

## **Partenariats en santé publique : leçons à tirer du transfert de connaissances et de la planification de programme**

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Cette étude qualitative visait à comprendre comment s'établissent et s'entretiennent les partenariats dans le domaine de la santé publique. On a mené des entrevues individuelles et des groupes de réflexion. Les participants sont des intervenants actifs au sein de six unités de santé publique de la province canadienne de l'Ontario, choisies à dessein, qui ont établi des collaborations en matière de planification de programme. On a constaté que ces partenariats jouent un rôle essentiel, mais qu'il existe très peu de documentation sur le processus comme tel. La plupart sont établis de façon ponctuelle, sans qu'on cherche à officialiser la démarche. Lorsqu'ils veulent s'associer des partenaires, les professionnels de la santé publique se fient à leurs connaissances expérientielles. Ces conclusions pourraient éclairer la planification en matière de santé publique et renforcer la création et la poursuite de partenariats en ce domaine et dans d'autres sphères. Le fait d'avoir analysé, dans un premier temps, la façon dont les partenariats se créent et s'entretiennent fait ressortir l'utilité de la recherche comme moyen de faire progresser les efforts de collaboration dans le domaine de la santé publique.

Mots clés : santé publique, utilité de la recherche

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

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The purpose of this study was to better understand how partnerships are initiated, maintained, and sustained in public health practice. A qualitative design was employed to conduct individual interviews and focus groups. The participants included practitioners from 6 purposively selected public health units in the Canadian province of Ontario that developed partnerships in program planning. It was found that partnerships play an essential role in program planning but that 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. These findings can serve to inform future public health planning 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 in supporting the use of research to advance collaborative public health efforts.

**Keywords:** collaborative research methods, decision making, nurse relationships/professional issues, nursing roles, public health, research utilization/evidence-based practice

## **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 component of program planning and are often formed between public health professionals and community stakeholders. Through the shifting landscape of public health, partnerships have been reconfigured, tied to changes in practice guidelines, funding mechanisms, and the increasing drive for multisector collaboration. 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 does and does not work and to capture some of the benefits and challenges of these types of relationship.

Partnerships are not uncommon in the field of 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, the media, and researchers). In some jurisdictions, partnerships are legislated. The Canadian province of Ontario, for example, has included partnerships with community stakeholders within the recently established *Ontario Public Health Standards* (Ministry of Health and Long-Term Care, 2008). The government of British Columbia document *A Framework for Core Functions of Public Health* also describes partnerships with community groups as a desirable way of working (Ministry of Health Services, 2005). For our purposes, we have chosen the following definition of community:

... 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 [CHNAC], 2008, p. 16)

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

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

## **Background/Literature Review**

### ***What Are 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” (World Health Organization [WHO], 2004, p. 141). In order to understand and appreciate the role of partnerships in public health, we must first examine the Canadian primary health care move-

ment in which health care is oriented. Canada's traditional biomedical, curative model of health care was expanded to include preventative (primary health) medicine in the 1970s with the release of the Lalonde Report (Lalonde, 1974). This shift acknowledged that health is shaped by factors beyond the health-care system and that 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 in health care (WHO, 1986). One could easily argue that Canada still has a way to go, given the small expenditures made, both federally and provincially, on preventative care. The Canadian Nurses Association has also moved forward on public health reform by adopting the principles of public health (Calnan & Rodger, 2002). Similarly, the principles have been reflected in standards of specific professions. For example, the *Canadian Community Health Nursing Standards of Practice* (CHNAC, 2008) makes clear the importance of building individual and community capacity in health as a form of empowerment through collaboration.

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" (WHO, 1986, p. 1). It has been envisaged as participatory, multisectoral, and focused on tackling the social determinants of health to reduce health inequities (Braveman & Tarimo, 1994). The World Health Organization (1986) sets out five strategies for achieving this goal: building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills, and reorienting health services. The principles of public health influence the organization and operationalization of Canadian health care (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 envisaged as egalitarian and empowering (Falk-Rafael, 2001, 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 its complexity and its multifaceted components, "partnership" is not easily defined. Partnership is a broad and encompassing concept (Sibbald, 2010) and several different partnership types have been identified. For example, MacIntosh and McCormack (2001) classify health partnerships at three levels (sector, discipline, and profession) into three

categories. In *multi*-partnerships, individuals work independently to achieve a common goal; these partnerships do not promote equality or active participation and thus are counterproductive to the achievement of public health goals, but rather espouse the expert as decision-maker. In *inter*-partnerships, partners from different domains work together to achieve a common goal. Lastly, *intra*-partnerships consist of partners from the same domain working together towards a common goal.

