Health promotion partnerships in Israel: motives, enhancing and inhibiting factors, and modes of structure

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SUMMARY
Multisectoral cooperation is an important strategy in working for health promotion. Fifty-two health professionals completed a questionnaire measuring factors motivating, enhancing and inhibiting partnerships. The respondents also reported the type or structure of the partnerships. The results indicated that partnerships were formed primarily in order to promote the project; however, previous positive experience with partnerships was also very important as a motivating force for joining partnerships. The three most important facilitating factors were related to project management: effective leadership, aims of the project, and sharing a vision and goals. The two most frequent items mentioned as very important barriers to partnerships were related to dysfunction of the steering committee. Two types or structures of partnerships were identified. The first was fragmental, where partnerships existed only at specific stages of the project; most respondents reported working within this structure. The second type was continuous, where partnerships existed through all the project’s stages. Using multiple regression analysis we found that health staff (mainly nurses) worked more frequently in fragmental partnership structures than did health promotion and welfare workers. In addition, the more experienced the respondents, the less they worked in fragmental partnership structures. These results highlight the importance of acquiring skills for working in partnerships and indicate a need for guidelines to be agreed by the partners at the beginning of the working process.

Key words: barriers; health promotion; partnerships; structure

INTRODUCTION
The need for new strategies to promote health arose due to the realization that health was influenced by a combination of social, political, environmental and medical factors. The health care system has only a small role in enhancing health in the community and cannot be expected to cope with all the factors causing ill health. One of the strategies suggested by the World Health Organization (WHO) was to use multisectoral cooperation (WHO, 1985). This strategy has been developed around the world during the last 20 years. Many terms are used to describe ‘working together’ (Naidoo and Wills, 2000). Some of these terms, such as collaboration and cooperation, refer to the process of working together, whereas others, such as partnerships, coalitions and alliances, pertain more to the organizational structure or unit that enables the process of collaboration. For example, Gray defined collaboration as a process through which parties who see different aspects of a problem can explore constructively their differences and search for solutions that go beyond their own limited vision of what is possible (Gray, 1989). In contrast, words such as ‘partnership’, ‘networks’, ‘coalition’ and ‘alliance’ are sometimes used interchangeably to pertain
more to the structures or organizational units that enable individuals and organizations to combine their human and material resources so that they can accomplish the objectives they are unable to bring about alone. For example, Gillies defined health promotion partnerships as ‘a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes’ [(Gillies, 1998), p. 101].

These organizational units can function on a local level, a national level, or both. In the present study, we will use the term ‘partnership’ to describe the structure that permits ‘working together’.

Creating a partnership and making it work is a time- and resource-consuming challenge. The assumption is that outcomes achieved by collaboration will be greater than those achieved by each organization working alone, so the effect of partnerships will be synergistic. However, research in this area is sparse (Gillies, 1998; Lasker et al., 2001).

Some research has examined variables enhancing and inhibiting partnerships. Naidoo and Wills suggested that a common task, selection of members for specific expertise, knowledge of one’s role, support while performing the task, and other characteristics are important for successful partnerships (Naidoo and Wills, 2000). Other facilitators of these partnerships may be continuity of participation, a funded coordinator, participants of appropriate seniority, skilled chairing, and a supportive organizational culture (Green, 2000). Not all partnerships have been successful. Barriers to successful partnerships are numerous, including such variables as competing professional rationales and interpersonal relations (Beattie, 1994). Other barriers are organizational uncertainty, limited resources and rapid turnover of participants (Green, 2000). General skills for working together are needed, and their absence may obstruct partnerships. They include communication skills, participation at meetings, managing time, and knowing how to work in a team (Naidoo and Wills, 2000). A review of the above-mentioned facilitators and inhibitors of partnerships revealed that most research focused on the project level and primarily emphasized factors of project management (e.g., common task, selecting the appropriate team), while neglecting other factors associated with the organization in which the participant works and interpersonal relationships between the participants. Factors such as the policy and goals of the home organization as well as personal acquaintances and aims should also be considered.

