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Building Bridges and Creating Synergies for Health

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Abstract

Projects that aim to encourage healthy lifestyles among children or adolescents require a multilateral approach that targets values, beliefs, and attitudes. This kind of influence requires close well-planned cooperation between families, schools, peers, and youth organizations. The distribution of roles and tasks – as well as efficient communication as an element of good cooperation, partnerships, networking, and synergy – becomes a key determinant of a project's success and the maintenance of children's behaviour. The aim of this article is to clarify the concepts and notions connected to synergy and partnerships focusing on health, as well as to point out the measuring tools which could be usefull in this area, and also to present examples of projects that serve as international best practices of health target synergy for the child and adolescent population.

Key words: **ENHPS, health promotion, Keep Fit!, partnerships for health, synergy, Viasano**

Słowa kluczowe: **efekt synergii, ENHPS, partnerstwo dla zdrowia, promocja zdrowia, Trzymaj Formę!, Viasano**

Historical background

In 1920, Charles-Edward Amory Winslow gave a new definition of public health. This was the beginning of modern public health as well as modern approaches to health promotion. The definition of public health as*:* "the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principals of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventative treatment of disease, and the development of social machinery which will ensure to every individual in the community a standard of living adequate for maintenance of health" [1], was adopted in 1948 by the recently established World Health Organization.

This fact opened a global debate about the understanding of the concept of health and its determinants. After many years and various international events (*The Lalonde Report* published in 1974) [2] and conferences – mostly based on fieldwork and research experiences held at Alma-Ata in 1978 – the WHO endorsed the *Declaration on Primary Health Care, the World Health Organization's Targets for Health for All*. This document set goals and was focused on partnerships and collaboration in the field of health promotion [3]. However, a real milestone in the development of a modern vision of health promotion was the establishment of *The Ottawa Charter* in 1986, during the International Conference of Health Promotion in Ottawa [4]. This key document defined health promotion as: "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing" [4], and pointed out that the health sector alone would not be able to fulfil the recommendations of the Ottawa Charter.

According to the definition, health promotion "demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health" [4].

Furthermore, Eriksson and Lindström, defined research in health promotion as a: "combination of research and development, stressing action and encouraging multi-disciplinary approaches", and, as core values of health promotion indicate: "equity, participation and empowerment" [5].

Since Ottawa in 1986, the world has changed and become ever more complex, varied and globalized. Two global organizations engaged in a process of creation policies connecting with health – United Nations and World Health Organization as a specific UN arm. According to the United Nations' vision of health, access to the highest possible level of health should be treated as a fundamental human right [6], and obviously, as a value [6]. It followed that creating policies, partnerships and building supporting communities was a purpose, as well as a strategy, for health promotion in a globalized world [7]. One of the required actions is to: "partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions" and to fulfil the *Health for All* commitments. To achieve this, two things are necessary: the *All for health* pledge and ensuring that "each sector – intergovernmental, government, civil society and private – has a unique role and responsibility" [7]. Constitution of the World Health Organization from 1946 states that "governments have a responsibility for the health of their peoples which can be fulflled only by the provision of adequate health and social measures" [8]. On that basis the *Health in All Policies* was developed as an "encopassing approach which goes beyond the boundaries of the health sector" and links policies: education, environment, transport, housing, economic, fiscal policies [9].

After meeting in Ottawa in 1986 subsequent global conferences of health promotion were held, as a kind of meta answer on calls for joint work and aliances. Adelain in 1988, Sundsvall in 1991, Jakarta in 1997, Mexico City in 2000, and nearly twenty years after Ottawa, in Bangkok in 2005 [10], *The Bangkok Charter for Health Promotion in a Globalized World,* was established to better fit changing realities and to reconcile Ottawa Charter with the modern, evidence based notion of multiple, interrelated determinants of health [11]. Next conferences took place in Nairobi in 2009, and in Helsinki in 2013 the *Health for All Policies Framework for Country Action* were define, as well as the *Helsinki Statement on Health for All Policies* were created to sustain, redefine and empower HiAP approach all over the world, as a "public policies across the sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity" [10, 12].

