CHAPTER IV

DATA EXERCISE: ASSESSING COMMUNITY HEALTH PARTNERSHIP SYNERGY AND FUNCTIONING IN KIENG SUB-DISTRICT, MUNAG DISTRICT, MAHA SARAKHAM, THAILAND

4.1 Introduction

Although public and private funders continue to invest in collaboration, many partnerships are struggling to realize the full advantage of collaboration and attain their goals (Cheadle, Beery, Wagner et al., 1997; Chirslip and Larson, 1994; Kreuter, Lezin, and Young, 2000; Wandersman, Goodman and Butterfoss, 1997). Moreover, there is often significant delay in achieving measurable changes in health status; these changes often take longer than the lifetime of many partnerships (Roussos and Fawcett, 2000). It has also been difficult to document the effectiveness of partnerships in achieving health goals due to lack of valid indicators that can be used to accurately assess a partnership's impact (Weiss, Miller and Lasker, 2001; Roussos and Fawcett, 2000).

Regarding the rich body of partnership literatures, partnerships face significant challenges in realizing long-range health goals and in documenting their ultimate effectiveness, many researchers and evaluators have focused on more intermediate or short-term outcomes of partnership efforts. Such intermediate outcomes have included quality of plans (Butterfoss, Goodman, and Wandersmand, 1996), implementation of programs (Fransisco, Paine, and Fawcett, 1993), and satisfaction of

partners (Kegler et al., 1998). These researchers and evaluators have also shed light on how partnerships function, and have studied how different aspects of partnership functioning – including quality of leadership and management, sufficiency of resources, and partner involvement – are related to the various intermediate outcomes (Weiss, Miller and Lasker, 2001). These literatures about partnerships has not; however, examined the extent to which partnerships are actually able to combine the contributions of partners in a way that allows a partnership to reach its collaboration potential. Assessing the level of partnership synergy can; therefore, provide people in partnerships and researchers with a new and valuable indicator of how well the collaborative process is working as well as a way of determining the degree to which a partnership is making the most of collaboration long before it is able to visible results (Weiss, Miller and Lasker, 2001).

Therefore, this data exercise is conducted to assess health partnership synergy in Kieng sub-district, Muang District, Maha Sarakham. The description of the study methodology; objectives, study design, study sample and data collection will be presented following the introduction section. Next, the paper presents the validity and reliability of the measures used, and provides a detailed description of these measures. The fourth part of this data exercise presents the descriptive information about partnership synergy, partnership functioning, and the experiences and perspectives of the partnership participants. The next section discusses the study findings and describes practical applications of the study findings. Finally, there is a bibliography that includes the work cites as well as additional key articles, books, and other resources that have informed this work.

4.2 Objectives

1. To determine the level of factors which are influence the partnership functioning in Kieng sub-district, Muang district, Maha Sarakham.

2. To find out key stakeholders that address partnership functioning in Keing sub-district, Muang district, Maha Sarakham province.

4.3 Operational definitions

Health partnerships are defined as any group of two or more stakeholders-both public and private, working together on health issues. Partnerships range from informal collaborative activities to formal contractual agreements between groups and organizations.

Partnership synergy is defined as the power to combine the perspectives, knowledge, and skills of a group of people and organization.

4.4 Study design

This data collection exercise is designed as a descriptive cross-sectional study applying both quantitative and qualitative approaches.

4.5 Study methodology

4.5.1 Study Area

The study area for this data exercise is Kieng sub-district, Muang district, Maha sarakhm, Thailand, is purposively selected. The essential reasons for this purposively selected this area are:

1. **Establishment of different community health groups:** According to the passage of the 1997 constitution, a number of community health groups were operated.

2. **Cooperation:** Based on the assurance of cooperation and support from the Maha Sarakham Provincial Public Health Office, Provincial Governmental Office and other community-based organizations. Therefore, cooperation and willingness to participate in the study are greatly high.

4.5.2 Study population

The purposive sampling random for 30 samples from the members of all group forms that have worked on health issues in Keing sub-district. Therefore the study population include:

- TAOs' members
- Village health volunteers
- Village committees
- Other existed groups members in the village such as youth group, mother's club

Inclusion criteria

1. The member of the organizations of the village and together with people and organizations to promote health and well-being in their communities.

2. Exited members

3. Be willing to participate in the study.

Exclusion criteria

1. People who are not the members of any groups in the community
2. People who are not willing to participate.

4.6 Study instruments

4.6.1 Quantitative Data

4.6.1.1 Primary data

- **Questionnaire development**

The data collection instruments for this data exercise are developed by the researcher based on the review of related literatures in order to collect and arrange information and with the accordance of the research experts' advice from Faculty of Pharmacy and Health Science, Maha Sarakham University. Some parts of questionnaire were modified from numerous previous studies, including:

- The National Study on Partnership Functioning (n = 752) (Weiss, Miller, and Lasker, 2001, Available: http://www.cacsh.org.). The results show that the partnership synergy is directly related to the following six dimensions of partnership functioning: leadership (ρ = .01), administration and management (ρ = .04), partnership efficiency (ρ = .02), non-financial resources (ρ = .02), challenges with partner involvement (ρ = .03), and challenges related to the community (ρ = .03).

- Medicine and Public Health: The Power of Collaboration (Lasker 2000), Available: http://www.cacsh.org.

- Community Participation in Health-System Decision Making: Survey 3 in a Series of Surveys of Health Authorities in British Columbia (Frankish et al, 1999: Available at http://www.ihpr.ubc.ca);

- Statewide Health Promotion Organizations: A Partnerships Resource for Local Agencies, (Health Development Section, Public Health Division, Victoria, 2000: Available at http://www.dhs.edu.ac);

- Strengthening Partnerships: Community School Assessment Checklist (Blank and Langford, 2000);

- Partnership Self-Assessment Tool and Guide to Successful public and Private Partnerships for Child Care, (Child Care Partnership Project 1999: Available at: http://www.nccic.org/ccpartnerhips); and

- Working Together: A Profile of Collaboration (Chrislip and Larson, 1994: Available at http://www.cacsh.org) shows that partnership synergy was correlated with; leadership effectiveness, administrative and management effectiveness, partnership efficiency, Non-financial resources, partner involvement challenges and community-related challenges at .85 and has a good internal reliability of .95.

Therefore, questionnaire (Appendix A) is developed to measure partnership synergy as well as to elicit key descriptive information about the partnership and the respondent's perspectives and experiences. Almost questions are close-ended; although, there are some open-ended questions that provide respondents an opportunity to clarify their answers and give additional information. There are two sections of the questionnaire to be used in this study.

Section I: Comprises demographic data and additional information about the respondents, such as gender, age, marital status, educational level, and occupation.

Section II: The measurement of the partnership synergy. Table 4.1 displays the content areas covered in each of the two questionnaires.

