanding of how programs (however defined) are planned, and not simply through describing techniques. Forester (1993, pp. 16-19) identified three criteria for the relevancy of a planning theory. First any theory of planning must be "empirically fitting" - that is, the account of planning practice must be such that the planner recognizes the account as closely descriptive of the experience. The planner would respond to such a theory with "Yes! That's how it is!" Secondly, a theory must be "practically appropriate" to the settings, the account must address the working interpretations of planners to the practical situations they face, the problems they identify and the strategies they decide upon. And, thirdly, the theory must be "ethically illuminating", helping planners to understand that any action, policy or intervention is value-driven and that professional judgments requiring ethical decisions are at the base of practice.

Langenbach (1988) and others (Posner, 1988; Sork 1994) have agreed that one model is insufficient to suit all situations and welcomed the diversity of frameworks and variety of lenses

within which we may view program planning in adult education. Educational planners have been challenged "to have recourse to accumulated lore, to experience of actions and their consequences, to action and reaction at the level of the concrete case, which constitutes the heart of the practical" (Posner, 1988, p. 94). This study of program planning in non-formal educational settings from the practitioner's perspective is considered to address these two critical issues.

Summary

The literature review began with an examination of the historical origins of program planning in curriculum design of the formal K-12 school system in the 1950s, discussed selected major planning models emerging in adult education in the 1970s and 1980s, and focused attention on the recent critique of the technical perspective and a shift to a more interpretive, interactive way of thinking about planning in the late 1980s and 1990s. Critical issues were identified which problematizes planning programs in non-formal educational settings and substantiate the need for more research in this area, particularly around the perceptions and experiences of the planners themselves.

Adult education program planning is rooted in Tyler's (1949) model of curriculum development linked to the formal K-12 school system. This model was congruent with the positivist tradition in social research and behaviourist influence from psychology which dominated education into the 1970s. These influences together with the "industrial systems" approach (Apple, 1990) have reinforced a systematic rational approach to program planning which has gone relatively unchallenged for the past few decades.

Over the past 10 years, however, a critique of technical-rational models of planning has emerged, creating an opportunity for new frameworks or lenses of planning to be developed. A shift to the interactive perspective and attention back to the social interaction of planning provides a broader framework within which to understand planning dynamics. The literature supports the need for a greater focus on practitioner's perception, and call for new metaphors within which to understand the planning process. By probing practitioners' thinking and using their own words about program planning in practice, such research may provide insights and perhaps alternate framings within which to broaden our understanding of this complex process.

Two major critical issues have been articulated from a review of the literature: the need for more practice-based studies in non-formal educational settings, and the need for frameworks of planning to address the gap between theory and practice. The literature points out the opportunity and need for further research, particularly from a "planning-in-practice" base, paying greater attention to the experience and perceptions of those who are immersed in the planning, the planners. If we seek to better understand "the working interpretations that planners have of the practical situation and problems they face" (Forester, 1993, p. 17), we will gather important information on the "political richness, ethical dilemmas and political judgments of planning practices" (Cervero and Wilson, 1994, p. 6). This understanding, in turn, will illuminate new insights, new questions, new patterns of action to explore, thereby contributing to a more empirically grounded theory of planning practice. Therefore, this study on the practitioners' experiences of planning health promotion programs in non-formal health care settings addresses an important area of needed research. The following chapter outlines in detail the research design for this study.

CHAPTER III

PARADIGM AND DESIGN OF THE STUDY

Chapter III explores the interpretive paradigm which grounds this study and outlines the research design. A discussion of the epistemological and ontological tenets of interpretivism first provides a framework within which to understand the methodology of this inquiry. Methodological decisions including the selection of a purposive sample of practitioners, the data gathering technique of in-depth interviews and an approach to the organization and analysis of the data are described. The issues of credibility of the inquiry as well as its limitations are addressed and the chapter concludes with a brief summary.

Interpretive Paradigm

Critiques of the conventional positivist paradigm have dominated the literature over the past three and four decades building a case for what Smith (1993) has termed the demise of empiricism. The challenge to traditional empirical knowledge with its scientifically established universal laws has led to a refocusing on the interpretation of meaning in social and educational inquiry. Lincoln (1990) portrayed science's break with empiricism as opening the doors for a "re-alliance [of science] with judgments, discernment, understanding and interpretation as necessary elements of the scientific progress or process" (p. 79). Thus, in Smith's (1993) view the decline of the positivist paradigm has created an opportunity for a lively debate over alternative paradigms, the three main contenders being the postpositivist paradigm, the critical theory paradigm and the

interpretivist paradigm. Denzin and Lincoln (1994) have identified the same three alternatives; however, they chose to use the term constructivist paradigm, rather than interpretivist paradigm.

The two terms, "interpretivism" and "constructivism," are essentially "unified by their opposition to positivism and their commitment to the study of the world from the point of view of the interacting individual" (Denzin and Lincoln, 1994, p. 100). Although subtle differences between the two have been written about (Schwandt, 1994), I consider the two to be of the same general perspective. For the purpose of this inquiry, then, the term interpretivism rather than constructivism will be used to avoid confusion.

Brief comment is also warranted with regard to the term qualitative vis-a-vis interpretive research. Denzin and Lincoln (1994), while acknowledging the complexity of the concept of qualitative research, offer the following generic definition:

> Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them....It has no theory, or paradigm, that is distinctly its own....Multiple theoretical paradigms claim use of qualitative research methods and strategies. (pp. 2-3)

Thus, qualitative research is portrayed as a general approach incorporating a variety of methods, which can be used across paradigms. Strauss and Corbin (1990) also wrote about qualitative method but in a more restricted manner, contrasting it to quantitative method. Qualitative method is "a **non**mathematical analytic procedure that results in findings derived from data gathered by a variety of means such as observation, interviews, document review," whereas quantitative method is linked to mathematical procedures that attach numbers to findings (p. 18). Both can be used in any paradigm, although some paradigms lend themselves to one more than the other (Miles & Huberman, 1994). For the purpose of this study, I use the term "interpretive" to refer to the underlying paradigm and overall approach of the inquiry, and restrict the use of the

term "qualitative" to mean method. In this case, of the different options included in the qualitative category, in-depth, unstructured interviewing of practitioners will be employed.

If one takes the position (as I have done) that the paradigm adopted by an inquirer has a profound and comprehensive influence on all aspects of the inquiry (Lincoln, 1990; Schwandt, 1994), then as researchers we are compelled to be clear on our paradigm of choice and to act consistently with its tenets. As I have based this inquiry on the interpretive paradigm, a discussion of this perspective is in order, followed by the implications of the paradigm for this study.

Nature of "Reality"

In response to the ontological question, What is the nature of reality? -- interpretivists hold that social reality is constructed; it is the meanings people give to their interactions with others. Reality can thus be understood as mental constructs in the minds of individual persons or groups who hold similar constructions of the phenomenon. Interpretivists reject the positivist notion of a pre-existing external reality waiting to be discovered. Interpretivists hold that there are no ultimate truths, no law-like generalizations, no universal social laws against which mental constructions can be matched for their accuracy or truth (Smith, 1989, 1993).

"Realities are apprehendable in the form of multiple, intangible mental constructions, socially and experientially based, local and specific in nature" (Guba & Lincoln, 1994, p. 110). Humans seek to describe and understand their world through their subjective filters of values, beliefs and attitudes; facts and values are inextricably intertwined (Berger and Luckman, 1967). In other words, we construct our own realities based on our social interaction in the world, and because of the uniqueness of individual experience, the constructs must be individually, socially and contextually created. Further, humans can change their constructions, and in this way

realities can change. Realities in social and educational inquiry are created not found, and we the human actors do the creating and recreating of our constructions as we interpret our own behaviour and that of others.

Accumulation of Knowledge

Epistemological questions focus on the nature and quality of knowledge. In the interpretivist view, reality is thought of as mental constructions created by humans in social interaction. Knowledge can then be understood as:

> Those constructions about which there is relative consensus (or at least some movement toward consensus) among those competent...to interpret the substance of the construction. Multiple "knowledges" can coexist when equally competent (or trusted) interpreters disagree, and/or depending on social, political, cultural, economic, ethnic and gender factors that differentiate the interpreters. These constructions are subject to continuous revision, with changes most likely to occur when relatively different constructions are brought into juxtaposition in a dialectical context. (Guba & Lincoln, 1994, p. 113)

This position assumes an inseparable relationship between the knower and the known as they socially construct reality/knowledge. The usual distinction made between ontology and epistemology (based on a separation of knower and known) does not hold for interpretivism. In contrast, the positivist view of an external, independent reality requires that the knower stand outside that which is known, and the task is to accumulate verifiable, objective facts and find universal laws.

Interpretive-based knowledge can also be characterized as emic knowledge focusing on understanding the perspectives and meanings of those experiencing the phenomenon. Such inside knowledge includes both propositional and tacit information, that is understanding not only from its words but from "broadly shared contexts of natural experience within which it is embedded" (Green, 1990, p. 235).

Thus, the accumulation of interpretive knowledge is relative and ever-evolving, and grows with the formulation of more informed and sophisticated constructions. The purpose of the interpretive inquiry, then, is to increasingly expand our understanding and reconstruction of the meanings that people hold about a social phenomenon. The aim is to work toward creating a consensus among those familiar with the concept while remaining open to new interpretations as information and sophistication improve. "The final aim is to distill a consensus construction that is more informed and sophisticated than any of the predecessor constructions" (Guba & Lincoln, 1994, p. 111).

Credibility of Inquiry

The interpretivist paradigm rejects the positivist notion of the existence of external, objective rules, standards or criteria which must be used to judge the quality of an inquiry. The credibility of positivist findings is dependent on adherence to scientific canons of procedure. From an ontological position, interpretivists consider such criteria a non-issue, because such independent criteria do not exist as positivists claim. Any criteria selected is a product of a social practice, which results in the values and theories of the criteria-producers being embedded in such criteria (Smith, 1993). From a practical research position, however, interpretivists are concerned as social scientists about the quality or credibility of their work.

Interpretivists respond to this issue of criteria of credibility by conceptualizing criteria as "characterizing traits of a practical and moral nature, that are constantly evolving and changing" as they are interpreted and reinterpreted with the changing times and conditions (Smith, 1993, p. 21). They are traits or values that *influence* our judgments as opposed to rigid, inviolate rules that make our judgments. Schwant (1994) compared these characterizing traits with ethical principles

in the process of ethical decision making. Some traits, like ethical principles, may apply to a situation but still require the exercise of judgement and interpretation. Based in a practical tradition, these traits are more like an open-ended list, not considered inclusive, but only represent possibilities "which help us to open up and carry on a dialogue about our judgments" (Greene, 1990).

Schwandt (1994) suggested such traits or norms as thoroughness, coherence, comprehensiveness, usefulness. Marshall (1990) provided one such list of 20 commonly agreed upon criteria, which might supply evidence of goodness of qualitative studies. Included are criteria such as detailed explication of method, researcher assumptions and biases stated, abundant evidence from raw data presented in readable, accessible form, and data preserved and available for re-analysis. Marshall clearly stated, however, that this was not a prescriptive list, but a guide. Interpretivists resist the pressure to try to make lists of criteria complete and abstract and turn them into positivist standards.

Interpretivists do not believe that "anything goes," that one interpretation is as good as another. Fundamentally, interpretivists hold that there is no way of judging a "correct or true" interpretation; however, "better" interpretations can be determined if interpretive researchers "engage in a free and open exchange of arguments...and come to share similar interests, purposes, values" which lead to agreement on one interpretation over another (Smith, 1993, p.119). As we broaden our understanding and gather more interpretations, the dialogue continues and that shared interpretation may change over time and condition. "In the end, what is true is a matter of the internal coherence of our interpretations and a matter of what we can agree, conditioned by historical time and culture, is true" (Smith, 1989, p.9).

Relativism is only a problem if one holds to the positivist notion of finding the right answers in the external reality. If one rejects this view, as interpretivists do, then the negative implications of the term relativism fall away, and relativism can be understood as "no more than an expression of our mode of being in the world" (p. 119). Similarly, the term subjectivity only carries negative connotations of bias when juxtaposed with the positivist's concept of objectivity which implies truth and value neutrality. Since value-free objectivity does not exist for interpretivists, criticisms of subjectivity and ethnocentrism are meaningless. Many of these rigid dichotomies such as objective/subjective; absolutism/relativism; fact/value are no longer useful and "interpretivists think it is time to move on and either dispense with the terms or recast them" (p. 127).

The issue of addressing the quality or credibility of interpretive inquiry continues to be embroiled in a lively debate and is ever evolving (Smith, 1993; Denzin & Lincoln, 1994). Guba and Lincoln (1994) as well recognized that the issue of quality criteria in interpretivism is, nevertheless, not well resolved, and further critique was needed. Miles and Huberman (1994) commented on the present state of analytic procedures: "For the time being, we seem to be in a lively, partially explored realm far removed from canonical sterility. To us it seems that research is more a craft than a slavish adherence to methodological rules" (p. 5).

Implications for Study

The major focus of this inquiry is: What is the nature of program planning from the perspective of practitioners? The question emerges out of practice and personal experience in a variety of planning situations in non-formal educational settings. The ontological and epistemological positions discussed previously are congruent with the assumptions made in this

study. Namely, I hold that there is no external objective reality called program planning, no one universal planning model to which researchers must uncover and practitioners must aspire. Rather, the social phenomenon of planning is a mental construction created by practitioners engaged in a social activity called planning, on which they each uniquely experience and are able to reflect on.

Developing knowledge about planning, then, is to expand our understanding of the interpretations that practitioners hold of their planning experiences in non-formal educational settings. From the interpretivist perspective, my aim as inquirer is to contribute to this broadening of the dialogue (Marshall, 1990) on the constructions of planning. In Denzin's (1989) terms this study proposes an analysis at the level of identifying concepts and speculating on relationships between concepts with a view to understanding the phenomenon. This in turn may lead at some further stage, to the development of different frameworks as we move to more sophisticated understandings of planning.

The interpretivist position requires that the researcher get *close* to the participants, to gain access to their inner understanding and thoughts on planning. This was accomplished by engaging in extensive interviews with practitioners as they reflected on and shared their different experiences of planning in their particular context of time and place. Unlike the positivist expectation of separation of researcher and researched, the interpretivist paradigm assumes a relationship between the inquirer and inquired. Thus, I participated in this inquiry not as a neutral, value-free observer, but as a human interacting with other humans to construct interpretations of planning.

Having examined the basic epistemological and ontological underpinnings of the interpretivist paradigm, I have found them to be most congruent with my own theories about

social phenomena and the nature of inquiry. Based on the premise that it is the *meaning* which humans give to their experience that is of significance (Burgess, 1984), the interpretive paradigm best suited this inquiry on practitioners' understanding and interpretations of the planning process. A methodology consistent with the purposes and assumptions of this interpretive approach was applied and will now be described.

Interpretive Methodology

Methodology is the third essential cornerstone of a paradigm, after ontology and epistemology. Epistemology determines purpose which in turn determines methodology (Schwandt,1994). Methodology can be understood as how we gain knowledge about the world. Methods are techniques for gathering and analyzing data (Schwandt, 1994, p. 119). As such "the methodological question cannot be reduced to a question of methods; methods must be fitted to a predetermined methodology" (Guba and Lincoln 1994, p. 108).

Within this interpretivist framework and a commitment to the broader conception of methodology, the more technical decisions of methods regarding the selection of respondents, data collection and analysis were determined. For example, key decisions around methods included the selection of the sample of practitioners, the choice of in-depth interviews as a means of data gathering. In the interpretive inquiry, the purposive sample is appropriate, because of the selection of individuals who best represent the phenomenon under scrutiny. A purposive sample is important in order to obtain ideas, good insights, and experienced critical appraisals (Kidder & Fine, 1987). Interpretive studies are interested in finding good informants - "an insider, a member of the group studied, willing to be an informant" (Fontana & Frey, 1994, p. 367). In this study,

practitioners central to the planning event located in health care settings that have recently established new formal health promotion programs comprised the purposive sample, as described below.

Selection of Organizational Health Care Settings

In the interpretive perspective the practitioner's understanding of their planning experience develops within a unique context of time and place. Two criteria for the selection of context were established:

i) The setting was to be a non-formal educational setting where education is not the primary purpose of the organization.

ii) The organization was introducing a new program initiative which has implications for the whole organization (as opposed to one department or division within the organization).

Health promotion programs in health care settings met these two criteria. Health promotion was an important direction supported by both the federal and provincial governments at the time of the study. In British Columbia, the Ministry of Health established the Office of Health Promotion in the 1989 to encourage British Columbians to take a more health promotion oriented approach to their health care. Because of the growing importance of health promotion and assisted by some seed money from the province, health care settings began to introduce new health promotion programs in their organizations. Therefore, health care organizations with new health promotion programs appeared to provide a suitable context. (It should be noted that the provincial government has since disbanded the Office of Health Promotion and replaced it with Population Health.)

Two types of health care settings, hospital and public health departments, were selected as:

i) Both were non-formal educational settings (i.e. settings where education was not the primary purpose) unlike universities and colleges which are formal educational settings.

ii) Health promotion was an integral part of their mandate for health care and practitioners in these settings themselves have indicated an interest in better understanding the planning of health promotion programs.

iii) Both settings provided an organizational context and boundaries within which program planning of health promotion can be studied.

iv) Both represented the public sector (as opposed to private, business/industry) organizations mandated to provide health promotion.

Despite the above stated similarities, richness of practitioner interpretations of planning health promotion programs was anticipated because of such considerations as:

i) Differing mandates: Hospitals had responsibility for acute care and treatment of patients while public health departments focused on general health and preventive services. The publics they served also differed.

ii) Differing organizational environments: Hospitals and public health departments varied in their institutional or community orientation, in the degree of bureaucratic administration, in the more particular and immediate circumstances of each organization at play.

iii) Differing individuals: The practitioners as well as the key players in each organization were unique individuals which affected interpretations of planning interactions.

The following criteria for selecting specific health department and hospital sites were established:

i) The organization had a formally designated health promotion program which was differentiated from a health education program.

ii) The health promotion program had a reputation of being new or innovative.

iii) The program had been in operation at least six months.

iv) There were specific individuals designated for the design and delivery of the health promotion program.

A list of public health departments and hospitals in the Lower Mainland was developed and contact made to determine which sites met the above criteria. Recommendations from the provincial Health Promotion Office staff on which organizations would be most useful to study resulted in the identification of six sites: three hospitals and three health departments.

Having identified the six specific sites, proper protocols of contacting the head of the organization and obtaining permission were followed as required by the University of British Columbia Ethics Committee. An invitation to participate was issued to the head of the organization. (Follow-up telephone or personal contact was made to obtain approval to proceed, to ensure clear understanding of the purpose of the study and to obtain names of practitioners to be interviewed. All sites contacted agreed to participate (see Appendix A for Protocol Documents).

Selection of Practitioner Respondents

Contact was then made with specific individuals who were identified as being responsible for the design and delivery of health promotion programs within their respective organizations. All

who were approached agreed to be interviewed. Participant practitioners met the following criteria:

i) They had been involved with health promotion planning in the organization for at least six months.

ii) They agreed to voluntarily participate in extensive interviewing as part of the study, and to provide their interpretations of their planning experience.

iii) They had formal responsibility for the design and delivery of the organization's health promotion program.

It should be noted that the focus was on planning a new program at the organizational level. These practitioners were individuals responsible for planning and implementing a new program on health promotion for the health department/hospital. The more important criterion was their responsibility in planning the overall program. They may or may not have been running the individual projects (e.g., Seniors' Fitness, Heart Health) themselves within the program.

Unstructured In-Depth Interviews

The major source of data for this interpretive study was in-depth unstructured interviews with practitioners. The aim was to establish "a human-to-human relation with the respondent and the desire to **understand** rather than to explain" (Fontana & Frey, 1994, p. 366). The interview serves the specific purpose of "exploring and gathering experiential narrative material that may serve as a resource for developing a richer and deeper understanding of human phenomenon" (van Manen, 1989, p. 66). Multiple interviews (three) were conducted with each participant, and held

approximately one week apart at times and locations convenient to participants (see Appendix B for Interview Format). Three interviews were deemed an adequate number based on the pilot test with three health care professionals who had experience in planning health services programs. These pilot interviews showed that respondents by the third interview were restating comments they had made previously. This was confirmed in the study, as practitioners comments became somewhat repetitive, and they themselves felt that after the third interview, they had nothing further to add. A series of three interviews at short intervals was thought to encourage a richness of response: by allowing time and familiarity to build rapport, by encouraging the practitioner to reflect between interviews, and by ensuring that the respondent was not fatigued. Rapport building and trust in the inquirer contribute to "stronger data" (Miles & Huberman, 1994).

The pilot test was also helpful in making necessary adjustments to the format and questions prior to actual interviewing of respondents. Pilot test respondents indicated their preference for unstructured interviews with a few open-ended questions, stating that they felt less pressured to give the "right" answers if faced with a series of questions. Interviews with the practitioners were tape recorded with the permission of the participants.

The **first interview** encouraged the researcher and practitioner to begin to establish a relationship in a supportive manner. The focus was on obtaining descriptive information about the organization's health promotion program and activities involved in the planning of the program. The practitioners were asked to describe how the health promotion program originated and how it came to be as it was at the time of the interviews. This approach encouraged the practitioners to tell their story with minimal interruption. A copy of the transcript of the interview was sent to practitioners prior to the second interview for verification and to stimulate their thinking for the next meeting.

The purpose of the **second interview** was to first provide an opportunity for the practitioners to clarify, correct or expand on responses given in the previous interview, and then secondly, to move the practitioners to a more reflective level asking them to think about planning the health promotion program. Practitioners explored their own roles/responsibilities in the process and talked about those aspects or events of the process that were the most meaningful to them. Again, the transcription of the second interview was forwarded to practitioners prior to the third interview.

The **third interview** continued to explore the practitioners' interpretation of their experience and provided an opportunity for them to add to or expand upon previous comments made. By the third interview, the relationship was established with the researcher and the practitioners were seemingly engaged in a reflective process. Towards the close of this interview, the inquirer asked the practitioners about their training and background.

In addition, the individual to whom the respondents reported directly were interviewed in one session to provide information about the organizational context and to verify the respondent's role, responsibilities and activities for health promotion within the organization. Also, available documents on health promotion were reviewed. This additional information was not directly relevant to this study's focus on the planner's experience of the planning process; however, such information was helpful to me, as the researcher, to better understand the contexts within which the practitioners constructed their experiences of the planning process.

In summary, then, the data collection involved a small sample of six practitioners, three from hospital and three from public health settings, in the Lower Mainland. The inquirer interviewed these respondents three times over a period of a month. A consistent unstructured

interview format with few open-ended questions was used. All interviews were taped with the approval of the practitioner.

Data Organization and Analysis

Qualitative data is essentially words, and full transcriptions of eighteen hour-long taped interviews (three per each of the six practitioners) resulted in an extensive amount of typed material. Some framework is needed to organize and manage the data to facilitate orderly analysis (Strauss & Corbin, 1990; Wolcott, 1990). The overall framework used was premised on an iterative, inductive creative process rather than a linear deductive and clear cut process. "Sensitizing a concept" occurs when the researcher leaves the concept non-operationalized until the researcher has entered the field and has learned the meanings attached to the concept by the person/s experiencing it (Denzin, 1989). Only then does the researcher characterize and operationalize the concept. The intent is to allow the meanings to emerge from the data. This approach was taken with regard to the concept of planning; practitioner's perceptions shaped the understanding and analysis of planning central to this study.

Data analysis in interpretive inquiry is an iterative and continuous process as the inquirer moves back and forth organizing, coding and analyzing the data. Strauss and Corbin (1990) commented on the "constant interplay between proposing and checking" (p. 111). Hence, the inquirer was prepared for the continuing movement among the raw data transcripts, the data summaries, the categories of codes and the interpretations which emerged. Working in one area raised questions and thoughts related to the other two areas, as the inquirer worked and weaved inductively with the data.

From the outset the interpretivist inquirer is also aware of the theory and value-laden nature of data analysis and is cognizant of her own assumptions, beliefs, and biases underlying the choices and judgments she continually makes as she works with the data. Memoing and the recording of thoughts, ideas, and value judgments assisted in increasing inquirer self-awareness.

Miles and Huberman (1994) from a post-positive paradigm identified themselves as "transcendental realists" - who believed that social phenomena do exist in the real world and that "some lawful and reasonably stable relationships are to be found among them." The object of transcendental realist inquiry is to search for "causal explanation and for the evidence to show that each entity or event is an instance of that explanation" (p. 4). They have, however, acknowledged various approaches to qualitative research, and maintained that:

> In epistemological debates it is tempting to operate at the poles. But in the actual practice of empirical research, we believe that all of us - realists, interpretivist, critical theorists- are closer to the centre, with multiple overlaps....Our view is...that it is possible to develop practical standards-workable across different perspectives-for judging the goodness of conclusions. (p. 4)

To this end, they identified "a fairly classic set of analytic moves" which may be used across different types of qualitative research. These analytic moves provide a general approach to data analysis which appears to be useful in this study and include:

- Affixing codes to a set of field notes drawn from observations or interviews
- Noting reflections or other remarks in the margins
- Sorting and sifting through these materials to identify similar phrases, relationships between variables, patterns, themes, distinct differences between subgroups, and common sequences
- Isolating these patterns and processes, commonalities and differences, and taking them out to the field in the next round of data collection

- Gradually elaborating a small set of generalizations that cover the consistencies discerned in the data base
- Confronting those generalizations with a formalized body of knowledge in the form of constructs or theories (p. 9).

Strauss and Corbin (1990), proponents of grounded theory, also espoused a post-positive position, as their purpose is to "generate a rich, tightly woven, explanatory theory that closely approximates the reality it represents" (p. 57). They suggested, however, that there are some grounded theory procedures which are also useful "for those alternative purposes" of theme analysis or concept development theory (p. 115). Again, this study took advantage of some of these procedures without jeopardizing the integrity of the inquiry. Some of the procedures which proved useful to this study were open and axial coding. Open coding is "the process of breaking down, examining, comparing, conceptualizing and categorizing data" (p. 61). Axial coding is the process whereby "data are put back together in new ways after open coding, by making connections between categories" (p. 96).

Given the importance of both making the data analysis stage manageable, yet cautious of the dangers of imposing pre-set categories, the following process was followed for this study:

Transcribing the interviews: All eighteen interviews, three per practitioner were fully transcribed, as well as the six single interviews with the practitioners' immediate supervisors.