Most of the research on partnerships has typically examined their development, and explored specific barriers and facilitators for partnerships, assuming that continuous partnership is the preferred mode of working (Butterfoss et al., 1998; Kegler et al., 1998a; Kegler et al., 1998b; Armbruster et al., 1999; Green, 2000). However, continuous partnership may not be the only way to form successful partnerships among organizations, communities and individuals. For example, Ancona and Caldwell argued that partnership success depended partially on the need to create more fluid and changing team boundaries (Ancona and Caldwell, 1998). These authors held that partnerships could be structured along four dimensions: high or low use of experts; full or part cycle membership; full- or part-time assignment to the team; and the extent to which there is a mix of core and peripheral membership (Ancona and Caldwell, 1998). Variance along these dimensions shifts the permeability and breadth of the team boundary on a range from ‘no partnerships’ to ‘full partnerships’, where the partnership forms a new organizational unit, with the collaborating organizations in the background.

Health promotion projects frequently share a common life cycle with identified stages such as needs assessment, and planning, implementing and evaluating the project (Naidoo and Wills, 2000). Hence, partnerships might vary in the stages they perform collaboratively as compared with stages that are performed by only some of the partners. These modes of structures are working patterns that are suitable for the individual partners and their needs, as well as the project’s need to relate successfully to the external environment (Ancona and Caldwell, 1996). For example, certain partnerships only work on developing mutual strategies and others may only deal with the actual operation of the project. Different demographic factors, and type of profession or experience with partnerships, might be related to the form of structuring due to the partner’s background and needs. Health promotion professionals coming from different professions such as health and social work may adopt different approaches to health promotion. A medical approach or a social change approach may be adopted depending on the personal approaches of the participants (Naidoo and Wills, 2000).
Furthermore, the type of project can also affect the working patterns partners choose to employ. In general, project type can be: (i) disease- or behaviour-oriented, such as preventing heart diseases or smoking cessation, which are both subject-related; (ii) setting oriented, such as the ‘health city’ collaborations or a partnership for health promotion in school; or (iii) age oriented, such as old age and adolescence.

In this survey, we asked what were the motives and factors enhancing partnerships, alongside barriers to partnerships, as perceived by the health promotion professional. We also asked what types of modes of partnership structure prevail in the Israeli health promotion arena and what personal aspects (occupation and experience), as well as type of project (health behaviour-oriented as compared with age- or class-oriented), contribute to their existence. The understanding of the different types of structure should promote research into characterizing the best-suited structure to the type of project, the participating organization and the personal aspects of the team. An understanding of these factors may facilitate interventions to enhance working in partnerships and to increase their effectiveness.

METHODS

Study sample and procedure

The research population comprised 150 health promotion professionals working in the different organizations dealing with health in Israel, such as health care services (governmental and non-governmental) and non-profit organizations. The list of professionals working in the field was provided by the Israeli Health Promotion and Health Education Association. These professionals received the questionnaire by mail and were asked to return it the same way. A total of 52 respondents completed the questionnaire and sent it back, giving a response rate of 34%. The non-respondents were characterized by a high proportion of professionals not working in collaborations; they did not perceive the questionnaire as relevant to their experience. This was gathered from a short telephone follow-up of some of the non-respondents.

The questionnaire

The questionnaire included data on partnerships in which the respondent participated, the partnership’s structure, perceived motives for joining the partnerships, perceived inhibiting and facilitating factors for partnership, as well as demographic questions. We developed the 36-item questionnaire after conducting a focus group with 10 professionals involved in health promotion partnerships, and four individual interviews. The 2 h discussion in the group was semi-structured and included a series of open-ended questions with follow-up probes concerning the various modes of structuring partnerships, as well as the motives for joining such partnerships and the barriers to partnerships. Analysis of the focus group discussion demonstrated heterogeneous interpretation of partnership structure. Some of the participants referred to partnerships that worked continuously in partnership throughout the entire project, whereas others referred to more fragmentally structured partnerships, such as when collaboration occurs on the steering committee, but not in the implementation phase of the project. Furthermore, the analysis of the discussions concerning motives, barriers and enhancing factors revealed three basic themes that emerged throughout the interviews, namely personal, organizational and project-related factors. Consequently, the final questionnaire adequately represented these three pivotal themes. After its composition, the questionnaire was reviewed by three experts in the field to determine its consensual and content validity, and it was consequently modified. The final questionnaire consisted of four specific subscales and demographic data.

