

Factors That Impact the Success of Interorganizational Health Promotion Collaborations: A Scoping Review

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Abstract

Objective: To explore published empirical literature in order to identify factors that facilitate or inhibit collaborative approaches for health promotion using a scoping review methodology.

Data Source: A comprehensive search of MEDLINE, CINAHL, ScienceDirect, PsycINFO, and Academic Search Complete for articles published between January 2001 and October 2015 was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines.

Study Inclusion and Exclusion Criteria: To be included studies had to: be an original research article, published in English, involve at least 2 organizations in a health promotion partnership, and identify factors contributing to or constraining the success of an established (or prior) partnership. Studies were excluded if they focused on primary care collaboration or organizations jointly lobbying for a cause.

Data Extraction: Data extraction was completed by 2 members of the author team using a summary chart to extract information relevant to the factors that facilitated or constrained collaboration success.

Data Synthesis: NVivo 10 was used to code article content into the thematic categories identified in the data extraction.

Results: Twenty-five studies across 8 countries were identified. Several key factors contributed to collaborative effectiveness, including a shared vision, leadership, member characteristics, organizational commitment, available resources, clear roles/responsibilities, trust/clear communication, and engagement of the target population.

Conclusion: In general, the findings were consistent with previous reviews; however, additional novel themes did emerge.

Keywords

interorganizational, collaboration, health promotion, partnerships, multistakeholder, scoping review, community engagement, sustainability

Objective

In the area of health promotion, partnership practices such as interorganizational collaboration are of particular importance due to the increasing impact of funding cuts amidst the necessity of meeting demands to reach multiple audiences. For the purposes of this article, interorganizational collaboration (hereafter “collaboration”) entails partners engaging as a group to work synergistically across organizational boundaries toward a common intended goal. In the health promotion realm, there are benefits to collaboration such as the potential for improved health dividends realized by leveraging individual skills and aligning shared resources (“collective impact”),¹ the reduced impact of geographical differences,² the potential for increased individual and organizational learning,³ and by virtue of the

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process of collaboration, the establishment of relationships that can improve and expedite future partnership opportunities.⁴

In order to define what constitutes a successful/effective health promotion collaboration, 2 general indicators of effectiveness have been identified by Zakocs and Edwards⁵: (1) collaborative functioning, or how well partners are working together, and (2) population health outcomes, or some assessment of the project end goals. Although a recent synthesis of the literature is currently lacking, reviews have been undertaken in the past to explore the factors and conditions necessary to promote collaborative functioning. Roussos and Fawcett⁶ reviewed 34 unique published studies of 252 collaborative partnerships or coalitions working at local levels to address a variety of community health concerns and identified key factors contributing to successful partnerships, including having a clear vision, leadership, technical support, available financial resources, action planning for change, monitoring progress, and demonstrating the value of project outcomes. Based on a review of 80 articles, book chapters, and practitioner guides from 1975 to 2000, Foster-Fishman et al⁷ suggested that the multitude of factors identified be organized into 4 broad categories: (1) member capacity (eg, the skills and attitudes of individual members), (2) relational factors (eg, positive working relationships), (3) organizational structure (eg, leadership and resources), and (4) programmatic objectives (eg, realistic goals).

Since these reviews, the research examining health promotion collaborations has grown, yet a gap exists extolling the key factors that may impact collaborative effectiveness. The purpose of this scoping review was to conduct an updated systematic search of the literature in order to identify those fundamental factors which have either a facilitating or an inhibiting effect on health promotion collaborations.

Methods

A scoping review was deemed appropriate for this review because our goal was to explore recurring themes within the existing literature and to give an overview of the type, extent, and quantity of research available on this topic.⁸ Because reporting guidelines do not currently exist for scoping reviews,⁹ a systematic search of the literature was completed following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses as a guide. Following Arksey and O'Malley's¹⁰ framework for scoping reviews, the present scoping review followed 5 stages: (1) identifying the research question, (2) identifying studies, (3) selecting studies, (4) extracting and charting the data, and (5) collating/summarizing the results. Consulting with stakeholders to inform or validate study findings is a suggested optional final step. Our author group represented a collaborative team that involved a number of stakeholders working on a collaborative project and were involved in all phases of this review.

Data Source

A comprehensive search of empirical literature on collaborative health promotion endeavors published between January

2001 and October 2015 was undertaken. MEDLINE, CINAHL, ScienceDirect, PsycINFO, and Academic Search Complete were searched using the phrases (Partnership OR Alliance OR Collabor* OR Health coalition) AND (Organization OR Agency) AND (Health promotion OR Prevention OR Community development). No unpublished or grey literature was searched.