Open coding: Each interview was carefully reviewed and open coded (Strauss & Corbin, 1990, p.73) or "unitized" (Lincoln and Guba, 1985). Each coded item was identified by interview and line number and placed in a typed list.

Developing an initial code list: The "regularities of meaning" were identified and developed into an initial list of codes, which evolved as the process continued.

Assigning items to code list: The inquirer coded the key items according to a code list. The code list was an initial preliminary list and in this iterative process was reworked, reduced, expanded, and refined.

Developing data display charts: In order to render the coded items in a more manageable form for analysis, where appropriate, data display charts were developed (Miles and Huberman, 1994). As there were six (6) cases of practitioners, in addition to comprehensive analysis of in-case data, the data across the six cases was also analyzed. However, caution was taken against the loss of design flexibility and "an undermining of the strengths of qualitative research by overly mechanistic data analysis" (Marshall and Rossman, 1989, p. 115).

Analyzing for themes, patterns, relationships: The inquirer searched for categories, themes, patterns, relationships; a search for regularities of meaning held by the participants in that setting (Marshall and Rossman, 1989). Inductive analysis involved the use of "indigenous typologies" that is, salient categories which emerged from the data which reflected how the participants classified the data, or "analyst-constructed typologies," which were uncovered by the researcher (Patton, 1990). As an interpretivist inquirer, I also acknowledged an interest in some areas: namely, the practitioners' use of language and metaphor, perceptions of key aspects of the organizational context and understandings of their roles and responsibilities.

Analytical framework: In order to move the analysis to a more conceptual level beyond descriptive commentary, frame analysis was used to make meaning of the findings. The frame analysis perspective is described more fully in a later chapter (Elgström & Riis, 1992; Schön & Rein, 1994) with a discussion of the insights from this perspective as applied to the study's findings.

To briefly summarize this data organization and analysis stage, transcriptions of all interviews comprised the raw data. The data was organized and analyzed following some guidelines offered by Miles and Huberman (1994) and Strauss and Corbin (1990). Data was analyzed in an inductive manner, and the search for regularities of meaning occurred in an iterative process which required constant movement back and forth between the proposed interpretations, the categories of code, the data summaries and the original transcripts. Through this process key findings were identified which are discussed in Chapter V. The findings are then further analyzed using insights from frame perspective as presented in Chapter VI.

Credibility of Study

All paradigms propose their own criteria for judging the "goodness" of an inquiry. The interpretivist paradigm rejects the positivist canons of validity, generalizability and reliability to establish credibility (Janesick, 1994). In their stead, interpretivists address the issue of credibility by proposing the use of traits or values that influence rather than make our judgments (Smith, 1993). Also proposed are open-ended lists of commonly agreed upon criteria which inquirers may select from to guide their work (Marshall, 1990). Miles and Huberman (1994) identified three conditions for stronger data and Guba and Lincoln (1985) offered a set of four trustworthiness criteria. Denzin (1994) portrayed the qualitative inquirer as a "researcher-as-bricoleur who uses any tool or method at hand" to solve the problem (p. 501). Consistent with this pragmatic approach, a number of authors' works have been referenced regarding the credibility, selecting criteria which are both morally and practically defensible (Smith, 1993) to this study. In his earlier work, Guba (1981) laid out four criteria of the trustworthiness of

qualitative research: truth value (internal validity), applicability (generalizability), consistency (reliability) and neutrality (objectivity). This set of trustworthiness criteria soon became suspect, because of its close parallelism with positivism (Lincoln, 1990). In later writings Guba (Lincoln & Guba, 1985) reworked the four original criteria replacing them with: credibility, transferability, dependability and confirmability respectively to reflect a constructivist/interpretivist perspective. These four criteria of trustworthiness are now briefly discussed in terms of this study.

Trustworthiness Criteria

Credibility: Credibility can be understood as the validity of the findings. The positivist view considers a finding valid if it accurately reflects some external reality. The interpretivist views validity as a matter of agreement at any given time and place; that is, the finding is generally acceptable or credible to a number of people based on their shared interests, purposes and values. "Any resolution of differences is...a question of dialogue and justification...an appeal to what 'makes sense' given these various interests, purposes, values, dispositions" (Smith, 1989, p. 89).

In this study, the credibility of the findings was addressed by the following strategies:

i) Participants reviewed transcripts of all three interviews and were given the opportunity to verify and comment on the transcripts, to correct or change statements made and to elaborate.

ii) The design of the study has been explained in detail with a solid rationale for methodological choices made in sample selection, data gathering techniques, and data analysis.

iii) Sufficient raw data has been provided (as will be seen in the following chapters) to demonstrate the connection between the presented findings and the phenomenon under study.

Transferability: Transferability addresses how knowledge is accumulated and consensus built, and is a challenge to interpretivists because of the context-specific nature of their findings. In positivist

inquiry, the responsibility is placed on the researcher to be able to generalize findings to other cases. To interpretivists, for "those of us interested in questions of meaning and interpretation in individual cases...traditional thinking about generalizability falls short....In fact, the value of the case study is its uniqueness; consequently reliability in the traditional sense of replicability is pointless here" (Janesick, 1994, p. 217).

Guba and Lincoln (1985) posited that the interpretivist inquirer is only required to provide a "thick" description of the inquiry context and processes, and "the final judgment (about the transferability)...is vested in the person seeking to make the transfer" (p. 217). Those inquirers must judge how these findings fit with that of their own context of study (Greene, 1990).
In this study, I have provided a sufficient description of the practitioner's interpretations of the context and content of planning, and leave the decision as to the possible transferability of findings to other inquirers interested in interpretive studies of planning in non-formal educational settings.
Dependability: The interpretive researcher acknowledges the need to address the sense of stability, the consistency of the human inquirer as the data gathering instrument. This was addressed at the level of methodological procedure and at the level of self-awareness of the inquirer. The researcher-as-instrument will be discussed in more detail.

In this study, dependability was addressed by consistency of methodological protocols in the following areas: selecting the participants, scheduling the interviews, using the same interviewer, employing the same general format and questions for all interviews, recording all interviews with the same device. The inquirer also maintained a level of self-awareness of physical and emotional state, of assumptions and biases which may have affected the interview by memoing and reflective periods prior to and following interviews.

Confirmability: Confirmability focuses on the neutrality of the findings. The positivist values objectivity (or neutrality) as a value-free detached look at the external reality; subjectivity implies a failure because personal biases are allowed to affect the observations. The interpretivist rejects the fact/value, inquirer/inquired, objective/ subjective dichotomies; therefore, such conceptions of objectivity and subjectivity are meaningless. However, if objectivity and subjectivity are conceived of differently, that is, the objective is that which we can agree upon through rational discussion, dialogue and persuasion, and the subjective as that point of view which is not agreed upon (Smith, 1989, p. 80), then the objectivity of the finding can be confirmed by dialogue and discussion. Findings were checked through triangulation techniques involving another researcher (Marshall, 1994) who read the interview transcripts and determined that in all six cases, there was a high degree of congruency between the written transcripts of the practitioners and the reconstructed stories and themes presented by the inquirer. Also, the practitioner's immediate supervisor was interviewed to determine congruency of the story of the program development and the challenges raised by the practitioner with regard to the organization's understanding of the concept of health promotion, the commitment of senior management, the resources and funding.

Authenticity Criteria

Responding to a challenge from their critics that criteria should evolve out of a naturalistic and responsive inquiry not a conventional one, Guba and Lincoln (1994) have developed a second set of criteria known as authenticity criteria. These criteria are considered "forms of knowing and action...to distinguish them from the methodological process criteria that we had designated as "trustworthiness criteria" (p. 114). These authenticity criteria include:

- fairness: judgments regarding multiple, socially constructed and often conflicting realities must be mediated in a fair manner
- ontological authenticity: heightened awareness of one's own constructions and assumptions
- educative authenticity: increased awareness and appreciation (though not necessarily acceptance) of constructions of other stakeholders
- catalytic authenticity: inquiry stimulates to action
- tactical authenticity: ability to take action, engage the political area on behalf of oneself, one's referent stakeholder or participant group.

Two criteria appeared to have some applicability to this study: ontological authenticity was addressed by the inquirer documenting her own position in this study, and educative authenticity dealt with by the general intent of the study to broaden our understanding of the social construct of planning. The first and last two criteria of fairness, catalytic and tactical authenticity reflected a more social action oriented direction to credibility. Denzin and Lincoln (1994) discussed this trend in qualitative research: "More action-, activist-oriented research is on the horizon, as are more social criticism and social critique" (p. 11). However, social understanding rather than critique is the intent of this inquiry, and, therefore, these latter criteria were considered outside its parameters.

Conditions for Stronger Data

Miles & Huberman (1994) have identified three areas which contribute to "stronger data" which have some applicability to this study. The three areas involve "better informants," circumstances under which data is collected and researcher's validation efforts. This study was

designed to find better informants in that the practitioners were "knowledgable, close to the event, action, process or setting" (p. 268). All individuals were articulate, of a reflective nature and claimed to have enjoyed talking about the topic - traits which supported the provision of a richer data base.

The second area of circumstances of data collection was also addressed in this design. Data is stronger if it is collected at a later date or after repeated contacts; collected in an informal setting and the respondent is alone with the researcher. This study involved a series of three interviews, held in private in a location of the practitioner's choice. Every effort was be made to establish a trusting, non-threatening relationship. In addition, practitioners were offered the opportunity to turn off the tape recorder to make off-the-record comments, which occurred only once with one practitioner.

The third area of validation efforts involved checking for research effects and biases, checking for representativeness, getting feedback from informants and triangulation (pp. 263-268). Once again, these considerations, suggested by Miles and Huberman (1994), may be viewed as useful across several paradigms, including the interpretivist paradigm. For this study, due to the passage of time, and movement of practitioners out of province, summaries of the three interviews were sent to only three practitioners, only one of whom responded with additional written comments.

Inquirer as Research Instrument

Lincoln and Guba (1985) noted the following characteristics of the human-as-instrument: the responsiveness and adaptiveness to personal and environmental clues; the holistic grasp of complex phenomena in context; the unique capability to process information immediately and feed

data back to a respondent for clarification and correction; perception to identify and explore atypical or idiosyncratic responses to achieve a higher level of understanding. These are the advantages of the human-as-instrument With extensive training and experience, the trustworthiness of this instrument can be refined (pp. 194-195).

Marshall (1990) focused more on the attributes that researchers brought with them, "their personal talents, experiential biases and insights [which are] used consciously" (p. 195). For Patton (1990), the credibility of the research was dependent on what the researcher brought to the study in terms of experience and qualifications. In response to this issue of background, my professional training in social work has emphasized the importance of interpersonal communication, particularly with respect to effective listening and feedback skills in an empathetic, non-judgmental fashion. Practical experience in program planning in the health field also afforded me familiarity with the content area of the study.

This inquiry process is a value-laden exercise where one acknowledges that the inquirer's decisions reflect personal preferences. The underlying assumptions, theories, biases, interests of the researcher all influence the choices made in the researcher's inquiry (Greene, 1990). Subjectivity is continually evident through choice of research focus, research question and methodology selected (Patton, 1990). In Smith's (1993) discussion of knowledge as value and theory-laden, "what counts as data and knowledge is influenced by the interests, purposes and social practices of those who lay claims to that data and knowledge" (p.49).

To better understand the individual's lived experience of a phenomenon, the inquirer must interact with the individual to access an interpretation of that phenomenon from the perspective of that participant. Interpretive inquirers use themselves to engage participants in an open-ended manner to gather a multitude of views and perceptions from which to create some consensus of

the phenomenon under study. The inquirer must be "close" to the participant in order to understand the depth, details and meaning to the participant. Kidder and Fine (1987) likened the inquiry approach to "a roving movie camera with variable exposures, a shifting focus, and nonroutinized selection of angles, duration, film speed and so on" (p. 59). The phenomenon under study cannot be separated from the context in which it occurs, nor can the interaction of the inquirer and the inquired be separated.

This discussion raises the issue of the inquirer as the instrument, the data gathering tool. The inquirer is not a neutral tool, but an integral part of the study. In Smith's words (1989), "An instrument does not simply reflect or mirror reality but contributes to constructing or defining social reality. Social scientists, then...are actually participants in the process of making social reality rather than discoverers of the qualities and characteristics of an independent existing reality" (p. 84). Having stated this, however, there are a number of strategies to maintain awareness of the influence of the inquirer on the inquiry which have already been discussed previously including memoing, self-awareness and reflection, a personal statement of voice included in the final writing.

Limitations of Study

This interpretive study contributes to our knowledge of planning by exploring practitioners' experiences of planning. As such, it makes no claim to test hypotheses or to establish generalizations about planning in non-formal educational settings. Rather, the practitioners' understanding of the phenomenon of planning provides rich data which has resulted in some "interesting and significant thoughts" (Smith, 1993) about planning in non-formal

educational settings and generated questions for further inquiry which will contribute to a more sophisticated and consensus-based understanding of planning. From the critical theorist perspective, interpretive inquiry has been criticized for its lack of "critical purchase" (Schwandt, 1994, p. 130). Interpretive theoretical frameworks reflect a politics of sociology of regulation not radical change (Burrell & Morgan, 1979). It should be noted that this is an interpretive, not a critical theory paradigm of inquiry, and thus, does not search for truths to contribute to radical social change.

Another potential limitation is related to the issue of language. For interpretivists, language is key, language is "the medium of expression and understanding within which we are constantly shaping and reshaping the elements of our world...language shapes the world" (Smith, 1993, p. 130). The language of positivism has long dominated the field, and interpretivists continue to struggle to develop the appropriate words to describe and conceptualize their work. For example, there is a lack of an appropriate language to describe the growth of interpretive-based knowledge. Some authors contend (Lincoln 1990; Green, 1994) that from the interpretivist perspective we have not yet developed the appropriate language to talk about forms of knowledge that are not hierarchic or taxonomic, descriptors from the positivist paradigm. Perhaps we need a view of knowledge that reflects a more "circular" or "amoeba-like" expansion of knowledge (Lincoln, 1990), and the challenge is to find the language, the metaphors and adjectives that mirror this continually expanding pool of knowledge.

The final area of limitation is of a practical nature of the dynamic nature of social interaction in a constantly changing environment. This study was undertaken within a specific context of time and place and therefore the findings are reflective of practitioners' experience within this context.

Summary

This chapter has served to ground the study in the interpretivist paradigm and describe the research design. A brief overview of the interpretivist position on the nature of reality and knowledge provided a framework within which to understand the purpose, design and implementation of this study. Congruent with this paradigm, the purpose of the study was to broaden our understanding of the phenomenon of planning in non-formal educational organizations through the multiple and rich constructions of those individuals directly involved in planning. The inquirer engaged a small, purposive sample of six planning practitioners in extensive interviews, in an open-ended manner about their constructions of the planning process of new health promotion programs. The intent of this methodology was to establish a supportive and open relationship in which the practitioners feel free to describe and interpret the planning process in any manner they choose. The three interviews offered ample opportunities for the practitioners to reflect and comment on these reflections with the researcher.

Full transcriptions of all interviews constituted the raw data for this study. The data was organized and analyzed in an iterative, inductive manner. Suggestions from Lincoln and Guba (1985), Miles and Huberman (1994) and Strauss and Corbin (1990) were helpful in this regard. The credibility of this study was addressed with reference to Guba and Lincoln's (1994) criteria of trustworthiness and authenticity, and Miles & Huberman's (1994) conditions for stronger data.

CHAPTER IV

THE PRACTITIONERS AND THEIR STORIES

In Chapter IV the practitioners tell their individual stories of their experience developing a health promotion program. The three interviews with each practitioner contained rich and detailed comments about these experiences. Hence, the stories themselves as recounted in this chapter present only the key highlights; thumbnail sketches of what happened. Additional information and details about the various experiences will emerge in the next chapter which describes and analyzes significant findings from the study.

The chapter begins with a description of the provincial context in which these activities were taking place. A brief profile each practitioner is then provided, followed by the story as told in his or her own words (see Appendix C for Summary of Practitioner Profiles). The reference numbers in parenthesis signify the number of the interview, followed by the page number of the transcription where this quote will be found. All the names have been changed to protect the confidentiality of participants and their organizations. Each story is followed by a brief commentary which identifies themes or key concepts raised by that particular practitioner. The chapter concludes with a summary discussion of these themes and concepts that constitute the key areas of findings in Chapter V.

Provincial Context

The 1980s have been referred to as the "seminal period" for health promotion in British Columbia as health promotion began to take root during the last half of this decade (Altman & Martin, 1994). The key events which gave impetus to the movement appeared to be a provincial workshop to explore the Epp Framework in Achieving Health for All (1986) sponsored by the British Columbia Health Association (BCHA). The British Columbia Healthy Communities Network (BCHCN) developed over the following few years. In 1989, Victoria hosted the National Conference on Health Promotion and Disease Prevention, at which time the BC Ministry of Health announced the establishment of a formal Office of Health Promotion (OHP). The OHP sought to encourage health care organizations and the public to think in a more prevention, health promotion oriented way, and has served to increase the profile and credibility of health promotion within the province.

Initially, health care organizations tended not to actively support health promotion initiatives because of a predominant commitment to the clinical service model. However, due to the increasingly higher profile of health promotion at both political and community levels, since the late 1980s into the mid 1990s, there has been "a slow but perceptible change among program administrators, researchers and front-line staff" (Altman & Martin, 1994, p. 161).

Each of the six health care organizations in this study established a new program. In some cases it was called health promotion; in others, wellness programs. The practitioners were all first incumbents in the new position and carried responsibility for planning and implementing this new program initiative. They have been in the position anywhere from six months to two and half years. The three hospital settings and the three health department settings are all located in the

Lower Mainland of British Columbia. A recession in the early 1980s increasingly focused attention on the deficit and growing health care costs. It was in this environment of fiscal crisis and budget cutbacks in the health care system that this study was undertaken. The hospitals in particular were recovering from the aftermath of a nurses strike in 1989.

Practitioners' Stories

Jess - City Hospital

City Hospital is an old and well-established teaching hospital with a staff of approximately 6,000 in the major city of Lower Mainland. The Hospital Board had established an Employee Centre some two-three years previously, and was supportive of the health promotion efforts of staff although at the time of this study there was no formally endorsed health promotion mission or philosophy statement. The Vice-President responsible for the Employee Centre and health promotion activities indicated the Board would be considering formal approval in the near future. Jess was a white woman in her mid-thirties, a trained medical technician with a degree in kinesiology and communications, a white female in her early thirties. Jess worked at the City Hospital for 18 years before becoming the health promotion coordinator. Having a personal interest in fitness for some years, Jess had for a short time run her own private fitness business. The administration had started an Employees' Centre for exercise and recreation and was interested in developing health promotion. Jess had developed a proposal for health promotion and was named coordinator. She had been in the position for 24 months at the time of the interviews.

Jess' Story

It really began with the Hospital's Employee Centre [which had been] in place for approximately two and half years. I became interested in the area of health promotion personally and wanted to explore opportunities with the hospital and [submitted] just a skeleton of a proposal. The administration obviously were very interested in the proposal [for health promotion]...but I don't think they really understood what it was or what direction they were going (1-2). I spent a lot of my first year doing a lot of research and reading everything I could get my hands on and talking to other people outside of the hospital setting about health promotion (1-3).

I did a mini-survey of the different areas (within the hospital) to get a sense of what people were thinking and feeling about health promotion. A lot of varied responses... [it's] very subjective to people's own label or interpretation. It's important to understand the development process within the context of culture (1-5). I'm convinced talking to people, their approaches are different, their support systems are different, their attitudes are different (1-6).

The hospital multidisciplinary back team was one of the first programs that we developed... there was a coming together, and a learning experience on everybody's part. The sort of sharing of experience and knowledge, and expertise. And it's easy enough to say it but when you actually have to put it into practice and get people to share their ideas and to recognize the strengths and weaknesses of everybody's approach, and then come to ...a more common ground (1-7). The program's been in place for almost two years. It seems to be working very well and the team has certainly grown together as a unified force, and feel very comfortable working as a team (1-8).

I think...it's important to involve the organization and the proper areas and individuals within the organization as part of that planning process. So it's a program that ...everybody takes ownership of, and that's what I've tried to develop through each of the programs that I've brought forward to the administration... and my role then became a coordinating role. It then identifies programs that may be appropriate for the hospital, brings the necessary people together to discuss the opportunity, look at the resources, pursue funding opportunities that exist (1-4). Trying to make sure that you're communicating all the time to all the groups, and hopefully they're communicating back to you, and issues are dealt with right away...But it's very de-energizing...there's a lot of frustration (1-11).

What I do is, I'm just the coordinator. I'll work with people, I'll come forward with ideas, and we'll work as a team, and I'll have my input but I certainly don't take credit for writing the whole proposal...And that works well because then people they get involved right from the beginning and it's their project. And usually what I do is fill it out and so they're comfortable I'll do the running around and then I'll pull away and they'll identify who is to lead it and take it forward. And that's how it works (1-24).

Let me think of the star programs...a comprehensive stop smoking hospital program...a health promotions newsletter....a resource library for health promotion...arthritis self management (1-14). [Other activities were arthritis self management, stress management, retirement club, speakers' bureau. Proposals were also developed for critical incident debriefing, collaboration with CBC on a television health promotion series, joint research with UBC on exercise and elderly women.]

[Because the concept of health promotion was] a wide-open frontier I took the approach of trial and error...starting with workable chunks to start building one program and do it well (1-

6). Some good advice [from my mentor] that had to deal with this huge mass, how to break it down into workable components...take it one step at a time and not try to do too much. And build from one really solid program, and build from that and move on to another program and keep making sure that you focus in on quality programming, and that you make your programs an integral part of the organization. So that the organization won't be able to do without you.

He certainly helped me learn how to fight some of the political storms, how to be prepared for a challenge...that [health promotion] is going to evolve slowly over time, and that there are people out there who are very supportive, and it's a matter of linking in with those people and building a support base and growing from there as a collective (2-8). I sometimes feel that the one on one approach, even getting little focus groups together...it's just sort of testing ideas, and once you've got those people and they're aware of who you are, then it's easy to get them involved in another program. It just kind of builds on itself and the momentum keeps gathering (1-19).

In terms of the employee health promotion, it has really been important - looking not just at employees but the people in general and their needs and what kinds of things motivate people and how we get them involved without sort of coercing them into changing behaviours and not beating them with literature and what-nots to do. Trying a much more positive message...taking a very pro-active approach is really important (1-20).

I think...the past two years have been the planning, the thinking...it needs that time talking to people, at your administrative levels, writing up, spending lot of time in developing proposals and thinking it through and getting that input, and get that support and identifying where your resources are, and then coming forward with a very solid plan, very specific goals and

directions....you need to make health promotion extremely manageable, extremely concrete, because it's so abstract. We need to take that time to really think where we're going (1-14).

These last years have really been a development of the model...it was very much in its infancy, embryonic phase and needed that development, needed an opportunity to prove itself. That's why, it seemed like almost a frenzied effort, like there was so much to do at the grassroots level, trying to make an impact on the employees, so that the employees would buy into it and then you were working at both ends, the employees and management (1-9).

Health promotion is growing leaps and bounds...it just started off as this rumbling in the horizon and suddenly it becomes a storm....Some days it feels where it sometimes gets to be too much and I think that that's when you need the support...Right now I'm hiring a coordinator for a stop smoking program, I've hired two new staff people for the employees centre (1-25). There is one area that I knew we had to break through and that was at the physician level...A lot of physicians don't know how to deliver the lifestyle message (1-26). There's so much that needs to be done in this area. I think that ultimately the physician is still perceived in the system as all powerful, somewhat god-like, and if they can be the ones to drive, then I think we'll see change happening much quicker (1-28).

I really believe that the model that's created here in health promotion is one that goes beyond the hospital. I would hope that this model is a strong model and that it creates enthusiasm for similar models in other hospitals. I really see that as an obligation to the whole system...It seems that this hospital has always been looked upon as a bit of a leader, a cutting edge...and that's always in the back of my mind, that it's important to be a good model (2-17).

Commentary

Jess had worked in this particular hospital for the past consecutive 18 years. Her familiarity with the system, her established network of people within the hospital and her loyalty to the organization reflected a effective socialization into the professional health care system. Acknowledging that the hospital's primary concern was to provide acute care services, Jess struggled for two years to develop a prevention-oriented program well aware that many within the hospital were sceptical of her work, and that senior management support was minimal. The organizational mandate issue, and the resulting marginality of the program, is a consideration which arises with other practitioners as well. Alluding to an organizational context of "political storms" and issues of vested interest, Jess experienced the political nature of planning and implementation. This raises the question of supportive and non-supportive environments in which practitioners do their work.

Jess' introduction of the program, piece by piece, was in response to what she felt was the Board's "show us" stance, a challenge of proving her own professional credibility and accountability of the program. Her incremental approach to planning was complimented by her focus on "coordinating" - working with people to identify and implement various health promotion projects, and her emphasis on the importance of the amount of informal learning that went on during the process. Jess' education and experience, her traits of high energy and initiative, her personal interest in fitness, her commitment to developing a credible program for the hospital, and her belief in involving others appeared to be important factors related to the individual which influenced the building of this program.

Doug - Trinity Hospital

Trinity Hospital is the second largest teaching hospital in the province with a staff of approximately 4,000. Located in the downtown area, the hospital serves a diverse group of corporate, transient and lower income populations. About four years previous to the study, the hospital had hired a new President who was spearheading an organizational change to bring the hospital into the 1990s, and had hired a number of vice-presidents out of industry and business. Doug was a white male in his early thirties, a professional consultant with a background in education and counselling. A longtime resident of British Columbia, Doug had been hired as the Director of Wellness programs and had been in the position about two years at the time of these interviews.

Doug's Story

This all pretty much started in the time that our present CEO came to [this hospital]...he's in his fourth year now. The hospital really needed to change direction...it wasn't growing (1-11). He got an [outside consulting] group to do an analysis of the hospital and make some suggestions about areas of growth. It suggested that this hospital very badly needed to take itself beyond its walls into the communities it served. (1-12). A hospital in Toronto...had a Women's Health Promotion program that was a revenue-generator for the hospital. So our president thought that this was such a great idea that he announced the hospital would be providing the corporate community with a wellness program...and this came as quite a shock to a lot of people in the hospital (1-13).

A wellness program committee [was] developed and looked at what it could do to generate revenues. They were already offering some seminars in stress reduction and

performance, save your back, smoking cessation, nutrition and AIDS in the workplace. They would need to gross about $200,000 a year to make the program pay and to break even (1-14). They decided they needed a full-time director of wellness programs, so two years ago ...I came on in that position (1-16).