Table 4.1: Content areas in questionnaire

Content area	Individual partner questionnaire (60 questions)
Partnership synergy	✓
Leadership	✓
Administration & management	✓
Efficiency of the partnership	✓
Non-financial resources	✓
Partners involvement challenges	✓
Community-related challenges	✓
Satisfaction with the partnership	✓
Decision-making	✓
Financial and capital resources	✓
Benefits & drawbacks of participation	✓
Composition of the partnership	✓
Partnership legal status & structure	✓
Partnership funding	✓
Partnership activities & plans	✓
Relationships among partners	✓
Importance of partnership goal to the partners	✓

The close-ended questions presented two (Yes and No) or more alternative choices are almost divided into 5 scales which are set in an ordering scale that provide the respondents the choice closest to their own view. The score are scaled in positive direction. That is, higher score is denoted to higher synergy of partnership and higher partnership functioning. The measurement of the agreement level was used in the terms as described in the table bellows:

Table 4.2 Scales used for agreement level.

Level of agreement								Score
Very good	Very involved	Strongly agree	Very positive	Very satisfied	Extremely high	All of them	All of the time	5
Good	Somewhat involved	Agree	Positive	Satisfied	High	Most of them	Most of time	4
Fair	Moderate	Neutral	Some positive some negative	Moderate	Moderate	Some of them	Some of the time	3
Poor	A little involve	Disagree	Negative	Dissatisfied	A little	A few of them	Almost none of the time	2
Very poor	Not at all involved	Strongly disagree	Very negative	Not at all satisfied	Not at all	None of them	None of the time	1

- **Testing and revising the questionnaire**

Any time new instruments are developed, it is critical to assess their reliability and validity (Weiss, Miller, and Lasker, 2001). Therefore, throughout this study, the content validity and internal consistency reliability for all scales used in testing these instruments are established as described in the following paragraphs.

☛ **Content validity**

Content validity is measured to the extent that the questions are relevant to and representative of the topic of interest. In order to assure content validity of the developed measures, a thorough review of the literature on partnerships and analyzed existing measures used in studied and evaluations of partnerships were conducted. It is also convened and worked with some experts who have extensive experience facilitating and/or researching areas from the Faculty of Pharmacy and Health Science, Maha Sarakham University and the advisor. Once the instruments were drafted, 20 interviews with diverse people were conducted to assure the relevance and interest of the instrument content to respondents and the consistent interpretation of questions across respondents. A number of significant revisions to the questionnaires were made based on the results of the interviews in order to maximize content validity and minimize respondent burden.

☛ **Internal consistency reliability**

It is important to assess the internal consistency of a scale to assure that the different items that comprise the scale are measuring one underlying construct (Daniel, 1997). Internal consistency reliability of the created instruments was assessed using partnership-level data (n = 20). Partnership-level score for the synergy scale was

derived by calculating the scale score for each respondent, which is the mean of scale items, and then taking the average score across the respondents within each partnership. Cronbach's coefficient alpha was the statistic used to test for reliability (cited in Hasroh et al., 2000). Table 4.2 contains a list of the scales, their respective alpha coefficients and the number of items per scale. The criterion for acceptable internal consistency reliability is generally .70 or greater.

Table 4.3: Internal consistency reliability for scales used in the analysis

Scale	Coefficient alpha	Number of items	Question numbers
Partnership synergy	.93	9	44 - 52
Effectiveness of leadership	.97	10	18a - 18j
Effectiveness of administration & management	.94	10	21a - 21j
Partnership efficiency	.76	3	41 - 43
Adequacy of resources	.84	9	29a - 29j
Difficulties governing the partnership	.85	6	58c, 58e - 58h, 58k
Problems with partner involvement	.85	3	58a, 58b, 58d
Problems related to the community	.83	4	59b - 59e

☛ **Test-retest reliability**

Test-retest reliability of the scales was assessed over a 4-week period on a sample of 20. The 4-week period was chosen to reduce both the potential for recall bias and the likelihood of true change. To minimize respondent burden, the second questionnaire is made shorter than the first, so that it would take only about 25 – 30 minutes to complete. To assess test-retest reliability, individual-level data were aggregated to the partnership level by taking the mean scale score for each respondent and calculating a mean for each partnership. Intraclass correlation coefficients were used; the coefficients for the scales and single item can be found in the Table bellow.

Table 4.4: Intraclass correlation coefficient of the scales used

Scale	Intraclass Correlation Coefficient (n = 20)
Partnership synergy	.73
Effectiveness of leadership	.66
Effectiveness of administration & management	.90
Partnership efficiency	.77
Adequacy of resources	.44
Difficulties governing the partnership	.74
Problems with partner involvement	.67
Problems related to the community	.67

In general, the test-retest reliability of a scale is considered acceptable if the intraclass coefficient is .70 or above. However, in exploratory work such as this, where concepts are being measured in new ways, intraclass correlation coefficients between .60 and .70 are considered acceptable (Daniel, 1997). It is possible that the reliability of these scales and single-items over time change in perception of the phenomenon due to heightened awareness that resulted from completing the first questionnaire.

☛ **Construct validity**

Tests of construct validity are used to establish that a new measure is correlated with other existing measures as expected, based on theory and existing research (Daniel, 1997). The construct validity of synergy was tested because validation of the primary outcome under study was particularly critical. To begin to test the construct validity of synergy, relationship to an existing scale designed to measure the effectiveness of the collaboration process was examined. This scale has good internal reliability (.95), and is part of a larger measure developed by Chrislip and Larson (1994) entitled Working Together: A Profile of Collaboration. Synergy was correlated

with this scale at .85. These results support the construct validity of the synergy scale, although additional confirmatory work in this area remains to be done.

- **Descriptive properties of the scales**

Table 4.5 presents the number of items, range, mean, and standard deviation for each scale, as computed with partnership-level data (n = 20). As noted previously, partnership-level scores for the synergy scale were obtained by calculating the scale score for each respondent, which is the mean of all scale items, and then taking the average score across the respondents within each partnership.

Table 4.5: Descriptive properties of the scales used in the analysis

	Number of items	**Variable range**	**Mean**	**S.D.**
Synergy	9	1-5	3.24	.24
Leadership	10	1-5	3.68	.39
Administration & management	10	1-5	3.55	.38
Partnership efficiency	3	1-5	3.19	.20
Non-financial resources	6	1-3	2.31	.15
Partner involvement challenges	3	1-5	2.44	.40
Community-related challenges	4	1-5	1.99	.38

Synergy: To measure synergy, respondents were asked questions such as whether the partnership is better able to carry out its work because of the contributions of diverse partners; whether the involvement of different kinds of partners has led to new and better ways of thinking about how the partnership can achieve its goals: whether the involvement of different kinds of partners has enabled the partnership to plan activities that connect multiple services, programs or system; and whether the partnership incorporates into its work the perspectives and priorities of the population

of interest. Responses to the 9 items in the scales were average to form a score with a range of 1 to 5, with larger values indicating higher lever of synergy.

Leadership: Respondents were asked to rate the effectiveness of the formal and informal leadership in the partnership in areas such as inspiring and motivating partners, working to develop a common language within the partnership, creating an environments where differences of opinion can be voiced, and resolving conflict among partners. Response categories ranged from (1) “Poor” to (5) “Very good”.

Administration and management: Respondents were asked to rate the effectiveness of the partnership in carrying out activities such as coordinating communication among partners and with people and groups outside the partnership, coordinating partnership activities, preparing materials that inform partners and help them make timely decisions, and evaluating the progress and impact of the partnership. Response categories ranged from (1) “Poor” to (5) “Very good”.