Inclusion and Exclusion Criteria

Articles with all study designs were included provided they met the following inclusion criteria: (1) were published in English, (2) involved health promotion, (3) involved at least 2 organizations in a partnership (note 1), (4) examined the collaboration process to identify factors contributing to or constraining the success, or lack of success, of a partnership, and (5) presented evidence that collaborations are well underway, resolved, or completed. Articles were excluded if they involved only a single organization, focused on primary care collaboration, included coalitions where organizations joined to "lobby" for a cause, or represented papers that did not empirically identify factors that facilitate or inhibit collaboration. Articles meeting the inclusion criteria were evaluated for methodological strength using a quality assessment tool adapted from Harden et al¹¹ (possible scores range: 0-11) independently by 2 members of the author team, given a recent review of scoping review studies that suggested that quality assessment scores are infrequently reported.¹² Harden et al identified 12 criteria to assess the quality of studies (eg, "Was there an adequate description of the methods used to collect the data?") and suggested that studies meeting fewer than 7 criteria be considered low quality, between 7 and 9 medium quality, and meeting 10 or more be considered high quality; however, 1 item ("Did the study involve young people in its design and conduct?") was not deemed relevant to the present review and was removed, so these numbers should be reduced by 1 when evaluating the scores studies received in the present review. In addition in the present review, the criteria for inclusion were not based on quality of the studies but on relevance to the research question⁸; thus, these quality scores are simply presented as a guide for readers when interpreting individual study results.

Data Extraction

A summary chart was created to record the study characteristics and extract data relevant to all the factors that were identified as facilitating or constraining collaboration success in each of the articles by one of the authors (N.H.). A second member of the author team (C.L.S.) then created a coding framework to include only those facilitating and constraining factors that were common across more than 1 study. Relevant article content was then coded using NVivo 10 into the facilitating and constraining factors in the coding framework. Other information from each study, such as the definition of success and description of the collaboration and partners (eg, community-based partner, research-based partner, rural vs

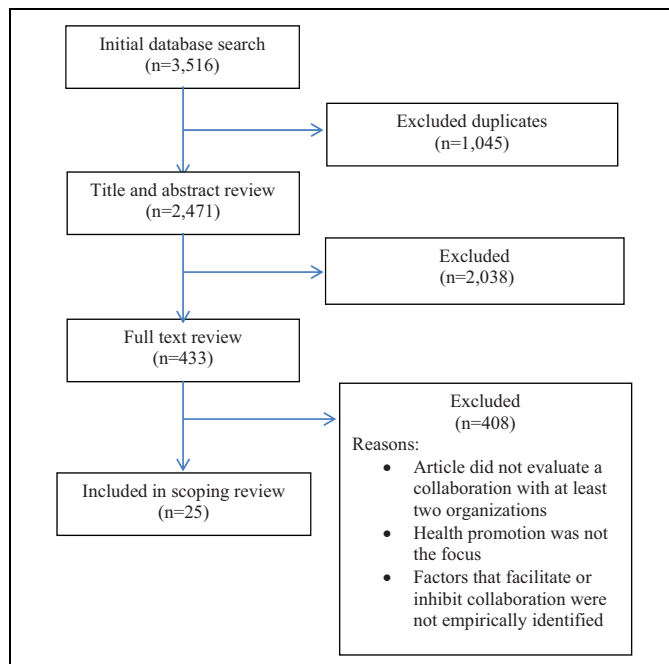


Figure 1. Pathway of articles identified and excluded.

urban), was also recorded in NVivo in order to identify characteristics underpinning diverse experiences. The 2 members of the author team then compared the data extracted (eg, which articles were identified as including which factors) using each of these methods, and differences were reviewed and discussed to reach agreement.

Data Synthesis

The most common factors across studies were identified and grouped into themes. NVivo 10 was then used to code relevant article content into the thematic categories identified in the data extraction.

Results

Findings From the Literature Search

The search retrieved 3516 articles that yielded 2471 articles after duplicates were removed with RefWorks (Legacy version). A full-text review of 433 articles was completed. After excluding articles that did not meet the eligibility criteria, 25 articles were identified for inclusion. A flow diagram summarizing article inclusion/exclusion is provided in Figure 1.

The 25 articles included in this review involved studies undertaken in several countries, including 14 from the United States,¹³⁻²⁶ 5 from Canada,²⁷⁻³¹ and 1 from Australia,³² Denmark,³³ Northern Ireland,³⁴ South Africa,³⁵ Sweden,³⁶ and the United Kingdom.³⁷ In total, 13 studies focused on a single collaboration (with a minimum of 2 partners).^{13,16,18,19,22,26,27,29,30,32,34,35,37} In contrast, 12 studies examined multiple cases of collaboration.^{14,15,17,20,21,23-25,28,31,33,36} Table 1 provides a detailed summary of article characteristics and quality assessment scores (range: 5-11).

The findings based on the themes that emerged from the data charting are organized below according to 3 sections: (1) the definition of collaborative success or effectiveness; (2) the factors that were found to facilitate collaborative effectiveness; and (3) the factors that were found to constrain health promotion collaborations.

Collaborative Success/Effectiveness

Collaboration success was often not explicitly defined in the included studies. However, indicators of collaborative functioning or, alternatively, the achievement of project goals were used to identify successful collaborations. In total, 8 studies focused on aspects of collaborative functioning.^{15,22-24,28,34,36,37} For example, in 1 study urban parents' initial and ongoing involvement as collaborative board members in an HIV prevention project was examined to identify factors that facilitated this involvement.²² In another study, representatives from community-based organizations were asked to describe the aspects of their "most collaborative projects" as well as their "least collaborative projects."²³ In 2 studies, project outcomes (eg, uptake and success of a program) were used as indicators of successful collaborations.^{19,35} The remaining 15 studies included some aspects of both collaborative functioning and project outcomes, and often the 2 were difficult to separate.^{13,14,16-18,20,21,25-27,29-33} For example, Mikkelson and Trolle³³ examined the products of the partnerships between 13 different collaborations for the promotion of healthier eating as well as whether these products could have been achieved without the partnerships. In another study, success was defined based on whether the project had been implemented, but this was evaluated according to the coordinated delivery of activities and the commitment of the collaborative partners.²⁷ One study focused on sustainability of community health promotion projects (after funding ended) and how the project grantees achieved this; the solutions included both a focus on maintaining and expanding partnerships, as well as finding ways to maintain the community-level interventions (eg, through policy changes or ongoing funding).²¹ Other studies also cited factors that were related to project or partnership sustainability as an outcome of successful health promotion collaborations.^{19,24,29} Table 1 includes a detailed summary of the way success was conceptualized in each study.