Motives for partnership

Participants were asked to grade the importance of eight items constituting reasons for joining health promotion partnerships. They referred to project-oriented, organization-oriented or personal motives. Items reflecting project-oriented motives included project publicity, project professionalism and overall project success. Items reflecting organization-oriented motives included promoting an organization’s reputation or an organizations’ goals, and the inability of the organization to conduct the project without partnership due to lack of adequate resources. Personal motives included pressure by a project leader to participate and previous positive experiences of such partnerships (see Table 1). Items had five response choices with verbal anchors for each choice ranging from 1 (not important) to 5 (very important). Cronbach’s alpha reliability score was 0.76.
Facilitating factors for partnership
Respondents were asked to indicate the importance of 10 factors in facilitating partnerships in health promotion. Items included: organization’s policy, policy of other organizations, shared goals, governmental support, the existence of health promotion networks, personal acquaintances, shared financial resources, shared human resources, constructive leadership and a strong belief in the project’s goals (see Table 2). Items had five response choices with verbal anchors for each choice ranging from 1 (not important) to 5 (very important). Cronbach’s alpha reliability score was 0.78.

Barriers to partnership
Respondents were asked to indicate the importance of 12 factors that hinder partnerships in health promotion. Items included: organizational policy, fear of not getting adequate credit, interpersonal conflicts, coordination problems, conflicting goals, lack of resources, over-domination of one organization, inexperience in partnership work, lack of explicit procedures for collaboration and lack of motivation (see Table 3). Items had five response choices with verbal anchors for each choice ranging from 1 (not important) to 5 (very important). Cronbach’s alpha reliability score was 0.76.

Modes of structuring
Respondents were asked to assess the extent to which they actually worked in partnership: from continuous partnership at all stages of the health promotion project, to fragmented partnership for particular needs at specific stages of the project. The final questionnaire consisted of two subscales based on factor analysis (Maximum Likelihood Rotation Varimax method): (i) five items describing fragmental partnerships with a reliability level of $\alpha = 0.72$; and (ii) three items describing continuous partnerships with a reliability level of $\alpha = 0.80$. Each subscale was measured by the mean response to the relevant items rated on a five-point Likert-type scale [range: 1 (very seldom) to 5 (very often)].

Demographic data
Occupation of the respondents was coded as 1 for health staff (e.g. nurses) and 0 for health

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Table 1: Motives for partnerships: means, standard deviations (SDs) and frequencies of professionals indicating ‘very important’

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project’s professionalism</td>
<td>3.30</td>
<td>1.19</td>
<td>67.4</td>
</tr>
<tr>
<td>Project’s goals are compatible with organization’s goals</td>
<td>3.26</td>
<td>1.15</td>
<td>65.1</td>
</tr>
<tr>
<td>Previous positive experience with partnerships</td>
<td>3.96</td>
<td>1.19</td>
<td>47.5</td>
</tr>
<tr>
<td>Project’s publicity</td>
<td>2.76</td>
<td>1.42</td>
<td>44.2</td>
</tr>
<tr>
<td>Organization’s lack of ability to conduct the project alone</td>
<td>2.76</td>
<td>1.28</td>
<td>37.5</td>
</tr>
<tr>
<td>Own organization’s reputation</td>
<td>2.49</td>
<td>1.38</td>
<td>33.4</td>
</tr>
<tr>
<td>Pressure to join from project’s coordinator</td>
<td>2.07</td>
<td>1.48</td>
<td>27.5</td>
</tr>
<tr>
<td>Organization’s lack of ability to finance the project alone</td>
<td>2.05</td>
<td>1.59</td>
<td>24.4</td>
</tr>
</tbody>
</table>

Table 2: Factors enhancing partnership: means, standard deviations and frequencies of professionals indicating ‘very important’

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean</th>
<th>SD</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective leadership</td>
<td>3.74</td>
<td>0.48</td>
<td>74.4</td>
</tr>
<tr>
<td>Strong faith in project’s aim</td>
<td>3.69</td>
<td>0.66</td>
<td>70.5</td>
</tr>
<tr>
<td>Shared vision and goals</td>
<td>3.61</td>
<td>0.51</td>
<td>68.2</td>
</tr>
<tr>
<td>Financial support</td>
<td>3.59</td>
<td>0.78</td>
<td>66.7</td>
</tr>
<tr>
<td>Policy of the original organization</td>
<td>3.53</td>
<td>0.64</td>
<td>59.1</td>
</tr>
<tr>
<td>Personal acquaintances</td>
<td>3.46</td>
<td>0.67</td>
<td>54.5</td>
</tr>
<tr>
<td>Human resources support</td>
<td>3.44</td>
<td>0.87</td>
<td>56.8</td>
</tr>
<tr>
<td>The strategy of other organizations in the partnership</td>
<td>3.32</td>
<td>0.62</td>
<td>41.5</td>
</tr>
<tr>
<td>Network of organizations practising health promotion</td>
<td>3.29</td>
<td>1.41</td>
<td>47.7</td>
</tr>
<tr>
<td>Governmental support</td>
<td>3.20</td>
<td>0.92</td>
<td>41.9</td>
</tr>
</tbody>
</table>
promotion and welfare workers (e.g. social workers). Experience referred to the respondent’s perceived experience of partnerships. Finally, the nature of the project was coded 1 for projects aimed at a specific age class of the population, and 0 for projects focusing on a specific health problem.