To the final shape of thinking of contemporary health promotion also political declarations were inportant. As WHO's global health promotion conferences cemented its key principals for actions, so that the UN endeavoured to keep the promise included in *Millenium Development Goals* in Rio 2011 conference resulted with *Rio Political Declaration on Social Demands of Health,* and a year after in 2012 with Rio+20 Outcome Document from the bigest UN conference – *Realizing the Future We Wantfor All*, as well as with formulation the post-2015 developmental goals framework [10, 13].

Many initiatives therefore arose to promote and support joint work in the field of health, for example: the 2013th Dakar Conference on Social Health Inequalities encouraged all the stakeholders, inside and outside Africa, to work together, to deal with inequalities, thus fulfilling the Millennium Development Goals [14].

It's worth to mentioned that European Union has a unique mandate for HiAP [9]. National polices are conected, dependent and co-determined by EU policy, and this existing strong legal basis provides the opportunity to implement *Health in All Policies* approach at European level. The answer on such a great opportunity was estabilishing, during the session of WHO Regional Committee for Europe in september 2012, *a new value – and evidence-based health policy framework for the Region*, called *Health 2020* [15]. "Health 2020 presents the social and economic imperative for action, showing clearly that health and well-being are important and essential for economic and social development. It focuses on health as a human right; whole-of-government and whole-of-society approaches to equitable improvement in health; strong and invigorated governance and leadership for health; collaborative models of working and shared priorities with other sectors; the importance of community and individual reliance and empowerment; and the role of partnerships" [15].

Also initiatives such as Health Promotion Europe (HPE) network were initiated to support joint work in the field of health [16]. HPE is a network "that brings together bodies at national and subnational level that are publically responsible for health promotion and disease prevention", with three domains of development: European Platform for Action on Health and Social Equity (PHASE) which "encourages public health communities to play an active role in the achievement of the EU's societal objectives while implementing the Health in All Policies approach"; Health Promotion Europe (HPE) that "identifies and implements effective health promotion policy and practice, to strengthen the resource base and the impact of health promotion across the EU", and Centre for Iinnovation, Research and Implementation in Health and Wellbeing (CIRI) which "develops case studies, tests innovative pilot projects, evaluates and analyses examples of effective and sustainable approaches to health and wellbeing across all groups in society" [16]. Under the auspices of HPE network the project *Crossing Bridges,* funded by European Union was carried out from January 2011 until June 2012. *Crossing Bridges* aimed on promoting the implementation of a *Health in All Policies*

approach in EU to improve health equity within and between Member States, by "the development of practical tools to turn HiAP theory into practice, investigating specific examples of inter-sectoral collaboration to identify effective methodologies that can be further developed, and developing the capacities of national and regional public health institutes in order to promote HiAP" [17].

The above mentioned key documents and strategies specified, either directly or between the lines, what is required for success in supporting health. It appears that the most important are: the appropriate use of available resources, partnerships, alliances, networking, and collaboration, which is caused by the need for working across different sectors and stakeholders in health promotion and dealing with public health problems.

Theoretical background

There is a consensus around the relevance of partnership, however the terms *partnership*, *collaboration, networking, alliance*, *synergy,* and others are not simple to define or be evaluated for their effectiveness.

Don Nutbeam, in *The Health Promotion Glossary*, explains the basic meaning of the above listed key concepts for modern health promotion [18]. An *alliance* for health promotion is a partnership between two or more parties that pursue a set of agreed upon goals in health promotion. *Intersectoral collaboration* is a recognized relationship between part or parts of different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone. More recent consensus, especially related to HiAP approach explaines this term using it only in context of actions carried out between two or more governmental sectors (with a synonym – *multisectoral)*, and using new term *multistaekholder,* when reffering to actors outside the government [9, 12].

Capacity building is the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners, the expansion of support and infrastructure for health promotion in organizations, and the development of cohesiveness and partnerships for health in communities. A *network* is a grouping of individuals, organizations and agencies organized on a non-hierarchical basis around common issues or concerns, which are pursued proactively and systematically, based on commitment and trust. Finally, a *partnership* for health promotion is a voluntary agreement between two or more partners to work cooperatively towards a set of shared health outcomes.