Many of the partnerships created in the 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, Trullen, Bonet, & Sauquet, 2003). Other partnerships in public health include community collaborations, which are driven by a need to consider context in collaborations (Eccles, 1996; Lantz, Viruell-Fuentes, Israel, Soffley, & Guzman, 2001; McHale & Lerner, 1996). Also, there is a growing body of literature on health-care networks that encompass a broader conceptualization of partnering (Cobb, Graham, & Abrams, 2010; MacLeod, Dosman, Kulig, & Medves, 2007). Most definitions agree on two key dimensions of partnership: inter- or multidisciplinary, and 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 that partnerships involve different disciplines and are thus professional in nature, which excludes individuals and communities as active partners in health and conflicts with the principles of public health care. We believe that public health partnerships are broader. We support the Community Health Nurses Association of Canada definition of partnerships:

... 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. (CHNAC, 2008, p. 17)

As well as being powerful tools for putting public health principles into action and for contributing 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, Lomas, Hamid, & Sewankambo, 2006; Ross, Lavis, Rodriguez, Woodside, & Denis, 2003). It has been argued that collaboration strengthens deci-

sion-making (Amabile et al., 2001) and improves planning and delivery processes (Denis & Lomas, 2003; Kitson & Bisby, 2008; Kothari, McLean, & Edwards, 2009). Partnering also allows for unique and informed perspectives on design (of research and/or programs) and ensures that the end product is relevant to users (Bartunek et al., 2003; Ferlie & Wood, 2003; Goering, Butterill, Jacobson, & Sturtevant, 2003; Innvaer, Vist, Trommald, & Oxman, 2002). Partnering early on in the planning process serves to increase ownership and use of results (Elliott & Popay, 2000; Kothari, Birch, & Charles, 2005; Lavis, Robertson, Woodside, McLeod, & Abelson, 2003). Scott and Thurston (1997) identify 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 the Local, National, and International Level***

The broad nature of the social determinants of health makes partnerships between sectors such as agriculture, food, housing, and education indispensable to improved health outcomes. At the local level, there is a need for community participation at all stages of care (e.g., planning, organization, and delivery) as well as for partnerships between health professionals and communities. There is support for the use of partnerships at the local, national, and international level. A number of the central tenets of the Ottawa Charter — for example, developing public health policy and strengthening community action — inherently require partnerships, as they cannot be fulfilled by any one group (Catford, 2004). Coordinated action and international partnerships (including those between governments, health sectors and other sectors, NGOs, local authorities, the media, communities, families, and individuals) are encouraged as way to ensure public health for all (WHO, 1978, 1986). For our purposes here, we have adopted the CHNAC (2008) definition of “community” (presented above, in the Introduction).

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

***Partnerships in the Context of Knowledge Translation***

In the KT literature, relationships are identified as a key ingredient in effective KT. Recently the KT literature began to spotlight partnerships as an essential feature of effective KT. Authentic two-way knowledge transfer and utilization is much more likely to take place in partnership relationships (Jansson, Benoit, Casey, Phillips, & Burns, 2009). Partnering also allows for unique and informed perspectives on KT (Bowen, Martens, & Crockett, 2005; Jansson et al., 2009; Ross et al., 2003). In addition, partnerships provide mutual learning opportunities for decision-makers (Bartunek et al., 2003) and researchers (Denis & Lomas, 2003; Rynes, Bartunek, & Daft, 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, Lehoux, Hivon, & Champagne, 2003; Kothari et al., 2009).

Pablos-Mendez and 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” (p. 81) is a key feature of KT. The Canadian Institutes of Health Research has coined the term “integrated knowledge translation” to capture the new, more collaborative way of engaging knowledge creators (researchers) and potential knowledge users (Graham, Tetroe, & Gagnon, 2009). 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” model in favour of more community-centred participatory models (Cargo & Mercer, 2008; Flaspohler, Duffy, Wandersman, Stillman, & Maras, 2008). This is part of the evolution of KT to better fit the principles of public health, which are meant to build community capacity, empower individuals, and ultimately increase one’s 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. These approaches are meant to democratize the knowledge-production process and increase community empowerment and ownership with respect to results and, in turn, health and well-being (Cargo & Mercer, 2008).