RESULTS

Respondents’ characteristics
Most of the respondents (74%) reported participating in partnerships: 58% of these projects dealt with a health problem such as dental hygiene and smoking prevention, whereas 42% of the projects concentrated on a specific age group such as adolescents or the elderly. Regarding their profession, 67.4% were health staff such as nurses and doctors, whereas 32.6% were health promotion and welfare workers. Most respondents (76.9%) reported having some kind of professional education in health promotion. About 17% of these respondents had studied health promotion in a Master in Public Health program, 22% had studied it as part of a bachelor degree program in associated areas such as nursing, and 61% had participated in non-academic health promotion courses.

Motives for working in partnerships
Means, standard deviations and the percentages of professionals responding with ‘very important’ to the eight motives for joining partnerships are presented in Table 1. An examination of the means and the most frequent answers indicated a similar pattern of findings, except for ‘previous positive experience with partnerships’, which had the highest mean but only 47.5% of respondents perceived it as very important. The most frequent motive for joining partnerships reported by the respondents as very important was related to the concern for the project’s professionalism; it was followed by the compatibility of the goals of the respondent’s organization with the project. These results indicated that partnerships are formed primarily in order to promote the project. However, previous positive experience with partnerships was also very important as a motivating force for joining partnerships. On the other hand, the least important as well as the least frequent motive for joining partnerships (<25%) was related to the organization’s lack of ability to finance the project alone.

Facilitating factors for partnerships
Means, standard deviations and the percentages of professionals responding with ‘very important’ to the 10 facilitating factors for participation are presented in Table 2, in descending order. An examination of the means revealed that none of them fell below the scale midpoint, and that generally the range of the means was relatively limited. However, examining the most frequent items rated as very important indicated a similar pattern of findings with a larger distribution range. The three most important facilitating factors (as well as the most frequent ones) were related to project management: effective leadership, aims of the project, and sharing a vision and goals. The least important facilitating factor was governmental support in forming partnerships.
Barriers to partnership

Means, standard deviations and the percentages of professionals responding with ‘very important’ to the 12 barriers to partnerships are presented in Table 3, in descending order. An examination of the means and the most frequent answers indicated a similar pattern of findings. The two items most frequently categorized as very important barriers to partnerships were related to dysfunction of the steering committee and lack of explicit procedures for collaboration. Between 43 and 45% of respondents perceived these items to be very important barriers. The next most important barriers were issues connected to personal commitment and conflicts, including struggles over leadership; around 30–37% indicated that these items were very important. Thus, these five most important barriers reflected the need for structured working procedures and processes that would enhance commitment and partnerships within the project. About 25–35% of the respondents rated lack of resources such as time, money and experience in partnerships as being very important barriers to collaboration. The least important barrier referred to the belief that the organization could execute the project on its own.

Mode of structuring

The 10 items of structure were factor-analysed to identify the specific modes of structuring (Table 4). From a Varimax rotation, two factors with eigenvalues >1.0 emerged, corresponding to our original theoretical expectation. Factor 1 appeared to represent fragmental partnerships for specific needs during specific phases of the partnership. Factor 2 reflected more participatory structuring, with respect to continuous partnerships through all the project stages and across all its hierarchical levels.

The mean score of fragmental partnerships structuring was 2.82 (SD = 0.95) and that of continuous partnership structuring was 2.50 (SD = 0.60). Paired t-test analysis was conducted for the mean score difference between the two modes of structuring. Fifty-four per cent of the respondents reported working very often in the fragmental type of partnership, and only 29% reported working very often in the continuous structure type of partnerships. These results demonstrated that fragmental partnerships were used significantly more often than continuous partnership structuring ($t = 2.36, p < 0.02$).

