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Global Health Promotion 2010 17: 17
DOI: 10.1177/1757975910375166

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Coordinated action checklist: a tool for partnerships to facilitate and evaluate community health promotion

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Lenneke Vaandrager⁴

Abstract: Coordinated action through partnerships is a core approach in community health promotion to deal with the multidimensionality of today's health and societal issues. The number of partnerships is increasing. However, facilitation and evaluation of partnerships is hampered by the lack and/or non-use of feasible tools. As a consequence, health promotion through partnerships is not optimally facilitated and evaluated. This article describes the development and piloting of a tool and guidelines to facilitate and evaluate coordinated action in community health promotion. The initial development of the tool was based on relevant literature, a conceptual framework to support social environments for health, and an inventory of existing tools. Appreciative inquiry principles contributed to the formulation of items. The result, a checklist for coordinated action, was further developed and assessed for usability in six different partnerships: a national program, an academic collaborative and four local partnerships. Results of the checklist were cross-checked and discussed with partners. Piloting the checklist resulted in a feasible tool helpful to partnerships because of its ability to generate actionable knowledge. The checklist enables the facilitation and evaluation of community health promotion partnerships that differ in context and level (both local and national), phase of the program and topics addressed. Cross-checking and discussing results with partners and triangulation with interview data increases the reliability of the results of the checklist. Piloting in multiple cases contributes to the checklist's external validity. (*Global Health Promotion*, 2010; 17(3): pp. 17–28)

Keywords: action research, collaboration, evaluation, community health promotion

Introduction

In today's health promotion the added value of coordinated action for health is generally acknowledged. In coordinated action, organizations

of two or more different sectors work jointly to achieve an outcome (1). Coordinated action brings about changes in the environment of health and thereby improves the health of individuals and populations and increases awareness of health

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(This manuscript was submitted on November 6, 2009. Following blind peer review, it was accepted for publication on January 26, 2010.)

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consequences involved in policy decisions and organizational practice, within and among different sectors. Central to coordinated action are partnerships for intersectoral collaboration and community participation (2,3). The number of partnerships is increasing rapidly because no agency alone has the resources to address the wide range of determinants of today's multifaceted public health problems (4,5) such as overweight and obesity, the rapid ageing of the population and the greater longevity of people with chronic conditions.

A review of collaborative partnerships found that partnerships convincingly contribute to supportive social environments of health (6). However, evaluation of partnerships is hampered by lack of information on how interventions bring about change in the social environment in favour of health (7,8). A lot more happens through partnerships than is measured, evaluated and reported. There seems to be a gap in knowledge on how to effectively facilitate and evaluate coordinated action for health (8), and little is known about appropriate strategies to evaluate partnerships (9). One of the reasons for this gap is the lack and/or non-use of feasible tools in practice (6,10–12) due to unfamiliarity with existing tools and guidelines. Science advocates the use of validated tools, and practice longs for tools that fit the multifacetedness of health promotion practice. This means that tools and methods need to be scientifically grounded, easy to adapt to specific needs in practice, easy to analyse, and relatively low in time demand and cost (13).

In previous research (14) a framework and guidelines to facilitate and evaluate supportive environments for health has been developed (see Figure 1). The framework is based on our experiences in case studies and a review of the literature on participation and collaboration. The framework visualizes the relation between the social environment, health predicting mediators (e.g. lifestyle) and population health outcomes (e.g. health status) and provides operationalizable variables that moderate the relation between the social environment and health predicting mediators. In the framework, participation and collaboration, both core concepts in health promotion (2,3), are used as entry points to make the social environment of health researchable and manageable by partnerships and communities. Participation and collaboration have been operationalized into variables (middle column). The

reason for choosing participation and collaboration as moderators is that they have an intermediary role in health and social change outcomes (15,16) and are central to the effectiveness of health promotion (17–22). Also, case studies show that (community) participation and (intersectoral) collaboration are measurable (13,23–25). The left column shows that the variables are applicable on an interrelated continuum of four levels: individual, organizational, coalition and community. The right column provides some possible operationalizations of variables. The framework serves as a summary of options available to facilitate and evaluate changes in the social environment for health. It can be used as a 'menu of menus' by choosing levels, variables and operationalizations (14).