Facilitating Factors

Shared vision, goals, or project objectives. One frequently cited factor for facilitating successful collaborations was the presence of a shared vision or clear and agreed-upon project objectives.^{13-17,23-27,29,30,34,36} This collective agreement was seen as especially important in partnerships between research and community-based organizations.^{13,23} Eriksson et al³⁶ also found that for a successful academic-practice-policy partnership, all parties must have a shared belief that the partnership was needed and a willingness to learn from one another. Likewise, realistic expectations and a common understanding of the

Table 1. Summary of the Characteristics of Included Articles Published Between January 2001 and October 2015.

Author (Year)	Country; Rural or Urban (If Applicable)	Health Focus of Collaboration	Description of Collaboration	Study Design (Qualitative/Quantitative)	Sample and Data Collected	Conceptualization of Success	Quality Assessment Score
Bourdages et al ²⁷	Canada; rural	Prevention of cardiovascular disease and lung cancer	In each of 4 subregions, the regional health authority and local community health centers jointly implemented projects	Qualitative	Semi-structured interviews (year 1 n = 20; year 2 n = 18; year 3 n = 12; year 4 n = 12) and focus groups with core staff and project partners from the subregions Questionnaires were completed by all individuals involved with implementation Document analysis of records and reports	How successfully the project had been implemented was defined by evaluation criteria drawn from previous studies of community collaborations and included 4 dimensions: 1. number of activities; 2. local coordination; 3. partnerships; and 4. roles/responsibilities	10
Brown et al ¹³	United States; urban	HIV prevention	The county of Santa Clara and 4 community-based organizations along with the Palo Alto Medical Foundation Research Institute collaborated to develop, deliver, and evaluate a series of HIV prevention workshops for at-risk women	Qualitative	Intervention staff completed monthly feedback forms Members from the community-based partners who had worked on the project completed a questionnaire and were asked to describe their perceptions of the strengths and weakness of the collaboration (n = 13) The process of forming the collaboration and strategies used to build collaborative capacity were described	A continued focus on what was important (women's health), coming together repeatedly to work out differences, and the development and delivery of an effective intervention	5
Corbin et al ¹⁴	United States	Cancer prevention	<i>Latinos in a Network for Cancer Control</i> (LINCC) is a community-academic partnership network with 130 members from 65 organizations that supports multiple cancer prevention projects	Qualitative	Interviews (n = 19) with academic and community members in the Latinos in a Network for Cancer Control (LINCC) partnership	Collaborative functioning (the Bergen Model of the processes that contribute to synergy and antagonism) in a community-academic partnership	10
Downey et al ¹⁵	United States; rural	Injury prevention	Four injury prevention coalitions (community-based partners with the National Highway Traffic Safety Administration, and SAFE KIDS) in predominately rural areas	Qualitative	A document analysis of mission statements, rules of operation, meetings, and historical documents (eg, progress reports, agendas, logs, newspaper articles) of injury prevention coalitions that were part of a larger research project were analyzed. The results were presented back to the coalition members for verification	Coalitions that were able to develop and sustain partnerships for injury prevention were considered successful	9

(continued)

Table 1. (continued)

Author (Year)	Country: Rural or Urban (If Applicable)	Health Focus of Collaboration	Description of Collaboration	Study Design (Qualitative/Quantitative)	Sample and Data Collected	Conceptualization of Success	Quality Assessment Score
Eisinger and Senturia ¹⁶	United States; urban	Health promotion	The Seattle Partners for Healthy Communities, an urban research centers, includes community activists, community agency representatives, health professionals, academics, and health care workers.	Qualitative	Interviews (n = 19 in 1998, and n = 19 in 1999) with board members from Seattle Partners, along with participant observation, field notes, and document analysis (meeting minutes, grant proposals, administrative records)	The accomplishments of the Seattle Partners (both projects and process) that are driven by community interests and are collaborative (ie, reduce inequity between researchers and community members)	10
Eriksson et al ³⁶	Sweden; urban	(1) Drug prevention, (2) Healthy city development, (3) Empowering families with teenagers	Three separate health promotion research partnerships between academics, practitioners, and policy makers (ie, case studies) were included	Qualitative	Interviews with agency representatives, politicians, and health professionals along with reflective dialogues and evaluation meetings	Partnership synergy was included as an indicator of success	6
Flicker et al ²⁸	Canada; both urban and rural	HIV prevention	Members from AIDS service organizations in Ontario, Canada, were asked about their experiences with collaborative community-based research (ie, involvement, facilitators, and barriers)	Mixed-methods	Survey (n = 39) and follow-up interviews (n = 25) with members (Executive directors and coordinators) of AIDS service organizations	Engagement in community-based research	10
Gee et al ¹⁷	United States; urban	Health promotion	In order to examine the Bureau of Primary Health Care's Faith Partnership Initiative, managers from 5 faith-based community health centers in 4 US cities as well as leaders from the neighboring religious congregations were asked about their experiences collaborating with one another (ie, extent to which collaborations existed, effectiveness of and barriers to these partnerships)	Qualitative	Interviews were completed with managers (n = 13) from 5 community health centers and leaders (n = 23) from 29 predominantly Christian congregations surrounding the health centers	Participants' descriptions of collaborations as mutually beneficial and resulting in more comprehensive care for patients	10
Gilbert et al ¹⁸	United States; urban	Reducing health disparities and prevention of type 2 diabetes	The <i>Healthy Black Family Project</i> involved a collaboration between an academic research center, a government public health department, and several community organizations and foundations, along with nonprofit organizations partnering to address health disparities	Qualitative	Interviews (n = 18) with foundation executives, project directors, civic organization leaders, community leaders, county epidemiologists, and university partners	The influence of the partnership in building organizational and community capacity to develop and implement the <i>Healthy Black Family Project</i> (along with ways to sustain partnerships)	7