The work presented in this article is one component of a larger study (Kothari et al., 2010a, 2010b) whose objective 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 in this work and is described here. The purpose of this article is to examine how public health partnerships are initiated, maintained, and sustained as a first step in supporting the use of research to advance collaborative health promotion efforts.

## **Methods**

### ***Design***

The data collected for and analyzed in this article come from a narrative inquiry intended to describe patterns of knowledge exchange among public health professionals and their various partners in program planning. We framed the study as what Lieblich, Tuval-Mashiach, and Zilber (1998) describe as a holistic, content approach to narrative analysis — where the focus is on drawing out themes related to content areas addressed in the narratives. Eliciting knowledge embedded in routine practice can be challenging given that such knowledge is difficult to articulate. We adopted Ambrosini and Bowman's (2001) two-step method involving individual narrative interviews followed by a focus group at each site.

This article examines in depth the partnership types, processes, and challenges experienced by our participants, which emerged as a major theme in 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 it, and what the role and function of the relationship were) and the consequences of those events (Riessman & Quinney, 2005). In narrative inquiry, participants are encouraged to tell their stories of what transpired. These stories are constructive as well as reflective (Chase, 2005; Clandinin & Connelly, 2000).

### ***Setting and Sample***

A multi-stage sampling process was used. The first stage was to sample public health units (PHUs). The province of Ontario has 36 PHUs. We purposively sampled along two dimensions: PHU teams, and the topic area(s) in which the planning teams 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 amount of involvement of their staff. Teams were included if they were currently planning a program/intervention or had planned one in the preceding 6 months. In order to allow for maximum variation, selection was based on geographic location and academic affiliation. To reduce participant burden, PHUs 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 conducted with all members of the PHU team. Participants could take part 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 of the planning initiative (according to Bruner's [1991] collective representation). These narrative map sessions started with a broad question (e.g., *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, this mapping also led to discussion of the various players involved in an initiative and their working relationships with each other. Maps were used as a focus group discussion tool, not as a source of data. All interviews and focus groups were audiorecorded and transcribed verbatim. Focus groups are very useful because they allow the participants to be an active part of the process, enabling the creation of group experiences (Kitzinger, 1995). Having individual interviews in addition to focus groups gave participants an opportunity to speak more freely and thus mitigated any power imbalance that may have occurred during the focus group.

### ***Data Analysis***

Individual interviews were analyzed first to elicit a deeper understanding 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 carried out separately by two members of the research team using a coding scheme similar to that used for the focus groups; codes were added or removed to fully capture the nuanced differences between the group and individual discussions. For the purposes of this article, we also selectively coded for content dealing with partnerships — how they were formed, challenges in their creation and maintenance, and any indicators of successful partnering.

Focus group data were analyzed next. The nine focus groups brought together planning team members, both within the same PHU and from PHUs in the same region, to think about the recent common initiative in whose planning they were involved and to describe all the steps (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 group data — that is, the coding scheme emerged from the data. We employed a holistic, content approach to identify the main content areas addressed in the narratives and the identified themes related to how these content areas were discussed.

We selectively coded for (1) types of knowledge, or 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 group transcripts, narratives were created; these 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.")

Ethical approval for the study was granted by the Health Service Research Ethics Board of the university.

## **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 partnership discussed by our participants and finish by discussing the challenges encountered in maintaining and sustaining partnerships.

### ***Participants and Programs***

In total, 24 individuals participated in one-on-one interviews and 47 participated in focus groups (see Table 1).

Participants discussed programs that were at different phases of development. Some programs had yet to be fully operationalized (planning

<b>Site</b>	<b>Individual Interviews (n)</b>	<b>Focus Groups (n)</b>	<b>Focus Group Participants (n)</b>
A	6	2	6
B	4	3	14
C	5	2	12
D	9	2	15
Total	24	9	47

phase), some were currently running (operational phase), and some had already been implemented (complete). Programs spanned 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 and 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%,  $n = 1$ ); a Public Health Dietitian (9.5%,  $n = 2$ ); a Public Health Nutritionist (4.8%,  $n = 1$ ); a Tobacco Control Coordinator (4.8%,  $n = 1$ ); and a Health Promoter (14.3%,  $n = 3$ ). Over 50% ( $n = 12$ ) of participants had 1 to 9 years of service in public health; only one participant had been in public health for more than 30 years (participant demographics are available upon request).

