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Partnerships in Public Health: Lessons From Knowledge Translation and Program Planning

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Running head: Partnerships in Public Health: Lessons from Knowledge Translation

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Abstract (100-150w)

Purpose

The purpose of this study was to better understand how partnerships are initiated, maintained and sustained in public health practice.

Design

A qualitative design was employed through individual interviews and focus groups.

Sample

Participants included practitioners from six purposefully selected Ontario public health units who developed partnerships in program planning.

Findings

Partnerships play an essential role in program planning, but minimal information is available regarding the partnership process. Most partnerships are formed on an ad hoc basis, with little formalization. Public health professionals rely on their experiential knowledge when seeking out and working with partners.

Implications

Findings from our research can inform future public health planning processes and strengthen the formation and maintenance of partnerships in public health, and other sectors. Understanding how partnerships are initiated, maintained and sustained is an important first step for supporting the use of research to advance collaborative public health efforts.

KEY WORDS: Partnerships, public health, knowledge translation, health promotion, narrative inquiry

Introduction: Partnerships play a central role in public health care and health promotion, and have been acknowledged as an important part of knowledge translation (KT). Partnerships are an essential part of program planning and are often made between public health professionals and community stakeholders. Through a shifting landscape of public health, partnerships have been reconfigured, tied to changes in practice guidelines, funding mechanisms and the increasing drive for multi-sector collaborations. In an effort to make better (research informed) decisions, many health professionals are recognizing the value of KT, and the inherent role of partnerships. In order to ensure effective partnerships in the context of public health, we need to explore what is currently being done to see what works and what does not and capture some of the benefits and challenges of these types of relationships.

Partnership relationships are not uncommon in public health. Public health professionals, and public health units or health authorities, frequently work in partnership with health and health-related agencies around program planning as well as with other key stakeholders (including the community, media and researchers). In some jurisdictions partnerships are legislated. Ontario, for example, has included partnerships with community stakeholders within the recently mandated Public Health Standards (Ministry of Health and Long-Term Care, 2008). The British Columbia Public Health Core Functions document also describes partnerships with community groups as a desirable way of working (Ministry of Health Services, 2005). For our purpose, we have defined community as:

a specific group of people, often living in a defined geographical area, who share a common culture, values and norms and are arranged in a social structure according to relationships that the community has developed over a period of time. ...They exhibit some awareness of their identity as a group and share common needs and a commitment to meeting them (Community Health Nurses Association of Canada, 2008).

A partnership implies two or more individuals or groups, coming together to work toward a common outcome or purpose. Partnerships can focus specifically on a health promotion intervention, or be more broad-based and higher level.

The knowledge translation (KT) literature is focused on supporting partnerships between knowledge producers and users of knowledge, for the purposes of the co-creation and sharing of knowledge for subsequent action (similar to program planning in public health). In this paper we use the KT literature as a lens to look at partnerships in public health program planning. The purpose of this paper is to examine how public health partnerships are initiated, maintained and sustained as a first step for supporting the use of research to advance collaborative health promotion efforts.

Background/Literature Review:

What is Public Health and Health Promotion?

Public health has been defined as: “The science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society” (Acheson Report, London, 1988). In order to understand and appreciate the role of partnerships in public health, we must first examine the Canadian primary health care movement in which health care is oriented. Canada’s traditional biomedical, curative model of health was expanded to include preventative (primary health) medicine in the 1970s with the introduction of the Lalonde Report (Lalonde, 1974). This shift acknowledged that health is shaped by factors beyond the health system and these factors should be addressed in a comprehensive public health framework. Spurred on by the Ottawa Charter in 1986, Canada began to include this reorientation of health care (Ottawa Charter, 1986). One could easily argue Canada still has a ways to go, given the small amount of spending both federally and provincially on preventative care. The Canadian Nurses Association also moved forward with public health reform in Canada by adopting

the principles of public health (Calnan & Rodger, 2002). Similarly, the principles have been reflected in standards of specific professions, such as the Canadian Community Health Nursing Standards of Practice (Community Health Nurses Association of Canada, 2008) where the importance of building individual and community capacity in health as a form of empowerment, through collaborative effort is clear.

Health promotion, a central element of public health, has been defined as “the process of enabling people to increase control over, and to improve, their health” (World Health Organization, 1986, page 1). Health promotion was envisioned as participatory, multi-sectoral in action, and focused on tackling the social determinants of health to reduce health inequities (Braveman & Tarimo, 1994). The five main strategies to achieve this goal are: building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services (World Health Organization, 1986). The principles of public health influence the organization and operationalization of Canadian healthcare (Martin, 2006), and are important elements in public health planning.

The Importance of Partnership

Partnerships play a central role in public health as framed by the foundational documents discussed above. Although partnerships are envisioned as egalitarian and empowering (Falk-Rafael, A., 2001; Falk-Rafael, A., 2005), the reality of a strong historical orientation towards biomedicine and expert opinion has presented challenges for their realization (Whitehead, 2009). The values that drive public health shape the concept of partnerships in this context, as well as their structure and function within the Canadian health care system.