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Table 1. (continued)

Author (Year)	Country; Rural or Urban (If Applicable)	Health Focus of Collaboration	Description of Collaboration	Study Design (Qualitative/Quantitative)	Sample and Data Collected	Conceptualization of Success	Quality Assessment Score
Goldberg et al ²⁶	United States; urban	Adolescent pregnancy prevention	The <i>Families in Our Community United for Success (FOCUS)</i> program involved a partnership between the Department of Health and Human Services, the Office of Adolescent Pregnancy Programs (OAPP), and Adolescent Family Life (AFL) along with 53 community partners	Mixed-methods	Over the course of the project, evaluators completed interviews, focus groups, and surveys with project leaders, parents, and project staff. Representatives (n = 35) from the community partners completed an online survey. A document analysis of program records, North Chicago demographic data, and historical documents (eg, public reports and newspaper articles) was also conducted	The recruitment and retention of parents and students, the effective use of community resources, and the establishment of partnerships with community organizations	9
Greaney et al ¹⁹	United States; urban	Obesity prevention	<i>Healthy Choices</i> was an intervention implemented in 120 middle schools in Massachusetts as a collaboration between the Massachusetts Department of Public Health (MDPH), the Blue Cross Blue Shield of Massachusetts (BCBS-MA), and the participating schools who applied for funding	Qualitative	Process data (eg, number of intervention activities reported) was used to identify schools with the highest and lowest implementation scores (n = 10), and purposeful interviews (n = 56) were completed with middle school employees representing different positions (administrators, teachers, food service personnel, and employees serving as intervention coordinators)	Successful implementation/uptake of the <i>Healthy Choices</i> program to encourage physical activity and healthy eating in schools	10
Heenan ³⁴	Northern Ireland; urban	Health promotion and reducing inequity	The <i>Greggan Health Information Project (CHIP)</i> was a partnership between local community partners and volunteers and the local Health Board and Social Services Trust (governing health agencies/local health authorities)	Qualitative	Interviews (n = 16) with the project manager, staff, community and voluntary workers, and directors of the Health Board and Social Services Trust, along with an examination of secondary sources (ie, articles and reports detailing the CHIP project)	A change in the delivery of health services to be more community driven	8

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Table 1. (continued)

Author (Year)	Country: Rural or Urban (If Applicable)	Health Focus of Collaboration	Description of Collaboration	Study Design (Qualitative/ Quantitative)	Sample and Data Collected	Conceptualization of Success	Quality Assessment Score
Horn et al ²⁹	Canada	Mental health promotion	The <i>Health Compass</i> project was led by the BC Mental Health and Addiction Services in collaboration with other provincial agencies (ie, BC Cancer Agency, BC Centre for Disease Control, BC Children's Hospital, and Sunny Hill Health Center, and BC Women's Hospital and Health Center) to improve the capacity of the Provincial Health Service Authority to deliver mental health services	Qualitative	Interviews (n = 3) with the internal project team (ie, the project manager, project lead, and executive lead) along with interviews (n = 18) with stakeholders (ie, steering committee, advisory committee, and external reference group)	Success was defined as the effective engagement of the collaborators/stakeholders in the process of developing the mental health promotion learning tools/resources for health-care providers	8
Joffres et al ³⁰	Canada	Cardiovascular disease prevention	The <i>Heart Health Partnership</i> included Heart Health Nova Scotia (a Canadian research team), and 21 provincial and municipal partner organizations that provide health promotion education	Qualitative	Reflection logs were completed by Heart Health Nova Scotia research staff on a regular basis. Regularly scheduled interviews were completed with members (n = 12) from 6 of the partner organizations (ie, the case study organizations), interviews were completed with representatives from all partner organizations (n = 21), and end-of-project interviews (n = 43) were completed with members of the 6 case study organizations	Increasing the partner organizations involvement in the collaboration, as well as building organizational capacity (ie, the ability to promote heart health)	10
Kegler and Wyatt ²⁰	United States: urban	Teen pregnancy prevention	The <i>Healthy, Empowered And Responsible Teens of Oklahoma City</i> project was led by the Oklahoma Institute for Child Advocacy and state health department in partnership with community-based organization in each of 5 neighborhoods	Qualitative	Interviews (n = 21) with neighborhood coordinators, task force members (including youth and adults), agency staff, state health department staff, and an evaluator, along with structured observations made during task force meetings during the planning and implementation phases, and document analysis of meeting minutes, agendas, and progress logs (completed by community coordinators)	Mobilization of a neighborhood task force for teen pregnancy prevention (ie, whether a partnership was formed, how often they met, attendance at meetings, etc).	9