The CEO came in with a corporate model idea (1-24), his VP of finance comes from BC Tel, he has a VP of organizational development that came from the Bank of Montreal. When I was first approached about the job I said, you need somebody with a health care background. [Doug had an education background and had never worked in health.] But they were intent on getting somebody that would come at something with a different perspective. And so, for the first four months that I was here I moved about the hospital, went to different wards (2-24) learning how a health care institution runs.

I came on with the expectation that we would generate $200,000 in our first year...and continue to develop a product line, something that we could move. I was sceptical... basically, what we have here is a group of people that want to start a small business, and something like 92% of the small businesses...go down in the first year (1-16). Market research showed that it would be very hard for us to break even in the first year...and couldn't expect to break even until the third year....that was a horrible reality sandwich for the committee (1-17). I went to management committee and said, you're going to have to fund it for a couple of years (1-18). Well the bottom line was we had to find a money maker...we had to find a place to generate revenues (1-18).

So I went off to two top health screening and assessment facilities in the United States and saw how they primed and pampered big business executives (1-18). We thought this executive health screening would have great potential to generate revenues for the hospital. The problem

was that the organization had to take an initial risk. It would take about a quarter million dollars front money to set this thing up (1-19). But the hospital wouldn't take the risk....At the same time we hit a crisis on health care in BC, as an aftermath to the nurses strike (1-20). Management committee wouldn't go for it. Lots of people felt that there were greater needs around here than for the hospital to be providing programming for a bunch of corporations.

So now I'm confused. I'm brought in to be director of a program...and there seems to be a change in attitude, a change in direction on the part of the CEO. (1-17). We came to that crossroads about a year ago. So in my first year I'm trying to find a way for external survival and revenue generation. And I realize that it's not there (1-21). The Board said no we won't give you any money to make this executive health screening work, and no, we don't want to can [the wellness program].

Time showed that [the CEO's] announcement in that way [at a corporate breakfast without discussing it first with his Management Committee] worked against success of the program. He did not communicate and discuss this with his hospital management committee. Not even his VPs knew that he was going to make this announcement (1-13). [They weren't] used to working in a culture where the big guy goes out and makes an announcement and then comes back and says: OK, ...now you guys produce" (1-17). The VPs were trying by their actions to communicate something to the CEO, that that's not the way you do business with us. And the wellness program became one of two or three issues that they wanted to make that point with (1-18).

This is where I really realized I could have gone into that group with any proposal and it wouldn't have gotten by that group because of the way the whole concept was initially introduced. And there was group dynamics going on within that administrative group (1-20). I think I felt

disappointed that the hospital wouldn't take the risk on health screening and assessment. I think it would have opened a lot of doors (3-7). I think that they lost a tremendous opportunity by not taking that risk (2-4).

[After the nurses' strike in 1989] one of the themes that seemed to come up again and again, was that the hospital didn't do anything for the personal well-being of the nurses (2-14). So with some investigating within our own organization, I decided we needed to go internal (1-21). So I went back to the board and I laid out a strategy for developing an internal program. I [thought] it would be a good idea if we ran a task force, we're looking for information and we're not bound by it. I sold that unanimously to Management Committee. It was a pushover to get (2-31).

I got together a group of lay people who understood their departments well, were respected...communicated well on the wards...and formed a task force (1-22). We ran that task force for three months, September, October, November...we had probably a dozen people. So we just broke into teams of two and ran around [the hospital] to different departments, employee groups, staff meetings and did basically a short survey, asked open-ended questions that would generate dialogue about what people felt they needed (2-15).

We got suggestions of 121 things. Very clearly, the hospital needed something in the area of stress reduction...something in the area of fitness and exercise...and something in terms of nutrition. So that was our goal, to provide programming in at least those three areas, and because we had the other programs developed and up and running, we threw them in. And so in January we started with the Staff personal health program (1-23). The Staff Personal Health Committee runs the quarterly calendar [outlining the activities] (2-15).

It's great to have the wellness program but the real place for things like staff personal health program - that's a personnel issue and should be done through a human resources function. So I have slowly over the last few months, begun to transfer those programs into our human resources functions...it dovetails nicely with ...staff education, staff training and development and staff enhancement (1-24).

So it's been a really interesting sequence and evolution. We are coming now to a crossroads. We've got this staff personal health program fairly well-established. Where do we go? What do we do? (1-24). I also recommended about a year ago that they didn't need a full-time director, that there was a way to do this that would be a lot cheaper...so in essence I was recommending that they can me...so I stopped being a fulltime employee and I became a [part-time] consultant to the hospital two days ago (1-25).

Commentary

Doug's familiarity with the organizational context was minimal. Unlike Jess, Doug recognized the need to orient himself to a new working environment. With a background in education, he had little knowledge of the health care system, the operation of an acute care hospital or the field of health promotion. Further, he was a new employee and needed time initially to understand the hospital setting, and do the necessary networking and building of contacts. However, similar to Jess, the issue of organizational mandate and the lack of fit of a prevention program in a tertiary care setting was evident to Doug.

Bringing in practitioners not trained in the health care field, with little personal of health promotion appears to have an impact on planning programs. His personal interest in entrepreneurial activities, and professional identity as a consultant/expert influenced his approach

to his task, which was to provide services to senior management. Initially this entailed the implementation of a revenue generating wellness program to the community. When senior management changed its mind and chose not to pursue profit-making ventures in the community, Doug assisted them to regroup and come up a viable alternative, an internal employee wellness program. Doug did the research, provided the information in position papers, but senior management made the decision. This situation speaks to notions of power and decision-making, and potential roles and strategies taken by the practitioner, who was driven more by pragmatics than by personal commitment to health promotion.

Gail - Sunnyview Hospital

Sunnyview Hospital is located in a smaller urban centre and serves a growing community of about 58,000. The community is increasingly comprised of retirees as well as young families. Because of the seniors' population, the hospital is overcrowded, and the Board believed that an off site prevention program would lessen the burden on the hospital. The Board supported the community-based Wellness Program and provided funds for the start of a diabetic education clinic which was to be the starting catalyst for the Wellness Centre. The Vice-President of Nursing who was also the acting CEO of the Hospital had written the initial proposal for the Centre, and was personally invested in its development. Gail was a white woman in her early fifties, a nurse who had been in a small rural hospital when she had the opportunity to become the Coordinator of the Wellness Centre of Sunnyview Hospital in the fall of 1990. Her interest in wellness, particularly for women was longstanding ranging back to her student days in the 1970s. Gail had been in the position for about 13 months at the time of the interviews.

Gail's Story

In between these careers [of teaching and nursing] and my personal life, I think that's when the seed was planted, that I began to realize this tremendous need particularly for women's health. I carried that little curl with me all through the 70s and into the early 80s....[While doing my Masters] my classmates and I spent hours and hours talking about what could we do to promote health and wellness (1-2). We pondered this need for a centre of some kind...where we were going to really look at women,..because we were women caring for women, we believed that women had been neglected for so long and their needs unmet (1-3).

When the VP of patient care services of Sunnyview Hospital and I had our initial interview back in May, and I told her what my dreams were,...well you could see the lights turning on...because I think she was looking for somebody who had that belief as well. And the fit was so right, it was just ordained (1-23). The Board is committed to community outreach programs. There 's some prestige connected to a hospital that has a Wellness Centre and has community outreach programs. because it's very visionary...[That's] the way that health care is going (2-1). The hospital board was... very strong in the selection of the name, and wanted it to be called the Wellness Centre (2-2). The Wellness Centre is a multidisciplinary driven, rather than nurse-driven and it is supported by the hospital and the board (1-23).

You must appreciate the number of meetings and the process of getting an advisory committee together who's going to sit on it, what were the appropriate positions, who would be supportive? And that was probably the key to the success of this venture, is the supportive people around it....the Vice-President of patient care, the Director of nursing, the lab, maintenance people, physicians, the medical community...the hospital staff and the community itself (1-6). And the beauty is that because we're so single-minded or focused, our focus is the same, our

philosophy is the same, the statements developed by the advisory committee..we all feel the same way, have the same beliefs. Therefore the advisory committee really is in agreement (2-15).

The spring and summer [of my first year] were spent in renovating an old fish market in a nearby shopping plaza which was to become the off site Wellness Centre. From September to December was the diabetic education program. [The decision was already made by the Board to offer this]. It's really since January [1991] the Wellness program got started. We [the advisory committee] developed timelines for the Wellness Centre, we look at our philosophy and our mandate, who and what we are, who are we going to serve, how are we going to do it , what do we believe - we developed that in December and January.

In February and March...was our networking [with] groups and agencies. During the fall and winter I spoke probably once a week. I went out and bought myself a power-suit. Navy with gold buttons, just a power suit...a Dior...I went out to whoever called me...and spoke about the Wellness Centre. The connections with all these health providing agencies...has been wonderful.

In March and April...we looked at a quick and easy program with guaranteed success: a foot care program (1-10). What's our next step after the foot care program? What are the programs we want to offer - once again I borrowed from the Women's Resource Centre [in Calgary] ...so the next three programs we're looking at are breast health, menopause, and a nutritional program - three at the same time (1-12). Our next step on the advisory committee is the continuation of the fall programming. What we want to do is rotate [the programs] through, use a rotating timetable...which offers them repeated...like a calendar (1-18).

We needed to short cut that process [of needs assessment]. I sit on the seniors' planning committee...a proactive group in town, multidisciplinary, crosses all boundaries ...and we look at what are the needs of the seniors in the community. The Wellness Centre's an educational

resource centre, with a very small treatment modality (1-10). There are people in the hospital who sit on various committees and give me information (e.g. Canadian Cancer Society, CNIB). That's another example of how a needs assessment is done at this committee level.

The other component of the Wellness Centre is the volunteer component...they do a tremendous amount of legwork for the programs, booking patients, answering the telephone, directing traffic, making tea and coffee, some bits of paperwork for me. There again, it wouldn't exist without them...All these (volunteer) people were just desperate to work at the Wellness Centre because it's a nice job...they enjoy it...it's high profile and is out of the hospital setting (1-19).

The bumps [in the process]... The major bump was the lack of support services - actual support services, the secretarial support services....and that continues to be a bump. I had to do minutes...a lot of that kind of clerical sort of things that were very time consuming and very hard for one secretary who does all the typing for almost all the nursing department. She probably put in 400 hours in getting the Wellness Centre going.

Another problem was the development of the forms for the diabetic education program, time consuming, challenging, frustrating they've all been redone three or four or five times (1-13). Also, the building is too small (1-14)...and making arrangements about doing the lab work (3-6). The other frustrating thing was finding a physician for my Wellness Advisory Committee. I need some advice from a physician. I don't know how I'm going to get over that because I must have asked five or six times now and I'm not getting anywhere. And I don't want to think that I'm being sabotaged, but I do have concerns (1-14).

What is going to be difficult for me because it's new is advertising the Wellness Centre. How am I going to do that? How do I get the people to come? So I have to get the message out.

The best way is to highlight it in the community news, the second thing is to put it on the TV, and the third thing I'll do is I'm going to do a TV presentation...not myself, but I think some of my staff. Advertising always has been very foremost in my mind - how to get the message out? (1-23).

Down the road our dream is to offer sort of a one-stop shopping on health care (2-6)...that the Wellness Centre will be self-supporting (2-16). I have visions, I have a dream that the Wellness Centre will be in a home, in a house...in a country style kitchen, there will be tea and coffee available, but it will be very informal, that we will have a library, a reading room and that we will have a very special sanctuary for women...I always keep it focused that this is an education resource centre (2-24).

I believe the whole thing is directed, I have a guardian angel on each shoulder. And without wanting to sound too immodest, I believe I have the personality for it, and the tools which is my higher education, and the support and the energy. When I talk about the Wellness Centre, it is the happiest part of my life. I think it's my belief that just makes things happen, and it's true, that old adage, that if you believe in it, strong enough, it will happen. It's true! You're looking at it. I'm a very ordinary person from a little mining town...who had a dream (2-21).

Commentary

Although Gail was new to this particular hospital and this province, she experienced a smooth entry into a relatively supportive organization. Her own long term vision and commitment to health promotion as individual lifestyle education meshed well with the hospital's plans for an offsite wellness centre, therefore, the issue of the fit of program to mandate was not an issue. This coupled with her training and experience with hospitals made an orientation to the health care

system unnecessary. Planning within the hospital setting was not problematic because of the support of senior management who had already made the commitment and allocated the dollars for the program. Rather than an internal focus on organizational context or politics, Gail's main concerns focused on selling the Centre's programs to the community and determining how she would go about this.

Gail appeared to take a very pragmatic approach to determining her priorities and her activities - using others' research and experience to make program decisions for the Wellness Centre. While involving others, she had the necessary authority and made the day-to-day decisions about the operation of the Centre: which programs to offer, who to hire, which community needs to address. The impression one is left with, is that while acknowledging the support from the hospital management, colleagues and the community, the Wellness Centre is Gail's personal triumph. This speaks to practitioner perception of personal power, authority and autonomy in decision-making and raises questions about the factors that would create this type of situation.

Nina - Mount Royal Health Department

The Mount Royal Health Department serves three municipalities in a wealthy area of the Lower Mainland. The Medical Health Officer was recently appointed from another province, and very active at the national level in the Heart Health Campaign. He envisioned major changes for his organization and promoted the position of Director of Health Promotion as the catalyst for this change. Nina was a white woman in her early thirties, with a Ph.D in interdisciplinary health studies. Coming from a background in research, university teaching and working with community seniors in eastern Canada, Nina joined the Mount Royal Health Department as Director of Health Promotion. This Health Department was located just outside the downtown area, in a wealthy

section of Lower Mainland. Nina had been in the position about 22 months at the time of the interviews.

Nina's Story

I was hired not quite two years ago. The medical health officer wanted to create a responsibility centre for health promotion within the organization (1-2). I have three areas [of responsibility]: one deals with my responsibility of overall health goals and information on health status, the other one is the community empowerment, working with the community, and the third is the community within in the sense of skill development and leadership....So that everybody [in the health department] does health promotion. I [also] have responsibility for strategic planning for the department,...forecasting, future scanning, trends analysis....I'm very conscious of providing that role to our organization (3-18). I've always worked in a fairly visionary mode (1-10)...and you don't have many visionaries in the health unit (1-22).

When I first came I had an office that was a closet, [now has a spacious office overlooking the harbour] and I didn't have any furniture because I had a new job that no one else had done, and I had two staff that already had been seconded....I had people who had a very fixed idea of what they thought they would be doing...they all thought they were going to be working on heart disease prevention. I kept saying, "I don't think the way to improve the health of the community is organ by organ."

Right now I've got a full-time nutritionist, another FTE on different projects, an MSW student, and another masters student doing publicity...with a community task force on substance abuse (1-14). So if I have 5-6 staff to manage and to make sure they follow the principles and

strategies, then I don't have any time left to do my projects...that's [the] reality of what I'm doing or learning to do.

In my mind...there's definitely a distinction between start-up in the first year [and implementation]: just being here, getting to know the department, and the community and not getting lost every time you go to a meeting...and the first real year of constructing the budget to then operate from (2-55). Because the work is process work, the primary focus was to get out ..and sort of suss out the network service of providers, municipal planners, acute care providers, community service providers, nonprofit, recreation (2-6).

So [in the first year] everything is health...and you need to work on everything (1-19)...and therefore nothing gets done....And the first year I probably worked myself out into major exhaustion, but I had to. I had to ...just respond. I think you can only take on two or three of them in terms of project management skills (1-22). [This year] three things for me are...substance abuse, seniors health network, and the dementia study (2-14). There's more than enough work to be done, so there's no point in working yourself into a complete lather. You might as well be selective and professional (2-8). Being pregnant, you suddenly have this sense that life is going to get more complicated, so therefore....you are just looking everywhere to streamline things (2-14).

So we're more into an implementation phase [in the second year]..but yet there are still start-up things to confirm...for example, the two staff people wanting job reclassification because everyone is doing different jobs..that to me is still part of start-up. But maybe it's no different from that cycle... where you write down what you think you're doing, you go out and do it, and then you reflect on that doingness and then you revise what is it you think you're doing, and then you start again (2-2).

And in an organization there is definitely an annual cycle...for me summer is a very busy time because of students, summer projects coming in....There's always research grants due in September and then there's the organizational cycle around the budget... in November....The other cycle in mind is that I told myself when I started this job that I would give it five years...so there is that 'don't expect too much too soon' and be willing to invest that kind for time into defining what it is (2-2).

We have a couple of studies going on right now...one is a needs assessment of caregivers, family members with dementia...I was used to managing the project ...but what I recognized is that I had to work from a management strategy which was more of a coach, and less of a leader (1-7) and letting other people take over leadership. If your sense of self has always been defined within the organization in terms of successful projects done...then it's hard to switch to being someone invisible in all of that. But that's a principle which we support each to do (1-17).

Now we're doing some focus groups... we're going with the community health nurses where the new mothers love the groups because they got to sit in groups of 8 and 10 and talk about what happened to them after the birth and the first three months (3-12). We do a lot of what I would call secretariat function [for community groups] we do the minutes and distribute them...we do posters...we have a desktop publishing.

I was co-chairman of a community task force on substance abuse...the dilemma I have is I work with three municipalities, so there's three city councils and six social planners...and we put together a healthy communities project which was turned down which was very frustrating. I think there was a certain amount of politicking involved, and when you hear about political stuff, you always feel helpless (1-17). We had such trouble with "healthy communities"...because of the relative tensions of social planners and physical planners and politicians (2-7).

You do these forays and then you do these retreats among the people (2-7). Last summer we developed a community health profile...so it was a foray to work on this project and develop it and distribute it. And the retreat has been to reflect on that and think about how we're going to do it again or how people are using it...Basically we left it to see what people would use...to see what would happen with the field and what other resources would become available (3-2).

It's a very old organization...old in terms of average age of the staff. Therefore, reasonably calcified....The part that's difficult in traditional health units is...people haven't been driven by information.They've been driven by what they did last year, plus 5%...so it's an issue of becoming a 21st century organization (1-3). I also know that there's this whole other agenda around health literacy and health issues (1-22). I think within the organization, we're on our way. I just did a paper on top ten trends in health care from the futures conference [I attended last summer], and I think people need to be aware of planning based on what is in the future instead ..of what's in the past (1-8).

In the community...it's a little bit different. You have to develop a literacy among the community as to what health is, what are the things that influence health (1-8). I'm thinking of inequities in the sense of poverty and education....Everyone just thinks if people would stop smoking...everyone would be happier (2-9). If people began to understand the issues around funding...basic principles and values, and what choices we are making right now....The literacy we're hoping to do in discussion groups, the vision I have is one of the study circles, along the Swedish model (2-10)...[but] the barriers have really been this tri-municipality environment...the territoriality around who gets to do what within the community.

Every six months [our own] staff have a retreat...and reflect on where we are (2-7). We met in January and [decided to do] three inequities projects: one with teens, one with seniors and

one with the Native Band. We wanted to do more work with the Native Bands in this area....The Chief wanted to create something that is strengthening people's sense of culture acknowledging that traditional foods are positive foods...and they decided on this Healing Feast business [this summer]. We had a wonderful time in that relationship (2-18).

With the teens...I didn't take into account that my criteria for a process for delivering program was different from the criteria of the service providers [the sponsoring organization]... [They felt] that you mustn't ask the teens to do too much because they are abused kids...But we asked the teens what would you do that would be fun, would make you feel better and enhance your health? And they came up with the make-over night and some dinners, and the things they want to do. So, it was really successful from their perspective...I wasn't there to provide the services and make food for the teens....We were there to help them get involved in cooking for each other, and if they were going..to a restaurant, they were going to earn the money with a bake sale (2-8). So we ran into real conflict ....because we hadn't aligned with the values and principles of the [sponsoring] organization (2-18).

Like in an evolving field ...you have to try these things, otherwise, you go nowhere. What I did last year won't be the same as what we're doing now won't be the same as what we're going in five years...the issue is you learn by doing. You don't learn by never going in the water (3-2). As we talk , it's quite interesting...you're pretty much on your own....it's very much up to the organization that's fostering or sponsoring the activity. There's not a lot of more lateral support to reflect on different roles and responsibilities. It's a double edged word. On the one hand it allows you to do what you want, on the other hand you are doing what you want on your own (2-4)

I guess the thing for me is [health promotion] is evolving,...it's kind of iterative. It's a loop, you start with defining it, then you go out and do it, and then every once in awhile you think, gee

I'd better return to defining it to make sure what I'm doing is still reflective of how the definition is (1-4).

Commentary

Similar to Gail's experience, the health department had shown tangible organizational support for Nina, creating a management position and allocating staff and a program budget. Unlike the previous hospital practitioners, health departments carry a prevention oriented mandate, therefore, for Nina, organizational mandate and program were congruent. What Nina's story does exemplify is the complexity of organizational level planning and the importance of the political nature of the planning environment. In her situation, Nina had to deal with not only the usual internal organizational challenges but the accountability to three municipal governments as well. Nina faced competing priorities from different interest groups, which at times was at odds with her own personal commitment to health promotion from a community development perspective.

Nina also held a very strong vision of what the nature and purpose of health promotion was and she believed it was her responsibility to help the "calcified" organization to learn, to improve its "health literacy." Thus, the concept itself was a key influence in Nina's formulation of her roles and strategies. Nina was the only practitioner with staff and a budget to administer, and sat at senior management as the strategic planner for the organization as well as responsibility for the Health Promotion program. This situation introduces the concept of power and influence in the practitioner's position within an organization which warrants further discussion.

Kathy - Glendale Health Department

The Glendale Health Department was located in a suburban area in Lower Mainland. The municipal government office is co-located on the site, which fosters frequent interaction between the "hall" and the health department. The Medical Officer of Health had been in that position for many years, and was close to retirement. The health department was also in the process of undergoing an organizational review and a strategic planning exercise when the health promotion position was introduced to the organization. Kathy was a white woman in her early thirties, a public health nurse who had worked in a number of rural and northern communities across Canada. She had been working as the Director of Education of the Heart and Stroke Foundation, a community based organization in Manitoba, when she moved to B.C. to take on the new position of Director of Health Promotion for the Glendale Health Department and had been in that position for 9 months at the time of the interviews.

Kathy's Story

On my first day on the job, I went around to all of the health department directors to find out what they thought health promotion was all about. And what they thought I was going to be doing. And I didn't get the same answer twice (1-8). I did spend the first six months trying to get to know the three levels: the municipal hall, the health department and the community, from the perspective of their composition and the issues that are key at the moment. I went to every meeting I could find just to find out what people were doing and let them know that I was here and what I might be able to do (1-7).

So here within the department, I've been doing some education...assist the staff in the development of programs, and particularly education materials (1-9). In the municipal hall I've

been involved in an employee wellness committee, in the clean air committee...also worked on the healthy communities project...and then in the community I've been working with an inter-agency group of people who do programming for seniors. I'm working on the family violence task force....I also work with five community schools and whatever the projects are that they're dealing with...one specific project is fetal alcohol syndrome (1-9). Initially when you're starting off, it would be like the (Fuller Brush) sales person, where you find every opportunity to sell your project, to figure out some way to get your foot in the door...In the first few months I was "meetinged" to death....just so I had some visibility and I was selling a product and that product was health promotion (2-21).

I didn't realize til about four months later ...there was no planned direction. I had a grasp of the community and I had a grasp of some of the issues and so I went to a senior management meeting ...and [said] these are the issues that I feel are crucial. I need some direction of what priorities you wish me to establish. It was at that point that I discovered there wasn't any direction (2-2). I tried to get the senior management of the health department to go through a strategic planning exercise but they weren't prepared to do that, so I had to identify some areas and encourage them to choose one (1-11). They have agreed to support a priority of heart health, but not with resources or funding, so I do have a project...to look at a heart health action plan using a public forum process (1-10). I personally don't feel that heart health was the most crucial issue but [agreed to take it on] because I really think I have to prove myself, and so it would be better to prove myself with a program that at least I knew something about, rather than an area that I was totally green in (1-12).

When I was hired for the job I was under the impression that these developmental stages had already been gone through, that it was part of the mission of the health department and that

they had already addressed how they were going to incorporate health promotion and change their focus, and that the education, the training of staff would be my responsibility, and then the application of the concepts. But the first two bits haven't occurred yet (1-15).

[I was] a department of one. The disadvantage is that you have no back up resources. So just the process of getting a set of minutes out means that you word process, you copy them, you fold, them, you address the envelopes and you mail them (2-5). People...tend to kind of forget that I'm here....There's a limit to how much you can do effectively. So you're a little bit invisible when you are a department of one. Although sometimes that's an advantage...gives me freedom to go off and do a number of different things (2-6). As a department of one, I have very little budget, so I don't have a lot of leverage...I don't have a power base (2-7).

I still haven't worked out a way of interacting with senior management as an equal because they don't know what I do, and they don't know what health promotion is. Communication with senior management is crucial, I have to tell them what I'm doing and how I'm doing it. They don't want to have any part in it, because they don't have extra staff hours and they don't have extra money, but by the same token they don't want things happening - it's very territorial, they don't want things happening in their territory they don't know about in advance (1-13).

Because there is no clear definition of what health promotion is and no specific directions I get asked to do all sorts of things. When you can't figure out whose suppose to do it, give it to Kathy (2-12). [For example,] when you have objectives, specific objectives, when somebody comes in with one of these off the wall requests, you can say, fine, can you just tell me where it fits into the objectives that we have agreed on...you have some kind of slot to put things in. When you don't have a plan...there isn't a rationale for saying this doesn't fit (2-14).

I guess I'm a process-oriented person. I would like to see some kind of definite steps that the health department was going to go through in order to reach nirvana at the end which was health promotion integrated into the traditional services of the health department (1-14). I'd like to see it a bit tidier. Ideally I would like to see that all of us work together, that I'm part of senior management...that senior management as a team looks at health promotion. But I'm beginning to understand...while they are vaguely aware of what each other does, they don't work as a team...So in the reality of the situation, my idea of idealism ...where we all work together, doesn't work. If there's going to be any kind of tidy organization to this, I'm going to have to do it on my own and... work as an autonomous unit (1-16). I will report back through senior management and to the various nursing groups or departments or programs that what I'm doing has implications with. And I seek advice from those groups before I start and try and make sure I'm not stepping on anybody's toes, because there is a territoriality that you have to be careful of. But then I would go ahead with it (2-21).