Due to the complexity and multifaceted components, defining ‘partnership’ is not an easy task.

'Partnership' is a broad and encompassing concept (Sibbald, 2010), and several different partnership types have been identified. For example, MacIntosh & McCormack (2001) classified health partnerships at three levels (by sector, by discipline, or by profession) into three categories. (1) *Multi-*partnerships involve individuals working independently to achieve a common goal. These partnerships do not promote equality or active participation and as such are counterproductive to achieving goals of public health, but rather espouse the expert as decision-maker. (2) *Inter-*partnerships involve partners from different domains working together to achieve a common goal. (3) Lastly, *intra* partnerships consist of partners from the same domain working together towards a common goal.

Many of the partnerships created in public health context can be described as 'academic-practitioner partnerships'. These partnerships are essential in maximizing and accelerating the transfer of results from researchers to end-users (Nieva et al., 2005) and are a function of enhancing knowledge creation (Bartunek et al., 2003). Other partnerships in public health include community collaborations, which are driven by a need to consider context in collaborations (Eccles, 1996; Lantz et al, 2001; McHale & Lerner, 1996). There is also a growing body of literature on networks in healthcare that encompass a broader conceptualization of partnering (see: (Cobb, Graham, & Abrams, 2010; MacLeod et al, 2007). Most definitions agree on two key dimensions of 'partnership': (1) different (or multi-) disciplinary individuals and (2) working toward a shared goal (Amabile et al., 2001; Jassawalla & Sashittal, 1998; LeGris et al., 2000; Walter, Davies, & Nutley, 2003).

It is important to note that this definition implies partnerships involve different disciplines and are thus professional in nature, which excludes the individual and community as active partners in health, and conflicts with principles of public health care. We believe public health partnerships are broader and support the definition of partnerships presented by the Community Health Nurses Association of Canada (CHNAC, 2008 page 17):

Relationships between individuals, groups or organizations where the different participants in the relationship work together to achieve shared goals. Partnership involves active and flexible collaboration between health care providers and clients, individuals and communities, includes choice, accountability, dignity and respect, and focuses on increasing clients' capacities for self-reliance using empowering strategies).

As well as being powerful tools to put public health principles into action and to contribute to individual and community empowerment, partnerships are thought to lead to positive outcomes including the use of research in decision making (Denis & Lomas, 2003; Lavis et al., 2006; Ross et al., 2003). It has been argued that collaboration strengthens decision-making (Amabile et al., 2001) and improves planning and delivery processes (Denis & Lomas, 2003; Kitson & Bisby, 2008; Kothari et al., 2009). Partnering also allows for unique and informed perspectives on design (of research and/or programs) and ensures the end-product is relevant to users (Bartunek et al., 2003; Ferlie & Wood, 2003; Goering et al., 2003; Innvaer et al., 2002). Partnering early on in the planning process increases ownership and use of results (Elliott & Popay, 2000; Kothari et al., 2005; Lavis et al., 2003). Scott & Thurston (1997) identified clear agreement over the sphere of interest (or the domain of the partnership), and high levels of communication as essential to a successful partnership.

Support for Partnerships at Local, National and International Level

The broad nature of the social determinants of health made partnerships between sectors such as agriculture, food, housing, and education indispensable to improving health outcomes. At a local level, there is a need for community participation in all stages of care (e.g., planning, organization and delivery) as well as partnerships between health care professionals and communities. There is support for the use of partnerships at a local, national and international level. A number of the central tenets of the Ottawa Charter – for example building public health policy or strengthening community actions – inherently require partnerships, as they cannot be accomplished by any one group (Catford, 2004). Coordinated action and partnership between countries (including governments, health and other

Partnerships in Public Health: Lessons from Knowledge Translation sectors, NGOs, local authorities, the media, communities, families and individuals) have been encouraged in order to ensure public health for all (World Health Organization, 1978 and World Health Organization, 1986). For our purpose, we define community as ‘a specific group of people, often living in a defined geographical area, who share a common culture, values and norms and are arranged in a social structure according to relationships that the community has developed over a period of time. ...They exhibit some awareness of their identity as a group and share common needs and a commitment to meeting them (CHNAC, 2008).

Partnerships between sectors, population groups and civil society are also viewed as a main feature of a health system that is oriented towards reducing health inequities. As public health care and health promotion practice has evolved since the 1980s, the need for complex, multi-sectoral and egalitarian partnerships has been reinforced in documents such as the Jakarta Declaration, Bangkok Charter for Health Promotion, and Galway Consensus (World Health Organization, 1997; World Health Organization, 2005; Allegrante et al., 2009). Further, there is research to support partnerships being more successful when they are participatory and egalitarian (MacIntosh & McCormack, 2001; Scott & Thurston, 1997; Gillies, 1998; Cargo & Mercer, 2008).