Based on this framework, a checklist for coordinated action has been developed.

The aim of this article is to (i) report on the development and piloting of a checklist for coordinated action, (ii) assess its ability to generate actionable knowledge to the mutual benefit of partners and partnership work, and (iii) assess its usability. The checklist is piloted by a multiple case strategy, that is, by implementing the checklist in different settings. Multiple case studies provide a basis for external validity, which means that the checklist is relevant to other situations. Internal validity is increased by the use of verification techniques such as data triangulation and checking results of the checklist with partners (1,26).

First, the rationale and methodology for the development and piloting of a checklist for coordinated action is explained. Second, in the results section, the scores and actions generated in the pilots and the usability of the checklist is evaluated. Third, strengths and limitations of the checklist, its accompanying methods and its output – actionable knowledge – are addressed.

Method

The rationale for developing a checklist for coordinated action derives from both the literature and the practical experiences of community health promotion. The route towards the development of the checklist consisted of two steps: setting criteria for the checklist and piloting the checklist in practice. In piloting the checklist we used an action research approach.

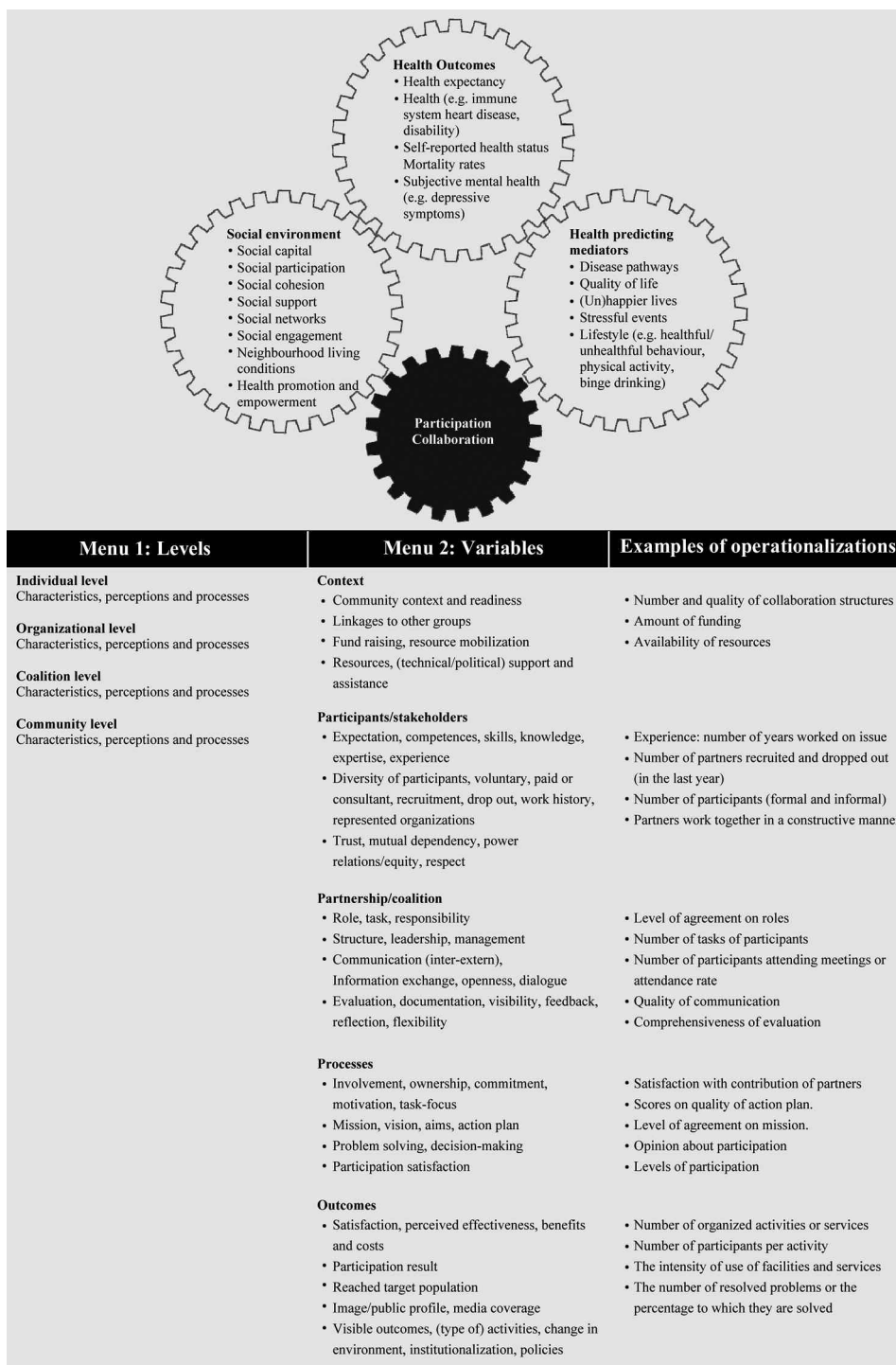


Figure 1. A framework to facilitate and evaluate supportive social environments for health promotion

Criteria for the checklist

Three criteria were considered in the development of the checklist.

First, an important success factor in coordinated action is visibility because it is an incentive for involvement and action (1). Therefore a tool needs to visualize results, for example by scores (27,28) or spiderwebs (12,29).

Second, a tool needs to facilitate and support communication. Communication, including feedback, cross-checking and discussing results with partners, promotes trust (9), increases satisfaction with evaluation and consequently increases participation (24,25), contributes to the involvement of the partnership (4), facilitates subsequent action (30) and contributes to the validity of results (15,30).

Third, a tool must be usable in all phases. To achieve and sustain coordinated action (1,5) partnerships need to be nurtured in all phases, e.g. initial mobilization, planning, implementation and evaluation (31).