Partnership efficiency: Respondents were asked how much they agreed or disagreed with the following statements: the partnership makes good use of partners' financial resources, the partnership makes good use of partners’ in-kind resources, and the partnership makes good use of partners’ time. Response categories ranged from (1) “Strongly disagree” to (5) “Strongly agree”.

Non-financial resources: Respondents were asked the extent to which the partnership currently has what it needs to work effectively and achieve its goals for each 6 non-financial resources, such as skills and expertise, connections to target populations, and endorsements that give the partnership legitimacy and credibility.

Response categories ranged from (1) "Has almost none or none of what it needs" to (3) "Has all or most of what it needs". Respondents were instructed to check "Not applicable" if they did not think that the partnership needed a particular non-financial resource.

Partner involvement challenges: Respondents were asked to assess the extent to which the partnership has encountered problems recruiting essential partners, retaining essential partners, and motivating partners to participate. Response categories ranged from (1) "Not at all" to (5) "A lot". Respondents were also offered a "Don't know" option.

Community-related challenges: Respondents were asked to assess the extent to which the partnership has encountered the following: lack of community incentives to motivate people and organizations to participate in the partnership; little history of cooperation or trust among people, groups and organizations in the community; and resistance by key people and key organizations to the goals and activities of the partnership. Response categories ranged form (1) "Not at all" to (5) "A lot". Respondents were also offered a "Don't know" option.

4.6.1.2 Secondary data

General information about the sub-district development plans records (in year 2001) that available at health center and Tambon Administrative Organization.

4.6.2 Qualitative data

The focus group discussion guidelines (Appendix B) and in-depth interview guidelines (Appendix C) are developed as the study instruments.

4.7 Data collection

The study used a combination of quantitative and qualitative methods concerning the partnership synergy that may reflect the interactions among different actors and institutions at various levels of the health system in Keing sub-district, Muang district, Maha Sarakham. The focus of the study was on characteristics of the partnerships as a whole; therefore, data were collected from multiple key informants in Keing sub-district, who could provide valid and reliable information about the partnership. Therefore, a selected set of informants was chosen from the different community-based organizations, including Tambon Administrative Organizations (TAOs), Sub-district Health Center, business, police station, and other community-based organizations or groups were selected in this administrative area. The techniques employed are shown in Table 4.6.

Table 4.6: Techniques employed in data collection

Techniques	Informants	Number
Focus group discussion	- 2 Village health volunteers - 4 Community representatives - 2 Private organization representatives	8
In-depth interview	- Presidents of TAO - Head of sub-district health center - Head of village	3
Structured questionnaire	Members of community-based groups, include: - TAO members - Local health providers - Village committees - Village health volunteers - Youth groups - Mother's club - Other existed groups in the community	30

4.7.1 Quantitative methods

Both primary and secondary sources of data were obtained throughout this study.

4.7.1.1 Primary data

- **Logistical preparation of data collection**

1. Preparation activities

At the original state, contacts the key organizations; Maha Sarakham Provincial Public Health Office (MK PPHO), TAO, health center, and all involved personnel in Keing sub-district, Muang district were made in order to explain the objectives of the study and to call for permission as well as to confirm about the availability and accessibility of records.

2. Data collectors selection and training

According to WHO (1995) recommendation that trained data collectors are said to be essential in research. Furthermore, due to limitation of time and to minimize the travelling costs, the data collectors for this study were selected from the Faculty of Pharmacy and Health Science, Maha Sarakham University. In the training process, data collectors will be trained to collect data, assign code, and handle missing information together and practice together at a pilot site. This is because some questionnaire that could only be answered with 'yes' or 'no', for 'yes' answer, evidence is required. For example, for target population a specific figure had to be shown. For some of the questions a workplan or graph had to be discussed with the interviewers. Moreover, this rigorous classification and verification of 'yes' answers ensures consistency between interviewing teams. In a team, there will be two data collectors. Therefore, the data can be completely collected within 2-3 days.

Table 4.7: The model training course for data collectors recommended by WHO (1995)

Topic	Aids	Time
1. How data are collected? - Objectives - Contents	Data collection forms	60 min.
2. Coding		15 min.
3. Practice session to enter data into data collection form - 10 sample data which are problem free, and illustrate how to transcribe data from records to the forms - 10 additional sample data illustrating various problems likely to be encountered (i.e. illegible data)	Sample Data for entry	60 min.
4. Observing and interviewing techniques		30 min.
5. Field practice - Visit and complete set of data for 1village - Complete summary table and report		1 day
6. Final discussion - Review field test experiences and address concerns and questions - Assign data collectors to working teams - Finalize data collection plan and organization of work (schedules, transportation, communication)	Schedule	½ day

4.7.1.2 Secondary data

The secondary data was obtained from all related documents and reports available at Keing Tambon Administrative Organization and Keing Health Center. However, before undertaking the data collection, the head of Keing health center and the president of Keing TAO were informed in order to prepare a schedule of visits.

4.7.2 Qualitative methods

While quantitative methods describe the patterns or pinpoints of specific problems that need attention. Qualitative methods are used to examine why these patterns or problems exist. The methods to collect qualitative data include in-depth interview, focus group discussion, and observation.

4.7.2.1 Focus group discussion (FGD)

Appointments were first made for the convenience of the respondents and suitable locating was selected. This is because the participants who participated in FGD are; two VHVs, four community-based organization representatives and two private organization representatives. All discussions will be taped and notes will be finalized while listening to the tape playback. The guidelines for the focus group discussion are listed in Appendix B.

4.7.2.2 In-depth interviews

In-depth interviews were conducted to further explore the perspectives and experiences of partnership synergy and functioning. Selection of informants at different operating organizations was purposive which included health care providers from Keing sub-district health center, local governmental officials from Keing Tambon Administration Organization, and Head of village.

4.8 Data management

4.8.1 Quantitative data

The survey data were checked and edited immediately after interviewed. and encoded for data processing using SPSS. Both survey data and secondary data were

analyzed using descriptive statistics. Frequencies, means, and standard deviations were computed for each item. The results of the community survey were triangulated with the findings in the key informant interviews and focus group discussions, and were presented in matrix form.

4.8.2 Qualitative data

The interview was audio-recorded with confidentially maintained by not recording the name of the key informants. Then the interviews were transcribed from Thai to English word by word. Qualitative data were presented in narrative forms using summative and verbatim quotes.

4.9 Data analysis

4.9.1 Quantitative data

1. The data collection will be analyzed by using SPSS.

2. The based line data will be summarized for descriptive statistic in terms of *frequency, mean*, and *standard deviation*.

4.9.2 Qualitative data

Content analysis will be explored on key factors affecting partnership synergy in Keing sub-district, Muang district, Maha Sarakham province.