Other authors defined "alliances, service work or partnerships as: working together and combining talents and strengths in order to achieve a common goal" [19], and "coordinated actions as organizations of two or more different sectors that work jointly to achieve an outcome and partnerships for intersectoral collaboration and community participation" [18].

Shaw, Ashcroft, and Petchey in their work concluded that: "The multidisciplinary nature of public health and the need for sustainable inter-organizational relationships must therefore be clearly recognized and supported in order to deliver policy" [20], and therefore another important term is needed – *mediation*. In health promotion, this is the process of reconciling different interests – whether personal, social or economic; individual or community; and public or private – in ways that both promote and protect health [21]. Nowadays, the term *facilitation,* in stead of *mediation,* is applied more often in statements, strategies and other types of documents.

There are many flourishing alliances that refer to various kinds of partnership. An interesting classification was done by Hayes et al. [22]. The authors described possible types of intersectoral collaboration joining managed care plans in not-for-profit or for-profit structures, with public health agencies in the USA [23], or collaborations between local authorities and primary care trusts in the United Kingdom [24].

In the USA, three kinds of *collaboration* were listed. The first works at a strategic level, based on an exchange of expertise, knowledge, and the sharing of services. Examples include childhood immunization, databases of communicable diseases, and partnerships for expanding the accessibility of health services. The second kind of collaboration occurs in functional areas: health planning and policy development, outreach and education, the provision of clinical services, data collection, and others. The third kind happens at a structural level: from low integration, where each structure is independent, to high integration, where the structures belong to one corporate entity. These three types of cooperation in a field of health promotion implemented jointly, cover all health promotion domain, and hellp to create beneficial environment to improve the health of community.

Another term requiring an explanation is *synergy* for health. Jones and Barry defined synergy as that: "what makes a partnership »tick«, as a degree to which a partnership combines the assets of all the partners in the search for better solutions and is generally regarded as the product of a partnership including vertical integration, shared know-how and shared resources". The synergy effect causes that partners "can achieve more by working together than each could achieve on their own" [25]. Lasker and Weiss pointed out that "in contrast to empowerment, which focuses on individuals, and social ties, which focus on dyadic relationships, synergy is the product of a group. It is created when a group of people and organizations combine their resources rather than dyadically exchange them" [26]. According that the synergy is a kind of "the breakthroughs in thinking and action that are produced when a collaborative process successfully combines the complementary knowledge, skills, and resources of a group of participants" [26].

Furthermore, resources are very important for health promotion and for creating partnerships that work in synergy. A Salutogenic interpretation of the Ottawa Charter, by Eriksson and Lindström, showed the importance of *investment for health* [5]. Investment for health refers to resources which are explicitly dedicated to health,

and health gain. They may be invested by public and private agencies, as well as by people as individuals and groups. Investment for health strategies is based on knowledge about the determinants of health and on efforts to gain political backing for public health policies [18].

A number of authors apply theories of organizational sociology and industrial organization onto public health. They explain that public health system activities are shaped by the resources available. The way that these resources are organized is also important, as well as the characteristics of the community [27, 28].

Evidence from the literature supports the thesis that creating synergies for health and – in a more metaphorical sense – building bridges that empower communities, brings benefits, as well as increases and develops possibilities for joint work and the achievement of health promotion goals [19, 29, 30]. To explore the meaning and relevance of creating synergies and partnership in public health and health promotion, one only needs to search for publications describing how to measure synergy in partnerships.