(continued)

Table 1. (continued)

Author (Year)	Country: Rural or Urban (If Applicable)	Health Focus of Collaboration	Description of Collaboration	Study Design (Qualitative/Quantitative)	Sample and Data Collected	Conceptualization of Success	Quality Assessment Score
Kraft et al ²¹	United States	Active living	25 community partnerships funded by the Active Living by Design national program	Qualitative	Data from interview documents and evaluation reports were analyzed for themes related to sustainability strategies. The community project grantee progress reports on project activities were analyzed for further sustainability strategies	Maintaining the community health promotion project after funding end (sustainability)	7
McKay et al ²²	United States; urban	HIV prevention	A collaborative board including parents, school representatives, members of community-based organizations, and university researchers oversaw the design, implementation, and evaluation of an HIV prevention program for youth	Qualitative	Interviews (n = 29) were completed with parent collaborative board members	Parent's initial and ongoing involvement as collaborative board members	11
Mikkelsen and Trolle ³³	Denmark	Healthy eating	13 different collaborative projects for the promotion of healthier eating. All partnerships had at least 1 health authority or research partner	Qualitative	Individuals representing the 13 different partnerships presenting posters about their projects at a conference on collaborations for healthy eating rated the strengths and weaknesses of their partnerships using a 10-item scale and an open-ended question. The posters were also analyzed	Outcomes included both products of the partnerships (eg, new resources) and aspects of the partnerships themselves (eg, did they take more time?)	7
Pavis et al ³⁷	United Kingdom	Drug prevention	The EVERGREEN project involved a collaboration between a national agency, local health authority, voluntary sector, and community-based partners for the reduction of drug-related harm	Qualitative	Retrospective interviews (n = 19) with members of the steering group, including representatives from the national agency, the health authority, the community groups, and project staff, along with participant observation and document analysis (meeting minutes, grant proposal, and evaluation documents)	The process of collaboration and the impact on the community	9

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Table 1. (continued)

Author (Year)	Country: Rural or Urban (If Applicable)	Health Focus of Collaboration	Description of Collaboration	Study Design (Qualitative/Quantitative)	Sample and Data Collected	Conceptualization of Success	Quality Assessment Score
Pinto ²³	United States; urban	HIV prevention	Representatives from 10 community-based organizations that provide HIV medical or social services were asked about their experiences collaborating with researchers	Qualitative	Interviews (n = 20) with the executive director and one other staff member of each of 10 community-based organizations that had previously been involved in collaborative HIV-prevention research projects	Representatives described the most successful and least successful collaboration their agencies had been a part of	11
Poland et al ³¹	Canada; both urban and rural	Health promotion	Partnerships between hospitals and community-based organizations were explored in 4 case study sites in Ontario, Canada	Mixed-methods	Interviews (n = 63) and focus groups (n = 2) with hospital and community representatives in the 4 case study sites, document review (eg, community newspapers, Chamber of commerce, district health councils), and a telephone survey (n = 139) with members of community organizations in one urban center	Success was defined by participants as either achieving a goal (eg, an effective intervention or improved service delivery) or in terms of the quality of collaborative relationships (eg, respect, communication, and mutual benefits)	10
Poulos et al ³²	Australia	Injury prevention	A reference group with representatives from 28 stakeholder organizations (eg, state sporting organizations, government and nongovernment groups) led by the New South Wales Sport and Recreation Division was formed to develop a state-wide sports safety policy	Mixed-methods	Telephone interviews with members of the reference group prior to the first group meeting (n = 25) and following the development of the policy document after the second group meeting (n = 24). 19 reference group members also completed a partnership map (n = 19) and checklist (n = 15)	Satisfaction with the establishment and operation of the reference group as well as with the policy outcome	8
St. Pierre ²⁴	United States; both urban and rural	Drug prevention	Representatives from 11 community-based organizations were asked about their experiences collaborating with schools (ie, strategies used) to prevent youth drug use	Qualitative	Group interviews/oral histories (n = 11) with representatives from community-based organizations who attended a 2-day meeting pertaining to their collaborative projects funded by the Center for Substance Abuse Prevention	Establishing and maintaining collaborations between community-based organizations and schools (for implementing interventions to prevent youth drug use)	5

(continued)

Table 1. (continued)

Author (Year)	Country: Rural or Urban (If Applicable)	Health Focus of Collaboration	Description of Collaboration	Study Design (Qualitative/Quantitative)	Sample and Data Collected	Conceptualization of Success	Quality Assessment Score
Uwimana et al ³⁵	South Africa; rural	HIV and TB coinfection (treatment and prevention)	The experiences of representatives at provincial, district, facility, and community levels regarding a national policy directive for the provision of collaborative TB/HIV services were examined	Qualitative	Interviews (n = 28) with health managers, community care workers, and managers in nongovernment organizations and focus groups (n = 6) with community care workers	Implementation of the national policy (ie, the collaborative delivery of TB/HIV services at the district, provincial, facility, and community levels)	9
Zahner ²⁵	United States; both urban and rural	Public health (eg, tobacco prevention, maternal/child health, immunizations)	Health department directors in Wisconsin were asked about their experiences collaborating with local public health partners (including other government agencies, nonprofits, voluntary agencies, community-based organizations, schools, and individual community residents) for public health	Quantitative	Local health department directors (n = 74) in 1 state completed 2 cross-sectional surveys	Whether or not the collaborative plans had been implemented (yes/no) and how effective implementation had been on a 4-point scale ranging from very successful to very unsuccessful	7