In order to examine whether participants working in the fragmental as compared with the continuous type of partnerships differed in their assessment of motives, enhancing factors and barriers for partnership, t-test analyses were conducted. Results showed that no differences emerged between the two modes of structuring (fragmental versus continuous) in the assessment of enhancing factors and barriers for partnerships. However, with regards to motives for joining partnerships, our findings demonstrated that overall, participants that engaged in continuous partnerships had higher motivation scores than participants who engaged in fragmented types of partnerships ($t = 62.39, p < 0.0001$). Specifically, the results showed significant mean score differences for four of the eight motives for engaging in partnerships. Project goals are compatible with organization goals ($t = –2.59, p < 0.01$), previous positive experience with partnerships ($t = –1.98, p < 0.05$), an organization’s lack of ability to conduct the project alone ($t = –2.03, p < 0.05$), and pressure to join from a project coordinator ($t = –1.98, p < 0.05$).

To explore the factors associated with the use of these two modes of structuring, we focused on two demographic variables, namely occupation and

<table>
<thead>
<tr>
<th>Item</th>
<th>Fragmental partnership</th>
<th>Continuous partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership mainly in the planning phase</td>
<td>0.57$^a$</td>
<td>–0.08</td>
</tr>
<tr>
<td>Partnership mainly in the operation phase</td>
<td>0.71$^a$</td>
<td>0.35</td>
</tr>
<tr>
<td>Partnership mainly for sharing budget</td>
<td>0.79$^a$</td>
<td>0.40</td>
</tr>
<tr>
<td>Partnership mainly for sharing resources</td>
<td>0.67$^a$</td>
<td>0.16</td>
</tr>
<tr>
<td>Continuous information flow in the partnership</td>
<td>–0.04</td>
<td>0.75$^a$</td>
</tr>
<tr>
<td>Partnership mainly on managerial level</td>
<td>0.86$^a$</td>
<td>–0.15</td>
</tr>
<tr>
<td>Partnership on all hierarchical levels of the project</td>
<td>–0.08</td>
<td>0.82$^a$</td>
</tr>
<tr>
<td>Partnership at all stages of the project</td>
<td>0.17</td>
<td>0.78$^a$</td>
</tr>
</tbody>
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$^a$Loading stronger than 0.6.
experience in partnerships, and one organizational variable, namely the nature of the project. These variables were the only ones found to be significantly correlated with the modes of structure in a bivariant analysis. Two multiple regression analyses were conducted for fragmented and continuous partnership structuring (Table 5). With respect to fragmented partnership structuring, the complete model accounted for 33% of the variance in this mode \( F(3,39) = 5.94; p < 0.03 \). The results demonstrated that the occupation of the respondent significantly predicted fragmental structuring. Health staff worked more in fragmental partnership structures than did health promotion and welfare workers. In addition, the more experienced the respondents, the less they worked in fragmental partnerships. As for continuous partnership structuring, the complete model accounted for 18% of the variance in this mode \( F(3,39) = 5.94; p < 0.03 \). The results demonstrated that the occupation of the respondent significantly predicted continuous structuring. Health promotion and welfare staff worked more in continuous partnership structures than did health staff. In addition, the nature of the project significantly predicted the mode of structuring. Our results demonstrated that projects that were aimed at preventing a specific health problem were structured more in a continuous partnership mode than projects that focused on a specific age group.

### DISCUSSION

Building health promotion partnerships is a formidable challenge and, as this study indicates, there is a need for structured guidelines on top of a voluntary agreement to promote them (Gillies, 1998). The main motives to join health promotion projects reported here were variables connected to the project itself. Motives connected to the home organization or to personal needs were mentioned less frequently; however, about one-third of the respondents did consider them very important. Hence, practitioners joined partnerships mainly because they assumed that the outcomes achievable by working in partnerships were better than those achievable by each organization working on its own (synergy) (Lasker et al., 2001). Previous positive experiences in partnerships were also high on the list of motives. This experience can affect participants both ways. Those with previous positive experiences may increase their participation in partnerships, whereas those having negative previous experiences may not want to work in partnerships again.