One of the research tools applied to measure synergy in health promotion partnerships is a scale developed in 2010 by Jacky Jones and Margaret Barry – *The Jones and Barry Synergy scale* [25]. This tool examines the conceptualization of synergy on a five point, and eight-item scale, and also includes the following dimensions: energy, outcomes, benefits, positive experience, complementary skills, work shared, problem solving, and added values. *The Jones and Barry Synergy scale* has a good psychometric characteristic, and is clear and easy to use. It is correlated with another partnership analysing tool, developed in 2000 – the *Weiss et al. synergy scale* [25, 31]. Using the Jones and Barry scale, process and product of partnership could be measured, whereas using the Weiss' scale only product, thus the first tool is more holistic in its nature [32]. Following method of measuring partnerships is a checklist of the coordinated actions, addressed to all levels of partnerships, and assessed in different partnerships: national programmes, academic collaborations and local partnerships. It is particulary helpful tool in creating partnerships, "because of its ability to generate actionable knowledge" [33]. The coordinated actions checklist includes elements from social context, health outcomes and health predicting mediators, and fulfills the following dimensions: suitability of partners, task, relation, growth, and visibility. It was developed in 2005, and revised in 2011 by John McLeod, as a unique checklist – *Checklist of a successful partnership for health promotion* [33].

The number of classical, as well as quite modern tools developed to measure and evaluate partnership was shown in **Table I**.

To create and follow up the synergy in partnerships, as well as to build networks aimed to increse cooperation among different stakeholders and sectors, are actions consistent with the win-win paradigm, successfully connecting governmental with profit and non-profit, public and private initiatives in health promotion, and "let everyone win, but in a different way" [34].

Much evidence of successful networks and collaborations in public health across the world, even those conducted through private-public partnerships, can be specified. These include: the HALL framework [19], the EPODE International Network to reduce childhood obesity prevalence through sustainable strategies based on Community Based Programmes [35], the Change4Life initiative [36], Food Dudes [37], Keep Fit [38], and many similar projects.

Case studies

To present examples of well-performing best practices, we decided to show instances from two European countries: Western – Belgium and Middle-Eastern – Poland. Description of main issues in a field of both case studies was presented to enable making comparison between partnership components: partners engagement, managing structure, goals, evaluating system, etc. We also would like to present more general, Europe-wide coverage initiative, which idea goes beyond the Old Continent and become a global approach, to feel the synergy effect started with HiAP approach and well-designed partnerships to implement its idea.

Poland

A Polish example of best practices for working in synergy is the National Educational *Keep Fit!* Programme, focused on healthy eating and physical activity among school children from the V and VI grade of primary schools and lower secondary school levels. The programme was initiated in 2006 and is still ongoing [38, 39].

The aim of the programme, on the basis of the WHO Global Strategy on Diet, Physical Activity and Health, is an education that promotes the sustainable development of healthy habits among school-aged children, by promoting the principles of an active lifestyle and a balanced diet, based on individual responsibility and free choices. It is open to all, including public and private schools. *Keep Fit!* consists of two main phases: the creation phase and the realization phase. The initial phase of invention and creation was led by two scientific units: the Institute of Food and Nutrition and the Department of School Medicine at the Institute of Mother and Child. The second phase of the programme, implementation to practice, is led by the partnership of the Chief Sanitary Inspectorate and the Polish Federation of Food Industry.

The methodology used in this programme is a bottom-up approach and a project method. The main idea is to get all the school community: students, parents, teachers and other school staff involved in the change of behaviour and habits. Schools organize extra-curricular activities to improve pupils' knowledge beyond the core curriculum and teaching programmes. The main purpose of these additional classes is to develop students' interest, particularly about nutrition and physical activity. After this, students, with the support of teachers and parents, prepare their own project. Every project should contain four stages: preparation, planning, implementation, and