Several tools that measure participation and collaboration were assessed. The tool that best fits the criteria is that developed by Verbeke et al. (28). An asset of the Verbeke tool is that it addresses four well-organized dimensions: task, relation, growth and visibility. The task dimension relates to concrete products and results such as the action plan. The relation dimension concerns interaction among the participants and can be compared to Sicotte et al.'s intra-group processes (32) and Schulz et al.'s dimensions of group dynamics (11). The growth dimension relates to the achievement and evolution of the partnership and is closely related to the visibility dimension that includes items on perceived image. On the basis of Verbeke's tool, a checklist was developed that reflects the previously mentioned criteria.

Developing and piloting the checklist

We used an action research approach to compose and pilot the checklist in close collaboration with six partnerships: a national program of the National Institute of Sport and Physical Activity (NISB), an academic collaborative (AGORA) and four local partnerships in three cities and one town in the Netherlands: Eindhoven, Zwolle, Delft and Epe. Table 1 provides an overview of the partnerships.

The partnerships were convenient samples stemming from the authors' contacts with practice. In three

partnerships, one or more authors were part of the partnership (B, C, F). In the other three partnerships (A, D, E), the first author guided the use of the checklist.

In line with our guidelines (14) items were chosen that can be considered as operationalizations of the variables in our framework (Figure 1). The chosen items were opportune for the specific situation and contexts of the partnerships. Some items cover more than one variable and vice versa. The checklist addresses all levels of partnership work, from the individual level to the community level. Therefore, some items are formulated in the 'I-form' whereas others address partners or the partnership.

To contribute to visibility, the checklist items convert the opinions of partners into quantitative variables by asking them to score the items on a Likert-like scale. The five answer categories are: no (score 0), probably not (score 25), no/yes (score 50), probably yes (score 75) and yes (score 100). The mean of items is calculated by adding the scores and dividing the result by the total number of partners. Dimensions are rated by adding the item scores and dividing the result by the number of items.

To facilitate and support communication, the *appreciative inquiry* principles (33) were applied in composing the checklist. Appreciative inquiry is an approach that inspires and stimulates partners by appreciating the value of what already exists and using this as a starting point for envisioning, dialoguing on and innovating desired changes. Appreciative inquiry has already been used successfully in health promotion (34,35) and as an interview tool (36). Applying the principles means that items and questions are formulated in a positive way. An example of an item on the checklist is 'The partnership is an asset to health promotion'.