### ***Why Partnerships?***

Partnerships emerged as an especially important element associated with both forming a program planning team and choosing which program to plan, as well as specific program details. Most PHUs drew upon the skills and professional expertise of their own staff. Therefore, planning teams were made up of both novices and individuals who had experience with a similar program or in a certain field, providing a mix of new (or textbook) knowledge and experiential knowledge. Discussion on 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 of both the knowledge of 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[s] [in the grocery stores] here in the city. One is highly organized and the [other] is less so. We go to the highly organized one, and they just — if anything urgent goes wrong we would have instant correction . . . instant help, and so I trust that . . . [because] I have worked with them before. (FG)*

Decisions on how to proceed with program planning were based primarily on professional experience (i.e., what has been done before, what has and has not worked) 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 were) 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 Partnership in Public Health***

Once a planning team had been established and a program decided upon, the participants often found that forming formal partnerships was critical to the planning and implementation of the program. Identifying partnership as an important factor was sometimes explicit (e.g., “Someone said we need to get partners”) but more often implicit (e.g., the planning team “just knew” that finding partners was an essential step in the program’s success).

Three types of partnership were discussed by our participants: (1) partnerships internal to the PHU (outside the planning team but internal to the unit); (2) partnerships internal to public health (outside the unit, with public health professionals from other units); and (3) external partnerships (external 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 particular groups or individuals. Participants often relied on experiential knowledge when making partnership decisions.

***Partnerships internal to the PHU.*** Participants in the focus groups and interviews had regularly partnered with colleagues outside of the planning team and internal to the PHU. This strong tendency to reach out to experts within their own unit was common to every unit. Several participants described the physical work environment as a key enabler of these partnerships: shared work space, common lounge/eating area, and small offices. All of these factors made conversations with colleagues a regular occurrence. Participants also felt that these kinds of partnership were part of the culture of their PHU. There was little discussion about whether this was a phenomenon of public health as a whole, but many participants agreed that their own unit supported collaborative partnerships.

***Partnerships with other public health professionals or other PHUs.*** 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 par-

ticipant replied, “We [want to] enhance what’s already happening and . . . give something to everybody that they want and need.” (FG)

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

*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)

This piggybacking 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 experience.

Participants also talked about the recent trend towards mandated partnerships external to the unit. These partnerships were often less dependent on prior knowledge and more dependent on explicit forms of knowledge (i.e., knowledge that frequently is codified [written] and communicated through language). While most of the programs discussed in this study were created internal to the unit, there was much discussion around the shift towards 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 . . . this was a way of working together . . . 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)

Often, 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 with which they were familiar. This was accompanied by confusion about the specific roles of the partners (LHINs versus PHUs).

Another important partnership with “professionals” was that with *researchers*. Unless researchers were formally affiliated with/linked to the PHU, partnering with researchers on programs was limited. The planning

team included researchers only when the health unit as a whole had a larger plan to include researchers on the team (i.e., it was not the planning team's decision). This was most commonly for the purposes of evaluation. The duration and level of involvement of the researcher varied. For example, one unit had a 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 relationships with researchers external to the PHU, with local universities or colleges. These partnerships were used at different stages in the planning process. A few of the PHUs had formal and ongoing partnerships with universities and researchers, but this was not the norm. Participants often sought support from university researchers when they needed research literature they could not access themselves:

*If [we] need something, then I can do that. There are a couple of people . . . one teaches part-time at [the university] and so she has access to that as well, so . . . 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)*

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

**External partnerships.** The most common form of external partnership was *community partnership*; nearly all focus groups and interviewees highlighted the importance of partnering with the community, such that community partnering was essentially a "natural" part of program planning. Participants felt that collaboration with members of the target community was an important way to draw on experiential knowledge in the community as well as to access knowledge not easily obtainable from written sources (for example, the cultural perspective).