Name of the tool	Dimensions	Source
Ranking scale for six process indicators for community participation (Rifkin's participation measurement)	Leadership	Rifkin S.B., Muller F., Bichmann W., *Primary health care: on measuring participation*. "Social Science and Medicine" 1988, 26, 9: 931–940.
	Organization	
	Resources mobilization	
	Management	
	Needs assessment	
A ladder of participation (Pretty's ladder of participation)	Self- mobilization	Pretty J.N., *Regenerating Agriculture: Policies and Practice for Sustainability and Self-Reliance*. Earthscan, London; National Academy Press, Washington 1995.
	Interactive participation	
	Functional participation	
	Participation for material incentives	
	Participation by consultation	
	Participation in information- giving	
	Passive participation	
Weiss et al. scale of partnership synergy	Leadership	Weiss E.S., Miller Anderson R., Lasker R.D., *Making the most of collaboration: exploring the relationship between partnership synergy and partnership functioning*. "Health Education and Behaviour" 2002, 29: 683–698.
	Administration and management	
	Partnership efficiency	
	Nonfinancial resources	
	Partner involvement challenges	
	Community-related challenges	
Coordinated action checklist (Checklist for coordinated actions)	General	Wagemakers A., Koelen M.A., Lezwijn J., Vaandrager L., *Coordinated action checklist: a tool for partnerships to facilitate and evaluate community health promotion*. "Global Health Promotion" 2010, 17(3):17–28.
	Siustability of the partners	
	Task	
	Relation	
	Growth	
	Visibility	
The Jones&Barry synergy scale	One dimension - synergy	Jones J., Barry M.M., *Developing a scale to measure synergy in health promotion partnerships*. "Global Health Promotion" 2011, 18(2): 36–44.
Checklist of a successful partnership for health promotion (The partnerships analysis tool)	Determining the need for the partnership	*The partnerships analysis tool, Victorian Health Promotion Foundation*, VicHealth 2011, Melbourne http://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/General/Partnerships_Analysis_Tool_2011.ashx, access: 9.07.2014.
	Choosing partners	
	Making sure partnerships work	
	Planning collaborative action	
	Implementing collaborative action	
	Minimising the barriers to partnerships	
	Reflecting on and continuing the partnership	

Table I. *Selected classical and modern tools applied in partnership assessment.*
Source: Own elaboration.

presentation. It is required that students are active in all stages of the project. In each school, there is a programme school coordinator, who is a connector with the Regional Sanitary Inspectorate Station.

Partners of the *Keep Fit!* programme are: the Polish Ministry of Education, the Institute of Mother and Child, the Institute of Food and Nutrition, the Polish Ministry of Sport and Tourism, the Warsaw University of Life Sciences, and the Jozef Pilsudski University of Physical Education in Warsaw, and this list is growing.

From the organizational and management perspective, every programme goes through the following phases: programme introduction at schools in 16 regions, preparing the database of schools participating in the current edition of the programme, issue and distribution of materials, strengthening and expanding cooperation at regional and local levels, training of regional and local coordinators in the country coordinating centre, training of school level coordinators and other representatives of school and local authorities involved, providing educational materials to schools, educational activities targeted to students and parents in schools and local communities, programme implementation in schools, informative and educational activities through mass media and the organization of mass events in local communities, supervision and monitoring of the programme, as well as supporting programme implementers, evaluation and reporting.

Since 2006, during the seven editions of the programme's implementation, 7,946 secondary and primary schools completed programme activities involving more than 5,215,000 students. From these figures it follows that *Keep Fit!* is the largest programme of its kind in the European Union, fully based on the recommendations of the European Commission and the European Platform on Diet, Physical Activity and Health.

Belgium

Partnerships, successful collaborations, and networking are the essence of the Viasano programme. This is a community based programme, which aims to prevent childhood obesity. It is based on the EPODE methodology developed after the satisfactory outcome of the Fleurbaix-Laventie study [40, 41] carried out between 1992 and 2004, on the basis of the North Carelia classical public health project. This methodology has also been adopted in Greece, Spain, the Netherlands, Romania, South Australia and Mexico.

Implemented in 16 towns in Belgium, the aim of the Viasano programme is to promote behavioural changes related to healthy food and physical activity. The target groups are children from 3 to 12 years old and their families, together with all local actors who can influence children's way of life at a local level: teachers, health professionals, associations, shop keepers, companies, etc.

The principles of the programme are: to change of the environment, education with no stigmatization of any product or food behaviour, and a step-by-step strategy aimed at changing behaviour. The Epode Methodology is based on four pillars, which imply partnerships with different target groups: political commitment at a local level, an independent scientific committee, coordination at national and local levels, and an ethical public-private partnership.