Partnerships in the context of knowledge translation

Relationships have been identified in the knowledge translation (KT) literature as a key ingredient for effective KT. Recently the KT literature has begun spotlighting partnerships as an essential feature of effective KT. Authentic two-way knowledge transfer and utilization is much more likely in partnership relationships (Jansson et al., 2009). Partnering also allows for unique and informed perspectives on knowledge translation (Bowen et al., 2005; Jansson et al., 2009; Ross et al., 2003). Partnerships also provide mutual learning opportunities for decision makers (Bartunek et al., 2003) and

Partnerships in Public Health: Lessons from Knowledge Translation researchers (Denis & Lomas, 2003; Rynes et al., 2001), and often lead to the development of new skills (or ‘spin-off’ benefits), which can affect knowledge production and the transformation of practices or modes of intervention (Denis et al., 2003; Kothari et al., 2009).

Pablos-Mendez & Shademani (2006) hold that “the dynamic interaction of people who come together to solve public health problems, to learn, and ultimately to drive productive change” is a key feature of KT (p. 81). The Canadian Institutes for Health Research (CIHR) have coined the term ‘integrated knowledge translation’ (IKT) to capture the new, more collaborative way of engaging knowledge creators (researchers) and potential knowledge users (Graham et al., 2009). The application of the term “knowledge creator” to researchers and “knowledge users” to other partners has been challenged in other conceptualizations of KT, which reject the traditional Research to Practice (RTP) model in favour of more community centered participatory models (Cargo & Mercer, 2008; Flaspohler et al., 2008). This is part of the evolution of KT to form a better fit with principles of public health, which are meant to build community capacity, empower individuals and ultimately to increase their control over the health and well-being process. Some participatory-based strategies taken up with KT include community based participatory research, participatory action research, participatory rural appraisal, and empowerment evaluation, among others. These approaches are meant to democratize the knowledge production process, increase community empowerment and ownership over results and in turn, over their health and well-being (Cargo & Mercer, 2008).

The results presented in this paper are one component of a larger study (Kothari et al., 2010a, Kothari et al., 2010b). The objective of the larger project was to describe patterns of knowledge exchange for program planning, with a focus on tacit knowledge. The area of partnerships emerged as a major theme from this work, and is described in this paper. The purpose of this paper is to examine

how public health partnerships are initiated, maintained and sustained as a first step for supporting the use of research to advance collaborative health promotion efforts.

Methods: Design: The data collected and analyzed for this paper come from a narrative inquiry that aimed to describe patterns of knowledge exchange among public health professionals and their various partners for program planning. We framed this study as what Lieblich et al. (1998) describe as a holistic, content approach to narrative analysis – where the focus is on drawing out main themes related to content areas addressed within the narratives. Eliciting knowledge embedded in routine practice can be challenging given that such knowledge is difficult to articulate. We adopted a two-step methods framework by Ambrosini and Bowman (2001), involving individual narrative interviews followed by a focus group at each site.

This paper provides an in-depth examination of the partnership types, processes and challenges experienced by our participants, which emerged as a major theme from the study. The narrative inquiry design allowed us to explore both the sequence of the partnering events (i.e., when the partnership was formed, what precipitated the partnering, and what was the role and function of the partnership relationship) and the consequences of those events (Riessman & Quinney, 2005). Narrative inquiry encourages participants to tell their stories of what transpired. These stories are constructive as well as reflective (Chase, 2005; Clandinin & Connelly, 2000).

Study Setting and Sampling: A multi-stage sampling process was used. The first stage was to sample public health units (PHU). In Ontario, Canada, there are 36 PHUs. We purposely sampled along two dimensions: PHU teams, and the topic area(s) in which the planning teams have worked. PHU teams were purposively selected (n=6). Recruitment of the teams was done through PHU directors, as per

ethics requirements. Directors were given an information letter detailing the project's goals and the involvement of their staff.

Teams were included if they were currently planning a program/intervention, or had recently planned one in the previous six months. In order to allow for maximum variation, selection was based on geographical location and academic affiliation. To reduce participant burden, health units that were already engaged with any of the authors in other KT research projects were not asked to participate in this study. Wherever possible, individual interviews were completed with all members on the PHU team. Participants could participate in both a focus group and an individual interview.

Data Collection: Data collection took place between September 2007 and December 2008. Individual semi-structured interviews, designed to elicit participants' narratives about the planning initiative were conducted. These were followed by focus group discussions aimed at drawing collective narrative maps about the planning initiative (according to Bruner's collective representation) (Bruner, 1991). These narrative map sessions started with a broad question (i.e. Tell me about the initiative you recently planned?) in order to uncover the underlying knowledge informing program decisions. Of particular relevance to findings pertaining to partnership, it was also discovered that this mapping also lead to discussion of the various players involved in an initiative and their working relationships to each other. Maps were used as a focus group discussion tool, not as a source of data. All interviews and focus groups were audio recorded and transcribed verbatim. Focus groups are very useful since it allows the participants to be an active part of the process, enabling the creation of group experiences (Kitzinger, 1995). Having individual interviews in concert with focus groups also allowed participants the opportunity to speak more freely and thus mitigated any potential power imbalance that may have occurred during the focus group.