I guess now I'm at kind of the 'prove' stage: okay we know what you do, now do something..so I've been working with a number of different projects in the various of those three levels [health department, municipality, community]. Right now...I do a lot of solid line interaction with a whole bunch of different groups. And they're all at various stages (1-8)...so I plan and develop different groups differently (2-10). Demonstration is key to the 'prove' stage. I keep thinking if I can...demonstrate some aspect of health promotion by doing this, maybe that helps the staff understand better what the concepts are (2-14). Those demonstrations (eg. helping a group learn how to chair and run a meeting) are constantly needed to get started...I think they're going to be needed in-house too, until I have a project that has grown, and I can demonstrate how the project works in the health promotion mode. That's going to be the best way of selling the

idea of health promotion within the house. So ideally that's going to be the Heart Health project (2-23).

We're a long ways from having incorporated health promotion concepts into our daily activities....And that's a process that I think is going to take about two years (1-4). We're looking at a 3-5 year commitment before we see any change occurring (3-10). I don't see (a plan) coming about... not as a department. Maybe I was just a bit eager at the beginning...trying to get them [to see me] in management or get the health department to provide some direction. And that may have been unrealistic on my part. That would have been ideal, it would have made the last seven months a lot less frustrating (2-19). I must admit...there are been many times where I just thought it was not worth the effort fighting the system and that I should look for another job. I'm on an upswing right at the moment... everything's looking better...good people to work with and that's been a real boon (1-23).

Commentary

Kathy entered into an organization where there was little commitment or interest in developing a health promotion program. Where Nina carried formal status and authority, Kathy faced an organizational context in which she felt powerless, particularly as she was a one-person department, with no additional staff or resources to do her job. Kathy's dilemma was made even more difficult by what she viewed as a lack of understanding of the concept of health promotion, and unwillingness of her colleagues to try and work out an agreed upon definition. This organizational context was further characterized by issues of "territoriality" and the traditional approach of being the expert to the community, rather than working with the community.

Having been a community nurse in rural areas, Kathy had expectations of people working together. Unable to make progress within the organization, she focused externally on community groups, with the aim of building her own reputation and credibility as a resource person. Her experience raises questions of what planning can be done given no clear mandate, resources or operational definition of the program. The roles and responsibilities, and the strategies and actions she took on vis-a-vis senior management, her colleagues and the community are interesting areas to examine given the low level of organizational support for the health promotion program.

Susan - Bridgestone Health Unit

The Bridgestone Health Unit was one of four large units comprising the urban Health Department. The Unit had about 120 staff serving a population of approximately 115,000-120,000 within its geographical boundaries. The Director of the Unit, Jim, wanted to shift the staff focus from the traditional one-on-one clinical generalist model to health promotion. Therefore, rather than hire a specific Director of Health Promotion to run a program, he set up a special project, called Focused Nursing Implementation, which focused on changing attitudes of all nursing staff. He brought in Susan, whom he had worked with several years earlier, to plan and implement the project. Susan was a white woman in her late forties, a nurse with a background in community health who was a long time resident of B.C. With a strong commitment to community development, she joined this Health Department to take help the health department shift to a health promotion orientation in service and had been in the position about 7 months at the time of the interviews. Susan formally reported to the Director of Nursing, Liz although Susan and Jim maintained a strong informal friendship.

Susan's Story

[Working with Jim previously in the early 1980s] I was organizing support services for the frail elderly ...for about five years in Vancouver (3-17). But the elderly said they [didn't] want any more care services, they wanted some kind of prevention program....So I just sat down with the older people, and [said], what kind of program do you want? And we wrote a proposal....[They took their proposal] to the city council committee of seniors ...and the Mayor at that time was Mike Harcourt, and the council [approved] for four new positions and they called it Seniors Wellness...back in 1984 (3-18).

Jim and I have the same kind of belief system (2-31). We basically believe that people have abilities to do these things for themselves, if you give them a framework to work with (3-18). [The Seniors Wellness proposal] really had a lot more to do with...mutual aid and self help, and citizen participation....About '86 I left this unit, went to another health unit and developed the program there. And I stayed over there until now. And Jim basically said "Susan, you have to come back to this unit! Help me put this thing (Focused Nursing Project) together....He was so desperate to try and change the practice [of his health unit] (1-18)...to move the nurses from a one to one focus, with the professional as expert...to a focus where there is more of a health promotion focus, working collectively (1-5)...so I came back last January.

The staff here have done a certain kind of program for twenty-five years and no one has really...examined what it is about and whether it has any merit (1-1). My definition of health promotion...is maintaining, or increasing people's sense of control over their work [lives].... people feeling that they have options and choices (1-13). I've argued that we should be doing community development and health promotion inside. We couldn't expect nurses to take a health promotion approach if they hadn't had that inside the Health Department (1-10).

My job is to come in and work with staff, to get them to look at...what they see the factors are that are contributing to the health (2-3). I designed the process for all 22 nurses....It was basically my design to say how we can shift their thinking and help them move from...this one to one profession in charge...to move into seeing the power of more self help, social support groups (1-6) I gave the process to the other two staff supervisors....I take the children's group [of 9 nurses]....Danielle takes the nurses who are working with adults [7] nurses. Louise is taking the youth group [6 nurses]. I take the children's group. We meet twice a week...for a couple of hours. We worked once a week from April and then with the summer, when they have a break, they are not in schools and they've got less a workload, we're meeting for four to six hours a week.

So I started the process by saying to them "let's start back at the beginning and let's look at what our job is" and they say that our job is to support the development of healthy children. Then what issues affect the health of children? And then I ask them to go to the library and look at what is the latest research on these factors. Then they all brought their searches back and through a process of looking at children [they discovered the importance] of the development of self esteem. And then they came down to four or five major factors influencing the development of self esteem, and the factor that was of great concern in this health unit, because we have very well educated high income earners [in this catchment area], was the kind of expectations parents made on their children....So from the health nurses; point of view, they went through a process...what we really have to look at in children up to the age of 12 is the development of self esteem and the factors that negatively impact or positively support self esteem, and a key issue in this specific health unit would be expectations, overprogram[ming] children (2-3).

So they worked through and they looked at all the issues...at the same time I had them looking at all the activities they do, in the schools, in any way that they worked with children, in

preschool, parent groups, and take every activity and say, does it do anything for the health of these children? And if it's an important activity, why we think it's important and why we would continue it (1-4).Through the process, they now have gone through for six months, they've realized that maybe they don't know all of the things that are important to children, and secondly they certainly don't know what parents want done or what teachers think are important, and they don't have any idea what children think are important to their health. Now they've come up with the idea of developing a survey and some kind of focus groups to go out and ask children, parents, and teachers what the major health issues are (1-4), and what kind of activities they [the nurses] should be involved in (1-5). Second, they gave up a number of things they've done traditionally, thirdly, they are going to develop on the computer sort of a library of resources...on information to parents about vision, hearing....and they could be putting them into newsletters (1-8).

I thought [the process] would take about six months. I've pushed it. I also wanted them to work together two to four hours because they now have a very cohesive group. And now they recognize one another's strengths and weaknesses. They know one another a lot better (1-9). So I was also working at...developing a group and helping them learn to reach consensus and so the process was modelling a number of things...I wanted them to learn negotiating skills (2-13).

You can put down a process, but I have done community development work and my one skill is fairly good facilitator, so my group is farther ahead than the other two because the other two are following it sort of in a linear fashion and I'm setting it up on a circular fashion (1-10). You want them to reflect on and then work through the information and reflect, so it goes back and forth. And you can see the pull, and sometimes there's real tension, and then my job is then to

reduce that, to try to bring it around so that everyone really has something to say, and all of their things are worthwhile (2-15).

Staff designed their space...they came in, changed their space because they decided they want it different. Then they, [Liz, Director of Nursing and a clerk] came in and changed it back] because these two people decided that it didn't make any difference (2-1). I lose it right there....they can't see that the bureaucracy and institutions have institutionalized their staff, and that as long as you keep taking these decisions away from the staff, why would you expect that they would go out and perform differently in communities because they don't know how (2-2). So I go back down to the staff...and say is there any negotiating in this? (2-1)...and they agreed to [three] possible options and management and they did negotiate...But it's the hardest part of working here.

I set the framework up but I don't control their thinking....We had 20, 25, 30 schools...usually the supervisor assigned the nurse...to the schools. I put all of the names of the schools out and the hours that we have to give them and said...OK now who is going to these schools? They said, no you assign them (1-10). I said no, first let's have some criteria about what pot of schools would look like, then we developed the criteria...so they organized their own school assignments...They have to be allowed to make all the decisions they can within their workplace (1-11) if we expect that they're going to go and work with citizens and let citizens make decisions.

So now you have a working group...I've done most of this work in June and July. I could just leave them to run the group themselves (2-14). By September I hope that they will go back into the schools with a new way of thinking. My hope is that eventually at the end of another

couple of years, the school program will be made up of a number of different kind of groups for parents, for teachers and for children around issues that they think are important (1-9).

Commentary

Susan was very familiar with the work environment having returned to the health department in which she had worked some years earlier. Therefore, she made fairly strong comments about an organizational context that continued to promote the traditional hierarchial and bureaucratic structure. The Director was personally committed to the health promotion concept, and had encouraged Susan to return to the organization to take on the position. Susan's long time experience with community health, working with disenfranchised groups and her commitment to an empowerment approach to health promotion were key influences in how she approached her job. She held a vision of changing the organization's way of doing business from the expert model to a more community development approach, where community groups examined the choices, set their priorities and made decisions affecting their lives. Helping the nurses to experience empowerment first was crucial to changing their approach when they went out to work with the community.

Susan's challenges were mainly internal: how to gain collegial support in what she viewed as a hierarchical, rigid bureaucratic system that wanted to control staff. Thus, her roles and actions were affected by her goal of setting up a process in which nurses could gain greater control over their work environment. Susan's story emphasized process, which is contrary to the task and product oriented nature of conventional planning models. It may be viewed as a case where experiential involvement of empowerment and buy-in from colleagues are the main reasons for the planning activity.

Summary

The six practitioners each told a unique story of the development of the health or wellness program in their respective organization. Embedded in their stories is valuable practitioner knowledge (Argyris, 1982; Eisner, 1991). In reviewing the individual practitioner's context and account, a number of themes emerged related to the planning experience. These themes included a consideration of practitioner background and training, different views of the concept of health promotion, the factors which influenced practice, and the roles and responsibilities, strategies and actions--and will be examined in greater depth in the following chapter.

Practitioners brought a range of education and training to this planning experience. Some came to the job with extensive knowledge and background with health care organizations, be it in hospitals (Gail, Jess) or health departments (Susan) while others were relatively new to the organizational context (Nina, Kathy). One practitioner was not at all familiar with the area of health care, nor health care organizations (Doug). Related to their differing backgrounds was also the unique configuration of values, beliefs and attitudes of each practitioner; as well, they varied in length of time in the position from seven to 22 months .Thus, individual profile and background influenced how they oriented themselves to and interpreted their working environment.

Another important influence on the planning was the varying views of health promotion and their familiarity with the literature and other current activities in the field. The hospital practitioners (Jess, Doug and Gail) all understood health promotion as essentially wellness, healthier lifestyle education and choices; although Doug and Gail represented two ends of the continuum with regard to knowledge with Doug dealing with this concept for the first time while Gail has been steeping herself in the field for over a decade. Whereas, the health department

practitioners (Nina, Kathy, Susan) tended to a view of health promotion as encompassing a community development, empowerment approach; again with Susan having practiced the concept for many years and Nina and Kathy with less direct experience.

With regard to organizational context, two types of health care organizations were included in this study: hospitals and health departments. Hospitals are mandated to provide tertiary acute care services, while health departments are to provide more community oriented prevention programs. Organizational mandate and its fit or lack of fit with the program was a consideration in the planning. Practitioners also paid attention to the certain aspects of the organization context which they saw as affecting their work such as the direction and commitment of senior management to the program, and collegial interest and involvement in the planning. Chapter V explores these themes further to establish the key findings of the study.

CHAPTER V

FINDINGS

In Chapter IV practitioners recounted their unique stories of planning a health promotion program. These accounts revealed a number of concepts and themes relevant to planning in the non-formal educational organizational context. In Chapter V the key findings of the study are presented in some detail to provide the necessary grounding and documentation to allow for a more analytical interpretation of the findings which will follow in Chapter VI.

To reset the stage for the discussion of the findings, I draw the reader back to the initial intent of the study: to broaden our understanding of planning in practice from the people who do it. This focus on the practitioner reflects a belief in "knowledge based in experience" (Eisner, 1991) and supports the need to understand planning "as seen through the planner's eyes" (Forester, 1993, p. 18). Chapter V begins with a presentation of the findings from the practitioner interviews. The findings are grouped in three thematic areas which are interrelated in practice but presented separately for clarity.

- *Language of practice*: Practitioner metaphors and language portray a conception of practice as an action-oriented, iterative activity distinguishing it from a theoretical view of planning as a "thinking" stage prior to implementation.
- *Factors influencing practice*: Practitioners identify three key factors within the organizational context that affect the planning of the program: the understanding of the health promotion concept, senior management commitment, and the involvement of colleagues.

- *Professional performance*: Practitioners identified a myriad of roles and responsibilities, strategies and actions consistent with the view of planning as a social communicative interaction directed to the people work of practice.

Second Order Interpretation

An interpretivist inquirer who seeks to reconstruct others' sense of meaning will inevitably reflect some of her own values (Greene, 1990). Thus, what may be considered a first-order perspective of inquiry, a description of "the so-called facts of a study which never speak for themselves" are, in fact, interpretations by the researcher. A second-order analysis involves concepts which are the notions used by the researcher to explain the patterning of the first-order concepts. "Thus the 'facts' one discovers are already the products of many levels of interpretation" (van Manen, 1979, pp. 39-40).

Within this second-order interpretation, a further distinction is made between the "field text" and "researcher text", acknowledging that "all field texts are selectively chosen from field experience" (Clandini & Connelly, 1994, p. 415) by the researcher. Aware that any number of interpretations are possible depending on the researcher texts selected, the findings discussed in this chapter represent *a* set, not *the* set of constructions on planning. A brief self-reflection on my background and interests may assist the reader in better understanding the selection and analysis of the researcher text (Patton, 1990). With a professional background in social work and education, I have maintained a longtime interest in social issues such as racism, family violence, poverty and a recognition of the systemic structures of inequity which underlie these issues. Both professional disciplines also emphasize the importance of interpersonal and communication skills

as people interact to address such community problems and target social change. Thus, this orientation may serve to explain the attention paid to practitioner comments the interpersonal communicative aspects of planning and a sympathy towards community development as an approach to social change. However, while acknowledging these predispositions, the intent is to provide a balanced view of the findings and in the analysis.

Language of Practice

The first group of findings includes a discussion of four topics: practitioner metaphors and language, their concept of planning, their thoughts on planning models and the challenge of planning at the organizational level.

Metaphors of Practice

Metaphors serve a function of "sense-making" (Richardson, 1994) and may engender new ways of seeing things. Metaphors have "ontological, epistemological and heuristic functions" (Proctor, 1991), and may "unveil nuances of meaning which we unconsciously assume in our discourse" (Soltis, 1968, p. 1). The practitioners provided various metaphors to describe their overall experience in planning a health promotion program in practice. Three of these metaphors are now described within the context to which they refer. For Nina, planning was similar to: "a military battle of wars and skirmishes...where one made forays and retreats...There's lots of landmines around. Don't be surprised if you step on one" (Nina, 2-11). The highly politicized environment of Nancy's health department as well as the three municipal departments to which it reports was reflected in this metaphor. Images arose of enemy parties laying in wait, making

advances, engaging in conflict and then having to fall back to await the next skirmish. Doug likened his experience to a sports game.

> It's like playing a game where the goal posts are always moving...you kind of look up to shoot to score, and the posts have now moved over here...you have to stay current within your own organization and you have to stay current with trends that are occurring in whatever that field is. (Doug, 2-36)

In Doug's situation, the Executive Committee hired Doug to set up a revenue-generating program for the corporate executives in the community, and then changed its direction toward a non-profit, internal program for hospital staff about a year later. This metaphor carried implications of competition, changing rules of the game, and victories and losses.

To Jess, planning was like exploring, where one was "venturing into new territory, forging new ground, starting from scratch, raising the flags and the balloons." Jess was feeling a bit overwhelmed with the responsibility of setting up a new program in a well-known urban hospital where there had been no local precedents. There was a combination of excitement of breaking new ground reflected in this metaphor as well as apprehension in charting the unknown.

A number of the practitioners also alluded to the creativity involved in the planning process. Jess spoke of feeling like an artist, creating on a blank canvas. Nina metaphorically likened the process to creative writing.

> In creative writing... there's the creator and the editor. What you have to do is commit yourself to being in a creative mode and not let the editor come in because if you do, you will never get your writing out. And I think in this job you have to be prepared to let the creator go and then to be able to reflect on it. (Nina, 2-11)

Aware of the dangers in pushing metaphors too far (Soltis, 1968), I believe they can be useful in graphically portraying some underlying themes about planning in practice. In thinking about these metaphors of battle, sports competition, and exploration, some common implications can be drawn. While there is a general goal for the practitioner in each (e.g. winning the game,

victory in battle and claiming new territory), the outcome is by no means guaranteed.One may even speculate that this grouping of metaphors carry underlying messages of male-power and domination. The metaphor of sports as war, or preparation for war is well known. The environment is more changeable and unpredictable than known, and controlled and there is no lack of opponents and obstacles, conflict and hardship. Practitioners themselves provide leadership and provide some direction to move the battle, game, or exploratory venture forward. Given the metaphors of creative writing and painting, there is an element of self-expression, autonomy and control hinted at as well. These metaphors all imply an action-oriented process involving interpersonal skill, judgments, risk-taking, team playing, coordination of effort on the part of the practitioner, and reflect a picture of planning as a more interactive, communicative activity.

In addition to these metaphors, practitioners also used adjectives such as: "tough," "not clean or straightforward," "messy," "circular not linear," "trial and error," "stressful," "frustrating" when talking about their experience of planning. The process itself has been described as "exploratory," "iterative," "reflective," "giving up control"-- "a process which requires a reciprocal working relationship," "a process in which tensions sometimes builds." Nina commented on the uncertainty involved: "You can't plan a car accident, and you find yourself in a crisis" (Nina, 3-4). The metaphors and adjectives from practitioners' practice do not portray planning as a rational, linear, staged process with clear outcomes based on a set of objectives which characterizes the procedural principles (Cervero & Wilson, 1994) and the stages of planning (Sork & Caffarella, 1989). These metaphors are more akin to a challenging endeavour involving the participation of others, an activity fraught with detours and dead ends where

practitioners weathered obstacles and survived conflicts through thought, effort and perseverance. Practitioner metaphors offer the opportunity to take a fresh look at planning.

When the planning process was working well, practitioners called up other metaphors. For Nina, planning was like an orchestra playing in which there was harmony and synergy among the different sections. The practitioner as conductor was coordinating the different musical sections with all contributing to the creation of wonderful music. For Jess, planning well was similar to "snowploughing."

> With the proverbial snowplough, making sure nothing gets in the way. The more departments or people that you involve in any program, there is a bit of vying for territory...a bit of confusion...a bit of fear...a bit of resistance. There's a lot of obstacles and concerns that are raised. Many of them have to be dealt with one-on-one. But I think...if you have to implement a program, that you have limited time and resources...you tend to snowplough. You try to move [the obstacle] out of the way. (Jess, 2-12)

Both metaphors carried implications of success and progress towards some intended outcome. In Nina's case, the coming together was a process of the product of the group being better than individual effort. In Jess' situation, it was determination and the removal of obstacles. Both metaphors, however, may be seen to contain masculine images of power. Both metaphors contain a centre of power providing leadership and direction, a person with authority: the conductor, usually male, demanding and controlling of the musicians; the snowplougher who drives the machine that physically pushes aside mounds of snow to clear the road.

One practitioner, the exceptional case, claimed the planning experience was "divinely driven." More intuitive and spiritual, Gail experienced:

> A miracle where everything fell into place.... where ideas and thoughts spin around and start drifting down like little raindrops. I feel blessed, that it's been almost divinely led. The Wellness Centre is going so well, I feel I have a guardian angel on each shoulder. (Gail, 1-17)

According to Gail, things were "unfolding as they should." The constellation of circumstances that surrounded this metaphor included a fully committed senior management, allocated program resources, enthusiastic and involved cohorts, a positive focus on wellness, autonomy in decision-making, and a pleasant physical environment to work in. In reality, this constellation of circumstances in the planning world is indeed rare, nor would many of us expect planning to be "divinely driven."

Planning as Thinking, Practice as Action

In talking about planning as a general concept, the six practitioners portrayed planning as: a reflective, mental activity involving "giving a rationale" (Nina); an activity that took time to enable people involved to work out "what they wanted to see happen" (Jess) and an activity that preceded implementation where "policy came down from above into the field for implementation, where people did what they wanted to anyway" (Susan).

When practitioners described their own particular experiences with the health promotion program, they did not use the word planning to describe what they did, nor did they generally refer to themselves as planners. Practitioners were more preoccupied with "getting the program up and running" and engaged in a wide range of action-oriented activities. As Susan stated:

> What I've observed, not being a planner myself, is often that planning is seen to be setting out the framework...In the health department we often have planners who give the rationale, give the background information, set up a program...when you bring a plan in from the top down, then it's up to the field to implement it. (Susan, 3-1)

Much of their language was focused around the implementation, the *doing* of the action (e.g. collecting information, distributing the minutes, doing market research, coordinating projects) rather than the reflecting, thinking, clarifying that they thought planning implied. They talked about "going to every meeting I could find" (Kathy), "doing a lot of one-on-one"(Jess),

"presenting a paper to Executive Committee" (Doug). If planning was considered a reflective stage prior to the implementation stage, then it is understandable that practitioners viewed themselves more as involved in implementation than planning. Therefore, the term "planning" as a separate stage preceding the "doing" was not reflected in these practitioner's experiences.

In adult education literature, planning is broadly conceived of as incorporating a wide range of activities including the thinking and action aspects of identifying needs, setting objectives, developing an administrative plan, implementation and evaluation (Cervero & Wilson, 1994; Sork & Caffarella, 1989). Yet, the practitioners viewed planning as a more narrowly defined mental activity which did not encompass the action-oriented responsibilities noted above.

In the field of policy implementation, the term implementation is also understood to include the various stages of planning, implementing and evaluating (Schneider, 1982). Pressman and Wildavsky (1984) viewed policy implementation as mutual adaptation, an evolutionary process which was partially prospective to design policies in advance which are less likely to fail and partially retrospective in order to cope after a breakdown. This approach they called "forward and backward mapping." In this sense, practitioners' stories have reflected the iterative forward and backward nature of the process. Williams et al. (1982) held that only 10% of the work was done when a policy has been set, and that the other remaining 90% was left in the realm of implementation (p.22). The stories also mirror this preoccupation with getting on with the operationalization of the program.

Planning Models: Not Walking the Talk

Practitioners expressed general familiarity with conventional planning models and their component parts of needs assessment, setting objectives, implementation and evaluation. Practitioners acknowledged the discrepancy between ideal models and what was practically feasible. Jess, in reflecting on the standard stages of a planning model, commented:

> Most of my reading is from texts...giving you guidelines and the how-to's and the practical step-by-step application. And I read this and I go [some laughter]...Oh, I only wish it were that easy....Do you wait for the perfect plan or just get in there and do it? (Jess, 1-11)

However, in practice practitioners did not design their work with reference to a planning model. Doug, thinking needs assessment involved directly talking to consumers, stated that needs assessment did not occur because of "the in-house arrogance" of the medical professional - "we're the health care professionals...we know what they need" (3-11); therefore, consulting with consumers was unnecessary. However, in practice, he organized an internal task force to hold focus groups with employees about what their needs for wellness were. Gail opted to use existing research as well as talking to people informally about what was needed rather than undertake a more time-consuming needs analysis. Jess, commenting on needs assessment, said "survey and assessments - that really doesn't get out to people. I sometimes feel that one-on-one approach, even getting little focus groups together [is better]...it's just sort of testing ideas" (Jess 1-19).

None of the practitioners described undertaking an objectives-setting exercise as part of their work. They tended to work within organizationally-established broad goals and directions. Only Nina was guided by a formal responsibility statement that had been developed prior to her arrival which outlined the three responsibility areas of health information, empowerment in the community and strategic planning within the health department. Some practitioners talked about evaluation but used a variety of criteria. Doug felt that he had done a good job because he had

targeted 60% of the hospital staff in the Personal Health Task Force activity. For Nina, "process is as important as outcomes when evaluating our work" (1-5). Kathy made the comment that evaluation needed more attention and should be dealt with in the setting up of the program, not after the fact; however, neither she nor the other practitioners had developed an evaluation plan.

Practitioners did not describe their actions in terms of the planning stages of the traditional model. For example, the practitioners did not conceptualize "sussing out the network" (Nina), or "orienting myself to the health care system" (Doug) as examples from the planning model stage of "understanding the context" or "reading the environment," although these were meaningful activities they engaged in. Therefore, it may be said that practitioners could "talk the talk" about planning models in theory, but they appeared to "walking a different talk" when in practice. None of the practitioners carried out formal needs assessments, undertook objectives setting exercises or prepared evaluation plans. This lack of connection between actions and stages of the model contributes to the weakened link between practice and theory (Brookfield, 1990; Sork & Caffarella, 1989).

Complexity of Organizational Level Planning

Practitioners commented on the difference between planning programs at the organizational level and at the project level. Programs which had an impact on and required the participation of other parts of the organization were viewed as being much more complex and time-consuming due to the complicated tasks of clarifying organizational philosophy, identifying responsibility areas, getting buy-in from senior management and fellow colleagues, and allowing time just to think and reflect. In contrast, specific, stand-alone projects were "succinct with cleaner and crisper objectives," "tighter, well-managed, " (Jess) and "easier to evaluate what you

are doing" (Doug). The challenges of organization-level were further complicated by the fact that health promotion was also a new program concept being introduced to the setting where it was not generally valued as a priority. For Nina, it had taken over two years for health promotion to have become more broadly-based and accepted in the health department.

> The organizational program has to have a longer time frame than the sub-projects in the sense that you decide on values and principles and processes and areas of criteria where we are responsible. (Nina 2-15)

Practitioners (Nina, Jess, Susan) emphasized the need for the organization to clarify its vision and provide a consistent philosophical framework for planning programs at the organizational level. This vision would have goals that would be quite general in nature in order to accommodate a constantly changing organizational environment. Practitioners' metaphors spoke to the uncertainty of the constantly changing environment. For example, one health department had just completed an organizational review, another was in the midst of a strategic planning process. The nurses' strike had left a major impact on the hospitals, and another round of budget cuts was anticipated by both the hospitals and health departments. In an uncertain environment, people have to "take risks" (Doug), be prepared to "make detours" (Jess), to experience "forays and retreats" (Nina)--as will be further explored in the section on Professional Performance.