The checklist has been applied in succession, that is, in one partnership after the other. After each application, the checklist itself was evaluated by the partnership, its coordinators and the authors. Results of the evaluation were used to improve the checklist for use in the next partnership. The first checklist was composed of 20 items. The inclusion and exclusion of items resulted in a core checklist of 25 items. In the fourth pilot, the partnership indicated that an item on continuation after the project period was lacking. As a consequence, the last item of the checklist was included. Depending on the situation and specific wishes of the partnerships, more items may be included.

Table 1. Overview of partnerships, characteristics and use of checklist

	A	B	C	D	E	F
Partnership	Project group <i>Heart for Lakerloper</i>	Academic collaborative steering group	Pilot programme <i>Overweight in the Neighbourhood</i>	Workgroup <i>Healthy and Affordable Food</i>	Workgroup Vitality Pilot of NISB	Project group <i>Healthy Ageing</i> Part of AGORA
Features	Eindhoven One of six neighborhoods in community programme in Eindhoven, a big city in the southern part of the Netherlands, started in 2000	AGORA Collaboration between practice and science in Gelre-IJssel Region, the Netherlands, set up in 2006	NISB National programme of the Netherlands Institute for Sport and Physical Activity (NISB), set up in 2007	Zwolle Workgroup, part of program Together, in Zwolle, a city in the rural north-east of the Netherlands, started in 2008	Delft Workgroup to set up integrated care facilities in two neighborhoods in Delft, a city in the western part of the Netherlands, started in 2007	Epe Program to promote healthy ageing in a rural town in the eastern part of the Netherlands, started in 2007
Theme	Healthy behaviour	Healthy ageing	Overweight	Nutrition	Overweight	Loneliness
Target group	Inhabitants	Elderly	Inhabitants	Low SES women	Low SES children	Elderly
Main partners	Municipal Health Service, Local grassroots organizations, Welfare work	Municipal Health Service, Wageningen University, Municipalities	Municipalities, Municipal health services and sport services	Municipal Health Service, Local grassroots organizations	Municipal Health Service, Municipality, Schools, Sport services	Municipal Health Service, Welfare Organization, Municipality, Mental Health Care
Use checklist	January 2007 in meeting	1. April 2007 Individually (combined with interview) and discussed in a meeting 2. May 2009 In meeting	1. June 2008 In meeting 2. September 2009 In meeting	December 2008 Individually (combined with interview) and discussed in a meeting	December 2008 Individually	January 2009 In meeting

In all six partnerships, the checklist was used to facilitate and evaluate the partnership and its actions. In AGORA and NISB, the checklist has been used twice, respectively with a time-elapse of two years and one year. In both partnerships, reasons to use the checklist again were that evaluation of the partnership was requested by the funding agency, the first positive experience with the checklist and that former results gained by the checklist could be compared with new results. In AGORA (2007) and Zwolle, the checklist was filled in as part of an individual interview. The

results, of both the interviews and the checklist, were fed back and discussed in a meeting. In Eindhoven, AGORA (2009), NISB (2008 and 2009) and Epe, the checklist was individually filled in during a meeting and discussed right away. In Delft, partners filled in the checklist individually at their office and the checklist was not discussed. Filling in took a few minutes. The checklist functioned as a discussion opener by asking partners on which items they scored high (and low) and why. In the discussions again the principles of appreciative inquiry were applied.

Table 2. Checklist for coordinated action and calculated mean scores of the partnerships