Data Analysis: Individual interviews were analyzed first to elicit a stronger understanding and analysis of how teams accessed, made sense of and used various types of information and knowledge (we asked them about typical planning processes, challenges faced, and strategies used in planning). Qualitative coding of the interviews was completed separately by two members of the research team using a similar coding scheme to the focus groups; codes were added or taken away to fully capture the nuanced differences between the group and individual discussions. For the purposes of this paper, we also selectively coded for content dealing with partnerships: how they were formed, challenges in their creation and maintenance, as well as any indicators of successful partnering.

Focus group data were analyzed second. The nine focus groups brought together planning team members both within the same health unit and from health units in the same region to think about the recent common initiative they were involved in planning and to describe all the steps that were involved (e.g., how does it happen? What are the influences? Is this typical?). Focus group data were analyzed by at least two independent researchers. A coding scheme was created inductively from the transcripts, and then iteratively used to analyze all focus groups (that is, the coding scheme emerged from the data). We employed a holistic, content approach to identify main content areas addressed in the narratives, and the themes we identified related to how these content areas were discussed.

We selectively coded for (1) types of knowledge, how knowledge was being used in program planning and (2) the role and function of partnerships in program planning; our study focuses more on the latter (for a description of some of the other findings see Kothari et al., 2010a). From the focus groups transcripts, narratives were created, which identified the key constructs (events, people and places) commonly described by participants.

The results presented below include both the focus group (team) and the individual analysis in aggregate. Anonymized verbatim quotes are provided to illustrate our findings from the participants' viewpoint. (Focus group participants are denoted by 'FG', interview participants by 'I'; both are followed by a unique site identifier (A-D) and numerical group or individual identifier).

Research Ethics: Ethical approval for this study was granted through the University [NAME] Health Service Research Ethics Board

Results:

First we present a description of our participants. This is followed by a description of the rationale behind partnering and the process used to initiate programs and partnerships. We present the different types of partnerships discussed by our participants and finish by discussing the challenges of maintaining and sustaining partnerships.

Participants and Programs: In total 24 individuals participated in 1-on-1 interviews and 47 participated in focus groups (see table 1).

Table 1: Sample for individual interviews, focus groups and focus group participants

Site	Total # of Individual Interviews	Total # of Focus Groups	Total # of Focus Group Participants
A	6	2	6
B	4	3	14
C	5	2	12
D	9	2	15
Totals	24	9	47

Participants discussed programs that were at different phases of development. Some programs had yet to be fully operationalized (planning phase), some programs were currently running (operational phase), and some programs had already been implemented (complete). Programs spanned across

several chronic health issues including tobacco/smoking cessation, diabetes programming, cancer screening (for women), and healthy eating/obesity strategy. The majority of participants were women, between the ages of 18-59. Most participants had a nursing background (71.4%, n=15), and were public health nurses (61.9%, n=13). Other participants included a Local Health Integration Network Consultant (4.8%, n=1); Public Health Dietician (9.5%, n=2); Public Health Nutritionist (4.8%, n=1); Tobacco Control Coordinator (4.8%, n=1); Health Promoter (14.3%, n=3). Over 50% (n=12) of our participants had 1-9 years of service in public health, whereas only one participant had been in public health for over 30 years (participant demographics available upon request).

Why Partnerships?: Partnerships emerged as an especially important element associated with both forming a program planning team as well as choosing which program to plan, and specific program details. Most PHUs drew upon the skills and professional expertise held by their own staff. In this way, planning teams were made up of individuals who had experience with a similar program or in a certain field and new team members, providing a mix experiential knowledge and new (or text-book) knowledge. Discussion about forming/using partnerships often began at the start of program planning.

While partnerships were seen as beneficial for many reasons, participants listed three overarching benefits: (1) providing new/additional resources (time, personnel, and funding), (2) providing fresh ideas, and (3) providing an ‘in’ within the community. Participants frequently described their reliance on experiential knowledge of community needs and prior experience with relevant programs in determining the best program to pursue. This was true both of the knowledge from public health professionals and the knowledge of the partners. Previous experience with community partners also guided collaboration with partners for new initiatives.