Abbreviation: TB, tuberculosis.

project goals were essential in a context where deep-seated community mistrust for the local government agency partner existed.³⁴ However, in a recent study of an academic-community partnership network, a broader vision for the goals or mission of the network allowed for a more inclusive/diverse membership.¹⁴

Leadership. Leadership was commonly identified as an important factor contributing to the success of health promotion collaborations.^{14-16,18,20,27,29,30,32,36} The importance of having decision-making mechanisms in place that enabled the input of all partner agencies as well as providing opportunities for individuals within each of the organizations to participate in decision-making were recognized as facilitating collaborations.^{13,16,27,32} In an injury prevention project, document analysis revealed that the leaders' ability to delegate tasks that were appropriate to individual member's skills was an important facilitating factor.¹⁵

Member characteristics. The individual member's skills and the diversity of group membership facilitated some health promotion collaborations, although the evidence was mixed.^{14-16,20,22,24,25,27,31-34} For example, in a project to mobilize community members to prevent teen pregnancy, an experienced coordinator who was already trusted in the community was successful in attracting community members; however, having a coordinator with the "right" characteristics did not ensure mobilization in another neighborhood.²⁰ Members who were enthusiastic and willing to volunteer their time and skills helped ensure the success of other projects.^{31,34} Although diversity of members was often seen as a positive,^{14,15,25,27,33} in a multiagency collaborative formed to develop a state-wide sports safety policy, the diversity of membership was seen as a challenge in that it limited the likelihood that a consensus would be reached.³²

Organizational commitment. The commitment of each partner organization to the collaborative initiative was also identified by a number of studies as an important factor for ensuring the individual collaborative members could actively contribute.^{13,18,21,27-31,36} In a multisectoral initiative between Heart Health Nova Scotia researchers and 21 agencies and community partners, the match between the project objectives and partner's organizational objectives was directly related to how involved each organization became in the project.³⁰ When strong organizational commitment was evident, organizations allowed dedicated time for staff to build the collaborative partnership.^{13,27,29,30,36} This was more likely to occur when the collaborative project goals were clearly aligned with agency mandates, allowing members to fulfill organizational expectations through project participation.^{30,31} Furthermore, increased organizational commitment could also support project sustainability. For example, in a study of 25 community coalitions that were granted funds for projects to support active living, many of the grantees described how organizational changes, such as

the creation of new departments or the institutionalization of a practice, supported the sustainability of their projects.²¹

Availability of resources. Resources such as administrative support, technical assistance, or appropriate training, and most importantly funding were identified by 14 studies as facilitating health promotion collaborations.^{13-16,19-21,23-25,28-30,33} For example, skilled administrative support, in the form of organizing meetings and facilitating communications between members, supported a partnership-based urban research center to promote the health of Seattle residents.¹⁶ In another collaboration, the lead agency provided technical support and training workshops to build the other partner organizations' capacity to address factors related to heart health.³⁰ In a school-based obesity prevention program, being able to consult the lead agencies for technical support was identified by the school employees interviewed as being more facilitating than financial support.¹⁹ Yet, across many studies, obtaining sufficient funding was clearly recognized as a facilitator of health promotion collaborations.^{13-15,19,21,25,28} Likewise, obtaining sustainable funding after initial grant moneys were spent was a factor identified as promoting project sustainability.^{15,19,21} In a school-based program for obesity prevention, sustainability was seen as requiring additional (not fewer) supports to enable faculty and staff to increase their involvement.¹⁹ In particular, these included reducing existing pressures on teachers' time, securing future funding, and maintaining the support of outside expert partners.¹⁹ In another study, continued financial support along with maintaining the initial collaborators' roles were necessary for ensuring that a drug prevention program would be sustained.²⁴

Clear roles and responsibilities. The findings of several studies suggested that clear roles and responsibilities for project members were important for ensuring project work moved forward.^{13-15,24,27,37} In 1 study, clearly identifying the responsibilities of each partner organization allowed for accountability, especially when key members left.²⁴ In a collaborative evaluation of a harm reduction intervention for women at risk for HIV, clearly defined roles helped to ensure that the responsibility for the program's implementation was shared by all partners and supported program sustainability when 2 of the original partners withdrew from the project.¹³ In a network of community-academic partners for cancer prevention, the loosely defined roles resulted in lower network-wide productivity; however, this was balanced by more productive subgroups with clearly specified roles.¹⁴ Finally, in another study, clear roles resulted in greater trust and therefore, a stronger collaborative.²⁷

Trust, communication, and relationships. Trust was another factor that was often cited as necessary for effective health promotion collaborations.^{18,23,24,27,31,36} In particular, taking time to develop trusting relationships with project partners was an aspect of the most successful collaborations between researchers and community-based organizations.^{23,36} In other studies,

community-based partners played a key role in establishing public trust in order to enhance the project outcomes. For example, several studies mentioned the importance of partnering with organizations or agencies that were already trusted institutions in the community^{18,20} or had wide-reaching influence in the community.¹⁵