4.10 Results

4.10.1 Quantitative data

4.10.1.1 Primary data

Section I: Demographic information

Table 4.8 shows that characteristics of the respondents. Fifty-three percent of the respondents were male and 46.7% were female. Twenty percent were between 20 and 29 years old, 30% were between 30 to 39, 26.7% were between 40 to 49, 13.3% were between 50 and 59, and 10% were age 60 and above. Thirteen percent of respondents graduated in Master degree or higher, 16.7% had a bachelor degree, 20% had a high school degree, 16.7% had a secondary school, and 30% had a primary school degree, and 3.3% did not attend school at all. Their current occupation were farmer (20%), laborer (10%), nurse (6.7%), public health personnel (6.7%), teacher (13.3%), other governmental officials (10%), own business (13.3%), and other (13.3%).

The vast majority of the respondents (83.3%) reported that they have previously worked with other people in the partnership prior to the present collaboration. On average, the partners spend about 9 hours per month on partnership activities. Almost three-fourths of partners (73.3%) feel that the goal of the partnership is “Very important”, 16.7% feel that it is “Somewhat important”, and only 3.3% feel that it is “A little important” and 6.7% feel that it is “Not at all important”. Consistent with this finding is that a high proportion (80%) of partners have attended most or all of the partnership meeting that they have been expected to attend. Virtually all (90%) of the individuals have attended most or all of the meetings that they have been expected to attend.

Table 4.8: The study population characteristics

Characteristics	Frequency (n=30)
Gender	
Male	16 (53.3%)
Female	14 (46.7%)
Age	
Mean (39.7) SD (11.18)	Min (20) Max (62)
20 – 29	6 (20.0%)
30 – 39	9 (30.0%)
40 – 49	8 (26.7%)
50 – 59	4 (13.3%)
60 and over	3 (10.0%)
Marital status	
Single	4 (13.3%)
Married	23 (76.7%)
Divorced	3 (10.0%)
Education	
None at all	1 (3.3%)
Primary school	9 (30.0%)
Secondary school	5 (16.7%)
High school	6 (20.0%)
Bachelor degree	5 (16.7%)
Mater or higher	4 (13.3%)
Occupation	
Farmer	6 (20.0%)
Labourer	3 (10.0%)
Nurse	2 (6.7%)
Public health personnel	2 (6.7%)
Teacher	4 (13.3%)
Other governmental officials	3 (10.0%)
Own business	4 (13.3%)
Other	4 (13.3%)

The 30 participants have a wide range of health goals, which include improving access to care for underserved populations, reducing high-risk drinking among college students, increasing childhood immunization rates, and strengthening their community's public health system. All of the participants are engaged in a number of different kinds of services and activities in order to achieve their goals. The most frequently mentioned services and activities include education directed at population/professional groups (86.7%), collection of data (84%), building community capacity (80%), analysis of data and other information (73.3%), and creating linkages among different kinds of services (60%).

Sixteen of the 30 participants have been in existence of partnership for 3 years or longer, and the other 11 participants were formed more than one year. Slightly more than half (17) of the partnerships are legally formalized; of these, 9 are non-profit organizations and 4 are organizations created by government, such as a commission, council or public authority. The partnerships vary in terms of the percentage of total funding that comes from organizations outside the partnership. Specifically, 13 receive 20% or less of their funding from organizations outside the partnership, 10 receive between 25% and 17 receive 75% or more of their funding from organizations outside the partnership.

All of the partnerships involve diverse types of organizations as partners. On average, the partnerships have 5 different types of organizational partners. At least 75% of the partnerships include the following: community-based organizations, hospitals/health systems, government agencies, and colleges or university. In addition, between 50% and 75% of the partnerships involve partners that are advocacy groups, religion organizations, businesses, or medical practices.

Section II: Descriptive findings of partnership

In this section of the paper, by looking at the individual items within each scale, it can report more specific information about the overall strengths and weaknesses of the partnerships in the studied area. For each of the items in the scales, the frequency, partnerships' mean score (x) and standard deviation (S.D.) are presented. The mean score reflected the average score for the 30 participants, and the standard deviation indicates the variation in the mean score for each item across the 30 participants. The descriptive qualitative and quantitative data that were collected to obtain a more

in-depth understanding of respondents' experiences with aspects of leadership, administration and management, and resources that were not covered in the scales were also presented. In addition, this section provides descriptive information gathered about the respondents' perspectives on the decision-making processes in their partnership, financial and capital resources of the partnership, the benefits and drawbacks of participation, and relationships among partners, as well as information about partners' satisfaction with various aspects of their partnership. Understanding participant's perspectives and experiences is critical to developing successful programs and tools that can help partnerships improve their functioning and levels of synergy.

Synergy

Table 4.9 presents each of the 9 items in the synergy scale with its corresponding mean score and standard deviation for the 30 participants. The mean scores indicate that the partnerships are generally strongest at incorporating into their work, the perspectives and priorities of the population of interest. This is exemplified in a number of comments written by partners. As one individual partner commented, "All members of the community are able to participate in an open and honest dialogue about the needs and concerns facing our community". Additionally, another respondent noted that impact of bringing diverse people together: "We are gaining the ability to solve creatively our community problems. Our greatest resource is in bringing components of our community together and creating new collaborative ways to improve the health of the public.

Table 4.9: Synergy (Range 1-5)

Items	Not at all	A little	Moderate	High	Very high	Mean	S.D.
How much does the partnership incorporate into its work the priorities and perspectives of the population of interest to the partnership?	0	2 (6.7%)	16 (53.3%)	7 (23.3%)	5 (16.7%)	3.50	.63
Agree/disagree: the partnership is better able to carry out its work because of the contributions of diverse partners.	**Strongly disagree**	**Disagree**	**Moderate**	**Agree**	**Strongly agree**	**Mean**	**S.D.**
	0	0	20 (66.7%)	8 (26.7%)	2 (6.7%)	3.40	.51
How much has the involvement of different kinds of partners led to new and better ways of thinking about how the partnership can achieve its goals?	**Not at all**	**A little**	**Moderate**	**High**	**Very high**	**Mean**	**S.D.**
	1 (3.3%)	1 (3.3%)	18 (60%)	6 (20%)	4 (13.3%)	3.37	.49
How much has the involvement of different kinds of partners enabled the partnership to plan activities that connect multiple services, programs or systems?	0	0	21 (70%)	4 (13.3%)	4 (13.3%)	3.30	.51
How munch support has your partnership obtained from individuals, agencies and institutions in the community that can either block the partnership's plans or help move them forward?	4 (13.3%)	5 (16.7%)	6 (20%)	9 (30%)	6 (20%)	3.27	.50
How successful has the partnership been in carrying out its plans?	4 (13.3%)	6 (20%)	5 (16.7%)	9 (30%)	6 (20%)	3.23	.49
Agree/disagree: The partnership has developed common goals that are understood and supported by all partners.	**Strongly disagree**	**Disagree**	**Moderate**	**Agree**	**Strongly agree**	**Mean**	**S.D.**
	6 (20%)	5 (16.7%)	4 (13.3%)	9 (30%)	6 (20%)	3.13	.40
Agree/disagree: The partnership has clearly communicated how its actions will address problems that are important to people in the community.	7 (23.3%)	5 (16.7%)	4 (13.3%)	8 (26.7%)	6 (20%)	3.03	.34
Agree/disagree: The partnership has done a good job of documenting the impact of its actions.	10 (33.3%)	2 (6.7%)	11 (36.7%)	3 (10%)	4 (13.3%)	2.63	.51

The synergy items that partnerships tend to be weakest on include documenting the impact of the partnership's actions, clearly communicating how the partnership's actions will address problems that are important to people in the community, and developing common goals that are understood and supported by all partners. Consistent with this finding, respondents remarked that there is a "need to work on getting the 'word' out to community to generate excitement and increase involvement of all segments of the community".