Again, Gail and her stand-alone, off-site Wellness Centre, presented the exceptional case with her view of planning at the organizational level as essentially a task of drawing up "a big calendar of events." This "global level" in her words, entailed timetabling and scheduling, recruiting and contracting program presenters, advertising offerings. This interpretation may be instructive, because it may suggest the way that current planning models are assumed to be applicable to organizational level planning. That is, focusing on the rational decision-making

aspects of individual programs and then stringing them together like laundry on a wash line. Consideration of planning at the organizational level involves a more interactive, iterative planning process.

Given the challenge of setting up a program which was not clearly defined, unstructured problems tend to need consensus (Adams, 1988; 1991). When more people are involved, the more diverse the views and the increased demand on the practitioner to facilitate and mediate these differing positions and views (Senge, 1990). This situation is further complicated by a non-formal education organization setting which does not consider the health promotion program to be of priority, or even consistent with its primary mandate.

Key Points

Four key points may be concluded from this discussion on planning in concept and practice.

- The metaphors and language are not congruent with conventional models of a rational, linear orderly process. Rather, planning in practice is described as a more uncertain, iterative process dependent on the changing nature of the environment and requiring interaction with others. It confirms recent renderings of planning as a communicative act of social and political interaction.
- Practitioners do not appear to find the language of planning from the literature relevant to their practice realities. They do not consider themselves as engaged in planning per se, which they conceptualized as a mental activity, but are very much involved in action and implementation.

- Although practitioners are familiar with conventional planning models they do not apply them in practice. This finding speaks to the need to discover new models which do make sense, to make them--in Forester's (1993) words -- more "practically appropriate."
- There is a distinction between the fairly clearcut planning of a specific project-level program and the increased complexity of planning at the organizational level. Attention needs to be paid to the assumptions underlying planning at the organizational level in non-formal educational organizations which differ from the assumptions underlying the conventional models premised on formal educational settings. Consideration of the above points provides one explanation for the gap in theory and practice identified in the literature.

Organizational Context

This study particularly focused on the planning of new programs in non-formal educational organizations in which education was not the primary purpose. The second grouping of findings cluster around practitioner perceptions of three key factors within this non-formal organizational context which influenced their program development activities. A brief comment on practitioners' perceptions of organizational structure and culture will provide a context prior to discussion of these factors. Participants' comments were quite similar, both in hospital and health department settings, noting them as hierarchical and bureaucratic in nature. Jess who had worked nearly two decades in the hospital stated: "I understand [the bureaucracy] has to be there, it's essential. This huge monolithic institution could not operate without a very strong bureaucracy" (Jess, 2-21). Susan found that in "most health agencies there is the doctor, the head nurse, supervisor and the

little nurses, then you go out the door and there is the citizen" (Susan, 1-11). However, practitioners varied in their view of whether the hierarchical and bureaucratic nature of the organization posed a barrier or restraint on their work as noted in the more accepting tone of Jess' comment and the veiled disdain in Susan's quote.

Settings were considered traditional and practitioners experienced resistance to change and to new ways of doing business. In Jess' hospital "there's certain territories that are established, and there's certain protection of those territories" (Jess, 2-14). Nina described her health department as "a very old organization...Therefore reasonably calcified. It's an old organization in that until the new manager arrived, you were awarded for number of years' service, not for innovation and competence" (Nina, 1-9). "It's very territorial, they don't want things happening in their territory that they don't know about" (Kathy, 1-13).

With regard to the external environmental context that impacted on the organization, health department more than hospital practitioners mentioned the social trends emerging: the legitimacy of empowerment, importance of consumer consultation, scepticism of professionals and expertise, advance of information technology (Kretzman & McKnight, 1994; Schön, 1987). Hospital practitioners focused more on the general economic situation, which in turn placed their organizations in positions of fiscal restraint and budget cuts, most notably evident in the nurses strike of 1989, the growing reality of user fees and entrepreneurial endeavours in health care. The concerns regarding limited resources and its impact on organizational context were noted by practitioners in both settings.

What appeared generally lacking, however, was any extended discussion of the larger political environment, the neo-conservatism and place of politics and power in the broader societal system and its impact on their organizations and the consumers of their services. Such

environmental socio-political-economic influences on their organizations were mentioned peripherally with casual awareness, but not pursued in any depth with regard to direct implications for their immediate work.

Factors Influencing Planning

When asked what were the key influences affecting program planning, practitioners identified three main factors in the organizational context which they considered as major factors influencing planning: clarification of and consensus on the concept of health promotion, the commitment and direction from senior management, and the support and involvement from colleagues within the organization.

Health Promotion Concept:

A major influence on the nature and direction of program planning was the health promotion concept held by the individual practitioner and the organization. While health promotion "continues to encompass a wide range of visions and practices sometimes quite remote from the original concept" (Pederson, O'Neill & Rootman, 1994, p. 376), it is important to recognize the impact of organizational context and mandate on program conceptualization. Organizational mandate influenced how health promotion was generally to be interpreted and it was within this context of understanding that the practitioners worked. For example, the hospital practitioners, Doug, Jess and Gail commented on the "sickness model" and the "anti-health promotion atmosphere of the tertiary care hospitals" (Doug, 3-14), aware that many of their colleagues felt "health promotion doesn't belong in a hospital" (Jess, 2-10). These organizational

attitudes affected how the goals were identified, and what type of projects and activities were undertaken.

Hospital focus of health promotion as wellness and lifestyle: All three hospital practitioners used the terms wellness and health promotion interchangeably, referring to individual health and lifestyle choice. In two hospitals, the term wellness appeared directly in the formal name of the program: the Wellness Program and the Wellness Centre.

> Health promotion is a tool to attain the goal of wellness....it's the way to achieve wellness by promoting health, you help a community achieve wellness. If wellness is the outcome, then health promotion is the process to the outcome. (Gail, 2-2)

Hospital practitioners looked to the experience of other hospitals, both in Canada and the United States in designing their wellness-oriented programs. The programs clearly targeted the goal of offering information and programs for a healthier lifestyle. This approach lent itself to individual-oriented programs which could be accessible cost-free to employees, or on a revenue generating/cost recovery-basis to persons in the community.

Health department focus of health promotion as community development: The three practitioners in the health departments viewed health promotion as built on the concepts of empowerment and community development: a process of enabling people to have some influence or control over those factors which affect their health. Nina believed health promotion involved "thinking about the broader picture issues as opposed to simply thinking about lifestyle...it involved determinants of health thinking such as developing supportive environments, health public policy and reorienting the health services" (Nina, 1-3). Stating it more bluntly, Nina said: "I don't think the way to improve the health of the community is organ by organ" (Nina, 1-10). Therefore, the target audiences for health promotion for two health departments included community groups, while the third concentrated on changing staff attitudes and behaviours prior to going out into the

community. These practitioners appeared to ground their concept of health promotion more in the literature, making references to documents and articles from the World Health Organization (WHO), Canada Health (formerly Health & Welfare Canada) and experts in the field. Determinants of health were viewed from the broader perspective of socio-economic inequities (i.e. poverty, pollution, housing as well as access to health services). This focus led to a goal of working with community groups on a gratis basis, as well as an internal focus of educating staff, changing attitudes and behaviours in the organization-delivered services to the community. This aspect of organizational change was potentially more disruptive than the delivery of wellness-oriented programs, particularly as it questioned the role of professional authority. As Susan stated,

> If you use the WHO definition of health promotion, increasing [individual and group] control and citizen participation, it is a very frightening thing when you really want to put it in action. (Susan, 2-19)

Doug may present the exceptional case, as he was essentially an entrepreneur with no background in health care, and limited knowledge of health promotion. With a background in education and as a professional consultant, Doug was used to providing a service as directed by the employer and felt all people involved in health promotion should be "entrepreneurial in spirit" particularly given the current fiscal climate.

The findings indicated that hospital and health department practitioners held essentially two different views of health promotion. Hospital practitioners understood health promotion as individual wellness and healthy lifestyle, while the health department practitioners interpreted health promotion as community development. This finding is not particularly surprising as much has been written about the hospital and health department approach to health promotion (Hancock, 1994), suggesting that hospitals with their medical treatment model would find

individualized wellness the better choice, while public health departments may have had an easier time of adopting the WHO definition of health promotion given their traditional focus on overall health of the public (Altman & Martin, 1994, p. 161).

Senior Management Commitment

Each practitioner faced a unique set of circumstances, yet all expressed the importance of senior management support as a crucial factor to planning. In the hospitals, senior management referred to the President and the team of Vice-Presidents, practitioners all reported to one of the Vice-Presidents. In the health departments, senior management was comprised of the Medical Health Officer (MHO) and the Directors of the different program areas, practitioners all reported directly to the MHO. Criteria such as resource allocation of program budget and staffing, time on senior management agendas, general prestige and profile of the program were indicators of this commitment. Senior management direction and commitment to the health promotion program varied in degree, continuity and stability. Looking at the end of high support, Gail was highly enthusiastic about the solid support from the hospital board.

> The board is committed to community outreach programs....There's some prestige connected to a hospital I think that has a Wellness Centre and has community outreach programs, because it's very visionary. (Gail 2 -1)

In settings where senior management commitment was uncertain and changing, and the inadequate resources to the program was a contentious issue, this factor became problematic. At the opposite end of low support, Kathy was given no resources and continually struggled with senior management.

> So I still haven't worked out a way of interacting with senior management as an equal because they don't know what I do, and they don't know how it is done....As a department of one, I have very little budget, so I don't have a lot of leverage....I don't have a power base, so I've had to try to develop ways to get around things. (Kathy, 1-12)

Consequently, trying to determine what to do was a major problem for Kathy. Somewhere in between was the mixed support Susan received for her program. Her MHO was a strong supporter, but her immediate supervisor did not understand the empowerment implications in Susan's approach to health promotion. Her immediate supervisor "can see we're changing and she can believe in all the concepts but she can't let go of control "(Susan, 2-1). This caused considerable frustration. "It's really problematic to try to bring on health promotion practices inside a system that isn't committed to decision-making and participation by all members of the group" (Susan, 1-17).

Senior management could also change its mind. Doug experienced a complete turnabout when the senior management of the hospital, the president and his vice-presidents, overturned their initial decision to develop an externally-oriented corporate program.

> We came to that crossroads about a year ago. I went to the board and laid out this stonewalling on investing money [in the Executive Health Screening project]... Gave them several options, and one of the options was for the hospital to just get out of this hole, buy me out of my contract...and it'd go away eventually. To my surprise they said, no, we won't give you any money to make this thing work, and no, we don't want to can it....So with some investigating within our own organization, I decided we needed to go internal. (Doug, 1-21)

This resulted in a major shift in commitment and direction from an external profit-oriented program to an internal wellness program as a benefit to employees.

With respect to the allocation of resources, this is a tangible indicator of support to the program. As outlined above, most of the practitioners faced low levels of resource allocation. Practitioners referred to two types of resource allocation: a program budget and clerical/ secretarial support for the program. The lack of resources budget was problematic for three practitioners who did not have a program and/or secretarial resources.

What these scenarios indicate is the marginal status of these programs within the context of the organization. While the practitioner response is detailed in the next section on professional performance, at this point it may suffice to say practitioners need to continually "read the context" and "anticipate the pressures, threats and opportunities available to them" (Cervero & Wilson, 1994, p. 127), and to actively promote their program.

> I think that's what the last two and a half years have been, is to wave...have us waving [our] hands in front of their faces, saying we're over here, this is what we can do, this is the direction we can go, and how do you like is so far? (Jess, 3-3)

Given the current fiscal restraint, resource allocation sent a message internally about how important a program might be, a reflection of the Board's commitment to the program.

This marginality of the program is important to highlight, as the literature, particularly with regard to formal educational settings, assumes legitimacy of the planning act and allocation of needed resources to complete the responsibility. However, in non-formal educational organizations, programs such as health promotion are not seen as essential and are even more vulnerable to budget cutbacks (Pederson, O'Neill & Rootman, 1994). Thus, the lower priority of these programs is a crucial factor to attend to in this environment, as practitioners may be more subject to changes in program direction or resources than in formal educational settings.

Collegial Support and Involvement

Irrespective of whether the health promotion concept followed an individual wellness or community development orientation, and regardless of the varied and changing level of commitment from senior management, practitioners in both hospitals and health departments noted the importance of support and involvement of colleagues within the organization. In

planning programs with organizational-wide implications, many of practitioners' efforts were directed at getting people within the organization to "buy-in" to health promotion.

> Health promotion had to be bought into by the whole administration, into by the whole organization, they had to believe in this concept and...want to enter into the exploratory process and support it....It's a program that I think everybody takes ownership of, and that's what I've tried to develop...a sense of ownership, and then my role, became a coordinating role....It brings the necessary people together to discuss the opportunity, look at the resources, pursue funding opportunities that exist. (Jess, 1-3)

Practitioners expressed different reasons for the importance of involving people: Doug felt the one-on-one was essential to building a sense of community and "finding champions" who would take up the cause within the organization.

> Individuals can't have empowerment projected onto them from above. They have to own it, it has to be part of them...the drive and the motivation for that needs to come from within...I think you have to build teams. (Doug, 3-23)

> Community building is great and there's lot of people who have written models for community building. But few of the models include developing champions...you need people to champion the cause. (Doug, 2-30)

Nina felt that by involving people, you increased the literacy within the organization. However, she did acknowledge that: "There are some bad actors - then leave it alone for awhile...no sense in hitting yourself against a brick wall" (Nina, 2-8).

The understanding and participation of colleagues were particularly important to the health department practitioners because their concept of health promotion required staff to substantially change their attitude and behaviour in carrying out community health work. The traditional approach of expert providing services was to be replaced with the facilitator model of working with people who set their own agendas. Susan's goal was for people to first experience the health promotion approach directly.

> Basically my design is to say how we can shift their [the nurses'] thinking and help them move from this one-on-one profession in charge to going out and advising people on how to manage things differently...help them move into seeing the power of more self-help,

social support groups....You also want them to recognize that they have to make sense of their own experience as staff-have to have the chance so they are working in groups, and the process I think is teaching them the advantage of working in groups. (Susan, 1-5)

This second grouping of factors within the organizational context that influenced planning activity focused on the health promotion concept, senior management commitment and collegial involvement. These three factors are one set of factors named by the practitioners in this study. In their research, Mills, Cervero, Langone and Wilson (1995) proposed three structural factors which constrained or enabled county agents' planning practices: organizational structure and culture, available resources and power relationships. The overlap in factors in the two studies reinforces the impact of organizational context on planning activities.

Key Points

This section on influential factors within the context has established the following three points:

- A distinction between two interpretations of health promotion exists. Hospitals focus on a concept of wellness, while health departments promote community development and empowerment. This distinction may have implications for organizational change. The program concept and organizational context are dynamically linked together.
- The commitment of senior management is not a given, a stable commitment. This situation speaks to the marginality and consequent vulnerability of these programs within non-formal educational organization and places some onus on practitioners to constantly garner support for their work within the formal power structure as they negotiate for resources and recognition.

- Practitioners identify the importance of collegial involvement and to broaden the base of support for the program within the organization. Given the marginal status of health promotion programs within the health care organizations, and generally their own lack of formal authority, the practitioners were reliant on the interest and good will of their organizational colleagues in maintaining the health promotion program.

Professional Performance

Roles and Responsibilities

This third grouping of key findings deals with roles and responsibilities, strategies and actions which I have collectively referred to as professional performance. Practitioners were concerned about building a credible program both within the organization and within the community, although this concern was translated into various challenges depending on the unique context and content of planning in each setting.

> I really believe that the model that's created here goes beyond [this hospital]...that it creates enthusiasm for similar models in other hospitals...I really see that as an obligation. (Jess, 2-17)

> I'm at kind of the 'prove' stage. Okay we know what you do, now do something. (Kathy, 1-8)

Organizational context affected practitioner's role in one significant way. Health department practitioners geared to a community development and empowerment view of health promotion were more likely to see themselves as change agents/question posers who may find themselves critical of the organization's way of doing business. In contrast, hospital practitioners promoting individual wellness viewed themselves more as implementors of programs, not

attempting to effect major organization change. In general, however, organizations appeared not to impose specific roles, other than perhaps formal position designations of manager, coordinator, director, or spell out expectations of how the job was to be done. Practitioners were given the general goal of planning and implementing the health promotion/wellness program. Beyond that, they appeared to have considerable freedom in interpreting their roles and responsibilities. For Nina, the vague job description "is a double-edged sword. On the one hand it allows you to do what you want, on the other hand you are doing what you want on your own" (Nina 2-4).

Throughout the interviews, practitioners identified a long and colourful list of roles and responsibilities they played in planning a health promotion/wellness program. The categories were not mutually exclusive and contained some overlap. These perceived roles affected the development of practitioner strategies and actions presented in the following section. Frequently identified roles (by three or more of the six practitioners) were committee chair/member, educator, coordinator/facilitator, resource person/information provider, networker/liaison; public relations promoter, proposal developer, coach/trainer, negotiator/mediator, question poser/ideas visionary and researcher. Only one practitioner called herself a planner, specifically a "process planner." This finding parallelled the finding that practitioners tended not use "planning" or "plan" to describe their activities. The variety of roles included tasks one would expect of a planner according to conventional models: committee work, providing information, proposal development. There were, however, an equal number of process-oriented roles identified as well (e.g. facilitator, networker, coach/ trainer, negotiator/mediator, supporter/encourager, question poser).

When asked to expand on her self-imposed tag of "jack of all trades" in program development Jess responded:

> Program development...in terms of major programs involves many different disciplines, and I think negotiating skills are very critical. Communication skills...not to suggest that we don't all of us have some of those skills, but they have to be honed to this job....Let me think about this...certainly proposal writing...grantsmanship...evaluation...research. (Jess, 2-1)

Practitioners felt they were effective in their roles because they were "people-oriented," "facilitative," "respectful." The role of coach in working with and encouraging others was evident:

> So there's that whole issue around being more of a coach and letting other people take over leadership....if your sense of self has always been defined in terms of and measured within the organization in terms of successful projects done, or some 'star' analysis made, then it's hard to switch to being someone invisible in all of that...but that's a principle which we support each other to do. (Nina, 1-8)

In Nina's view, coaching was not viewed as leadership. Yet the coach is a key position, carrying authority and planning strategies. Leadership is embedded in their jobs, although practitioners tend to describe their responsibilities as facilitating process. Leadership was also alluded to in practitioners' metaphors and constitutes another area requiring further research. One example of practitioner leadership is provided by Jess who explained how she accessed money from a funder:

> The whole criteria [for getting funding] is that your employees have to decide for themselves what activities they want to follow. You can't direct them...but the employees just sat there, looking at us like we were mad...it was really very uncomfortable...so I pulled out an old EAP [Employee Assistance Program]idea...formed a committee and developed an EAP proposal" (Jess, 1-22).

The findings that practitioners played multiple roles is not surprising. The selection of these roles was a combination of the understanding of the health promotion concept, the organization's expectations, as well as their own individual training, expertise, experience and talents. What was of interest is the emphasis placed on roles related to working with people, with building support and consensus. By understanding what roles practitioners thought they were

playing, we can better understand how each practitioner looked at issues, and what strategies and activities practitioners pursued.

Strategies and Actions

Practitioners mentioned a wide range of strategies and actions. While it was not possible to determine whether these strategies and actions were consciously tried, or constructed post facto, they were part of the practitioner's thinking and guide for action. These strategies and actions were interrelated, contributing to the complexity of practice, but have been grouped into categories for the purpose of discussion and do not represent any particular order of priority. Despite the difference in the understanding of the health promotion concept as wellness or community empowerment, practitioners in both hospitals and health departments frequently expressed the importance of involving people in the process and used similar strategies and actions. Jess felt it was,

> A learning experience on everybody's part...the sharing of experiences and knowledge and expertise. This has been one of the benefits of health promotion, it's this coming together. (Jess, 1-7)

While seeking support from co-workers is commonly assumed, the priority given this aspect in the strategies and actions was unexpectedly high. Practitioners emphasized the time spent in communicating and coordinating, educating and networking with colleagues, strategies which were consistent with the process-oriented roles and responsibilities identified previously. The following four strategies, which impact on each other, exemplify practitioner work with colleagues and the community.

Networking one-on-one. Practitioners highlighted the importance of the one-on-one contact with individuals, spending time to listen to their questions and concerns of others. Gail felt

that "being available for people is important...that's my strength" (Gail, 3-15). For Nina "you need to be able to network and you need to build mentors and you need to find support people" (Nina, 2-12). This informal networking was important to building relationships throughout the organization, as well as gathering information useful to planning and soliciting individual support. Doug spoke of the purpose of networking as community-building and finding champions "so if I got a new contract [to do this health promotion program again]- that would be the first thing I would ever do is pick up partnerships and build community with people, to be the vision centres and the drivers" (Doug, 3-25). He took a one-on-one approach to find out why people were not supportive, did his background work so there were no surprises when people came together in a meeting. Practitioners believed that this interpersonal approach was more effective than management directives from above in encouraging individuals to become actively involved in the program. Also central to this concept of one-on-one interpersonal networking was the attention paid to use of language. Jess felt that it was important to speak "the language of the environment at all levels" as she engaged individuals of different status and departments.

Creating opportunities for participation. Practitioners were all part of various committees, task groups, working groups to develop the health promotion program, sometimes serving as chairs and other times as members, or resource persons. Other strategies included secondment (Nina), focus groups (Doug), attending other departmental meetings (Kathy), and advisory committees (Gail). Susan set up a group process premised on the learning circle, where group members did the research, raised questions and talked and debated. People struggled but made their own decisions, experiencing "empowerment" which they then could apply to their work with clients in the community.

> The nurses have to be allowed to make all the decisions they can within their workplace If we expect that they are going to go and work with citizens and let citizens make decisions.

> We work in a group and we try to develop a reciprocal working relationship...so I'm not telling them...I work with them. (Susan,1-11)

Practitioners noted that such opportunities needed to be perceived as genuine, and not token, therefore involving people in actual decision-making was crucial "from all sectors of the hospital" (Doug, 2-27). These opportunities paid attention to the relationships among people, with the goal of creating a sense of community, creating team spirit and building partnerships. Two practitioners (Nina and Gail) mentioned the value of involving others in a values clarification exercise in which the philosophy and principles of the program were developed. Jess stressed the positive strengths in people as they engaged in health promotion activities:

> Quite often [the staff here] don't realize just how talented they are, And they've never had the opportunity to do [something together], and they've been sort of spoon-fed a lot of the time, and been put into a system and told that they have to perform....But to get people out of that, these are very bright people....They say "Oh, I can't do that, oh I can't think that way" and they surprise themselves, it's just wonderful to see that happening. (Jess, 3-29)

Encouraging and facilitating learning. Practitioners felt that the education of both managers and staff was central to their work, and commented on the learning that went on during the planning process. Learning included learning about the organization, about health promotion/wellness, about how to work with people, and about one's self. Facilitating and encouraging others in the organization to learn was a challenge. "How can you get people to buy into something they don't really understand ...so that whole education process is quite important"(Jess, 2-2). Practitioners modelled this attitude, as well as using other opportunities inherent in such strategies as the individual contacts, committee work, to promote this orientation. Jess felt excitement not only about "watching others learn" and in her own learning she found herself becoming less rigid, "directing traffic less."

> [The health promotion program] was probably my first real challenge in program development and that was a really good learning ground. It was dealing with the politics at the hospital and the union, the environment, and it was definitely a learning experience....And it was very foreign to me to come into a field where...it was just like dealing with a blank canvas and winning and selling the idea, selling the concept, getting the support. (Jess, 3-24)

These comments on ongoing, informal learning are consistent with the literature about learning organizations and creating the necessary climate and opportunities (Senge, 1990). Jess set up working committees with representatives from different areas; involved people so that they could learn from each other.

Communicating and negotiating. The emphasis on people interaction is congruent with Forester's (1993) framework of planning as a communicative, social act. As such, planners spend considerable amount of time talking to and working with people.

> If process is your work then you need to develop skills in process management. So there has to be a common way in communicating what you are doing in projects....There has to be a language. (Nina,1-22)

The social interactive process requires effective communication skills as characterized by active listening, empathetic attitude, checking it out, giving feedback (Ivey, 1990). Jess referred to these skills when she pointed out the value of listening to their questions and hearing others' concerns; Nina talked about learning to listen without immediately reacting, or giving advice. However, the communicative act entails more than skilful communication, as the four dimensions of effective communicative acts "shape listener's beliefs, consent, trust and understanding" (Forester, 1993). Thus, practitioners carry an ethical responsibility in their planning work. Practitioners engage not only in communication but negotiation in their interaction with others.

> Because the nature of the work means giving up control....It's all negotiation. [The] three critical skills for the whole healthy communities movement were: conflict resolution, consensus building and cross cultural work. Not necessarily culture in terms of ethnic group. And heaven knows you get none of those in graduate school. (Nina, 2-13)

> We're negotiating because...there's limited resources and there's lots of discussion and debates about how the resources should be spend in health care. And when you're negotiating for your program....why this program and not that program, getting people to buy-in, getting people to give you that support, that's a requirement of negotiation ...Sometimes you may [reach] a mutually agreed upon result that may not have been apparent from the outset....[We need] to become very conversant of a number of the different disciplines and their own biases and...looking at it from their perspective. (Jess, 2-3)

Within the current environment of limited funds and pressure on service delivery systems to do more with less, organizations will increasingly have to do their own planning. They are likely to assign this responsibility (if indeed they deem it important) to staff with other duties, for whom planning is a luxury they do not have time for. Listening to practitioner talk may provide clues to a more meaningful framework for practice. Practitioner comments about the value of clarifying philosophical frameworks and working from a strengths perspective are two possible suggestions. Or, as Nina proposed: "Hire a visionary who can buy others in and think across disciplines" (Nina, 2-11).