There are two community room [grocery stores] here in the city, one is highly organized and the one is less so we go to the highly organized one and they just, if anything urgent goes wrong

we would have instant correction, right, instant help and so I trust that ... (because) I have worked with them before (FG-B1)

Decisions on how to proceed in program planning were based primarily on professional experience (i.e., what has been done before, what worked, what does not/did not) and secondarily on other forms of information (such as grey and academic literature, conference/workshop presentations, and information obtained from electronic mailing lists). When working with partners, participants strongly believed that program planning decisions should be (and are) made through group consensus. The strong acceptance of and need for consensus seemed to drive program planning and the development of partnerships in all of the units we studied.

Types of Partnerships in Public Health: Once a planning team had been established, and a program decided upon, participants frequently identified forming formal partnerships as critical to the planning and implementation of programs. Identifying partnership as an important piece was sometimes explicit (i.e., someone said we need to get partners), but more often it was implicit (that is, the planning team ‘just knew’ finding partners was an essential step in program success).

Several types of partnerships were discussed by our participants: (1) partnerships internal to the PHU (outside the planning team, but internal to the health unit), (2) partnerships internal to public health (outside the health unit, with public health professionals from other units) and, (3) external partnerships (to both the unit and public health). These partnerships were formed for different reasons and participants were not always able to explain why they chose to partner with certain groups/individuals over others. Participants often relied on experiential knowledge when making partnership decisions.

(1) Partnerships internal to the PHU: Participants of the focus groups and interviews regularly partnered with colleagues outside of the planning team, and internal to the health unit. This strong tendency to reach out to experts within their own unit was common to each unit. Several participants

described the physical work environment as a key enabler to these partnerships: sharing work space, having a common lounge/eating area, and small offices. All of these factors made conversations with colleagues a regular occurrence. Participants also felt these kinds of partnerships are part of the culture of their public health unit. There was less discussion on whether this was a phenomenon of public health as a whole, but many participants agreed his/her own unit supported collaborative partnerships.

(2) Partnerships with Other Public Health Professionals or Units: Partnerships with other professionals or units were used at different stages in program planning but always with the attitude of making the most of available resources (time, people, and money). When asked why a planning group chose to partner with a neighbouring health unit, one participant responded:

We (want to) enhance what's already happening and make it you know, give something to everybody that they want and need. (FG-A1)

Participants commonly talked about getting program ideas from other professionals through the use of electronic communication and resources (i.e., using information obtained through electronic mailing lists or websites). While these are not direct partnerships per se, there were several examples given of more formalized partnerships (with units where the initial idea had started) developing once program planning had commenced.

and that's why we tend to partner up with someone like [nurse from another unit] who has a program she wants to deliver, a specific health enhancement program, we've got facilities, but we haven't got any program staff (FG-C2)

This 'piggy backing' with other larger programs, or with smaller programs in other health units, was often used in order to maximize limited resources (due to lack of funding). Participants were aware of these other programs based on their experiences.

Participants also talked about the recent trend towards mandated partnerships that were external to the unit. These partnerships were often less dependent on prior knowledge and more so on explicit

forms of knowledge (i.e., knowledge that is often codified (written) and communicated through language). While most of the programs discussed in this study were created internal to the unit – there was a lot of discussion around the shift toward provincially mandated or required partnerships, (i.e., a ‘top-down’ approach). One example given was mandated connections (partnerships) between public health teams and regional health planning bodies (in Ontario, these are known as ‘Local Health Integration Networks’, or LHINs) by the provincial nursing association;

... the proposal was to strengthen the role of the health unit, working with the LHIN because of the political funding, we try to and this was a way of working together I mean whereas we know the people at the LHIN they call us, we call them, ... it was a pilot and the pilot was the dyad between the health unit and the LHIN. (I-A1)

Often times mandated partnerships meant dedicated funding. However, participants felt that it made partnering more methodical and less grass roots (i.e., less ‘bottom-up’) and somewhat counter to the types of planning and implementation processes with which they were familiar. This came with confusion about the specific roles of the partners (LHINs versus PHUs).

Another important partnership with ‘professionals’ was *partnerships with researchers*. Unless researchers were formally affiliated with/linked to the public health unit, researchers on programs was limited. The exception to having researchers on the planning team was when the health unit as a whole had a larger plan to include researchers on planning teams (i.e., not the planning team’s decision). This was most commonly for the purposes of evaluation. The duration and level of involvement of such a researcher varied; for example one unit had their researcher/evaluator on the program planning team from the design phase (i.e., at baseline), while another unit had a researcher/evaluator join in at the end to perform a summative evaluation.

Participants also talked about their relationships with researchers external to the PHU, with local universities or colleges. These partnerships were used at different stages during the planning process. A

few of our PHUs had formal and on-going partnerships with universities and researchers, but this was not the norm. Participants often sought support from university researchers when they wanted research literature they could not themselves access;

if (we) need something then I can do that, there are a couple of people, like one teaches part time at [the university] and so she has access to that as well, so that I mean we certainly take advantage of opportunities like that, and we're good about sharing that, it would be nice to have a more formal process in place to access (information). (I-C2)

There was a similar discussion in a few of our focus groups about the use of reports (such as literature reviews, theses, and presentations) created by universities in program planning. One group, for example used the literature review portion of a larger report to support their decision to include more stakeholder discussions in the program planning:

(3) External Partnerships. The most common form of an external partnership was *community partnerships*; nearly all focus groups and individual interviewees highlighted the importance of partnering with the community – in this way, community partnerships were essentially a ‘natural’ part of program planning. Participants also felt that collaboration with members of the target community was an important way to draw on experiential knowledge from the community, as well as to share knowledge that was not easy to obtain from written sources (for example, cultural perspective).