The first pillar is a strategy based on the belief that politicians at a local level are able to change the local environment or its inhabitants' behaviour. The willingness of politicians is key for the successful implementation of the programme. The mayor and deputies sign a commitment chart for four years.

The second pillar is a multidisciplinary expert committee, responsible for the general strategy, the prevention messages delivered to towns and for the evaluation of tools created for the programme's implementation in towns. The experts are also the spokespersons for the programme and have regular full meetings with the national coordinators.

The third pillar is a bilingual team in charge of the general management of the programme together with the management of the towns. The national coordinator organizes training, creates communication tools, actions and pedagogical tools, and organises events such as annual symposiums which gather all the actors of the programme. The national team is also responsible for the communication, visibility and advocacy of the programme. At a local level, the Viasano project leader, who is an employee of the city hall nominated by the politicians, is responsible for the implementation of the programme. He is asked to organize a steering committee based on existing partnerships with local actors. The Viasano coordinators provides tools and methods to help project leaders to motivate local actors in their activities towards families.

The fourth pillar is the ethical public-private partnerships (PPP). There is collaboration between the Viasano programme and partners: health professional associations, patients' associations, and scientific associations such as the Belgian Association for the Study of Obesity, etc. Their provide visibility and moral support to the program, likewise private partners financially support it. The role of partners is legally regulated to give a transparent and ethical framework actions implemented in the field [35, 42].

The Viasano programme is also a member of the EPODE International Network, which gathers 25 community-based intervention programmes around the world and participates in a European Comission study on social inequities in health.

International level

One of the oldest and most successful bridges for health is the Health Promoting School movement. It has been active in Europe since 1991 and was initiated by the WHO Regional Office for Europe (WHO/EURO), as a three-year pilot project led in 1992–1995, entitled: *Health Promoting School*.

In 1992, the European Network of Health Promoting Schools (ENHPS) was founded. During the first ENHPS conference in Greece in 1997, the ten principles of the Health Promoting School were defined: democracy, equity, empowerment, the school environment, the curriculum, teacher training, measurement of success, collaboration, community, and sustainability. At the centre of the theoretical approach of HPS is the concept of habitat as one of the bases for creating partnerships and building bridges. The second concept is the eco-holistic model of a school, creating a specific environment and climate which implies the existence of connected dimensions inside the school, factors outside the school, as well as objective conditions, such as legislation or policy, which influence the school. This project goes much further than promoting health at schools, it also participates in the social and economic development of whole societies.

After almost 20 years of spreading the HPS idea, the changes in Europe in turn enforced four major areas of change within the network:

- firstly, legislative changes on an educational, as well as an administrative level, at the end of 1990;
- secondly, the access of new members to the European Union (e.g. Poland in 2004) leading to many adjustments in the field of social life, policy, legislation, structure and a complex worldview;
- thirdly, globalization and the expansion of western lifestyles with unhealthy food, and a sedentary use of leisure time because of access to new technologies;

- fourthly, the people working inside the network were no longer the same, a generational gap appeared, some people retired, some moved to another place of work, and some faced burn out.

As mentioned in the theoretical background section, any change within a partnership can severely damage alliances and require mediation and the reestablishment of collaborative rules. Therefore, the necessity for building new bridges appears and after new legal regulation, new models for creating cooperation, building new networks of connections, and preparing and making new policies and agreements. For this reason, since 1st January 2008, the project was re-established and the ENHPS became the European Network of Schools for Health in Europe (SHE), on the basis of an agreement of WHO/EURO, the Council of Europe, and the European Commission. The SHE network is the European platform for school health promotion and is now coordinated by the Dutch Institute of Health Improvement, with the WHO as the Collaborating Centre for School Health Promotion. This network is a response to the growing community of professionals who are interested and involved in the development of health promoting schools in Europe. It aims to provide information, exchange best practices and contacts, which help to spread the main idea [43].

This ongoing project is an excellent example of a partnership at international, national and local levels, as well as between different sectors and groups such as students, teachers, school staff, parents and the wider community. It is also a good example of a successful bottom-up approach.