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

Planning teams that had strong relationships with their community at a unit level had less difficulty 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." There was also agreement that partnering with the commu-

nity fostered trust-building in the community, which our participants felt was vital to the success of any public health program:

*I've learned that it takes so long . . . 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 . . . because unless you have an inside person who is trusted . . . working with you, it doesn't work, and that's something I've learned. (FG)*

Partnering with the community also had its challenges, one example being lack of engagement by the community. One health unit discussed its community's lack of engagement despite efforts on behalf of the unit to get the community involved. Participants also discussed geography as a challenge to community partnerships — this was especially true for units that served several communities spread over 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 considered the media 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 partnership, followed by television. These relationships were very beneficial for the units. Participants acknowledged the importance of matching media campaigns with the specific needs of the community and the area — for example, reaching individuals in rural towns. One health unit spoke highly of using the local arena to promote its programs. This was especially true for province-wide initiatives — participants believed that their own knowledge of what does and does not work in their community was more valuable than a “one size fits all” media approach:

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

A third type of external partnership was with *other non-health organizations*. These partnerships were often strategic, such as to attract the attention of the public or of funding agencies:

*Our advocacy role, of course, is paramount, so 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)*

Participants also cited the securing of full-time funding, with the aim of handing off the program to the partner, as another strategic reason for forming partnerships. This approach frees up the resources of the PHU while ensuring that the program is still available to the community. One example given by a focus group was a children's program to promote a healthy and active lifestyle:

*We don't run it, but we're in partnership with [name of children's centre], with the YMCA, with the board of health . . . it's a group of people who all recognize that there's 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's a benefit to working together on these things. (FG)*

There was also discussion, in a few of the interviews and focus groups, about “non-traditional” media partnerships for the purpose of program promotion. The partners in these cases included restaurants, stores, hockey arenas and community centres. Participants agreed that making the community aware of the program was the priority, and they chose partners who would help them to meet that goal by getting the word out.

### ***Maintaining and Sustaining Partnerships***

Our participants described a successful partnership as one in which a variety of partners come together with public health professionals and both groups see the program and the partnership as important:

*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)*

Participants spoke of several challenges and issues in developing, maintaining, and sustaining partnerships. They acknowledged that it takes time to build and develop trusting partnerships. Four major challenges were discussed: conflicting ideas, proximity, turnover, and funding.

***Conflicting ideas*** (about how to run the program or about appropriate outcomes) was frequently mentioned as the reason for a partnership's failure. One participant said, “Just because an agency had said they would partner with you does not guarantee that they would stick with you.” Another group elaborated on this challenge:

*Our partners often don't share the same viewpoint when it comes to evidence. They don't have to care about it so they don't want to care about it . . . so you do it because you don't want to lose them as a partner and you*



*know they'll walk if we toe 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)*

**Proximity.** An important factor in developing and using partnerships in program planning was how close partners were located geographically. The partnerships described often entailed proximal and familiar partners; both community and academic teams that were geographically close to their partners tended to pull expertise and knowledge from them 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)*

The ability to have face-to-face meetings was seen as a “huge advantage” in getting partners on board. Some of our participants expressed ease in forming partnerships (and connections) with agencies and community groups due to the small size and cohesiveness of the community. A sizeable distance between the planning team and the program's partners was seen as a challenge to the effectiveness of both the program and the partnership.

**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 to effective partnerships:

*When you're in partnerships and . . . somebody . . . just happens to [be in] 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)*

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

*It's the trust. If you betray the trust of the community they'll never come back to you . . . people assume you're the leaders of the community . . . it's the trust part of it . . . every time a new person comes on . . . they're think-*

*ing, 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)

**Funding.** Many of our participants talked about challenges associated with partnering and funding. Funding to run programs was often difficult to find, and even with partnerships the funding was not always guaranteed or consistent. There was also some discussion about the dearth 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 . . . 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)

This difficulty in locating and securing funding made partnering even more of a necessity. Despite the challenges inherent in partnering, partnership was often a way to improve funding or to gain access to program funds.

Although the challenges discussed by our participants were significant, overall they believed that these were outweighed by the benefits of partnering. They gave examples of successful long-term partnerships as reasons for working through the initial challenges. One group spoke of its media partnership as essential to the program's success. Another group spoke of the invaluable link with the larger provincial network in bringing ideas to fruition.

## **Discussion**

### ***Perceptions About Usefulness of Partnerships in Public Health***

We know from the literature that early and ongoing engagement of partners of any sort is essential to ensuring uptake and buy-in (Lomas, 2000; Martens & Roos, 2005). This is certainly true for public health initiatives: the earlier that partners are engaged, the more likely they are to stay involved and to support the programs that are delivered (Lencucha, Kothari, & Hamel, 2010). This is particularly important in public health, where the success of so many programs depends on public involvement — without the participation 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 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., grassroots) 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 did not necessarily mean that the partnership would be more or less successful (either for the public health professional or for the target community).