These partnerships translated to providing opportunities for two-way co-creation of knowledge with individuals outside of their immediate team, as a way to adapt planning ideas to local realities.

Planning teams who had strong relationships with their community at a unit level had an easier time partnering with community stakeholders, and building on existing community partnerships. This was often attributed to the development of trust, which took both time and ‘insider know-how’ on how to achieve. There was also agreement about how partnering with the community fostered trust building in the community which our participants felt was vital to the success of any public health program.

For me, I've learned that it takes so long and it's taken years to say well I can walk into a different community, but if I betray the trust of that community I can never go back again, you know, ... because unless you have an inside person who is trusted, you know, be working with you, it doesn't work, and that's something I have learned. (FG-B3)

Partnering with the community also has challenges, one example being lack of engagement from the community. One health unit discussed their community's lack of engagement, despite efforts on behalf of the unit to get the community involved. Participants also discussed geography as a challenge of community partnerships – this is especially true in units who serve several communities in a large geographic area. For example, one unit that served many different communities (in a large geographic region) found it difficult to reach certain remote target communities.

Another important external partnership was *media partnerships*. Participants felt the media was an extremely important and valuable partner in public health programs. Long-term relationships with radio and print media were the most common form of media partnerships, followed by television. These relationships were very beneficial to the units who had them. Participants acknowledged the importance of matching media campaigns to the specific needs of the community and geographic area; for example knowing how to reach individuals in rural towns. One health unit spoke highly of using the local arena as a great way to advertise their promotion programs. This was especially true when participants talked about province-wide initiatives where participants felt their own knowledge of what works and what does not in their own community was more valuable than a 'one size fits all' media approach.

it appears that the ministry is, is really gung ho at implementing campaigns, mass media campaigns because they do want to reach a lot of people but campaigns are, are valuable but only to a certain degree, right and for some people... is not enough to make them change their behaviour... especially at the regional level (I-D8)

A third type of external partnership was with *other non-health organizations*. These partnerships were often made for strategic reasons such as increased attention from the public or from by funding agencies.

Our advocacy role of course is paramount so when, when you've got the Canadian Cancer Society voice behind something that you're trying to pass municipally, provincially or federally, that can make an impact and so that's sort of our perspective, ... (partnering) is very important (FG-C1)

Participants also cited obtaining full-time funding, with an aim to hand-off the program to the partner as another strategic reason for involving partners. This frees up the resources of the PHU, but also ensures that the program is still available to the community. One example given by a focus group was a children's healthy and active lifestyle program:

we don't run it, but we're in partnership with the [X] Children's centre, with the YMCA, with the Board of Health, you know, it's a group of people who all recognize that there is a program that needs to be delivered in the community. ...it's not any one of us that's really taking the lead, we're all, we recognize there is a benefit to working together on these things. (FG-C2)

There was also discussion in a few interviews and focus groups about 'non-traditional' media partnerships for the purpose of program promotion.

These 'non-traditional media partnerships' with other organizations included partnering with restaurants, stores, and other public venues (such as hockey arenas or community centres) to get the word out. Participants agreed that having the community aware of the program was the priority and they chose partners to meet that goal.

Maintaining and Sustaining Partnerships

Our participants felt a successful partnership is one where there is a variety of partners coming together with public health professionals, and both groups see the program and the partnerships as important.

Well when we first thought of [the program] we started with just a few heads around the table at the health unit and knowing that this seemed to be very successful in our [other] office, but successful from the point of view that there were other interested partners that were willing to help make these programs... (I-A3)

Participants talked about several challenges and issues in developing, maintaining and sustaining partnerships. Participants acknowledged that building and developing trusting partnerships takes time. There were four major challenges discussed by our participants: conflicting ideas, proximity, turnover, and funding.

(1) *Conflicting Ideas*: Clashing of ideas (on how to run the program, or on the appropriate program outcomes) was frequently mentioned as the reason for a partnership not working. One participant highlighted this by saying, “Just because an agency had said they would partner with you, does not guarantee that they would stick with you”. Another group had a similar discussion of this challenge:

Our partners often don't share the same view-point when it comes to evidence, they don't have to care about it so they don't want to care about it and they want to do their affairs...so you do it because you don't want to lose them as a partner and you know they'll walk if we tow a real hard line. So, I feel like we're always (tied), and trying to figure out where the balance is, and sometimes you get it and sometimes you don't. (I-A3)

(2) *Proximity*: An important factor for our participants in developing and using partnerships in program planning was how close partners are located geographically. The partnerships described often involved working with more proximal and more familiar partners – both community and academic teams that were geographically close to their partners tended to pull expertise and knowledge from these partners more frequently and with greater ease.