As noted, the focus group run prior to the development of the closed questionnaire discussed a series of factors important in enhancing or facilitating partnerships. In the questionnaire responses, all these factors received mean scores above average, indicating that they were all of importance, but factors pertaining to leadership and the process of working within a partnership were the foremost among them. This coincides with the findings of Naidoo and Wills, who suggested that a common task is important in motivating partnerships (Naidoo and Wills, 2000). Leadership and faith in the vision, goals and aims of the project will affect the partners’ willingness to invest resources such as time, money and innovation in the project. However, a high percentage of respondents also reported that personal aspects such as acquaintances and networks enhanced partnership. These are two factors that can be encouraged comparatively easily, without investing large amounts of resources, in order to increase the working formation of partnerships.
This pattern emerges even more obviously from an analysis of the barriers to partnerships. The likelihood of working together was low if the coalition or other type of partnership and its participants did not have the explicit procedures and skills to work as a team. Respondents perceived factors portraying a disruptive process of working together, such as a dysfunction of the steering committee or lack of an explicit procedure for partnership, as playing an important role in inhibiting participation. Many partnerships, including steering committees, lack the skills for working collaboratively and do not have a working plan or guidelines that have been thought through and agreed among the partners. If this kind of guideline existed it could help to avoid conflicts or fear of not obtaining adequate credit and so forth. Moreover, incorporating sanctions into the work plan or guidelines when participants did not adequately perform their task could enhance their commitment to the project.

Together, these results emphasize the need for guidelines to work in partnerships. At the start of each partnership it would be helpful to agree on guidelines for working together, including how credit will be given, communication between collaborators, tasks, and sanctions for the participants that did not perform their tasks. These guidelines cannot be suitable for all types of partnership, as different types of partnership structures seem to exist and the guidelines would have to be prepared for each partnership type.

Obviously, partnerships may operate in many ways. Although most research has been conducted on organized partnerships in the form of continuous partnerships, this is clearly not the only way that partnerships can function (Butterfoss et al., 1998; Kegler et al., 1998a; Kegler et al., 1998b; Armbruster et al., 1999; Green, 2000). Moreover, within each partnership the participants may collaborate in a different manner. Asking respondents to identify the type of partnership they participated in most frequently indicated two types. In the first, partnership was maintained throughout, from the beginning of the project to the end (continuous partnership), and in the second, partial partnership occurred at different time-points during the planning and implementation of the project. We cannot assume that one structure is better than the other as this has not been studied, and a way to compare the success of one partnership with another needs to be developed. Each type of working process or structure should have guidelines to maximize the success. Moreover, we perhaps need to look at specific factors that could help us choose the structure most suitable for a specific program.

In this study, we found three variables associated significantly with the type of partnership the respondent reported working with most frequently. Health professionals and welfare staff were more likely to work in the continuous structure, whereas nurses and doctors preferred the partial or fragmented partnership. This finding is in keeping with West and Poulton’s survey (West and Poulton, 1997), which showed that health care teams scored significantly lower than others, including social workers’ teams, for various team-functioning factors. This might be a result of the different approaches of each practitioner. Nurses and doctors may have adopted the medical approach to health promotion, which is expert-led and top-down, and demands less partnership with organizations outside the health care system (West, 1997). The health promotion and welfare practitioners may have adopted other approaches to health promotion, such as empowerment, social change or education, which demand working in collaboration with other organizations such as the education system, community organizations, etc. (Naidoo and Wills, 2000). In addition, the more experience the respondents had the more they participated in continuous partnership. This finding might imply that the respondents learned from their own experience that better results could be achieved by working continuously together and not fragmentally. Finally, our findings showed that the nature of the project was also associated with the mode of structuring. Projects aimed at a specific age group were less likely to be of a continuous partnership structure than projects that focused on a particular health problem. Together, these findings imply that certain demographic and project-oriented factors might influence the tendency to structure the partnership continuously or more fragmentally. However, further research is needed to explore additional antecedents to each mode of structuring, and to test the relationships between these structural modes and a project’s effectiveness.

The study’s limitations are mainly the low response rate of those registered in the health promotion and health education association. This may only partially represent the health promotion professionals in Israel. However, this issue may not be a major limitation in our sample, because
in Israel, there are not many professionals working in partnerships. A high proportion of those not responding to the survey do not work in partnerships, so our sample may actually represent those working in health promotion collaborations.

To conclude, the present study’s findings support the importance of acquiring skills for working in partnership and imply a need for a working plan or guidelines to be agreed upon by the partners at the beginning of the partnership. In addition, the results should encourage researchers to explore alternative structures of partnership, and to test their comparative effectiveness and not assume that the only way to collaborate was by forming coalitions.

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