Leadership

Descriptive data collected about leadership indicate that shared leadership is the predominant mode of leadership within the 30 participants. When respondents were asked about whether they provided either formal or informal leadership in their partnership, 70% reported playing a leadership role. 66.7% of partners responded positively to the question. Some respondents had an opportunity to play a leadership role for the first time. As one individual partner wrote, "This was my first experience as a leader. I am usually just a worker".

Findings also showed that changes in leadership are common in the 30 participants. When asked about changes in leadership, about half of the respondents indicated that there had been a change in leadership in their partnership since they become involved. Of those respondents who cited a change in leadership, 20% thought the changes was "Very positive", 46.7% thought it was "Positive", 30% thought it was "Both positive and negative", and 3.3% thought it was "Negative". The qualitative data suggested that respondents experienced changes in leadership as more negative than positive. As one respondent noted, "Changes in staff and leadership impact negatively on continuity of partnership and historical knowledge". Another respondent reported that "Experiences have fluctuated considerably over the four-year life of the partnership due to changes in leadership".

Table 4.10 lists each of the items in the leadership effectiveness scale with its corresponding mean and standard deviation for the 30 participants. On average, the leadership of the partnerships on the study appeared to be particularly effective at tanking responsibility for the partnership. The leadership was also rated highly on its

ability to foster respect, trust, inclusiveness, and openness, and on its ability to create an environment where differences of opinion can be voiced. As one respondents reported "Values, diversity, and diverse opinions have been encouraged and supported by the leadership thereby creating a very open and inclusive process". Another respondent similarly noted "As the open and trusting attitudes of leaders continue to encourage sharing, the partnership grows as an example and developer of community health". The areas within leadership effectiveness that need the most improvement across the 30 participants are resolving conflict among partners, developing a common language within the partnership, empowering people involved in the partnership, and helping the partnership be creative and look at things differently.

Table 4.10: Leadership (Range 1-5)

Please think about people who provide either formal and informal leadership. Based on your experiences in this partnership, please rate the total effectiveness in each of the following areas:	**Very poor**	**Poor**	**Fair**	**Good**	**Very good**	**Mean**	**S.D.**
Taking responsibility for the partnership	0	0	7 (23.3%)	19 (63.3%)	4 (13.3%)	3.90	.60
Creating an environment where differences of opinion can be voiced	0	1 (3.3%)	7 (23.3%)	18 (60.0%)	4 (13.3%)	3.83	.56
Fostering respect, trust, inclusiveness, and openness	0	0	10 (33.3%)	17 (56.7%)	3 (10.0%)	3.76	.45
Combining the perspectives, resources, and skills of partners	0	1 (3.3%)	9 (30.0%)	17 (56.7%)	3 (10.0%)	3.73	.55
Inspiring or motivating people involved in the partnership	0	2 (6.7%)	8 (26.7%)	17 (56.7%)	3 (10.0%)	3.70	.57
Communicating the vision of the partnership	1 (3.3%)	1 (3.3%)	11 (36.7%)	12 (40.0%)	5 (16.7%)	3.63	.64
Helping the partnership be creative and look at things differently	1 (3.3%)	2 (6.7%0	15 (50.0%)	7 (23.3%)	5 (16.7%)	3.43	.42
Empowering people involved in the partnership	1 (3.3%)	3 (10.0%)	14 (46.7%)	7 (23.3%)	5 (16.7%)	3.40	.50
Working to develop a common language within the partnership	1 (3.3%)	2 (6.7%)	20 (66.7%)	4 (13.3%)	3 (10.0%)	3.20	.48
Resolving conflict among partners	3 (10.0%)	0	20 (66.7%)	4 (13.3%)	3 (10.0%)	3.13	.55

Overall, respondents are satisfied with the leadership in their partnership. Sixty-three percent of respondents reported feeling “Very satisfied” with the leadership in their partnership and 30% of the respondents reported feeling “Satisfied”. Only 3.3% of respondents reported being “Not at all satisfied” or “A little satisfied” (Table 4.11). Partnership organizational representatives and individual partners reported similar levels of satisfaction. These feelings are captured by an organizational representatives who commented “We have capable and dedicated leadership and everyone is made to feel valuable and appreciated by the partnership”.

Figure 4.11: Leadership satisfaction

Scale	Percentage (n = 30)
Very satisfied	63.3%
Satisfied	30.0%
Somewhat satisfied	0.0%
A little satisfied	3.3%
Not at all satisfied	3.3%
Total	**100%**

Administration and management

Almost of the organizational representatives are involved in the administrative and management functions in their partnership. However, partners’ involvement in administration and management activities is less widespread than their involvement in the leadership of their partnership. Fifty-six percent of the respondents are “Not at all involves” or “A little involved”, while 43.3% are “Somewhat involved” or “Very Involved”.

Although some partnerships appeared to have sufficient resources to support their administration and management activities, many do not. When asked about the extent to which the partnership has the funds and in-kind contributions it needs to adequately support its administrative and management activities, 13.3% of partners responded that their partnership has "All of what it needs", 33.3% responded "Most of what it needs", 40% responded "Some of what it needs", 6.7% responded "Almost none of what it needs", and 6.7% responded "None of what it needs".

Table 4.12 lists the items in the administration and management scale with their corresponding frequency, means and standard deviations for the 30 participants. These data indicate that, on average, the partnerships in the study are most effective at coordinating partnership activities, managing and disbursing funds, coordinating communication among partners, and performing secretarial duties. The administration and management activity most in need of strengthening is providing orientation to new partners. As expressed by one respondent "The complexity of the partnership arrangement is intimidating to newcomers. Many people resigned before they ever get productively involved". This feeling is noted by another respondent who noted that "I experienced a long learning curve in understanding the work of our partnership. There was no meaningful orientation for me". Additional administration and management areas in need of strengthening include evaluating the progress of partnership and coordinating communication with people and groups outside the partnership.