Partnership Items and scores (means 0–100)	A	B1	B2	C1	C2	D	E	F
	N = 7	N = 14	N = 12	N = 14	N = 13	N = 7	N = 8	N = 5
General								
1 The partnership is an asset (to health promotion).	100	93	90	88	88	96	97	85
Suitability of the partners								
2 To attain the goals of the partnership, the right partners are involved.	77	83	85	76	79	88	80	71
3 Equity of the partners is essential for good collaboration.	75	80	68	70	69	79	78	60
4 The contribution of the different partners is to everyone's full satisfaction.	82	79	98	75	81	89	84	85
5 I have a special interest in participating in the partnership because of my position or organization.	61	73	65	70	71	86	72	65
6 I am able to contribute to the partnership in a satisfactory way (time, means, etc.).	90	82	94	84	88	93	75	85
7 I feel involved in the partnership.	75	88	83	75	71	86	69	55
8 I can contribute constructively to the partnership because of my expertise.	79	93	94	84	88	93	91	75
Task dimension								
9 There is agreement on the mission, the goal and the planning within the partnership.	79	89	90	75	85	93	91	75
10 The partnership achieves regular (small) successes.	78	59	76	63	76	87	70	74
11 The partnership functions well (working structure, working methods).	71	45	63	63	73	82	72	75
12 The partnership evaluates progress at regular intervals and makes adjustments if necessary.	89	63	100	60	81	89	75	65
Relation dimension								
13 The partnership partners communicate in an open manner.	75	59	61	69	71	86	59	75
14 The partnership partners work together in a constructive manner and know how to involve each other when action is needed.	*	70	79	58	77	89	72	80
15 The partnership partners are willing to compromise.	84	59	69	66	70	91	67	71
16 In the partnership, conflicts are dealt with in a constructive way.	*	61	60	80	77	89	56	75
17 The partnership partners will carry out decisions and actions loyally.	86	61	73	59	63	96	69	75
	*	50	70	71	69	89	75	80
	*	50	60	56	62	**	66	60
	82	75	83	66	77	89	69	65

Table 2. (Continued)

Partnership Items and scores (means 0–100)	A N = 7	B1 N = 14	B2 N = 12	C1 N = 14	C2 N = 13	D N = 7	E N = 8	F N = 5
Growth dimension								
18 I create goodwill and involvement for the partnership within my organization.	72	71	82	72	77	71	73	70
19 Giving feedback to the local officials on behalf of the partnership is satisfactory.	82	86	90	80	85	92	75	80
20 The partnership is willing to recruit new partners in the course of time.	58	58	75	59	63	19	72	55
21 The partnership succeeds in mobilizing others for actions.	79	79	81	79	73	89	88	80
Visibility dimension								
22 The partnership maintains the external relationships in an accurate way.	68	59	82	69	85	82	75	65
23 The partnership is seen as reliable and legitimate by external relations.	82	69	78	66	57	77	63	60
24 The image of my partnership in the outside world is good.	*	58	65	64	77	89	66	60
25 The partnership takes care of continuation after the project period.	*	71	86	71	44	69	59	55
Mean score of all items	82	79	84	63	54	75	57	55
	*	*	77	*	54	75	69	70
	78	71	79	70	73	84	73	70

Notes: The numbers are the mean scores of individual partners on a Likert-like scale; no (score 0), probably not (score 25), no/yes (score 50), probably yes (score 75) and yes (score 100); * = Item was not included in this case; ** = Item could not be answered because no conflict had occurred.

Results

Scores and actions

Table 2 presents the mean scores of the pilots on the core checklist of 25 items.

Discussion centred on establishing the reasons behind the scores, both the high scores (successes) and low scores (points to improve). Feedback and discussion enabled clarification of the reasons for high and low scores and, following from that, action could be taken (see Table 3).

All the partnerships view themselves as an asset to health promotion. In particular, the suitability of partners, based on expertise and involvement, is highly appreciated.

In Eindhoven, the score on the item 'The contribution of the different partners is to everyone's full satisfaction' was relatively low. The discussion revealed that the score was low because the number of activities for inhabitants was far less than initially planned. This is an example of a qualitative operationalization by the partners. After discussion, it was agreed that an action plan would be developed to set up activities for inhabitants.