Poland and Belgium were involved in this project from an early stage. Every country involved in ENHPS developed their own inner country-specific structure of management, but generally speaking, the implementation of the programme began at a local level and moved to an international level (bottom up). At the local level, society needs are analysed and concrete actions are decided and planned. All the schools share the same values and principles but schools and their partners are free to organize what fits better within their cultural, organizational, and political environments. At the national level, the national coordinator provides methodological help with advice, training and tools. At the international level, the International Planning Committee develops methodological tools for the national coordinators, fosters the sharing of experience, and organizes symposiums to develop coordinators' knowledge and skills.

In the European Network of Schools for Health in Europe *partnership is a method and a goal* [44].

Two main organizations, except WHO, which support globall health-promoting schools movement are International Union for Health Promotion and Education (IUHPE), and Centres for Desease Control and Prevention (CDC). This two players created unique partnership theirselves. They collaborate jointly to build bridges between health and education sectors, and to facylitate and support already existing local partnerships. Through creation and dissemination resources and tools this partnership facylitate dialogue between sectors all over the world [45–47].

Benefits and obstacles of partnership

"Success requires common purpose and broad collaborative efforts by people and organizations across society in every country: governments, nongovernmental organizations, civil society, the private sector, science and academe, health professionals, communities – and every individual" [15]. Koelen, Vaandrager and Wagemakers listed prerequisties for successful alliances: institutional factors, policy, planning horizons, funding, personal and interpersonal factors, attitudes and beliefs, self-efficacy, social identity, timeframe, clear roles and responsibilities, building on capacities, communication structure, visibility, and management [19]. Similarly, in the "starter's kit" for applying HiAP there are six general key components to achieve health, health eqiuty and other societal goals, while working in alliances or partnerships: establish goals; frame planned action; identify supportive structures and processes; facilitate assessment and engagement; ensure monitoring, evaluation, and reporting; build capacity. Furthermore the compliance with principals in management, such as: legitimacy, accountability, transparency, participation, sustainability, collaboration, was underlined as significant [12].

In Jones and Barry's study, aimed to identify the key factors that influence synergy effect in partnerships, authors considered features which determine the quality of relationships among partners: community involvment; boundary-spanning skills (negotiation, able to see the opportunities, connectors, estabilishing a climate of trust, optimism, perseverance, necessary for partnership effectivness); organization and disciplinary culture; trust and mistrust; power; leadership; as well as administration, management and efficiency [32].

To avoid naive optimism it have to be noted that, beside the unquestionable benefits, there are also risks and obstacles in the process of creating and sustaining partnership. While reviewing the literature, a number of hurdles for achieving success in cooperation, partnership, and networking are mentioned. Different authors explain, in their opinion, the most important pitfalls. Greg and O'Hara list the different identification and interpretation of values [11]. Shaw, Ashcroft and Petchey mention irrelevant relationships and communication [20]. Inconsistency of goals and difficulties to coordinate joit actions are also obstacles in working across sectors and stakeholders. Taylor-Robinson et al. point out dealing with the complexities of the task, such as cultural barriers, including: different outcomes between sectors, different professional languages, and difficulties with the dissemination and implementation of guidance across sectors, jurisdictions and territories. Another complexity would be macro level influences, such as economic factors and public pressure [24]. Hayes et al. listed an unclear distinction between how well the service is being delivered and what outcomes the service is achieving [22]. Kreuter, Lezin and Young pointed out that, as a result, partnership have a high early failure rate [48]. Weis, Miller Anderson, and Lasker concluded that collaboration can be *tremendously adventageous*, considering fact that building effective partnerships is time-consuming, resource intensive and

very difficult [31]. Roussos and Fawcett noted that health partnerships faced the problem of achieving visible population-level outcome, because it usually takes longer than the lifetime of many partnerships [49].

Despite these potential hurdles, well-managed collaborative projects can cope with risks and bring many benefits because of the added value of synergy. This is extremely important, especially with regard to projects targeted at the health of children or adolescents. When encouraging healthy lifestyles, there is a need for a multilateral, complex approach that targets children's values, beliefs, attitudes and behaviour. That kind of influence requires close, well-planned cooperation between educational environments: family, school, peers, and others e.g. sports or cultural organizations. For this reason, the distribution of roles and tasks – as well as efficient communication as an element of good cooperation, partnerships, and networking – becomes a key determinant of a project's success and the maintenance of children's behaviour.