The theme of practice as social interaction is central to Cervero & Wilson's (1994) notion of why people engage in such activity, for what purpose. They contend that practitioners should responsibly involve others in order to develop "substantive democratic processes" in the negotiation of interests within structured relationships of power. This purpose introduces the notion of ideology which will be discussed in a later chapter. The above noted strategies of networking, creating opportunities for participation and communication and negotiation are not benign, neutral activities. In finding internal champions and drivers, in developing strengths and talents and, in garnering support, practitioners are doing much more than process facilitation. They make judgments and provide leadership often from behind. "If you're a change agent, you are always bringing people a little bit forward" (Nina, 2-12). "I guess you do things and don't realize that you are making judgments or executive decisions" (Gail, 1-15).

Other common strategies mentioned by the practitioners are more in line with conventional strategies expected in planning, and while task or product-oriented, they still require involvement with others. These activities of providing information, setting priorities and promoting the program are dealt with briefly as they are common strategies discussed in the planning literature.

Providing information. Practitioners recognized that senior management within the organization often lacked sufficient information on which to make decisions. Strategies employed included getting the information, either doing the research themselves (Nina) or using other existing studies and sources (Gail), and then taking the time to write it up and present it in an organized manner to senior management. For Doug, this took the form of writing position papers with options; for Jess, this meant writing up proposals for each project; for Nina, this entailed doing actual research studies. It is of interest, that most planning models assume understanding and initial commitment to a program, therefore, the writing up of position papers to clarify thinking or management commitment is not usually considered a common strategy of a conventional model of planning.

Setting priorities. Practitioners carried a myriad of responsibilities, and setting priorities was key to managing their job. Choice of what project to work on was handled in different ways. This was done in discussion with the supervisor, as Nina negotiated to keep her projects limited to no more than two or three projects. Jess was careful to take and develop one program at a time, the choice depended on the interest shown in a project by colleagues. Gail selected programs for the Wellness Centre which she felt were almost guaranteed success. Not only limiting priority activities, but paying attention to their likelihood of early success was important. Having some early successes helped to motivate people and draw positive attention to the health promotion/

wellness program. Hence, strategic choices of activity were crucial.

Promoting the program. Promotion of the program was more important in some settings than others where services were being provided directly to the community, for example, the Wellness Centre. Strategies for promotion were formal and public-relations oriented which included newspaper articles, speaking engagements, spots on Cable TV, brochures and pamphlets. Promotion internal to the organization included informal strategies such as modelling the principles, doing in-service education, and acting as a resource.

Key Points

The third group of findings on professional performance support the following three points:

- Based on their understanding of the health promotion concept, there is a distinction between the organizational change role of health department practitioners and the promoter of individual wellness role of hospital practitioners. The former role lends itself to the potential of increased conflict with others inside the organization.
- Practitioners indicate they play myriad other roles (e.g., research, proposal writer, salesperson) which seem common themes in both settings; a finding common in the literature (Kowalski, 1988).
- Both hospital and health department practitioners emphasize the time and effort they expend on engaging others in the process, which reflects the highly interactive nature of practice (Adams,1990; Posner, 1988) in contrast to limited attention to the administrative or technical aspects of their work. The findings on professional performance are consistent with portrayals of planning practice as a social, communicative act.

Summary

This chapter has presented the key findings from the interviews with practitioners. Three thematic areas were discussed, the first being practitioners' language of practice. The findings on practitioners "talk" about planning in practice were based on the metaphors they chose, the language used to describe what they did, comments made about planning models, and the challenges encountered at the organizational level of planning. Practitioners employed a variety of metaphors, which conjured up colourful images of a challenging experience in uncertain, changing environments, involving strategic action and the participation of others. These images did not mirror activity found in conventional planning models. Practitioners experienced planning practice less as a movement along a straightforward path, and more as a creative dance with a variety of partners to a changing musical backdrop.

Practitioners conceived of planning in theory as a thinking process, a reflective stage that preceded implementation. They generally did not seem to think of themselves as planners, given the view of their work as action-oriented. Practitioners expressed a familiarity with standard planning models and appeared to be well socialized into the conventional models of planning, which are instrumental, or task focused in nature. Yet, it was apparent when talking about practice, practitioners did not see their activities as reflecting these models and concepts.

The practitioners all considered themselves involved with programs of an organizational-wide scope. Organizational planning was more complex and time-consuming as it required a philosophical value-based framework within which program planning could take place as well as the involvement of a greater range of people. This situation was further complicated by the knowledge that their program was not viewed as primary to the organization. What this translated

into in operational terms was not more structured needs assessments and objectives-setting exercises, but a focus on learning to work in ambiguous situations, to juggle a myriad of roles and competing demands, and to genuinely involve people in the process.

Therefore, from these findings on concept and practice, it can be suggested that the language and models of conventional planning in the literature are not reflective of practice. This study suggests that one step in addressing the theory and practice gap may be to develop frameworks which more closely reflect practice and carry more relevant meaning for practitioners. Other alternative framings of planning as a communicative social act (Forester, 1993) or "negotiation of interests within relationships of power" (Cervero & Wilson, 1994) are emerging to provide practitioners with a language which better reflects their realities of practice.

The second thematic group of findings focused on factors in the organizational context that affected practitioner planning: the understanding of the health promotion/wellness concept, senior management commitment and the involvement of their colleagues. The first factor, the program concept to be planned and implemented, had a central impact on the process. While not surprising, this study confirmed that hospital practitioners understood health promotion as individual wellness, whereas health department practitioners conceptualized health promotion in terms of empowerment and community development. Thus the organizational mandate influences the general direction of program development. This difference in concept led to very different foci and challenges: hospital practitioners were looking for individual lifestyle programs and projects that individuals would support. In contrast, health department planners faced challenges of attempting to change traditional attitudes and ways of doing business within the organization. Practitioners brought with them their own notions of health promotion and those with views different from the organization experienced additional challenges in program development.

Practitioner knowledge and familiarity with the health promotion literature and field clearly affected program development direction.

The second factor centred around senior management commitment and direction. Where practitioners lacked this direction and commitment, their planning and implementation efforts tended to be limited. Conversely, where these conditions were in place, practitioners seemed to experience a wider scope of action. However, individual practitioner strategies and actions mediated this finding. This study further highlighted the uncertainty and changing nature of commitment, which is particularly relevant where the program to be offered carries a marginal status within the organization.

The third factor centred around the support and involvement of their colleagues within the organization. Practitioners spent considerable time garnering support for the program, and believed that this was important to do not only to obtain ideas and feedback, but to also include others in the decision-making process in order to develop organization-wide ownership of the program. However, hospital practitioners seemed to have had an easier time of it, as their concept of wellness as individual lifestyle choice was less threatening than the community development approach requiring a change in attitude and behaviour in staff's day-to-day work. Thus, the findings around organizational context indicate that practitioners are aware of and sensitive to elements in their organizational context. The ability to read the environment is not a new finding. What is significant is the different perceptions practitioners may hold of these different aspects of organizational context, and how they respond to them in action.

The third thematic group of findings concerns the area of professional performance. The findings show that practitioners played a variety of roles and undertook a wide range of strategies and actions in their planning practice. Given the broad mandate to set up and operate a health

promotion program, practitioners were then generally left to interpret organizational expectations within the context of their own understanding of health promotion/wellness, and their own talent and skills. Expected responsibilities included research, proposal writing, and public relations. What was unexpected was the degree to which practitioners wove the common thread throughout their discussion of roles and strategies of the centrality of involving others in their activities. Consistent with this focus on interaction with others, practitioners named roles which entailed such responsibilities as negotiation, mediation, advocacy, and mentorship. Strategies and actions undertaken to complete these responsibilities included: networking one-to-one, creating opportunities for participation, encouraging learning, providing information, setting priorities, and promoting the program. Throughout this discussion on professional performance, the themes of leadership and making judgments are implicit, although not directly addressed by the practitioners. They appear not to recognize or at least articulate the nature of leadership and influence they potentially can exert in shaping programs.

Practitioners' talk about roles and strategies seemed situation and organization specific, with limited awareness of, or at least discussion of how their roles and strategies link to an understanding of the influence of more systemic and structural issues on their practice. Socialization into any profession can lead to less critical thought (Eisner, 1991), which raises the question of curriculum of the professions and the suggestion that professional education in program development call attention to the ideological assumptions which can potentially underlie development activities. As any course of action is based on selecting some values over others, Forester's (1993) position for ethically illuminating practice and Cervero and Wilson's (1994) support of democratic processes introduces the possibility of normative, value-driven professional responsibility. "People's political perspectives guide them toward the kind of error they would

rather make- and consequently, the kind of learning they would rather attempt" (Pressman and Wildavsky, 1984 p. 224). Findings support the position that when practitioners possess a clarity of vision and a commitment to its development, they have a direction for action. Chapter V has served to detail a description of the findings. These findings will now be considered further at a more analytical level within a frame analysis perspective in Chapter VI.

CHAPTER VI

ANALYSIS OF FINDINGS

The findings as outlined in Chapter V confirm the recent trend in the literature toward viewing planning as a communicative act of negotiating within a socio-political context (Mills et al., 1995). The interactional nature of planning practice is consistent with the paradigm shift from an empirical to an interpretivist approach to knowledge discussed in Chapter III. The findings based on practitioner knowledge take on additional colour and meaning when analyzed through the conceptual lens proposed in this study, namely, the frame perspective. In this chapter, two approaches of frame perspective, Elgström and Riis' (1992) negotiated frame factor theory and Schön and Rein's (1994) situated frame analysis, are introduced. The key findings from the previous chapter will then be analyzed using insights from these two approaches.

Two Frame Perspectives

Negotiated Frame Factor Theory

Based on work done by Dahllof (1971), Lundgren (1981, 1985) defined frame factors as "factors that limit the teaching process by setting time, personal and space limits" (1981, p. 23), and later expanded the definition to include attitudes, values, beliefs and competencies. Lundgren refined frame factor theory further by differentiating three different systems of factors: i) a *justice* system of formal rules which regulate the educational process, ii) a *goal* system of curriculum

documents to govern the educational process, and iii) a *frame* system of residual factors which constrain the educational process.

This third system of residual factors interested Elgström and Riis (1992), as they proposed that it was within this grouping of frame factors that negotiation and bargaining took place. The authors further refined the definition of frame factors as:

> Factors that constrain the intellectual space and the space of action within a process, which the actors at each point of time during the process cannot influence or perceive they cannot influence in the short run. (p. 104)

Elgström and Riis analyzed the curriculum development process in Sweden using an integrated approach of both frame factor theory and negotiation theory. Conceptualizing the curriculum planning and development process as negotiation, they proposed that negotiations were possible in a number of frame factor areas. Using a metaphor of drama, the frame factors included the *theatre* of the formal decision-making locus, the *arena* of the specific organizational set-up, the *actors* or participants, the *problems* or issues at hand and the *solutions* or relevant alternatives. The degree of negotiability, however, varied with the perception of the actors, some seeing a factor as negotiable which others considered non-negotiable.

An important distinction was made relative to these frame factors. Elgström and Riis differentiated between what they called *meta-negotiations* which are negotiations about the frame factors themselves and *substantive negotiations*, negotiations which occur within the frame factors. "By engaging in meta-negotiations actors make attempts to change power relations and to reach a more favourable negotiatory position in re-opened substantive negotiations" (p. 105).

Elgström and Riis (1992) further proposed that negotiations could be distinguished in three ways:

i) by a win-win versus win-lose reward structure, ii) by a distributive or competitive versus integrative or cooperative, non-confrontational mode of negotiation, and iii) by the actor's intent. The actor's purpose could be further differentiated as "target-oriented" with clear specific goals in mind, "departure-oriented" with unclear goals but desiring a change and the "status quo-oriented." Thus the two theories of negotiations and frame factors become intertwined in an iterative process of practitioners negotiating around certain frames and framing their negotiations; comprising Elgström and Riis' *negotiated frame factor* approach.

Situated Frame Reflection

Elgström and Riis focused on the identification of frame *factors* as constraining limitations, either real or perceived, and their negotiability. Schön and Rein (1994) took it a step back to the process of *framing* and attention to *the frames* themselves. Contending that the only way to make sense of social reality is through frames, framing then becomes "the operation of selectivity and organization of complex, information-rich situations" (pp. 23-30); a process shaped by a variety of factors both internal and external to the unique individual. Frames were then presented from a more general approach as "underlying structures of belief, perception and appreciation" (p. 23). A major assumption here is that all frames are open to reflection, negotiation and ongoing reformulation.

Writing about the field of policy analysis, these authors further developed the concept of frames by identifying three levels of specificity of action frames:

- The *policy action frame* is the individual level at which an institutional actor uses to "construct the problem of a specific policy situation." (I will use the term *program* action

frame rather than policy action frame throughout this analysis as this term better fits the focus on program planning in this study.)

- The *institutional action frame* is a more generic action frame that reflects the institution's "prevailing system of beliefs, category schemes, images, routines, and style of argument and action."
- The *meta-cultural action frame* represents the "broad, culturally shared systems of beliefs" reflected in the larger society. (pp. 23-33)

Because human beings have the capacity to reflect in action, the authors proposed the need for *critical situated frame reflection*, a process by which actors reflect on the different levels of frames through specific practice problems. By engaging in reflection with others, a dialectical process is triggered where old and existing frames are considered and evolve into new frames as a way of resolving policy disagreements and controversies. Although developed for the policy area, situated frame reflection can also be applied to the realm of program planning, particularly in relation to this study where a new program concept can be viewed as an organizational level policy to be implemented.

Linking Micro-Macro Levels

At the micro level, Argyris' (1982) microtheories of action has relevance for the discussion on situated frame reflection. Because of our need for "ontological security in the enactment of daily routines," as individuals we develop and articulate our frames within an integrated coherent personal explanation which orders our activities and gives them meaning (Giddens, 1984, p. 87). In Argyris' (1982) view people reason differently when they think about a problem simply to

understand it than when they are required to take some action about the problem. This reasoning is situated reasoning which necessarily occurs within a specific context of action.

> Human beings produce much conversation, and listen to even more...they too have the problem of making sense out of anecdotal data and individual cases - they solve this problem by developing their own theories of action... and use these theories of action to understand and to act in the work in which they are embedded. The theories of action are like master programs in their heads.(p. xvi)

It is these theories of action that Argyris called "microtheories," distinguishing further between "espoused theories," goals, assumptions and values that people claim guide their decisions, and "theories in use" which are their actual guides to decision making. People have "microtheories" in their mind, tacit designs of how to accomplish one's intentions (Bratman, 1987). Practitioners make many judgments and develop knowledge during their experience with the health promotion program. This knowledge has been referred to by Schön (1983) as "tacit knowing-in-action - those tacit recognitions, judgments and skilful performance" (p. 50), and by Giddens (1984) as "practical consciousness: all things which actors know tacitly about how to 'go on' " (p. xxii).

These microtheories can be accessed and developed through self-reflection and through reflection with others. Reflection and discussion help make these thoughts more explicit by revealing tacit *norms* underpinning our judgments, *strategies* and theories implicit in our patterns of action, *feelings* which lead us to one course of action over another and the roles we construct for ourselves within broader organizational contexts (Schön, 1983, p. 62). Thus, individual microtheories can be considered the glue which gives coherence to the framing process and holds the practitioner's frames together.

Focusing on the individual practitioner is only half of the equation. The greater challenge is to understand the link of individual action and interaction to larger systemic structures within

which these actions occur. Giddens (1984), in his structuration theory, held that human agents and structures should not be construed as two independently given sets of phenomena. He found the terms micro and macro to be misleading, as they seemed to be pitted one against the other, while in his view, neither had priority over the other. There is, in fact, a continuing mutuality of influence and interplay between the human agency and structural levels. "All social systems, no matter how grand or far-flung, both express and are expressed in the routines of daily social life." Structure is always both constraining and enabling because "human agents through their situated activities in diverse action contexts produce and reproduce the structuration of social systems" (pp. 25-36).

Agents make sense of the activities in which they engage by the process of framing which regulates and gives meaning to these activities. Situated frame reflection is a means by which an individual develops awareness of alternate frames with implications at different levels of impact. When practitioners increase their awareness of the different frames that influence their own and others' thoughts, actions and feelings, this not only helps move the actors beyond the specifics of the immediate situation but automatically broadens the scope of actions and options open to the individual. This critical reflection is crucial to the uncovering of "hidden ideologies" (Apple, 1990) of which we are often unaware because we are too well-socialized into our professions (Griffin, 1983). Therefore, critical analysis of the frames through which we carry on daily activities is central to situated frame reflection. When people then act on their beliefs embedded in the frames about the environment, then they are attempting to influence and construct that environment. Such individual - structural influences are called "transactional effects" by Schön and Rein (1994). Thus the micro-macro link, or the mutual interplay of structuration, comes about through reflection and action of the human agent.

Insights from Frame Perspectives

Having briefly reviewed the frame perspectives of Elgström and Riis (1992) and Schön and Rein (1992), the findings outlined in Chapter V will be considered in light of selected insights from these two approaches. The frame analysis perspectives provides an instructive way of understanding how practitioners make sense of the social realities in which they are embedded. More specifically, from Elgström and Riis' (1992) negotiated frame factor theory I refer to the concept of *frame factors and their negotiability.* From Schön and Rein's (1994) work, relevant to this study are the concept of *levels of action frames* and *situated frame reflection.* These insights from the two frame perspectives will be applied to the three key areas of findings outlined in the previous chapter: language of practice, influencing factors within the organizational context, and professional performance of roles and strategies. Both commonalities among practitioners and individual practitioner experience will be noted. The previous brief mention of Argyris' (1982) microtheories of practice is consistent with an interpretive study as individuals create their own integrated understanding which underlies their approach to practice.

Language of Practice

Applying Schön and Rein's (1994) concept of levels of action frames, practitioner metaphors can be examined at three levels. Nina's metaphor of planning practice as a military battle provides a useful example of the three levels and how they mesh together to form a coherent approach. At the program level, Nina constructs her specific problem of operationalizing a health promotion program as personal risk-taking, engaging in forays and retreats, and leading her troops strategically to avoid planted landmines. At the institutional action level the military

battle scenario connotes an environment of conflicting interests over contested territory, a plausible description of the organizational structure with its clear hierarchy of positions and its culture of prevailing attitudes of internal competition among vested interests. At the meta-cultural action frame level, this same metaphor can be construed as embodying the broadly shared values of Western culture with regard to rugged individualism, personal victory, the conquest and acquisition of scarce resources in a harsh and competitive climate. Should Nina be aware of and critically analyze her metaphor from these action frame levels, would she concur that the values and beliefs they represent are ones she would wish to pursue?

The examination of metaphors within this frame analysis raises the question of how deeply certain frames of action are embedded in the language of planning practice. Are there perhaps frames of gender embodied in some metaphors? For example, Doug's metaphor of a baseball game played in a soccer field is consistent with one view of male moral development based on rules and regulations, as opposed to the emphasis on maintaining relations found in women's moral development (Gilligan, 1982). Reflection of metaphors also begs the issue of the use of alternative metaphors and their underlying frames and implications for action. Perhaps we need to examine why more feminist-oriented metaphors such as quilt-making, gardening and cultivation which carry frames of co-operation, networking, connectedness, empathy and mutuality are not as predominant when talking about "serious" matters of practice. An example of such a metaphor and how it can redirect our understanding and our actions can be found in another of Nina's metaphors of an orchestra playing together to illustrate practice when things were going smoothly.

> It would be like an orchestra, wouldn't it? It would be in the sense of everybody has to understand the characteristics of the piece of music but they would be playing different tunes. But you have to make sure, in some sense, that there's some harmony and synergy that would come out of it. And so I think it comes back to that issue of attention to

process and values and principles. And that people rely on those values and principles. (Nina, 2-15)

Therefore, this study suggests the relevance of examining the metaphors of practitioners, in order to better explain how we socially and politically construct our planning practice (Cervero & Wilson, 1994).

In addition to the metaphors, closer examination of practitioner terms and the frames of action implicit in them also warrant further attention. Practitioners in this study used the same terms with different meanings and purposes. For example, "networking" served the purpose for Doug to gather a critical mass of health promotion people in different organizations in order to lobby the government, whereas Kathy saw networking as sharing information, commiserating with and getting support from others in similar situations. This comparison also suggests the possibility of gender differences in the understanding of networking. In another example, "facilitation" meant responsibility to arrive at some resolution to Jess, whereas to Susan, it simply meant working with people through a process. Thus, commonly used terms such as networking, facilitation, co-ordinating, conflict resolution require further study, perhaps in Marton's (1984) terms to uncover different conceptions of meaning and their implications for practice, which may be linked to the different level of action frames as well.

Practitioners conceptualized planning in more active than contemplative terms, a reflection perhaps of the Western penchant for action than the Eastern bias towards meditation and reflection. It is rather paradoxical, but perhaps timely, that Schön and Rein (1994) promote increased practitioner reflection about practice in the current socio-cultural environment which emphasizes a high degree of visible, even frenetic activity. A greater valuing of reflective activity may contribute to its improved legitimacy as a part of planning practice. As Jess suggested, "To

the senior management, I would advise that they go into retreat and brainstorm, to put their ideas forward as to what they envision, what health promotion means to the organization" (Jess, 2-18).

Factors Influencing Planning

Practitioners in this study identified three key influences or frame factors within the organization which affected their program development activity: clarity and consensus on the concept of health promotion, the degree of senior management commitment and direction, and amount of collegial support and involvement. Frame factors and their negotiability provide a useful lens in this discussion. Whether a frame factor is construed as a limiting or supporting influence depends upon the congruence between the individual practitioner and the organization's (i.e., senior management and colleagues) understanding of that frame factor. The practitioner's perspective determines the perceived degree of negotiability around the limiting frame factor.

Health promotion concept. With respect to the first factor, hospital practitioners did not consider the concept problematic because their conception of health promotion as individual wellness was congruent with the organization's. However, the health department practitioners' view of the health promotion as community development and empowerment required that the organization rethink and change its way of doing business; hence, the factor was viewed by the practitioners as more of a constraint.

Having perceived a constraint, depending on the degree to which practitioners believed they could influence the situation, they came to view a factor as negotiable or non-negotiable and respond differently. Kathy believed both senior management and her colleagues within the health department did not understand and were not interested in learning about health promotion. She initially attempted to get the health promotion on the management agenda but finally gave up and

focused her attention on the outside community. Kathy is an example of one who perceived a number of key frame factors within the organizational context as ultimately non-negotiable. Susan, however, continued to challenge management when she thought they were not acting in accordance with their stated commitment to an empowerment notion of health promotion.

Senior management commitment. Senior management commitment and direction, including resource allocation, the second commonly identified influencing factor, was perceived as a constraint by practitioners in two hospitals and two health departments when the program was not viewed as a priority or central to the organization's mandate and not allocated adequate resources. Again, practitioners varied in their perceived ability to influence or negotiate the situation. When Doug realized that hospital senior management reneged on its commitment to support the Executive Health Screening project, he adapted to this constraint, switching to a new focus on the internal employee wellness program. In contrast, when Jess' hospital senior management also did not commit resources to the program, she actively sought out partnerships to seek resources. In the belief that by gradually building a credible health promotion program, piece by piece, she would be able to attract the necessary resources.

> I just think we can't sit back waiting for the administration or the hospital to support it. I think the reality is we have to go out there and find the funding support....It's almost as if I knew that...I was going to have to go out there and justify health promotion being here. (Jess, 1-19)

The constraint was perceived as negotiable over the longer term, as Jess began incrementally to build a case for more administrative support dollars which she eventually received.

Collegial buy-in. The third influencing factor was the involvement and support of colleagues within the organization. Elgström and Riis' (1992) competitive versus co-operative approaches to negotiation are relevant here. Two practitioners in health departments, Susan and Nina both believed in a redistribution or sharing of power, an arena of possible change for the

organization. Their approaches, however, differed: Nina took a gradual, structural, co-operative strategy of "infecting the organization" through secondments, modelling and empowering others consistent with the win-win, co-operative model.

> You have to reward them (staff)...and profile them consciously...Somehow it kind of clicked, I shouldn't be (meeting the Mayor). I should be sending the line staff who are working on the caregiver study because they should meet the Mayor...I can tell you it's done more good will. These women are just blossoming...Their peers see them as experts. (Nina, 3-17)

Susan's approach was more confronting because of her dislike of institutionalized power and she was often in conflict with her immediate supervisor. For example, Susan continued to advocate for the nursing staff with management (of which she was a member). In her opinion, staff control over decisions to re-arrange their desks, or to refuse to develop a manual on lice which they considered low priority and not useful, were within the scope of reasonable staff empowerment, although contrary to management directives.

Applying Schön and Rein's (1994) action frames, the practitioners's stories indicate they are involved in action frame self-reflection. The factors noted above: health promotion concept, senior management commitment and collegial involvement appear embedded in the program level action frame, that is, the level at which the individual institutional actor constructs the problem of a specific program situation. Most practitioners generally focused on these factors as they directly related to the specific and immediate practical program problems at hand. Preoccupation at this immediate action frame level may in part be due to the lower priority and vulnerability of health promotion programs within the organization, a problem of marginality of adult education-oriented programs within non-formal educational settings.

The program action frame alone can be criticized for reducing the analysis to a micro or individual level of perception and action. Additional action frames at higher levels of specificity

are needed to broaden the practitioner's understanding at a more macro level. Two practitioners did venture beyond the policy action frame level as they articulated their concerns. Susan targeted the institutional action frame level of control with her comments about the health department.

> This is the hardest part of working here, I find that I just lose it because they can't understand, they can't see that bureaucracy and institutions have institutionalized their staff, and that as long as you keep taking these decisions away from staff, why would you expect that they would go out and perform differently in communities? Because they don't know how. (Susan, 2-2)

Nina moved beyond the specificity of this individual program action frame level to the more meta-cultural level as she questions the sacred positions of professionals and the shift in paradigm to empowerment as we move into the 1990s.

> If you're a professional, nurse, or a professional doctor, or a professional social worker- forget it, because you're hung up in being a social worker, that you're going to always see [health promotion] from the point of view of social workiness, or nurse-iness. I don't think any one profession owns [health promotion]. And in some sense the thrust of the whole health promotion movement is not anti-professional but a different professional role...an interdisciplinary person....The task of the 90s is going to be to break that professional dependency and to get people involved in doing more for themselves and their community. (Nina, 3-18)

Thus, Nina's and Susan's considered the health promotion program at the three levels of action frames: the individual program frame level of a specific practice situation, the institutional level frame of organizational change, and the meta-cultural level with its implications for the broader society. While these two practitioners articulated awareness of these various frame levels, Holstein and Gubrium (1994) contend that all practitioner work is conditioned by "arrays of local interpretive resources - recognizable categories, familiar vocabularies, organizational missions, professional orientations, group cultures, and other existing framework for assigning meaning to matters under consideration" (p. 266).