In AGORA (in 2007), the results of the individual interviews and the score on the item 'There is agreement on the mission, the goal and the planning within the partnership' revealed that partners held different views on the mission and goals of the healthy ageing program. Cross-check of those results with partners further clarified that the views on mission and goals ranged from (only) health education to a broad range of facilities and services that contribute to health and wellbeing, like for example transport. Discussion sessions that followed contributed to improved mutual understanding and respect for different visions and disciplines. Two years later, discussing high and low scores on the checklist revealed that many (small) successes had been recorded. The partners agreed that these successes needed to be celebrated as well, and this was done right away. The discussion also revealed that continual attention must be paid to communication. Moreover, it was considered important to involve more municipalities. As a result, it was decided to add an alderman to the steering group. In other partnerships, effected changes included agreement to expand the number of meetings for the partners to exchange experiences (NISB in 2008), the plan to initiate actions to embed the

project (Zwolle), and efforts to strengthen involvement of organizations and the elderly (Epe). In Delft, the results of the checklist were not discussed with partners. On the basis of the Delft scores the project coordinator decided to split the partnership into smaller groups in order to increase efficiency. In NISB (in 2009) the checklist was used during the last meeting of the partnership and follow-up focused on publicity of results and development of future activities.

Usability of the checklist

Overall feedback from partnerships about the usability of the checklist was positive: items were understandable, the checklist could be filled in quickly, counting scores was simple, adaptations could be made easily and especially discussing results with partners generated actionable knowledge. According to the partners, the 'I-formulated' questions were easier to answer than items addressing all partners or the partnership. The scores on the checklist were a good starting point for discussion. In general, highly rated items were acknowledged as non-problematic or as successes. The lower rated items were of most interest for discussion because they unravelled differences between partners and points to improve. Overall, use of the checklist and the accompanying methods (feedback and discussion) was found to be complementary to day-to-day partnership work, contributing to team building and enabling partners to sustain coordinated action. In addition, partnerships used the results for external evaluation purposes, such as in progress reports required by funding agencies.

Discussion

Checklist

Items on the checklist often address more than one variable of participation and collaboration. They can also be applicable for different levels (individual, organizational, coalition and community), and to a broad range of dimensions (task, relation, growth, visibility) of partnership work. This can be a limitation because only a few items can be included in each dimension. Moreover, items can be, and in our pilots were, interpreted differently by partners. Both limitations however can be assets as well. The strength of the checklist is not the number

Table 3. Actionable knowledge generated by the checklist and follow-up

	A	B1	B2	C1	C2	D	E	F
Partnership	<i>Eindhoven</i>	AGORA	AGORA	NISB	NISB	Zwolle	Delft	Epe
Successes	Partners are loyal and the image of the partnership is good.	Partners are suitable, have the right expertise and feel involved.	Involvement of partners and (small) successes are achieved.	Right partners are represented and partners feel involved.	Partners work together in a constructive way and successes are achieved.	Partnership calls itself a 'dream team' and role of project coordinator is central.	Partnership was not discussed.	Partners' expertise is used well and communication is open.
Points to be improved	Participation of inhabitants is low.	Partners have different visions on mission and goal.	Communication between partners is limited. Knowledge dissemination to municipalities is weak.	Partners lack opportunities to exchange experiences.	The image and visibility needs to be improved. Activities to continue collaboration need to be set up.	Embedding of partnership in local structures is lacking.	Not discussed.	Involvement of other organizations and the elderly is low.
Follow-up	Developing an action plan to involve inhabitants.	Discussion sessions to clarify roles.	Structures for communication and knowledge exchange. Alderman in steering group.	Special meetings (e.g. work visits), newsletter and email contact.	Articles based on the results of the pilot will be published. In new NISB programme, the partners will be involved.	More attention to growth and visibility dimension of partnership.	Partnership was split into smaller groups on specific activities.	Meetings with organizations (e.g. municipality, church) and the elderly.

of items but the inclusion of the 'right' items: items that initiate discussion, which in turn generates actionable knowledge at all levels and on all dimensions. In our pilots it appeared that discussion about the meaning of items between the partners helped to reveal the actual dynamics of the partnership and to unravel ongoing processes. A significant element of the checklist is the scoring system because it visualizes strengths (e.g. successes) and weaknesses (points to improve) on items and on dimensions. In AGORA and NISB, the 2009 results could be compared respectively with the 2007 results, and 2008 results. In 2009, in both partnerships scores and discussion revealed that collaboration had improved and that many successes had been recorded. In AGORA, improvement has been considerable. In NISB the improvement has been moderate, because visibility needs to be improved in order to end the pilot program in a proper way.