Table 4.12: Administration and management (Range 1-5)

Based on your experiences in this partnership, please rate the effectiveness of this partnership in carrying out each of the following activities:	Very poor	Poor	Fair	Good	Very good	Mean	S.D.
Coordinating partnership activities, including meetings and projects	0	0	0	26 (86.7%)	4 (13.3%)	4.00	.42
Managing and disbursing funds	0	1 (3.3%0	5 (16.7%)	21 (70.0%)	3 (10.0%)	3.87	.48
Coordinating communication among partners	2 (6.7%)	0	4 (13.3%)	20 (66.7%)	4 (13.3%)	3.80	.45
Performing secretarial duties	1 (3.3%)	1 (3.3%)	3	21 (70.0%)	4 (13.3%)	3.73	.47
Preparing materials that inform partners and help them make timely decisions	0	0	4 (13.3%)	22 (73.3%)	2 (6.7%)	3.67	.50
Applying for and managing grants	1 (3.3%)	2 (6.7%)	10 (33.3%)	12 (40.0%)	5 (16.7%)	3.60	.57
Maintaining databases	3	2 (6.7%)	10 (33.3%)	9 (30.0%)	6 (18.0%)	3.43	.49
Coordinating communication with people/groups outside the partnership	2 (6.7%)	2 (6.7%)	16 (53.3%)	5 (16.7%)	5 (16.7%)	3.30	.49
Evaluating the progress and impact of the partnership	3 (10.0%)	0	15 (50.0%)	10 (33.3%)	2 (6.7%)	3.26	.44
Providing orientation to new partners as they join the partnership	5 (16.7%)	4 (13.3%)	10 (33.3%)	9 (30.0%)	2 (6.7%)	2.96	.49

In general, respondents reported that they are satisfied with the effectiveness of the administration and management in their partnership. Overall, 60.0% of the respondents feel “very satisfied”. These findings are supported by the respondent who wrote “This is one of the best run partnerships I’ve worked with. Information is readily available and shared freely. Relationships have been built in levels of never have happened if it were not for the partnership”. Table 4.13 shows differences in levels of satisfaction.

Table 4.13: Satisfaction with administration and management

Scale	Responses (n = 30)
Very satisfied	18 (60.0%)
Satisfied	8 (26.7%
Somewhat satisfied	2 (6.7%)
A little satisfied	1 (3.3%)
Not at all satisfied	1 (3.3%)
Total	100%

Efficiency

Table 4.14 presents the 3 items in the efficiency scale along with the item frequency, means and standard deviations for the 30 partnerships. The efficiency item with the highest score is making good use of partners' in-kind resources. Partnerships appear to be slightly less efficient in the use of their partners' time. Nonetheless, qualitative data suggested that making the best use of partner's time is particularly important to partners. One respondent commented "We were asking for a major time commitment, that most people don't have. They want to know the bottom line as to what is expected of them". Partnerships are least efficient in their use of partners' financial resources.

Table 4.14: Efficiency (Range 1-5)

Items	Strongly disagree	Disagree	Moderate	Agree	Strongly agree	Mean	S.D.
The partnership makes good use of partners' in-kind resources	1 (3.3%)	1 (3.3%)	15 (50.0%)	6 (20.0%)	7 (23.3%)	3.56	.40
The partnership makes good use of partners' time	1 (3.3%)	3 (10.0%)	16 (53.3%)	6 ((20.0%)	4 (13.3%)	3.30	.42
The partnership makes good use of partners' financial resources	3 (10.0%)	2 (6.7%)	17 (56.7%)	6 (20.0%)	2 (6.7%)	3.07	.45

Non-financial resources

In Table 4.15, the items that comprise the non-financial resources scale are presented with their corresponding frequency, means and standard deviations for the 30 respondents. The mean scores indicated that there are non-financial resources that the partnerships in the study have not been able to obtain which are critical for partnerships to be able to work effectively and achieve their goals. The non-financial resources that are *least* sufficient among the 30 respondents in the study are data and information; connections to target populations; and connections to political decision-makers, government agencies and other organizations/groups.

Table 4.15: Non-financial resources (Range 1-3)

For each of the following types of resources, to what extent does the partnership currently have what it needs to work effectively and to achieve its goals?	**Has almost none or none of what is needs**	**Has some of what it needs**	**Has all or most of what it needs**	**Mean**	**S.D.**
Skills and expertise (e.g. leadership, administration, evaluation, law, public policy, cultural competency, training, community organizing)	0	18 (60.0%)	12 (40.0%)	2.40	.19
Influence and ability to bring people together for meetings and activities	0	20 (66.7%)	10 (33.3%)	2.33	.22.
Endorsements that give the partnership legitimacy and credibility	3 (10.0%)	17 (56.7%)	10 (33.3%)	2.23	.21
Connections to political decision-makers, government agencies, other organizations/groups	3 (10.0%)	19 (63.3%)	8 (26.7%)	2.16	.22
Connections to target populations	3 (10.0%)	21 (70.0%)	6 (20.0%)	2.10	.23
Data and information (e.g. statistical data, information about community perceptions, values, resources, and politics)	5 (16.7%)	20 (66.7%)	5 (16.7%)	2.00	.23

Data from the questionnaires also indicated that in-kind resources provided by partners are essential. When asked about how important such in-kind resources are for their partnership, 90% of the partnership responded "Very important" and 10.0% responded "Important". There was no responded "Somewhat important", "A little", or "Not at all important".

Financial and capital resources

In addition to measuring non-financial resources, the study also collected data for descriptive purposed about the sufficiency of the 30 respondents' financial and capital resources, including money, space, equipment and goods. Table 4.16 presents the frequency, means and standard deviations for these items across the respondents. Of these resources, money if viewed as least sufficient. Qualitative data provide confirmation of this finding that additional funding from the partners is needed to adequately support the administration and management activities of the partnerships. As one respondent commented that "We need additional funds to continue and improve our consortium's effectiveness. We are fortunate to have one of the best coordinators, but fear losing him due to increase in budget to provide him with salary increases". As partnerships try to increase their sufficiency of money, there is great concern about the consequences of vying for already scarce funds. One respondent noted that "I am concerned the partnership will become a competitor for grants with existing community organizations". The key stakeholders who gave supporting funds are both private and public organizations: 76.7% were community based organizations e.g. religious organizations, village development groups; 60% were governmental organizations; and 43.3% were NGOs.

Table 4.16: Financial and capital resources (Range 1-3)

For each of the following types of resources, to what extent does the partnership currently have what it needs to work effectively and to achieve its goals?	**Has almost none or none of what is needs**	**Has some of what it needs**	**Has all or most of what it needs**	**Mean**	**S.D.**
Space	0	20 (66.7%)	10 (33.3%)	2.33	.32
Equipment and goods (e.g. computers, books, medications, food)	0	22 (73.3%)	8 (26.7%)	2.27	.33
Money	3 (10.0%)	22 (73.3%)	5 (16.7%)	2.06	.33

Challenges

For the two scales measuring challenges, the higher the mean on an individual item, the more of a problem that challenge presents. Table 4.17 illustrates the frequency, mean and standard deviation for each item in the partner involvement challenges scale. The partners involvement challenge most troublesome for the 30 partnerships is recruiting essential partners. Recruiting partners is challenging yet critical for partnerships. As one responded stated "We have somehow failed to attract key community stakeholders and power brokers. The board requires new partnership – it needs revitalizing through some new members with assorted talents".