Open communication was also identified as important factor to both promote a climate of trust and facilitate the collaborative processes.^{13,15,16,20,24,27,29,36} For example, Downey et al¹⁵ identified that meetings that were productive and inclusive of all members' input were important in keeping members engaged in an injury prevention collaborative. Yet, another study showed that trust and communication improved over time as relationships were established, and these in turn resulted in swifter decision-making and more effective meetings.¹⁶

Indeed, the existing relationship between project partners was another factor that was identified as facilitating health promotion collaborations.^{14,24} For example, preestablished coalitions were found to be in the best position to develop a community drug prevention plan because members already had trusting relationships and a shared vision.²⁴ There was also some evidence that rural partners may benefit from close networks and existing relationships. In a study of community mobilization, 2 rural areas were provided funding first, because of previous success in implementing similar projects in rural areas.²⁷ Yet, in a study of 924 different local public health system partnerships, no statistical differences between rural and urban/suburban areas were found in whether plans had been implemented.²⁵

Engaging the target population. Many studies also highlighted the importance of getting the input of members from the target population (eg, community residents), in order to enhance the likelihood that the project met the needs of the people it was intended to serve. This was primarily accomplished through engaging community-based organizations or agencies.^{13-18,20-28,30,31,34,35,37} Developing collaborative health promotion projects based on perceived needs of the community provided a vehicle for health promotion collaborators to garner important community support for their respective initiatives^{20,23} and build sustainable and community-driven projects.²⁷ Furthermore, when community-based organizations partnered with researchers, it was important that the community organization members were able to participate in decisions about the project evaluation.^{13,16,23} When members of the target population were engaged successfully, there was an emphasis on the importance of inclusive participation and the mutual benefits that result^{14,15,26,27}

Constraining Factors

Constraining factors were often the absence or inverse of the facilitating factors. For example, a lack of a common goal or differing expectations for project outcomes was found to cause tension in health promotion collaborations.^{16,24,27,35}

Insufficient funds to support the collaborative project was another common barrier.^{14,21,28,30,35} Themes around a lack of time and competing priorities also emerged frequently as constraining factors,^{19,23,28,30,32} and this was especially salient for individuals from organizations that served rural compared to urban areas.²⁸ In a youth substance abuse prevention project, inadvertently leaving out members of the target community in the planning process resulted in a program that was stigmatizing and did not fit the community's needs.²⁴ Yet, government mandates or policy directives to collaborate appeared to actually lower the likelihood of successful implementation in the absence of time to develop meaningful relationships between partners.^{25,35} Finally, a lack of clear roles,^{27,35} mistrust,³⁴ and poor communication^{13,14,27} were identified as factors that could undermine health promotion collaborations.

Tension due to power conflicts could also negatively impact collaborative functioning.^{23,27,28,30,34,35,37} When organizations sought to maintain their autonomy/control^{18,31} or were in competition for resources,^{14,17,31} successful collaboration was viewed as an elusive goal. In partnerships between researchers and community-based organizations, power differentials concerning access to and ownership of research findings held potential for creating tension and hindering collaborative relationships.^{23,28} Similarly, unequal power between hospitals and community groups was recognized to be a deterrent to collaboration in another study.³¹ Others identified "unequal status" with respect to investment in the collaboration as a potential source of conflict. One study where smaller partners felt forced to invest greater human resources to balance the financial contribution of the larger partner concluded that it may be necessary for all partners to be on an equal footing to ensure a successful collaboration.³³ However, in a study of a multiorganization drug prevention collaboration, the authors suggested that it is not realistic to expect all members to make equal contributions of time, resources, or skills.³⁷ Finally, an additional constraining factor to collaborations was that of conflict between members. Emotionally charged decision-making exacerbated by time constraints was reported to result in conflict that undermined the ability of an urban research center committee to unanimously support the collaborative projects selected for funding.¹⁶ However, in a teen-pregnancy prevention project, the existence of conflict did not impact collaborative efforts related to community mobilization if it was resolved quickly.²⁰

Discussion

The findings of this scoping review extend knowledge of the factors that promote and constrain health promotion collaborations and point to some key research priorities to pursue in future work. A focus on project sustainability as an outcome of successful collaborations emerged as a novel development since previous reviews.⁵ Similar to previous reviews,^{6,7} several key factors contributed to interorganizational collaborative success, including a shared vision, leadership, member characteristics, organizational commitment, available resources, clear

roles/responsibilities, trusting relationships, and engaging members of the target population.

Interpretation of the factors that impact the success of inter-organizational health promotion collaborations identified in this review must take into consideration the way success was conceptualized. Many did not explicitly indicate how success was being defined, and the implied conceptualizations of collaborative success or effectiveness varied greatly. Zakocs and Edwards⁵ reviewed the coalition-building factors in published articles between 1980 and 2004 and found 2 indicators of collaborative effectiveness: collaborative functioning and the achievement of project goals. Similarly, the articles in this review focused on a range of indicators of both collaborative functioning and project outcomes to identify successful collaborations. Furthermore, a new indicator that emerged in the present review was a focus on project sustainability as an outcome of successful health promotion collaborations. It seems possible that because health promotion collaborations are increasingly trying to accomplish more with fewer funds, concerns around project and partnership sustainability have come into more direct focus. Furthermore, as research has evolved on health promotion collaborations, sustainability after project end may be a natural next step in the evaluation of what a successful partnership entails.