Several key findings from this study help us to better understand the function of partnering in public health. Planning teams consisted of individuals with wide experience; team members ranged from experts to newcomers in the field. This intentional mix was seen as both a teaching tool for experts (which supports the results of similar research [Denis & Lomas, 2003; Rynes et al., 2001]) and a learning experience for novices (Bartunek et al., 2003). Our findings are consistent with the public health trend towards group consensus in decision-making. However, we now have a deeper understanding as well as evidence showing that decisions are often based on experience (i.e., what has been done before) rather than on explicit knowledge (e.g., grey and academic literature, conference/workshop presentations, and information from electronic mailing lists). 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 those of Estabrooks et al. (2005), who found that nurses frequently privileged experiential knowledge over 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 widespread agreement that partnerships are essential to the provision of effective and comprehensive public health initiatives. Despite some of the issues and challenges faced, most groups reported positive partnership experiences. These positive experiences were attributed to the existence of strong community relationships, opportunities for collaboration, defined roles within the partnerships (in the case of both formal and informal partnerships), and tools (or forums) for communicating and sharing information at every stage of program planning (electronic mailing lists, Web sites, etc.), all of which are important in establishing channels of communication and keeping them open. Our findings are supported by the work of Bowen et al. (2005) and Goering et al. (2003), who describe components (or enablers) of effective partnering.

### ***Barriers to and Facilitators of Partnering***

Partnerships are not easy to develop and maintain. They are time-consuming and can be accompanied by conflicting ideas (about how to run the program or about the appropriate program outcomes). Further, turnover in partnering organizations often results in loss of knowledge with respect to the partnership, the historical investment behind it, and how it functions. Our participants saw turnover as a major challenge in creating partnerships. This reinforces the idea that partnerships work best when members know each other in advance. Some authors report more favourable outcomes when the partners were previously known to each other (Denis et al., 2003). However, it is also important to work with new (unknown) partners, in which case time for partnership development and relationship-building is critical so that the type of expertise needed will be available. Recall that favourable outcomes can occur both when the partners are known to each other in advance (Denis & Lomas, 2003) and when they are not (Golden-Biddle et al., 2003).

In our study, close geographic proximity to other stakeholders and previous relationships with stakeholders (for example, with a small community) were facilitators in forming partnerships. This finding corroborates the previously cited finding in the literature related to the effectiveness of partnerships in which the partners are known to each other (Denis et al., 2003). In the present study, smaller communities, which also self-identified as cohesive, had an easier time establishing ties with partners.

Not surprisingly, the solutions to challenges suggested by our participants are in line with the findings reported in the literature. For example, units that 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 leads to 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 for 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 the time to build trust within the community, in order to ensure program success. It is evident from our findings that long-term partnerships are highly valued and are regularly used in

program planning and implementation. Research has shown that such long-term collaborations can offer important learning opportunities, which in turn can effect significant organizational and cultural changes (Denis & Lomas, 2003). As partnerships develop into “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, p. 220).

The findings show that relationships with partners can be either mandated or ad hoc, but most often public health professionals experience the latter, where seeking and forming partnerships is part of the process. While there are advantages and disadvantages 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 develop a repertoire of sustainable partnerships. A challenge faced by many public health professionals is the time it takes to build relationships and the trust needed to sustain those relationships.

### ***Strengths and Limitations***

This study was carried out using only a small sample of PHUs in Ontario, Canada. The intention was not to produce results generalizable to other health units, but rather to gain insights into the various ways that knowledge is used by public health professionals within processes of public health program planning. While partner agencies were invited to take part in the focus group sessions, they were not well represented in our discussions. Partners might have a different perspective on partnering with PHUs, which could be explored further in future research in order to examine the intricacies of partnerships from the perspective of both partners.

Although many focus groups and individuals discussed the importance of long-lasting partnerships, there was very little discussion by the groups around how to actually achieve enduring partnerships. This is another area that merits further investigation.

### **Conclusion**

Our results provide some insights into 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. The findings point to a strong reliance on experiential knowledge for determining partnership membership, while geographic proximity and mandates for collaboration acted

as catalysts for 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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