Table 4.17: Partner involvement challenges (Range 1-5)

To what extent has the partnership encountered the following challenges?	**Not at all**	**A little**	**Moderate**	**High**	**Very high**	**Mean**	**S.D.**
Problems recruiting essential partners	0	0	15 (50.0%)	5 (16.7%)	10 (33.3%)	3.83	.42
Problems retaining essential partners	0	1 (3.3%)	16 (53.3%)	5 (16.7%)	8 (26.7%)	3.67	.46
Difficulties motivating partners to participate	2 (6.7%)	1 (3.3%)	15 (50.0%)	4 (13.3%)	8 (26.7%)	3.50	.45

Table 4.18 lists the items in the community-related challenge scale. As shown in this table, the 30 partnerships in the study, on average, are not encountering the community-related challenges to the extent that they are encountering challenges with partner involvement. However, the community-related challenges that the partnerships reported encountering most often is lack of incentives in the community to motivate people to participate. This result is consistent with the finding that the partnerships are having difficulty motivating partners to participate.

Table 4.18: Community-related challenges (Range 1.5)

To what extent has the partnership encountered the following challenges?	**Not at all**	**A little**	**Moderate**	**High**	**Very high**	**Mean**	**S.D.**
Lack of incentives to motivate people and organizations to participate in the partnership	0	0	15 (50.0%)	10 (33.3%)	5 (16.7%)	3.67	.42
Little history of cooperation or trust among people, groups or organizations in the community	0	0	19 (63.3%)	5 (16.7%)	6 (20.0%)	3.57	.51
Resistance by key people and key organizations to the goals and activities of the partnership	0	18 (66.7%)	6 (16.7%)	4 (13.3%)	2 (6.7%)	2.67	.33

Decision-making

Descriptive data collected suggested that the way in which decisions are made varies across the 30 respondents. Respondents were asked to indicate the different types of decisions-making processes used in their partnership; responses are reflected in Table 4.19. For this item, respondents were given the option of choosing more than one answer category.

Table 4.19: Decision-making in the study partnerships

How are decisions made in the partnership?	**Responses (n = 30)**
By all partners	29 (96.7%)
By a committee consisting of a voluntary group of partners	20 (66.7%)
By the staff director	11 (36.7%)
By a committee consisting of an elected group of partners	10 (33.3%)
By coordination/management office	10 (33.3%)
By a committee consisting of a staff-appointed group of partners	5 (16.7%)

Additionally, based on responses, of the 30 respondents in the study, 30.0% followed written procedures for making decisions "All of the time", 43.3% followed written procedures "Some of the time", and 26.7% followed written procedures "None of the time". In general, respondents in the study reported feeling positive about the decisions-making processes. When respondents were asked about the portion

of decisions made by the partnership that they support, 20% responded "All of them" and 66.7% responded "Most of them". Also, most respondents believed that their partnership make decisions in a timely manner. When asked to rate how often decisions were made in a timely manner, 16.7% responded "All of the time", 70.0% responded "Most of the time", 10.0% responded "Some of the time", and 3.3% responded "Almost none of the time". However, when asked about how comfortable they are with the way decisions are made, 56.7% reported feeling "Very comfortable", while 43.3% responded that they felt only "Somewhat comfortable". Qualitative data revealed even less positive feelings about decision-making processes. As one individual respondent noted "To some extent it seems that a small group actually make decisions- leaving many of us disengaged and on the periphery". Another respondent stated that "Important decisions and true collaboration are with a few members. It is more important to 'look good' to outside than really work with all the local folks".

Table 4.20: Decision-making process

Items	Not at all	A little	Moderate	High	Very high	Mean	S.D.
Feeling comfortable involvement in decision-making process	0	0	8 (26.7%)	13 (43.3%)	9 (30.0%)	4.03	.58
	None of the time	**Almost none of the time**	**Some of the time**	**Most of the time**	**All of the time**	**Mean**	**S.D.**
Decision made in the timely manner	0	1 (3.3%)	3 (10.0%)	21 (70.0%)	5 (16.7%)	4.00	.51
Decision-making follow the written procedures	0	0	0	13 (43.3%)	17 (56.7%)	4.56	.36

Benefits and drawbacks

The descriptive data showed that the 30 participants receive important benefits from involvement in their partnership. When questioned about the importance of the benefits received, 73.3% of the respondents reported that they are either "Very important" or "Extremely important". Table 4.21 shows the benefits asked about in the questionnaire with the percentage of people who reported receiving each benefit. In general, respondents reported receiving similar benefits.

Table 4.21: Benefits received by respondents

Types of benefits	Percentage
Development of valuable relationships	29 (96.7%)
Ability to make a contribution to the community	28 (93.3%)
Acquisition of useful knowledge about services, programs, or people in the community	27 (90.0%)
Enhanced ability to address an issue that is important to me/my organization	26 (86.7%)
Increased use of expertise or services	25 (83.3%)
Acquisition of new knowledge and/or skills	25 (83.3%)
Ability to have a greater impact that I could have on my own	23 (76.7%)
Enhanced ability to meet the needs of my constituency or clients	23 (76.7%)
Heightened profile/recognition	20 (66.7%)
Enhanced ability to affect public policy	20 (66.7%)
Enhanced ability to meet performance goals	NA
Acquisition of additional funding to support my organization's activities	NA

The development of relationships is clearly an important benefit of participating in a partnership. This sentiment is expressed by a respondent who wrote "I've made important connections to some partner organizations and to many committed, caring individuals". Another respondent wrote "When all is said and done, I receive the most from the relationships with other people, many of whom I would have no contact with except for through the partnerships". As the data indicated, the vast majority of the 30 participants also feel that an important benefit is the ability to make contribution

to the community through their participation. One respondent noted receiving "tremendous satisfaction in the ability to make a difference in the quality of life in one's community".

However, there are also some drawbacks that respondents experienced as a result of participating in partnerships. When asked about the level of concern about drawbacks experienced, 53.3% of the respondents reported being "Not al all concerned", 26.7% reported that they were "A little concerned", 16.7% were "Somewhat concerned", and 3.3% were "Very concerned" or "Extremely concerned". The drawbacks listed in Table 4.22 are those drawbacks asked about in the questionnaire with the percentage of people who report receiving each drawback.

Table 4.22: Drawbacks experienced by respondents

Types of drawbacks	Percentage
Diversion of time and resources away from other priorities or obligations	15 (50.0%)
Frustration or aggravation	11 (36.7%)
Insufficient influence in partnership activities	5 (16.7%)
Insufficient credit given to me for my contributions to the partnership	2 (6.7%)
Being associated with partners that have negative images	5 (16.7%)
Conflict between my job and the partnership's work	4 (13.3%)
Less independence in organizational decision-making	NA
Strained relations within my organization	NA
Loss of competitive advantage (e.g. in obtaining funding or providing services)	(3.3%)

Those who reported that the partnership takes time away from other priorities may be torn between those other priorities and the work of the partnership. One respondent commented that "I regret that my participation is limited by my other responsibilities". Insufficient influence in the partnership, as well as frustration and aggravation, are reflected in the comments of an individual partner who noted that

"I'm just a concerned citizen trying to make a difference in my community. Lots of times I feel left out, as everyone belongs to agencies and talks about their programs".

Although there are a number of drawbacks respondents reported experiencing, the majority of respondents felt positive about their experiences in their partnership. For 53.3% of the respondents, the benefits of participating "greatly exceed" the drawbacks and for 36.7% of the respondents the benefits "exceed" the drawbacks.