Overall, the facilitating and constraining factors identified in the 25 studies reviewed were consistent with previous research.^{6,7} In comparison to previous reviews, engaging the target population stood out as increasingly important factor for facilitating health promotion collaborations. The emphasis on community-based participatory research as an approach to ensuring equity between researchers and program end users³⁸ has grown in popularity over the past decade, yet in the studies reviewed members of a target population were engaged in many different ways. In some studies, including members from the target population as *partners* in their health promotion collaborations helped ensure the project met the needs of the population it was intended for.^{15,27} In other studies project staff (eg, coordinators) that represented the target population were hired, however, care needed to be taken that they were effective liaisons within the community.^{20,24} Project staff who were not members of the target population could also effectively mobilize community members provided they adopted a community engagement perspective.²⁶

Also consistent with previous literature, the constraining factors often appeared as the inverse of the facilitating factors cited. One of the most notable of these was the time commitment that collaboration involves. Indeed, although those espousing the benefits of collaboration often point to the potential to increase impact without increasing current levels of resource investment (eg, by avoiding duplication, enhancing coordination, etc), it appeared that the extra time investment caught some project partners off guard.^{13,30,32} Ensuring time for collaborative partners to build relationships, understand each other's perspectives, and make decisions³³ is important for success.

Two additional constraining factors not often identified in previous reviews also emerged. These were tension due to power differentials, and conflict between members. Ensuring

equity in a partnership may be necessary for a successful collaboration,³³ but equity needs to be balanced by an acceptance of partner diversity. Indeed, in the present review some studies identified member diversity as a facilitating factor,^{14,15,25,27,33} and others found that diversity can slow decision-making and limit consensus.³² It is possible that a combination of factors accounts for these different findings; for example, if member roles are clearly defined, then member diversity is less likely to be an issue because the individual responsibilities of different members will be understood. Diversity can create synergy (the optimal combination of complimentary partner strengths, values, and perspectives for better solutions),^{39,40} but it takes time to engage members effectively and create that added value.³³ Nembhard³ found that collaborative effectiveness depended on whether partners truly capitalized on potential interorganizational learning. Members must not only contribute their unique skills/knowledge but also help to build the capacity of their partners in order to create synergy.³⁷

The findings in this review need to be considered in the context of the limitations. The factors summarized here are not comprehensive. Factors that were only identified in 1 article were not included in this review. A vast range of different partnerships and topics were covered in this review; as such, the factors identified were only those things that cut across several of these diverse health promotion collaborations. Therefore, numerous potential facilitators and constraining factors specific to the individual health promotion topics, partners, or reasons for collaborating may have been excluded. Previous reviews have included gray literature and captured many more diverse elements of collaboration.⁷ In addition, differences between fostering health promotion collaborations in rural and urban contexts are not yet well defined in the literature. In the studies that involved rural-based collaborators, there were indications that rural settings provided a unique context for health promotion collaborations although findings were not consistent. More research is needed on the key differences between urban and rural contexts for collaboration to determine whether the facilitating factors differ between these contexts. The factors identified in this review resulted from primarily qualitative studies in which collaborative success was often not well defined. Future research that examines the relative contribution of the facilitating factors to collaborative success is needed. The detailed, narrative findings represented in these qualitative studies provide direction for selecting appropriate measures for monitoring and evaluating success in developing collaborative functioning and, in the absence of suitable measures, the findings provide direction for developing robust assessment approaches and tools.

Given the qualitative nature of the studies reviewed, it remains unclear the extent to which each of the facilitating and constraining factors identified contribute collaborative success. Nevertheless, the diversity of health promotion topics, partners, and locations in the studies in this review lends confidence to the importance of the facilitating and constraining factors that are likely to be important considerations in supporting collaboration effectiveness regardless of context.

Conclusion

The factors contributing to successful health promotion collaboration (or hindering them) identified in this review represent potentially important factors to be considered in models to guide community health collaborations. As interagency partnerships for health promotion become more and more common, it is increasingly necessary to consider factors that facilitate and constrain collaboration.

SO WHAT?

What is already known on this topic?

Previous reviews have identified factors that facilitated health promotion collaboration, such as a clear vision, leadership, technical support, financial resources, and demonstrated project outcomes.⁶

What does this article add?

The findings support and update previous reviews. Furthermore, additional novel themes emerged, including a focus on project sustainability and the importance of engaging members of the target population in program planning.

What are the implications for health promotion practice or research?

The facilitating/constraining factors identified in this review should be given consideration by those engaging in collaboration for health promotion. It is also important for interorganizational collaboratives to clearly define what partnership and project success looks like to inform ongoing evaluation and development of the collaboration effectiveness. Finally, sustainability appears to be an emerging area of interest, and may become an integral part of future health promotion practice.

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Note

1. As the focus of our study was on collaboration at the organizational/group level, we excluded studies that involved individual level health promotion collaborations (eg, doctors, nurses, etc). However, group-level collaborations could include coalitions, community-based organizations, service delivery agencies, and so on. Essentially, any larger organization that partnered with at least 1 other organization.

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