I think we're really fortunate due to our geography and in our population that we end up working really collaboratively together. There's not a lot of time spent having to get to know the partners because it's always the same people around the table and so you can really get a lot done. (I-A2)

Being able to have face-to-face meetings was also seen as a “huge advantage” to getting partners on board, who may not have originally been. Some of our participants expressed their ease in forming

partnerships (and connections) with other agencies and community groups due to the small and cohesive community. Alternatively, having sizeable distances between the planning team and the program partners was seen as a challenge to making both the program and the partnership effective.

(3) *Turnover*: Another challenge to creating successful partnerships was turnover in partnering organizations. A few units described having a hard time forming partnerships, since “all of the players don’t necessarily know each other from past projects”. Staff who were new to the partnership (non-PHU) did not always understand existing partnerships, the historical investment behind them, or their function. Participants saw this as a challenge for effective partnerships.

when you’re in partnerships and this is somebody who’s in this position and has not been in that position for whatever reason and just happens to become that position, and doesn’t understand the role of public health, that can be a challenge in and of itself. They don’t understand how a health unit works, why you’re doing what you’re doing, and some of the other partnerships that they don’t understand why we’re a part of. (I-B2)

The same issue can be true for staff within the health unit, where building trust in partnerships is a challenge; participants described this not as an issue of turnover, but of new staff coming on board.

... it’s the trust, if you betray the trust of the community they will never come back to you, so people assume you are the leaders of the community...it’s the trust part of it, and you can go you know, every time a new person comes on ...and they’re thinking we send this person into the community and it will all get done. You won’t get anywhere with the community unless it’s a trusted individual. (FG-B1)

(3) *Funding*: Many of our participants talked about the challenges with partnering and funding.

Funding to run programs was often difficult to find, and with partnerships, the funding was not always guaranteed or consistent. There was also some discussion about the lack of funding available to public health programs, and the challenges of working within limited funding pots;

some money pots are trickier than others, they then took our program that, and piloted it, but we piloted it and they took it on, ... And we got no credit whatsoever ... we don’t even access that funding pot now, ... forget that and we go on to other sources. (FG-D1)

This difficulty to find and secure funding made partnering even more of a necessity. Despite the challenges inherent to partnering, forming partnerships was often a way to improve, or gain access to, program funds.

The challenges discussed by our participants were significant, however overall our participants felt the benefits of partnering outweighed them. To this end, participants gave examples of successful long-term partnerships as proof for working through initial challenges (one group talked about their media partnership as essential to program success, another group talked about the invaluable link with the larger provincial network to bringing ideas to fruition).

Discussion:

Perceptions of Usefulness of Partnerships in Public Health: We know from the literature that early and on-going engagement of partners of any sort is essential to ensuring uptake and buy-in (Lomas, 2000a; Martens & Roos, 2005). This is also true for public health initiatives: the earlier partners are engaged, the more likely they are to stay involved and support the programs delivered (Lencucha et al., 2010). This is even more important in public health where so many of the programs depend on public involvement for success – without the involvement of ‘key’ partners, the program might not survive. Partnerships are formed with communities, media groups, academic centres, other health professionals and health units.

While our participants did not always explicitly acknowledge the role of partnerships with other health units in their own planning, it was evident in both focus groups and in individual interviews that other professionals (most notably researchers) played a role in program planning. Partnerships were described as either required (e.g., mandated) or inspired (e.g., grass-roots) in origin. Formal guidelines (and often accompanying funding opportunities) seemed to make partnering confusing and less organic

for planning teams (especially in determining partner role and function); however this does not necessarily mean the partnership will be more or less successful (either to the public health professional or the target community).

There are several key findings from this study that help us to better understand the function of partnering in public health. Planning teams in our study consisted of individuals with a wide variety of experience ranging from topic experts to those new to the field. This intentional mix was seen as both a teaching tool for experts (which supports previous similar research (Denis & Lomas, 2003; Rynes et al., 2001)), and a learning experience for novices (similar to the findings of (Bartunek et al., 2003)). Our study follows the public health trend of group consensus for decision-making. However, we now have a deeper understanding, and evidence that these decisions are often based on experience (i.e., what has been done before) rather than explicit knowledge (e.g., grey and academic literature, conference/workshop presentations, and electronic mailing lists information). Generally, our findings conform with those of Rycroft-Malone et al. (2004), who developed a taxonomy of knowledge sources including research, professional knowledge/clinical practice, local information, and patient experiences/preferences, and with Estabrooks et al. (2005), who found that nurses frequently privileged and preferred experiential knowledge to more traditional formal sources (i.e. books, journals). Similarly, decisions on when and who to partner with in public health initiatives are largely based on experience with the partner and the community.