The positive approach, based on appreciative inquiry, builds on strengths and assets of partnerships and their work and thereby contributes to the partners' enjoyment in using the checklist and to increasing preparedness to take action. The positive approach possibly also generates (purposely) bias. However, in most of the pilots the discussion about successes and points to improve came up simultaneously. Michael (36) also reported that negative experiences were conveyed as well as positive experiences and that, all in all, appreciative inquiry contributed to a richer understanding. Therefore, the scores need to be interpreted relatively and in combination with the results of checking among partners, discussions and, if possible, interviews. When the checklist is being discussed, probing the reasons behind relatively high and low scores works very well, as our pilots show.

Facilitating participation

The checklist was developed in a participatory way, and consecutively applied and evaluated. This resulted in continual improvement of the checklist. To support participatory use, the checklist is flexible, both in items to be included and accompanying methods to discuss the outcomes. Partnerships that use the checklist, should realize that the main function of the numbers in the checklist is to summarize strengths and areas for improvement at a glance and that the main asset of the checklist is to stimulate feedback and discussion.

In feedback and discussion, partners are challenged to reflect on the dynamics of their work, ongoing processes, outcomes, their own and other partners' position and contribution and so on. This was confrontational in two partnerships, but in the end sustained coordinated action. Confrontation presents an opportunity to clarify different views. However, partners need to feel safe and comfortable to do so. When a partnership is not running smoothly, we advise to conduct individual interviews in combination with the checklist. This may help to unravel what is going on and facilitate discussion. By discussing the different views, the partners set in motion a learning process that potentially creates a way to combine different views, and reach consensus and thus leads to an innovative project. In general, active facilitating increases the chance of successful collaboration and desired outcomes for all partners (37).

Actionable knowledge

In this study, we used an action research approach, resulting in the generation of actionable knowledge in all partnerships. Cook (38) recommends 'action' as a legitimate component in research designs for programmes that aim to effect community-level change. A tool needs to meet validity criteria: both internal validity (10), which is addressed by using verification techniques (participant check, triangulation), and external validity, which is based on practice-based research with attention to context and to connectedness of program levels (39). Paying greater attention to the issues of external validity and to intermediate or process outcomes enhances relevance to particular settings and will lead to better applications and program (40,41). Therefore, we expect the results of this study to be relevant to other partnerships. However, a number of relevant issues still need to be addressed. These issues are the further refinement and improvement of the checklist and its use, the optimum composition and number of required items, the most appropriate accompanying methods and the features and context of partnerships that need to be taken into account. Up to now, our research is characterized by its explorative nature. To address the mentioned issues and to further validate the checklist, more research is needed. Future research can be focused on the continuation of the

present research: evaluate the use of the checklist in more partnerships and to re-use the checklist at multiple times in the same partnerships. Also, future research can focus in more detail on how items are interpreted by partners.

Conclusion

The action research approach facilitated the development and piloting of a checklist with 25 core items. The checklist is a useful means for partners to overview their working and monitor their successes as a partnership promoting change. In combination with feedback and discussion, the developed checklist enabled the facilitation and evaluation of community health promotion partnerships that differ in context, phase of the program, scale (national and local), topics addressed (overweight, healthy ageing) and number of partners. The use of the principles of appreciative inquiry in the checklist and methods contribute to improving communication and communication structures, to visibility, to clarifying outcome expectations, to celebrating (small) successes and to facilitating regular evaluation.

Cross-checking and discussing results with partners and triangulation with interview data increases the reliability of the results of the checklist. Piloting in multiple cases contributes to the checklist's external validity. The parallel investigation of the checklist in different partnerships resulted in all cases in actionable knowledge. The checklist helped partnerships in this study to understand processes and to create community and systems change and hence can potentially contribute to achieving population-level health outcomes.

Acknowledgements

The article is partly based on data gathered as a part of the pilot project *Health Promotion Framework*, carried out in 2007. This pilot was organized by the Netherlands Institute for Health Promotion (NIGZ) and funded by the Netherlands Organization for Health Research and Development (ZonMw). AGORA's healthy ageing project is funded by ZonMw. We are grateful to all partnerships who participated in developing and piloting the checklist. We also thank Jenneken Naaldenberg for her comments on a draft version of this article.

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