While individual self-reflection is crucial, also key to situated frame reflection is the interaction and discussion that must take place among actors at all levels of the organization.

From practitioners we hear examples of discussions with senior managers, supervisors and peers about the health promotion program. Nina talked with her staff in retreats every six months - reflecting on their philosophy and approach. Susan worked with a group of nurses:

> Basically, I really feel that the staff need to go through a process of examining their own thinking, of stepping back from their day-to-day activities...assess the value of them....I wanted them to be able to share their ideas and get their ideas out and be aware of their differing approaches. (Susan, 1-6)

Susan reported discussing the concept of health promotion extensively with her supervisor, the Medical Health Officer. Similarly Gail spoke frequently with her Vice-President of Nursing and the Advisory Committee about the Wellness Centre. However, what is noticeable here is that the reflection and discussion going on with other practitioners within the organization occurred when there was congruence on the concept of health promotion. Perhaps this is an example of the converted talking to the converted. The more interesting question, is what reflection and discussion occurs when there is disagreement. Kathy's situation of not being able to get health promotion on the management agenda is a lost opportunity to examine other participants' frames.

From practitioners we also hear that not enough time is spent in reflecting and thinking things through. From Doug,

> It's been kind of fun to go back and look over it. [Reflection] is a good exercise for me. It's something you don't usually do, you're so caught up with the here and now and getting to the next thing that you don't stop and look back, and we should probably do that in our organizations more. (Doug, 3-25)

The findings suggest that from the frame reflection perspective, more time should be devoted to stakeholders in the organization reflecting together on their action frame levels, particularly at the institutional and meta-cultural levels.

Professional Performance

The third area of findings on professional roles and responsibilities, strategies and actions highlighted the importance of practitioner responsibilities in working with people and engaging them in health promotion activities. Practitioners identified roles of facilitator, coordinator, mediator, negotiator as they engaged in networking and creating opportunities for participation and learning. The people work of planning shaped their communication and negotiating strategies of how to get "buy-in" from others, both senior management and colleagues alike.

From a negotiated frame factor perspective, it can be suggested that the intent of negotiations affects the roles and strategies undertaken. In Krumholz and Forester's terms (1990) the effective planner has to be "professionally able, organizationally astute and most of all politically articulate"(p. 225). By this last term, they mean the planner's ability to "define issues, set agendas, working on problems without being invited to do so" (p. 225). This implies that the practitioner has a clear vision of what is to be achieved. According to Elgström and Riis' (1992) classification of negotiations, the actor's intent of negotiations can affect the roles and strategies undertaken. Nina and Susan can be considered target-oriented in their negotiations, as they articulated a goal of empowerment and organizational change which shaped their approach to health promotion. As change agents they sought to actualize community empowerment. Nina grappled with issues of who held the power, whose priorities would prevail: the health department, the three municipal governments or the community group. Supporting the Native community desire to hold a healing feast (which was not a department priority) was an example of putting this vision of community empowerment into practice. Susan also experienced conflict; as a manager, she chose to actively support the empowerment of staff against management in a number of situations. In contrast to these target-oriented practitioners, Kathy can be considered as

departure-oriented as she is geared for some change but held no clear vision of what community development was supposed to look like within the health department. The hospital practitioners: Doug, Jess and Gail can be considered status-quo oriented, as they hold the same conception of health promotion as individual wellness as their employer hospitals do. No hierarchy of evaluation is implied here, as all practitioners held some vision of their programs. These examples, then, suggest the potential impact of negotiation purpose related to vision on practitioner roles and strategies.

Recent writings on organizational development stress the critical nature of creating and maintaining vision (Senge, 1990). This view inevitably raises the structured relationships of power that need to be addressed in building commitment to that vision. If the vision of responsible planning involves developing substantive democratic processes (Cervero & Wilson, 1994) or ensuring "domination-free discourse which allows for true social, political and economic learning of citizens" (Forester, 1993, p. 264), the vision can be understood as reflecting a meta-cultural frame of individual empowerment and democratic principles--the same meta-cultural frame level in Nina's and Susan's vision. These practitioners acted on this vision and in turn acted on their environment which in turn will act upon them in a recursive manner.

From a frame analysis perspective, planning a new health promotion program invites the practitioner to engage in meta-negotiations. Although actors may have little room to manoeuvre where directives are specific and detailed, in this study of a new program concept, where many of the parameters or details were not specified, practitioners were given a relatively wide scope of action and flexibility in carving out their jobs. In such a situation possibilities exist for actors to engage in meta-negotiations, where the intent is to change the relevant framework for planning (Elgström & Riis, 1992) and as a result, have a greater impact on the structure within which the

decisions are made. Nina's action to formally set up a secondment which allowed others to be exposed to health promotion and then to return to their original position affected who was to be involved in decision-making and how, was a meta-negotiation. Similarly, Jess' initiative in setting up interdisciplinary work groups around non-threatening health promotion activities opened the door for people from different parts of the hospital to work and learn together, thus breaking down the isolation of departments and creating a new forum of interaction. Both Nina's and Jess' valuing of learning (at the program action frame level) and the awareness of the organizational structure (at the institutional action frame level) can be considered to have affected their strategies. These strategies can also be understood as structuration in action, as they altered the normal routine interactions of people, setting a new precedent for the structuring of relations within the organizations, which in turn will shape succeeding routine interactions.

I would be remiss in concluding this section without some consideration of the question of why some practitioners tend to view factors as non-negotiable and others are not as likely to accept the status quo. In their professional performance, some practitioners seem better equipped to raise analysis of frames to broader levels and others seem limited to more immediate concerns. This study suggests that there are individual characteristics that must also be considered, such as educational background, work experience, personal interpersonal style. The focus on the individual connects back to Lundgren's (1985) expanded version of frame factors to include personal values, beliefs, attitudes as well as competencies. The three action frames of program, institutional and meta-cultural may be further enriched by a fourth level of individual practitioner frame. The fact that Kathy came from the Prairies with its strong sense of community affected her expectations of team work from her health department colleagues. Susan commented that her background as one of seven children raised to take control of their own lives and make their own

decisions had an impact on her dislike of authority. Nina's former life as an "academic star" caused some difficulty in her adjusting to the invisible coach role. Doug's background in consulting in education and his personal interest in entrepreneurial activities contributes to his interest in the revenue-generating Executive Health Screening project. Gail's personal experience with health care problems of female family and friends is credited for her commitment to a women's health centre. These personal attributes and experience of practitioners are hinted at throughout these findings, but never directly addressed.

> Practitioners of everyday life are not "organizational dopes": mere extensions of organization thinking. They exercise interpretive discretion, mediated by complex layerings of interpretive influence. They also carry with them the biographical basis for resistance, personal and interpersonal histories that compete with organization categories as means for interpreting experience. (Holstein & Gubrium, 1994, p. 268)

A more comprehensive analysis of the individual practitioner would be instructive in this regard. Such an individual action frame level is in keeping with the interpretive perspective in developing knowledge on a case-by-case basis about planning practice.

Gender and Power

Up to this point, the discussion has focused on topics identified by practitioners in their interviews. An equally important issue is what the practitioners did not identify as they recounted their stories. What is missing has as much significance as that which is included (Mills & Simmons, 1995). Noticeably absent was any substantial discussion of gender, and while references to power were evident, for the most part, they did not exhibit extended critical analysis. Practitioner comments on gender were brief and passing. For example, gender was raised by the one male practitioner regarding the high proportion of female staff in the hospital. "We have a

women's wellness program which is made up of several components: a seminar on PMS, on menopause, on nutrition, on osteoporosis in women....Our [hospital] employee base is about 87% [women]...that's our big chunk" (Doug, 1-2). Doug also commented on how women and men engage differently at meetings: women establishing rapport about home and children, men establishing pecking order by status. Gail attributed her longstanding interest in women's health issues from her professional experience with women in small rural hospitals, and to her personal experience with female family members health concerns. Kathy's comment exemplifies the manner in which references to gender are inserted almost as an aside:

> I think networking with other health promotion people provides a reality check...there are four of us in the province that are working at a municipal level...and so that provides an opportunity to brainstorm solutions. But more than anything, I think, in speaking with the other women - they're all women - it's the frustration of [knowing] what health promotion is and not be able to accomplish that...I know they are bumping up against the same thing. (Kathy, 3-2)

The last phrase of "bumping up against the same thing" was intriguing as it was not clarified and could possibly refer to the power relationships in the organization's bureaucracy, or in the field of health promotion or in society in general-- all situations in which women hold less power. One might have anticipated additional comments, as five of the six practitioners were female, on their attention to networking, the nurturing of relationships, the contextualizing of events as part of women's ways of knowing (Gilligan, 1982). Practitioners may be thinking more about gender than what was manifested in the interviews, as I did not specifically ask about gender or probe their comments in this area further.

Gender is inextricably bound up with power relations. Given that women predominate in staffing both hospitals and health departments while the positions of power, the senior management positions of President and Medical Health Officer, tend to be male-dominated, there was little critical analysis of the structured relationships of power inherent in organizations or in

the larger society. The area of health promotion, and more generally, health care, is an example of occupational sex segregation as the field of caring for others has been long considered a female domain (Martin, 1994, p. 210). This gendering of occupations is an example of structural power defined as:

> The potential power of actors to influence others. It is an attribute of relations, not individuals, and it is determined by the control that actors have over events or resources that others value. (Molm & Hedley, 1992, p. 2)

It is at this macro level that structural power allocates the resources and status privileges differentially to men and women. The result is the reproduction of continuing gender differences at the more micro levels where opportunities and constraints are structured, where actors operate. When practitioners did talk about power and authority, it was mainly from the perspective of the program action frame level at the practical level, who held what power in decision-making that affected their immediate program development activities. Formally, they were aware of their position in the organizational hierarchy, aware that their ability to control staff and budget dollars affected potential power. Only two of the six had power according to the traditional criteria of status, staff and budget control and decision-making capacity: Nina and Gail. Gail's power rested in autonomy as her program was off-site, and considered separate from the regular mandated activities of the hospital. Nina, however, as Director of Health Promotion and Strategic Planner did hold a formal position of power within the organization. With staff and a budget, and a mandate for organizational change, Nina was in a more advantageous position to define the problem and the alternatives to be considered.

Gender influences how we view power and power relations: men being more likely to conceive of power in terms of domination while women view power in terms of relationships and nurturing (Candib, 1994). Practitioner comments appear to mirror this distinction. Doug stated,

"I'm pretty low on the totem pole around here...there wasn't any way that I was able to manipulate that situation [to get senior management to support the Executive Health Screening project]" (Doug, 1-20). Nina said:

> I'm really excited about recognizing that my power is only proportional to the number of people I can enroll in some sense to think like I do within the organization....maybe not think the way I do, but act more strategically and more collectively or collaboratively. (Nina, 1-4)

This quote of Nina's while expressing interest in relationships with others, also hints at the potential for manipulation through influences. This begs the question of the ethical nature of practitioner's intentional actions which will be raised in the final chapter.

Kathy also viewed herself as relatively powerless. Kathy felt like an lesser partner at the senior management table as she had neither direct line staff to supervise or a budget to control. Jess also sat lower in the bureaucracy with little recognition or resourcing, yet while she felt "overwhelmed" at times, Jess did not express this as powerlessness, and started to develop a program by creating opportunities and seeking out resources. This difference again speaks to how practitioners vary in their responses to organizational constraints.

The major point of this discussion is the importance of power and gender relations and their relative invisibility in the stories of practitioners. From my perspective, interpretation of practitioner knowledge requires that the underlying frame factors of gender and power be made more visible, more explicit, and that their implications at the varying levels of program, institutional and societal levels be reflected upon. Aside from Nina and Susan, the practitioners generally did not speak extensively about structured relationships of power or frame their work in terms of potential influence on negotiating interests within these structured relationships. Again, it should be noted that this does not imply that practitioners lacked awareness of these issues, only that they were not articulated in the interviews. Reflection in gender and power relations at all of

the three action frame levels suggested by Schön and Rein (1994) would be instructive. Clearly, further research in the area of perceptions of gender and power relations in planning practice would be valuable.

Empathic Knowledge

An analysis of gender and power brings us to the concept of empathy as it relates to frame reflection. Empathy has long been viewed as part of women's nature, part of women's work and associated with female skills and traits inherent in caring for others--and as such undervalued by Western societies (More & Milligan, 1994). Empathy has been defined as the capacity "to leave the security of one's own beliefs, feelings, and frame of reference at least briefly in order to approach the feelings, thoughts, and world of another...in a good faith effort to 'hear' the other" (pp. 3-4).

In situated frame reflection actors reflect *through* the specific problems, on the old and new frames, importing key elements and evolving new frames through a dialectical discourse with others engaged in reflecting on the same issue. The challenge is, first to become aware of our frames because they are usually tacit and we are not cognizant of their impact on the way we organize and construct our thoughts, feelings and actions (Schön & Rein, 1994, pp. 34-40). Genuine and effective frame reflection also requires that we put ourselves "in other people's shoes" if the practitioner is to discover and understand the frames of others in order to dialectically derive a new frame reflection, moving disagreements and conflicts closer to resolution. Thus, the concept of empathy with its inherent value of mutuality, a core feminist practice, becomes critical to situated frame reflection.

> The more I learned the more I realized how much I didn't know, and really how other people were struggling with the concept too...what was necessary was to have individuals like myself out there and attempting to try to work towards that understanding and...opening up opportunities for discussion. (Jess 1 - 10)

Communication and the building of relationship is necessary in situated frame reflection with others. "Empowerment arises in the context of a relationship. The experience of mutual empathy and empowerment can be facilitated through the creation of growth-promoting relationship contexts in any area" (Surrey, 1991). Feminists observe that as women encounter "unequal meetings" (Noddings, 1984) - they engage in an empowerment approach that mutually enhances both the other's power as well as their own. The ethical and responsible use of empathy and empowerment reap positive rewards. However, the misuse of empathy and empowerment process is also a possibility and warrants a caution. Being attuned to another's thoughts and feelings can also be used to control and manipulate behaviour (Lang, 1994). Jess particularly emphasized the importance of listening to others and establishing relationships. However, in making the comment, "and once you've got those people...then it's easy to get them involved...and the momentum keeps gathering" (Jess, 1-19) - the question of possible manipulation arises.

Practitioners all spoke to the importance of relationships as they created opportunities for learning and participation. However, to limit the discussion on empathy to positive interpersonal relations and not consider its broader ramifications is to "naturally confine it to the caring, nurturing activities of a 'private' domain, and rob it of its political influence "(Code, 1994, p. 88). In contrast to empathic relationships, bureaucratic societies value formal structures and association, thus contributing to our isolation and,

> Harm our capacity to take the perspective of others onto our selves and our situation, to imagine alternatives that come from shared experiences....Even institutions that profess to look after people's needs - medical care, social welfare, education - [have been] marked by the same absence of empathy. (pp. 77-78)

However, within the last few decades, professionals in many fields have become aware of the concept of empathy (More & Milligan, 1994, pp. 3- 5), as they realize that by remaining at a distance and being personally absent from those they serve, they miss essential detail. Thus the knowledge derived from empathy has taken on a new legitimacy.

The Western quest for objectivity, certainty and control has shaped what is considered knowledge and is reinforced by a psychological and social "dis-ease" with uncertainty related to ambiguity, intimacy and interdependence. Thus, knowledge derived from empathy is easily devalued because it is associated with relational and empathic skills linked to the women's domain (More & Milligan, 1994). Empathic knowledge is congruent with emergent interpretive epistemology because it can accommodate ambiguity, and therefore, knowledge about life as it is lived (Code, 1994). The construction of empathic knowledge remains open to interpretation and reinterpretation and is based on "a case-by-case interpretive inquiry, which resists totalizing or universality....The 'fit' of each empathetic claim has to be assessed, separately and sensitivity" (pp. 84-87). Thus, the emergence of empathic knowledge as it increases as a legitimate source of knowing carries with it a potential to alter the day-to-day interactions of human agents which in turn affects the larger social structure within which the daily activities occur.

Summary

Within the context of increasing legitimacy of interpretive inquiry and the reconceptualization of planning as a communicative, social act, it is but a short and expected step to focus on individual practitioner understanding of planning practice. In this chapter, insights from frame perspectives were used as the lens through which to interpret the findings of the study

around practitioner metaphors and language of planning practice, factors within the organizational context and professional performance. The identification of frame factors and their negotiability, the levels of action frames and situated frame reflection were key to the analysis.

Analysis of the first theme area of language of practice suggests that practitioner choice of metaphor and language is important to carefully examine.

> We learn a language that is categorical, and categories frame our perception....Yet labels and theories are not without their costs. The very order that they provide engenders expectations that often impede fresh perception. Labels and theories provide a way of seeing. But a way of seeing is also a way of not seeing. (Eisner, 1991, p. 67)

Eisner draws attention to this phenomenon of the unseen as the "liability of antecedent knowledge." As we seek to make explicit our antecedent knowledge, as embodied in our metaphors and language, we may uncover new ways of seeing. An examination of metaphors used by practitioners from frame analysis reveals how they may be interpreted as reflecting action frames at the program, institutional and meta-cultural levels, and how they are used to interpret our experience, and shape and rationalize practice. While language may function to control and shapes us, because language is dynamic, we can also use language to shape our reality. Such an orientation also suggests that we introduce new metaphors into the planning literature which may lead to the uncovering of more creative knowledge.

With regard to the second group of findings, practitioners identified three key frame factors which influenced the planning experience: the health promotion concept, the senior management commitment and the collegial involvement. Factors were further viewed as negotiable or non-negotiable depending on the perception of the individual practitioner. This perception is key, as it shapes what practitioners consider within their scope of influence or action. These three frame factors and their negotiability, in interaction with a fourth personal frame factor of values, beliefs, attitudes and competencies (Lundgren, 1985) are relevant to the

third area of findings on professional performance. The practitioner's microtheory of practice affects practitioner choice of roles and actions, influencing where, when and how practitioners both create and respond to "windows of opportunity" or "obstacles to be ploughed through." Particularly in planning new programs, practitioners have the opportunity to engage in meta-negotiations and can influence the decision-making framework within which the content or substantive negotiations then take place.

The frame analysis raised significant issues around the relatively invisible frame factors of gender and structured relationships of power, and the need to examine these frames at the different action levels, and their implications for practice. An analysis from the gender-power perspective would contribute to a broadening of frame factors which then acts to reshape our understanding and ultimately our visions. In any interpretive inquiry, the interpretation is always open-ended, subject to new information, new ideas and new interpretations.

Practitioners appear to value reflection but have difficulty finding the time to engage in this activity. Perhaps it is necessary for writers of adult education planning literature to further examine the importance of reflectivity and mutuality, to encourage practitioners to reflect on frames which drive not only their own but other people's visions, thoughts, actions and feelings, and to do this through communicating with others. The literature addresses the iterative nature of planning, with reference to an entry point at any stage of the conventional model (e.g., needs assessment, objective-setting), and a back and forth weaving of the tasks connected to these stages. We might consider the possibility that practitioners do not move iteratively in and out of various action-oriented tasks, but back and forth between reflection and action within a complex and dynamic environment of interests and power relationships. To effectively engage in situated frame reflection requires an empathic practitioner open to understanding the frames of others.

Here we arrive at the potential of empathic knowledge, the knowledge which may be gained in relationships of empathy and mutuality.

CHAPTER VII

SUMMARY AND IMPLICATIONS

Program planning in adult education from the 1950s into the 1980s was generally viewed as a technical-rational process; a view consistent with the positivist approach to social phenomena. With the challenge to the positivist paradigm came a renewed interest in the interpretation of meaning in social and educational inquiry (Smith, 1993). A discernible shift occurred from tangible activities and products to practitioners themselves and their perceptions of the phenomenon under study (Eisner, 1991; Forester, 1993). In line with the interpretive approach, program planning over the past decade has been portrayed more as a social interactive process. This study was designed to learn more about program planning from practitioners and to understand how those who are directly involved in planning make sense of their work. The research addressed two critical issues in the adult education literature: the need for additional practice-based studies grounded in practitioner experience particularly in non-formal educational settings, and the long-standing concern regarding the gap between the theory and practice of program planning.

The research question posed in this study was: What is the nature of planning programs from the perspective of practitioners? The question incorporated three specific areas of inquiry: an investigation into the language and metaphors practitioners used in talking about the practice of planning, the factors they identified as key influences on program planning, and the roles and actions they undertook in their professional work. Practitioners who were actively engaged in planning health promotion programs in health care settings were the focus of the research. Six

individuals, three from hospitals and three from public health departments in the Lower Mainland of British Columbia participated in three in-depth interviews. The transcriptions of these taped interviews offering "rich descriptions of individual, unique events" (Argyris, 1982, p. xvi) provided the data for this study. In this final chapter, the key findings are first briefly recounted followed by the insights gained from a frame analysis of these findings. The chapter concludes with a discussion of the study's contributions to our current knowledge about planning and implications for further research and professional curriculum development. A summary of the links among the three thematic areas of findings, the insights from frame analysis and the implications for practice are diagrammed in Figure 1.

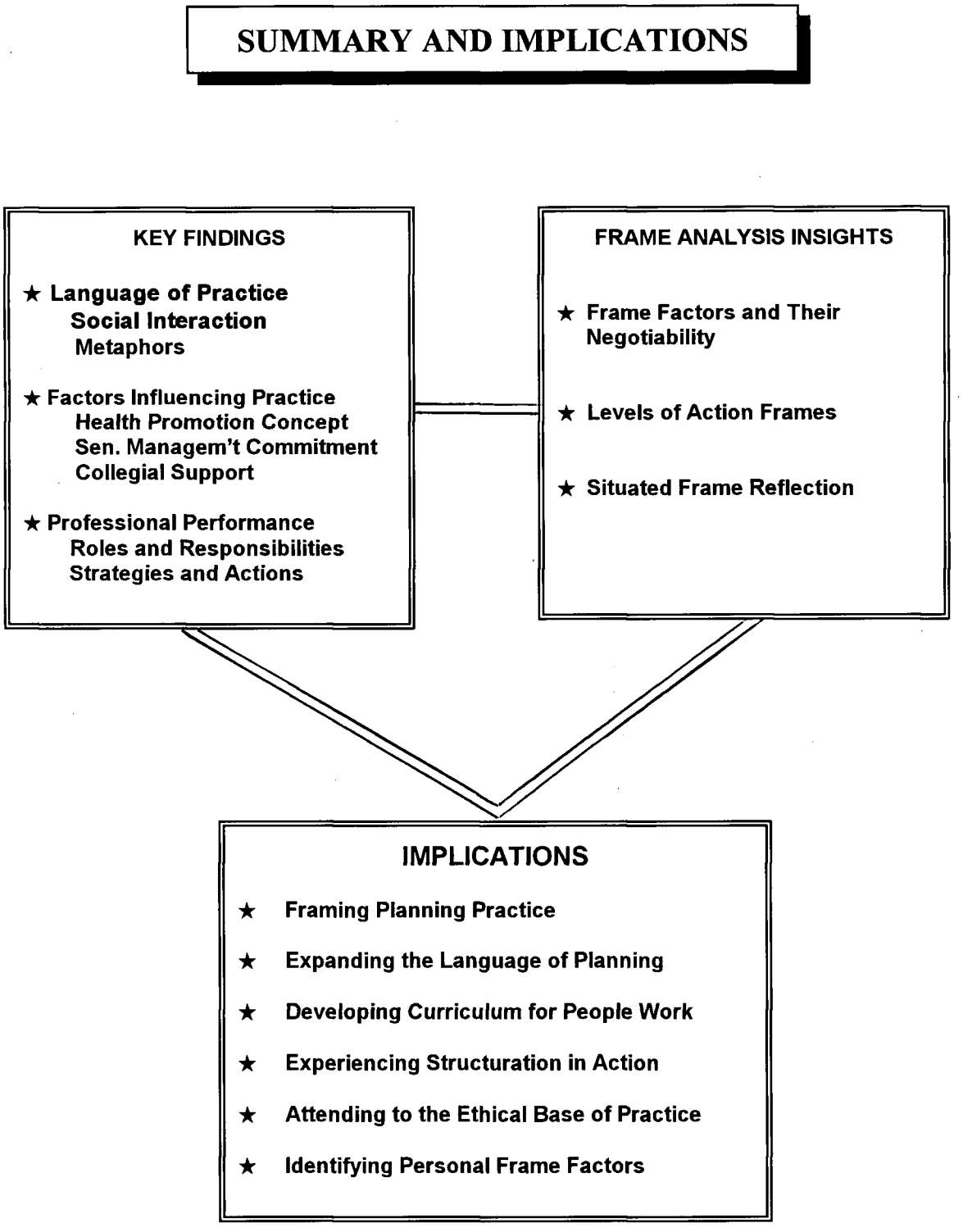
Findings

The findings discussed in detail in Chapter V are presented briefly in the three following thematic areas: language of practice, factors influencing practice and professional performance. The three areas are not to be held as mutually exclusive categories but are inextricably integrated in practice.

Language of Practice

The language of conventional models of planning does not capture practitioners' experienced realities. Practitioner descriptions of planning emphasize the uncertain, dynamic and demanding aspects of social interaction and planning environments. Metaphors of military battles, sports events, adventures of exploring are colourful representations of competition, leadership,

Figure 1


SUMMARY AND IMPLICATIONS
KEY FINDINGS
★ Language of Practice
Social Interaction
Metaphors
★ Factors Influencing Practice
Health Promotion Concept
Sen. Managem't Commitment
Collegial Support
★ Professional Performance
Roles and Responsibilities
Strategies and Actions
FRAME ANALYSIS INSIGHTS
★ Frame Factors and Their Negotiability
★ Levels of Action Frames
★ Situated Frame Reflection
IMPLICATIONS
★ Framing Planning Practice
★ Expanding the Language of Planning
★ Developing Curriculum for People Work
★ Experiencing Structuration in Action
★ Attending to the Ethical Base of Practice
★ Identifying Personal Frame Factors

strategic action, risk-taking in complex undertakings. Such images differ markedly from the conventional view of planning as a technical-rational decision-making process.

Factors Influencing Planning

Practitioners identified three key frame factors within the organizational context that influenced practice. The first factor, clarity and consensus on the concept of health promotion, illustrates the dynamic interrelationship between the interpretation of the program concept and the organizational setting. The hospital focus on wellness and lifestyle and the health department focus on community development affected the direction and nature of program planning activities. The second factor of senior management commitment addresses the formal relationships of power and control over resources. In health care organizations where education is not the primary mandate, health promotion programs can be viewed as being of less priority, with lower status and fewer resources. The third factor of collegial involvement points out the systemic nature of planning practice in which many parts of the organization are affected by the program to be developed. Practitioners must work to broaden the basis of support, to engage in networking and buying-in their colleagues in order to maintain program survival.