Impact of Partnerships on Program Planning: There was wide-spread agreement that partnerships are essential to providing effective and comprehensive public health initiatives. Despite some of the issues and challenges faced, most groups had experienced positive partnership experiences. These positive experiences were attributed to having strong existing community relationships, opportunities to collaborate, defined roles of the partnerships (for both formal and informal partnerships), and having

Partnerships in Public Health: Lessons from Knowledge Translation tools (or forums) to communicate and share information, at every stage of program planning (such as electronic mailing lists, websites, etc); all important in establishing and maintaining open and on-going channels of communication. Our findings are also supported by the work of Bowen et al (2005) and Goering et al. (2003) who have both suggested components (or enablers) of effective partnering you need to expand here a bit.

Barriers and Facilitators to Partnering: Partnerships are not easy to develop, nor are they easy to maintain. They are time consuming and may be accompanied by conflicting ideas (on how to run the program, or on the appropriate program outcomes). Further, turnover in partnering organizations often results in loss of knowledge with respect to the partnerships, the historical investment behind them, and how they function. Participants saw this as a major challenge in creating partnerships. This reinforces the idea that partnerships work best when members are known to each other; some authors report more favourable outcomes when partners knew each other prior to formalizing their partnerships (Denis et al., 2003). However, it is also important to work with new (unknown) partners; to this end, it is important that that time for development of partnerships and relationships building is critical so that the type of expertise needed can be obtained. Recall that favourable outcomes can occur either when partners know each other prior to formalizing their partnerships (Denis & Lomas, 2003) or when partners do not know each other in advance (Golden-Biddle et al., 2003).

Close proximity to other stakeholders (geographically speaking) and previous relationships with stakeholders (for example, small community), was a facilitator to forming partnerships. This finding also corroborates the previously mentioned research related to the effectiveness of partnerships where partners are known to each other (Denis et al., 2003). In this study smaller communities, who also identified themselves as being cohesive, had an easier time establishing ties with partners.

Not surprisingly the solutions to challenges, suggested by our participants are in-line with what we know from the literature. For example, units who had more face-to-face interaction tended to self-report more successful planning and implementation processes (Innvaer et al., 2002). Kothari et al., (2005) hold that increased interaction contributes to a foundation for informal, longer-term partnerships between the researcher and the end-user.

Lessons Learned: Collaboration with the target community was important for sharing experiential knowledge as well as providing program planners with important community knowledge. Moreover, co-creating knowledge through discussion with community partners allowed teams to adapt planning ideas to their current reality and context (an important success factor in program implementation). This suggests that public health professionals need to take time to build trust in the community to ensure program success. It was evident from our findings that long-term partnerships are highly valued and regularly used in program planning and implementation. Research has shown that such long-term collaborations can offer important learning opportunities, which in turn can affect significant organizational and cultural changes (Denis & Lomas, 2003). As partnerships become more developed, they (should) become “more effective and institutionalized relationships, one should expect a gradual shift in emphasis within the partnership work, from being activity-driven to becoming more strategic, looking and planning for opportunities to yield synergistic rewards” (Brinkerhoff, 2002).

From our research we found that relationships with partners can be either mandated or *ad hoc*, but most often public health professionals experience the latter where looking for and forming partnerships is part of the process. While there are pros and cons to both approaches, we acknowledge the benefits of formalizing both the partnership itself and the partnership process in order to better capture ‘best practices’ in partnering, and to create a repertoire of sustainable partnerships. A major

challenge faced by many public health professionals is the time it takes to build relations and trust in those relationships.

Strengths and Limitations: This study was done using only a small sample of PHUs in Ontario, Canada. As such, and considering the methodology used, the intent was not to produce results generalizable to other health units, but rather to gain insights into various ways knowledge is used by public health professionals within processes of public health program planning. While partner agencies were invited to join the focus group sessions, they were not well represented in our discussions. Partners may have a different perspective on partnering with PHUs which could be explored further in future research in order to understand the intricacies of partnerships from both partners perspective.

Despite many focus groups and individuals discussing the importance of long-lasting partnerships, there was very little discussion by the groups around how to actually achieve this. This is another important area that deserves further investigation.

Conclusion: Our results provide some insight into using partnerships as a way to advance health promotion. It is clear that partnerships play a key role in health promotion and public health planning. Health promoting strategies are developed in collaboration with health agencies and community-based organizations from multiple sectors. Findings point to a strong reliance on experiential knowledge for determining partnership membership, while geographic proximity and mandates for collaboration acted as catalysts to partnership momentum and success. Challenges to partnerships conformed to those similarly identified in the KT literature. This understanding of the intricacies of partnership processes provides an access point to the introduction of evidence-informed decision-making for collaborative health promotion programs.

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