Lessons learnt

Many different examples of partnership in the field of health promotion could be found. Every best practice and every project has its own dynamics, strengths, risks and obstacles, as was shown in examples. However, at the place where two group of people meet and work together, there is always a need for dialogue, understanding, and common work in favor of partnership. This is especially important in case of projects targeted to the child and adolescent health – health leaders should move from fragmentation and division to cooperation and seek for synergy, as the only way to achieve desired health goals.

Learning jointly from theory and from practice, partners need to follow a basic steps on their way to build the effective partnership (**Figure 1**).

There are qualitative and quantitative measurement methods and tools used in the field of the synergy (Table I). To improve the efficient networking and partnership, there is a need to check how effective and synergic is our cooperation by using the existing tools or developing the new tools and methods suitable for specific partners and goals. It is also important to learn from best practices, as well as to evaluate the ongoing programmes and improve them. The study of Weiss, Miller Anderson and Lasker showed that partnership and synergy were more closely associated with effective leadership "that effectively facilitates productive interactions among partners by bridging diverse cultures, sharing power, facylitating open dialogue, and revealing and challenging assumptions that limit thinking and action and partnership efficiency which is the degree to which a partnership optimizes the use of it's partners' time, financial resources, and in-kind resources" [31]. Jones and Barry research shows that the most important factors for effective partnership and also predictors of synergy in partnership are trust, leadership and efficiency [32]. Critical for effective partnership functioning are skills in building trust and integrative leadership. Through collaborative process the trust-building mechanisms should be created during the forming phase of the partnership, and during the entire process, attention paid to the listed factors contributes to maximizing synergy to achieve the full potential of the health promotion partnership.

There is also a need to apply the veriffied approaches and models at the starting level of building partnership, for example: The healthy alliance framework HALL [19] or The partnerships analysis tool [33], as well as frequently evaluate and sustainably support partnership with bridging the gaps.

When a group from different sectors works jointly, as is usual in the field of health promotion in the child and adolescent population, partners have to fill the gaps, build bridges, think strategically and search for this *"tick"* in their partnerships to "achieve more by working together than each could achieve on their own" [25].

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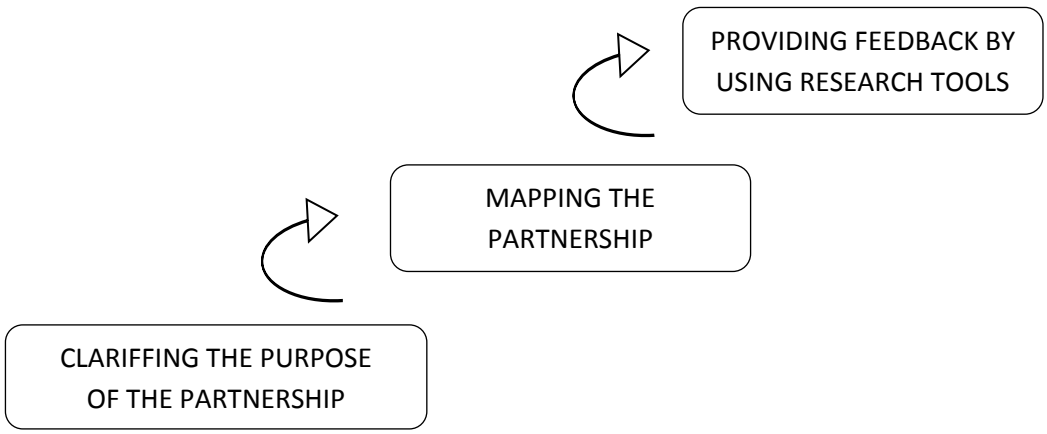

Figure 1. *Steps to succesful partnerships.*

Source: Model created on the basis of The partnerships analysis tool, Victorian Health Promotion Foundation, VicHealth 2011, Melbourne.

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