Professional Performance

An examination of the myriad roles and responsibilities, strategies and actions undertaken by practitioners highlight the importance of the people work of planning, regardless of the organization's focus of health promotion on wellness or community development. While practitioners may not have the formal position of power and authority to direct the work of others, they do encounter rich and varied opportunities in their contact with people where they

may potentially influence agendas, interpret work tasks and thus shape the program to be constructed.

The three thematic areas of findings are consistent with the overall portrayal of the social interactive nature of planning practice currently reflected in the literature. While these findings are of interest at the level of descriptive commentary, they take on more significant meaning when viewed through the conceptual lens of a frame analysis.

Insights from Frame Analysis

The frame perspective can be understood as a way of organizing information and interpreting a social phenomenon by imposing different frames or underlying structures of values, beliefs and attitudes upon that phenomenon. Elgström and Riis (1992) and Schön and Rein (1994) provide two approaches to frame perspective. Insights from these two approaches are used to further interpret the findings. More specifically, the notion of *frame factors and their negotiability* is borrowed from Elgström and Riis (1992); the two concepts of *levels of action frames* and *situated frame reflection* are taken from the work of Schön and Rein (1994). Applying these insights from the frame perspective selectively to the study's three theme groups of findings provides one way of interpreting how practitioners organize and make meaning of the work of planning programs.

Frame Factors and Their Negotiability

Three key frame factors (second theme area of findings) were considered as major influences on the development of the program: the health promotion concept, senior management

commitment, and collegial support. Practitioners' identification of factors which affect their work has frequently been addressed in the literature. However, the salient point here is the recognition that practitioners further interpret a factor, framing it as supporting or constraining, and consider the degree of negotiability around it. This framing varies with the individual practitioner, and helps us to understand practitioner action.

For example, where factors are considered constraining such as in a situation where the practitioner's and the organization's understanding of health promotion are not congruent, or where senior management does not allocate adequate resources to the program -- how practitioners interpret, strategize and act on these constraints emphasizes the need to attend to practitioner perception of the negotiability around these factors.

> Any practically appropriate account of planning, then, should address (though not necessarily accept) the planner's senses of constraints. It should help us to understand that one of the most significant constraints that planners face is *their own perception of the constraints* [italics added] in any given situation. (Forester 1993, pp. 17-18)

Therefore, factors frequently and often simplistically noted as insurmountable obstacles to planning and assumed to be intractable, such as an "impenetrable bureaucracy," " lack of resources" or "resistant senior management" deserve closer scrutiny from an interpretive perspective.

It is equally important to pay attention to frame factors which have not been explicitly articulated by practitioners. Practitioners, although they may have thoughts on the subject, did not specifically discuss factors such as gender or power to any extent, closing off potentially important avenues of interpretation and action. This observation raises the question of the importance of rendering underlying frame factors of gender and power more visible in a critical analysis of planning practice. Through awareness and articulation of such missing factors, we can

expand "our domains of knowledge" and begin to notice and interpret these new domains, which in turn affects our experience (Eisner, 1991, p. 66), which in turn affects our action.

Level of Action Frame Analysis

From practitioners' stories, the language of practice (first theme area of findings) centres on the program action frame level, that is, the level at which the practitioner constructs and seeks to resolve specific and immediate program concerns. Given their responsibility for the new program, this level of action frame is fully understandable and expected. However, some practitioners also talk about the organizational and societal implications of their program -- indicating an awareness of the other levels of action frames, the institutional and the meta-cultural.

From practitioners' metaphors, we gain some insight into how an individual orders and makes sense of social reality. Practitioner metaphors of planning practice as battles, sports events, ventures of exploration emphasize the uncertainty of the environment, the competition of vested interests, and the developing nature of activities and outcomes. If we accept that metaphors are complex reflections of societal values and beliefs, by further examining the values and beliefs embedded in the metaphors, we can begin to understand how we socially and politically construct our experiences of planning. From an action frame level of analysis, these metaphors can be seen to contain not only the specific program, but the organizational and the broader societal levels of understanding of how the world works (Schön and Rein, 1994). Practitioners who develop an awareness of the various levels of analysis through their metaphors and language may broaden their understanding and questioning of how they construct their world.

Situated Frame Reflection

Effective situated frame reflection requires reflective talk among various actors in the planning context, a sharing of individual perspectives as they move to develop commonly held frames within which to resolve differences and take action. The findings on professional performance (third theme area of findings) of roles and responsibilities, strategies and actions also indicate that practitioners appear to reflect and act mainly at the tangible program level. In this study, practitioners also engaged in reflection and interaction with persons at higher levels within the organization but usually among like-minded colleagues. The findings suggest that when practitioners explore their planning challenges at different action frame levels with others holding different perspectives, they may expand their viewpoint, and broaden the issues to which they pay attention.

Practitioners also indicated that engaging in reflection with their colleagues was an important but often neglected activity. The iterative nature of planning mentioned in the literature involves not only movement back and forth among the technical tasks or stages of planning, but can be considered to occur at the reflective level, where action is shared by ongoing consideration of the micro to macro levels of frame analysis. Insights from frame perspectives propose that the more frame factors and levels of action frames one becomes aware of, the richer the understanding and the potential scope of influence and action. Actions resulting from this quality of reflection may result in practitioners becoming involved in more "responsible" planning (Cervero & Wilson, 1994) within the organization and the broader community. Thus attention to frame factors and negotiability, and to action levels of frames through the context of the immediate practice situation can be potentially illuminating for practitioners. Reflection can clarify

aims, and "our aims influence our language, and our language influences our perception" (Eisner, 1991, p.67).

Implications

A review and integration of the key findings and the analysis of these findings from a frame perspective lead to a consideration of their implications. This inquiry on practitioner perceptions of program planning contributes to the body of planning knowledge in the following six areas:

- framing planning practice
- expanding the language of planning
- developing curriculum for the "people work" of practice
- understanding structuration in action
- attending to the ethical base of planning practice
- identifying personal frame factors of practitioners.

All areas are interrelated, as each is connected to and carries implications for the other areas.

Framing Planning Practice

Insights obtained from the frame analysis of the findings contribute to our understanding of planning, as was discussed in the previous chapter. Briefly stated, it may be said that by examining frame factors and their negotiability, by identifying the different levels of action frame analysis undertaken, and by reflecting on the degree of intrapersonal and interpersonal reflection carried out, practitioners can potentially become more aware of the institutional and societal

structures impacting on the planning process. Such awareness serves to enlarge the perceived scope of possible individual response and action. In this way, frame analysis offers practitioners a way to understand planning from a more comprehensive and critical perspective.

A fruitful exchange of situated frame reflection further assumes a respect for others' ideas and the establishment of empathic relationships. Feminist perspectives on connected knowing, inclusiveness and empathic understanding (Belenky, 1985; Gilligan, 1982; More & Milligan, 1994) can enrich the discussion in this area. The caring professions of social work, nursing, teaching -- all of which have been gendered as female occupations -- have long known the importance of empathy to developing effective and empowering working relationships among people. Considerable work in these fields has already been done on empathy, interpersonal communication and the professional use of self which may profitably be shared with planning practitioners as useful and significant knowledge. Within the interpretive paradigm, empathic knowledge is increasingly viewed as a legitimate source of knowledge.

Expanding the Language of Planning

The limitations of traditional planning language premised on a technical-rational model has been well-documented (Adams, 1991; Apple, 1990; Cervero & Wilson, 1994; Pennington and Green, 1976). The findings confirm the more recent conception of planning from an interpretivist perspective as social interaction involving acts of communication and negotiation; they also provide a richness of metaphor and language upon which to further explore the conversation about planning. Through an enriched understanding of practitioner perceptions emerges the potential to rename and reconstruct the planning concept to better capture the experiences of planning practice.

Practitioners use metaphors and language to describe planning as an uncertain, iterative, complex activity which involves the participation of others, emphasizing the people work of planning. Such comments affirm recent discussions in the planning literature over the past decade as learning (Pressman & Wildavsky, 1984), as consensus building (Adams, 1991), as a communicative act (Forester, 1989) and as negotiation of power relationships and interests (Cervero & Wilson, 1994). Practitioner metaphors of leading military battles, winning sports events, exploring new territory constitute a rich mine for future research as we further contemplate these images.

Practitioners describe themselves as action-oriented, not primarily engaged in planning per se, which they conceive of essentially as a thinking stage prior to implementation. This raises the immediate question of what terms would more accurately reflect practitioner work. In the adult education literature, some writers (Boyle, 1981; Kowalski, 1988) prefer the term program development to planning to address this very concern. However, the concept of program development, similar to other words commonly used by practitioners such as networking and facilitation often carry different understandings. Terms such as negotiation, communication, democratizing processes presently appearing in the planning literature are other examples of such concepts warranting further study. Another fruitful area of research to be pursued may be Marton's (1986) phenomenographical approach to uncovering different conceptions of these concepts, which may aid in the building of common understandings and use of terms, contributing to improved communication.

Language is dynamic -- language may control and shape us, we may also use language to shape our reality (Smith, 1993). Facing the challenge of an established history of the language of positivism in the field, interpretivists continue to develop an appropriate language to talk about

forms of knowledge that are not hierarchic or taxomic in nature from this previous tradition (Lincoln, 1990; Green, 1994). This same challenge remains in the area of program planning if the language of practice and language of theory are to be more closely aligned and understood within an interpretive perspective.

Developing Curriculum for the "People Work" of Practice

Involving people in the planning process has long been recognized as an important general principle in the literature (Boyle, 1981; Knowles, 1980); however, the people work of practice has not been "a primary source of insights about planning" (Cervero & Wilson, in press). Practitioners in both hospitals and health departments, regardless of their focus on health promotion, have confirmed the centrality of interpersonal communicative activities in their process-oriented roles. The challenge to promote and obtain support for the health promotion program appears to be greater in non-educational institutions where the primary mandate is health care not education, and the program is more likely to be viewed as marginal and thus more vulnerable.

The social interactive nature of planning implies practitioners must be skilled in working with people. Program planning curriculum would benefit from including greater attention to communication and interpersonal skills such as active listening, group process, conflict negotiation, and consensus-building. In the current context of valuing individual and community participation and empowerment, practitioners need to become more familiar with process and facilitation skills, working from a strengths perspective and building on the capacities of the target group populations. This approach is applicable to planning programs around any number of community education concepts: for example, empowerment, anti-racism, community care, gender

equality, sexual harassment--which may be controversial in nature, yet require a high degree of people involvement.

The focus on interpersonal communication and relationships while a key component of the practitioner's collection of knowledge and skills, does not imply that the technical knowledge is no longer of import. As shown in the study, practitioners continue to organize meetings, carry out research, write proposals, plan workshops. As the focus tends to blur the backdrop, with the current attention to social interaction, it is important to maintain a balance of both process and technical roles in practice. This caution is particularly relevant with current thought in the literature which reflects a growing anti-professional feeling (Schön, 1987). Rather than a dichotomous approach of technical versus process-interactive roles, or professional versus non-professional, it would be more consistent with an interpretive approach to ask how we are naming the problem and to explore how such concepts as "professional," " planning," and "expert" are being constructed and reconstructed. Further interpretive research is needed to include other players in the planning process such as managers, colleagues, and consumers to enhance our understanding of the dynamics of communicative acts of planning. Research needs interpretive analysis "tied to meaning-giving capacity and predispositions of diverse social and political actors" (Forester, 1993, p. 34).

A final comment about curriculum relates to assisting practitioners in developing a capacity for frame analysis. Both in the consideration of a range of frame factors as well as reflection on the different frame levels, a more integrated look at planning across several disciplines may be beneficial. As different disciplines use different tools which in turn render different meanings, curriculum planners may look to other fields such as to organizational development for thoughts about the learning organization (Senge, 1990), to sociology and social

work for the concept of community development (Kretzmann & McKnight, 1993), to psychology for individual empowerment and solution-focused therapies.

Understanding Structuration in Action

Structuration is the process by which both social reproduction and social transformation occur (Giddens,1984); a process in which human agency interacts on and is acted upon by the social institution. Power relations and interests both structure planner action and are reconstructed by planner action (Cervero & Wilson, 1994). The concept of structuration can serve to provide a broader, long range view to practitioners of their day-to-day work, and may assist them to appreciate their potential sphere of influence and action, and impact on the organization and societal structures.

This study on health promotion provides a useful example in understanding structuration in action, illustrating the human agency-structure link. Hospital practitioners view health promotion as wellness and individual lifestyle choices -- considered the micro level, while the health department practitioners focus on a more macro level of community development and empowerment which assumes organizational and societal change. The concept of health promotion is not dichotomous, but requires and embodies both aspects in its understanding and implementation. From a wellness perspective, as individuals gain greater control over their decisions which affect their health, they have more information and decision-making power, and engage in more balanced, equal power relationships with medical professionals. In turn the medical professionals increasingly acknowledge the rights of patients as consumers, resulting in shifts in the professional-patient relationship. In community development approaches to health promotion, the focus is on group empowerment, where group members feel "empowered," that is,

they have some choice in matters that collectively affect their health. Such choices may then entail requests for changes in the larger structures, for example, in the way services are organized and provided to the community, which in turn affects the way society views the health care system. In this way, practitioners engaging in their routine interactions in both individual wellness and community development, may become more cognizant of how these routine interactions form the basis of constructing and reconstructing power relationships, and can impact not only on the immediate program but also on the organization and society.

The other side of social transformation to be considered is social reproduction of existing power relationships. Practitioners may also question the institutionalized approach to health promotion. The high profile nature of health promotion over the past two and half decades can also be understood within the context of a declining global economy, a spiralling national debt and soaring health care costs. As no course of action is neutral, the question can be raised as to the possible "hidden agenda" of this health promotion phenomenon promoted by government and its potential for further control of resources, and continued disempowerment of certain groups within society.

The frame perspective, with its distinction between meta-negotiations (about the framework or structure of negotiations) and substantive negotiations (about the content) also carries import for thinking about structuration. Meta-negotiations provide a way of understanding how practitioners can influence the basic frame factors of how planning is to be carried out, who is to be involved, and where, when and how decisions are to be made. Such negotiations are about interests and power relationships (Elgström & Riis, 1992). Some practitioners in this study were involved in meta-negotiations of this nature, which could affect organizational power structures and relationships. Other practitioners were engaged in more substantive negotiations

around the content specific program offerings (e.g. diabetic education or nutrition). Consideration of this distinction might lead to better understanding of the complexity and difficulty practitioners face in non-formal organizations when charged with responsibility for setting up a program which involves different levels of negotiations. In this way, practitioners may understand more clearly how their everyday transactions affect and are affected by the larger institutional and social structures.

Attending to the Ethical Base of Practice

The current reconstructing of the planner from "neutral technician" to a valued-based professional carries major implications for a professional curriculum. If, as has already been suggested, responsible planners carry a commitment to democratic processes, we are promoting a more normative model of planning. While democratic process is consistent with adult education goals of individual empowerment and societal change, care must be taken not to create another reified model of planning to replace the technical-rational model.

As this study has established, the social interactive nature of planning is key to effective planning practice. The communicative act requires more than skilful communication; it involves the four dimensions of shaping others' beliefs, consent, trust and understanding (Forester, 1993). Therefore, practitioners carry an ethical responsibility in their planning work. Indeed, ethical practice could be considered another frame through which to examine the three thematic areas of findings. Perhaps, practitioners are to be encouraged to scrutinize their own thinking from an ethical perspective and make more conscious choices about their use of language and metaphors, about the influencing factors that they select to focus on, and about their actual strategies and actions.

Ethical challenges could arise, for example, around the concepts of empathy, process and empowerment. The argument for practitioners skilled in developing interpersonal, empathic relationships has been made to accommodate democratic processes. However, the potential misuse of these concepts in practice must also be considered, recognizing that the interpersonal skills training can also be used for manipulation for one's own ends (Lang, 1994). Similarly, while process and facilitation are important to planning practice, the possibility also exists for endless, non-productive process with process becoming an end in itself. Taking the position that practitioners do "have a concrete place in the matrix of power"(Cervero & Wilson, 1992, p. 147), further discussion and research is required on the nature of power inherent in planning positions and the use and abuse of power. Empowerment is also a term that appears to go hand-in-hand with democratic planning; however, caution is warranted. We must look beyond the rhetoric of empowerment and understand who uses it for what purpose, who benefits from what results. As one practitioner states after an experience in community coalition planning:

> As practitioners, we should be cued to be aware of those situations in which interests, roles and relationships, as well as the ability to influence based on these may not always be facilitative to the empowerment planning process. In fact, it is very likely that the empowerment process could get lost or subverted in the midst of power relationships, interests, and sociostructural and economic issues. Thus, we are mandated to work with the participants in planning environments to identify, quantify and track the benefits and effects from the planning room to the community streets. (Carter, in press)

This quote stresses the importance of practitioner accountability, and the need for evaluation of effort, not only in product but process. In this study, however, practitioners made few comments about evaluation or the development of evaluation plans. Lack of attention to this key area of practice suggests that evaluation needs to be re-examined with regard to how it is currently conceptualized and incorporated into planning curriculum.

Practitioners to some extent talked about their overall vision of health promotion; however, they do not make explicit the reasons for their ethical base of practice, in other words, their justification or basis for ethical judgments. More work is needed in clarifying practitioner reasoning of ethical practice (Sork, in press). Ethics deal with what is considered *right* and *correct.* Increased interest in professional ethics is seen by some as "a desire to retrieve human values and moral concerns from the high-tech influence of science, professionalization and rapid technical innovation" (Walrond-Skinner & Watson, 1987, p. 5). An interesting avenue of research to pursue may be connecting the concept of empathy in effective planning practice and the issue of ethics.

Identifying Personal Frame Factors of Practitioners

The interpretivist perspective holds that individuals socially construct their realities. As we have seen from the study, knowing more about how practitioners think, feel and act, and the interplay among these aspects provides a richer information base from which to understand the influence of the practitioner on the planning process. Argyris' (1982) concept of microtheories of action may be considered a useful framework for such an analysis. The practitioners themselves represent an interesting mix of individual profiles of gender and age; they also vary in professional background, educational level, with familiarity with health care organizations, with length of time in the job, and by previous work experience. Practitioner comments about their personal lives, their upbringing, their values and beliefs also influence their thinking and actions. Sork (in press) also queries what characteristics of the individual planner might add "depth to our understanding of the social dynamics of planning."

The study's findings underscore the importance of the individual practitioner, each with his or her own configuration of personal attributes and thoughts. Thus, in addition to the three levels of action frame presented: program, institutional, and meta-cultural, a fourth level of individual action frame, can be proposed. This frame level focuses in on the values, beliefs, attitudes and competencies each unique practitioner brings to the planning situation. Research in this area may be instructive in locating certain communication styles, personality attributes, professional training, background characteristics which may lend themselves to more effective planning practice when viewed as involving negotiation of interests and power. Similar to the architect with artistic abilities, or the surgeon with exceptional manual dexterity, planners require unique knowledge, skills and sensitivities.

Having made this argument, however, it should be acknowledged that practitioners do not operate in isolation, but "mind-mediate" (Eisner, 1991) their experience and their environment. Through interpretive practice, this mind-mediation "engages institutional frameworks, formal and informal categories, and long-standing cultural patterns - socially established structures of meaning....[as] the accomplishment of order and meaning is highly localized, artfully crafted yet contextually conditioned" (Holstein & Gubrium, 1994, pp. 266-270).

Contribution to Theory Development

Much of the literature on program planning has focused on providing models of practice rather than developing theories of planning; efforts have been directed towards clarifying ways of going about planning rather than explaining how planning occurs. This study, similar to the work of Cervero and Wilson (1994) and others, departs from this tradition to take a closer look at how

practitioners understand this form of practice. This understanding is an important first step in the development of planning theory, if theory is to be useful in describing and explaining this social phenomenon.

Theory requires the identification of key concepts which are then linked in meaningful relationships. Cervero & Wilson have proposed such concepts and relationships through their interpretation of planning as "negotiation of interests through structured relationships of power." This study contributes to the development of planning theory by taking this view a step further by expanding our understanding of some of these concepts. For example, to understand negotiation in practice, more needs to be said about the possible purposes, forms and outcomes of negotiation. This study, through its discussion of such concepts as meta- and substantive negotiations and frame factor negotiability, may help to broaden our thinking about the nature of planning when it is best regarded as a process of negotiating interests.

Concluding Thoughts

In undertaking this study, and in anticipation of rich and varied responses, my intent was to explore practitioners' perceptions of their planning experience in order to deepen our understanding of our social construction of planning. Viewing planning practice as a communicative, social act as reflected in practitioners' stories frees us to expand the boundaries of the concept and, therefore, the grounding on which the body of planning knowledge rests. The interpretation of the findings from a frame analysis highlights the value of reflection and the importance of paying attention to what we are paying attention to. Through careful consideration of practitioner language, metaphors and experience, we may be able to enrich our vocabulary of

planning, expand our thinking and increase the sensitivity and effectiveness with which planning is undertaken. In this way we continue to broaden our conversation about the social phenomenon known as program planning. Areas of further research and considerations in the theory and practice of planning have been identified. Efforts in these areas will contribute to a renewed interest in discovering the linking threads between theory and practice. The dance of program planning continues -- as the dancer learns new steps in tune with changing rhythms of contemporary strains.

This interpretive study on practitioner perspectives on planning represents an analysis taken at one point in time, the experience of stepping into a flowing stream of a dynamic and ever changing social context. In the manner of interpretive inquiry, the conversation remains open-ended, subject to further thoughts and interpretations.

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The world is round and the place which may seem like the end
may also be only the beginning.

Ivy Baker Priest

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APPENDIX A: PROTOCOL DOCUMENTS

- Letter of Invitation
- Summary of Research Project
- Agency Participation Consent Form
- Participant Consent Form

RESEARCH PROJECT: PLANNING HEALTH PROMOTION PROGRAMS:

AGENCY PARTICIPATION CONSENT FORM

I have read and understand the purpose and procedures of the research and agree, on behalf of the organization, to participate in the study.

It is my understanding that:

- Individual/s responsible for the design and delivery of health promotion program in this organization will be interviewed on a voluntary basis.
- Two to three interviews will be required, each lasting approximately one hour.
- The researcher will analyze documentation relating to the health promotion program which will voluntarily be made available to her by my organization.
- Neither my name, the names of the interviewees nor the organization's name will be revealed to anyone other than the researcher and her Research Supervisory Committee members.
- The organization has the right to refuse to participate or withdraw from participation at any time without prejudice.
- By signing this form, I acknowledge receipt of a copy of the form and attachments describing the research project.

_____
signature

_____
title

_____
name of organization

_____
date

RESEARCH PROJECT

PLANNING HEALTH PROMOTION PROGRAMS

PARTICIPANT CONSENT FORM

I have read and understand the purpose and procedures of the research and agree to participate.

It is my understanding that:

Two to three interviews will be required, each lasting approximately one hour.

Neither my name nor the organization's name will be revealed to anyone other than the researcher and her Committee members.

I have the right to refuse to participate or to withdraw from participating at any time without prejudice.

By signing this form, I acknowledge receipt of a copy of the form and attachments describing the study.

_____
Signature

_____
Title

_____
Name of Organization

Date: _____

APPENDIX B: INTERVIEW FORMAT

INTERVIEW FORMAT

Feedback from Pilot Study

Three professionals in health and social services participated in a pilot study consisting of three interviews. The researcher had some questions prepared. Respondents in this pilot indicated a preference for telling their "own" story of how a program was planned/developed rather than respond to a list of questions, which tended to produce fragmented answers. Respondents also stated that they worried less about "correctly answering" the researcher's questions, and that their reconstruction of the process also provided their own triggers about significant events and factors.

Therefore, in the actual study, the questions posed by the researcher were kept to a minimum. Comments about their roles/responsibilities; organizational context and influences on the process came out naturally in the story-telling. All six practitioners in the study were asked the following questions:

Interview #1

- Could you describe the activities currently offered under the health promotion/wellness program in this hospital/health department?
- Could you tell me the story of how the health promotion/wellness program developed in this hospital/health department?

Interview #2

- Practitioners were asked some initial questions to clarify points they had made in interview #1.
- If you were a consultant to another hospital/health department which was setting up a health promotion/wellness program, what advice would you give to the CEO and senior management, and what advice would you give to the person who would be directly responsible for setting it up?
- What difference, if any, is there between planning something at an organizational level versus at the specific project level?

Interview #3

- Practitioners were asked some initial questions to clarify points they had made in interview #2. They were also given an opportunity to comment further on any area they had raised during interviews #1 and #2.
- Could you tell me about your professional background?

APPENDIX C: SUMMARY OF PRACTITIONER PROFILES

APPENDIX C: SUMMARY OF PRACTITIONERS' PROFILES			
PRACTITIONER/HEALTH CARE SETTING	LENGTH OF TIME IN POSITION	EDUCATION/EXPERIENCE	ENTRY INTO HEALTH PROMOTION/WELLNESS PROGRAM
JESS, Co-ordinator of Health Promotion City Hospital	24 months	• medical technician background • 18 years at City Hospital • personal interest in fitness	• submitted proposal for health promotion at Hospital's Employee Wellness Centre • last 2 years spent developing & co-ordinating a variety of programs for hospital staff
DOUG, Director of Wellness Program Trinity Hospital	22 months	• education background • first experience in health care organization	• hired to manage Hospital seminars for profit to the community • focus changed to develop internal wellness programs for hospital employees (e.g. smoking cessation, nutrition)
GAIL, Co-ordinator of Wellness Centre Sunnyview Hospital	13 months	• nursing background • long term dream of Women's Wellness Centre	• hired to set up an off-site Wellness Centre for community • developed series of rotating wellness courses (e.g. diabetic education, footcare)
NINA, Director of Health Promotion Mount Royal Health Department	22 months	• interdisciplinary Ph.D in health • background in teaching, community work	• hired to set up new program and institute organization wide changes • working with community groups from community development approach
KATHY, Director of Health Promotion Glendale Health Department	9 months	• nursing background • background in Heart Health Community education	• hired to help Health Unit to change from traditional public health nursing approach (one-on-one) to a health promotion approach working with groups
SUSAN, Prevention Supervisor Bridgestone Health Unit	7 months	• nursing background • involved in Seniors Wellness & health promotion since 1980's	