Partner relationships

In order for diverse people to be able to work together effectively, time must be spent building good relationships. The questionnaire asked respondents about four aspects of relationships: trust, respect, discord, and power differentials. For the 30 respondents in the study, relationships among partners are generally positive. When questioned about trust, almost all respondents (90%) reported feeling that they will not be taken advantage of by other partners. In terms of respect, 96.7% of the respondents reported that the contribution they make to the partnership is appreciated. Qualitative data support these findings as one respondent noted that "We all trust one another and enjoy one another's company. No one is there with an axe to grind. We really are altruistic – working for an improvement in the community's health and well-beings". In addition, a partnership expressed that "As in all relationships, trust is a big issue. A successful partnership must be built on trust and a common vision".

Discord in the partnership was measured by asking respondents whether they have experienced strained relations with other partners due to disagreements or differences in perspectives. Only 16.7% of the partners reported having strained

relations with other partners. One respondent supported this finding by commenting "At this point, I have not experienced strain with any agencies or partners. At this point, all partners seem to be working together to help improve our community". To measure power differentials, respondents were asked about their level of influence in the partnership as compared to other partners. Nineteen percent of the respondents feel as though other partners have more influence than they do in decisions about partnership activities.

Table 4.23: Relationships in the partnership

Items	Strongly disagree	Disagree	Moderate	Agree	Strongly agree	Mean	S.D.
Respect: The contribution they make to the partnership is appreciated	0	1 (3.3%)	1 (3.3%)	18 (60.0%)	10 (33.3%)	3.63	.42
Discord: The experience about strained relations with other partners due to disagreements or differences in perspectives	5 (16.7%)	20 (66.7%)	0	5 (16.7%)	0	2.16	.38
Trust: They will be taken advantage of by other partners	12 (40.0%)	15 (50.0%)	0	2 (6.7%)	1 (3.3%)	1.83	.32

Partners satisfaction

Table 4.24 depicts respondents' satisfaction levels with various aspects of their partnership. The table shows that 30 respondents generally have high levels of satisfaction with their partnership. The qualitative data support the quantitative findings and indicated that these respondents have very positive feeling about their partnership experience. The satisfaction that partners have with the way people in the partnership work together is exemplified by the comments of one organizational representative that "I always know that if I don't have the time to do something, someone else will step in and do it". This feeling is supported by the respondent's comment, who wrote "We are a great team and I am proud to be a part of this partnership".

Table 4.24: Partner satisfaction

How satisfied are you with ...	Not at all satisfied	A little satisfied	Somewhat satisfied	Satisfied	Very satisfied	Mean	S.D.
The way the partnership has implemented its plans?	1 (3.3%)	3 (10.0%)	4 (13.3%)	8 (26.7%)	14 (46.7%)	4.16	.31
The partnership's plans for achieving its goals	1 (3.3%)	3 (10.0%)	5 (16.7%)	8 (26.7%)	13 (43.3%)	4.13	.32
Your influence in the partnership?	1 (3.3%)	2 (6.7%)	4 (13.3%)	9 (30.0%)	14 (46.7%)	4.10	.34
Your role in the partnership?	1 (3.3%)	2 (6.7%)	4 (13.3%)	9 (30.0%)	14 (46.7%)	4.10	.36
The way people and organizations in the partnership work together?	1 (3.3%)	2 (6.7%)	8 (26.7%)	7 (23.3%)	12 (40.0%)	3.90	.38

4.10.1.2 secondary data

- **Health information**

Table 4.25: Number of deaths by leading cause of death: 2000

Cause of death	1998	1999	2000
Heart disease	844	820	902
Cancer (all forms)	323	492	887
Disease of the respiratory system other than the upper respiratory tract	158	188	200
Liver and pancreas disease	128	138	140
Nephritis, nephrotic syndrome and neprosis	115	120	100
Diabetes mellitus	105	127	200
Tuberculosis (all forms)	97	79	90
Accident and poisonings	76	54	302
Diseases of oesophagus, stomach ad duodenum	45	61	60
Pneumonia and other diseases of lung	43	36	30

Source: *Maha Sarakham Provincial Health Office (2000)*

4.10.2 Qualitative data

4.10.2.1 Focus group discussion

When the focus group discussion was conducted, the researcher was assisted by two well-trained research assistants. To avoid gender bias, eight participants were purposive sampling for 4 males and 4 females, who are VHVs, Head of village, community-based organizational representatives, and NGOs' representatives (see also Table 4.3).

The results of the focus group discussion can be concluded into three parts: the reasons for involving in the community activities, reasons for not involving in community activities, and suggestions made by the participants.

1. Have you been working as a team?

1.1 If yes: What reasons have brought you to work as a team?

- People were willing to attend the community meeting if they were informed about the meeting.

- All participants expressed commitment to values of mutual support, solidarity, working together and helping each other.

- Participants expressed their interests in participation were more likely to hold the following beliefs: that they knew the law; that they were part of the community; and that they could influence decisions within the community, that they interest in collective participation were that they felt part of the community, and that they believe they could influence it.

- Community leaders, sometimes did not act in the best interest of the community, they are act likely to represent factional groups or to be bound to powerful interests through which they can capitalize benefits for themselves.

1.2 If no: What specific constraints have kept you from working as a team?

- Most of participants stated that they could not play their role adequately because lack of clear communication channels with the community. One participant stated that "Sometimes we are not informed about the meetings, or community activities properly".

- Lack of interest and apathy prevented people from participating. One participant stated that

- Fear of expressing their views on health care performance or local government performance. "People are resigned to receiving any old thing and do nothing to look for alternatives to improve things". Another stated that "People are used to being treated badly and to being abused and do nothing about it".

- Too time-consuming.

2. What made the collaboration happen?

- First, the governmental campaign programs that encouraging people to join in the programs.
- Governmental mandates
- Community problem identification
- Community needs

3. Who was involved?

- Village committees
- Youth groups
- Mother's club
- Local health providers
- TAO
- Some of people living in the community
- Some other external organizations such as university, NGOs

4. What was the collaboration trying to achieve?

- To encourage people to involve in the community activities.
- To promote and prevent the spread of communicable diseases such as heamorrhagic dengue fever, Leptospirosis.
- To improve quality of life of people in the community.

5. What actually happened?

- Lack of planning.
- Run out of money and necessary resources.
- There were many conflicts among the members.
- Difficult to bring people to work together.
- The program will continue whenever there is some money.

6. What do you think were the critical elements that determined the project's success or failure?

- Money: "Even though the community has strong commitment to work together, if there is no money to run or administration and management the program, the program might end shortly".

- Power: "even though we know that we have some kind of power to work on the working task, it somehow limited by key personnel or key organizations in the community"

- Supports: "without supports from professionals, health providers, TAO and other community organizations, work seemed to be difficult to achieve its goals".

- Solidarity: "everyone should participate in the programs"
- Community values: "work together for our community"

7. What was most rewarding about working as a team?

- Interactions with other people.
- Feeling of being involved.
- Learning about the health-care system and community development.
- Feeling of contribution.
- Seeing positive changes in community.
- Partnering with other community governing bodies.
- Sharing my resources.

8. What changes, is any, do you would like to see in community?

- More involvement and input of people at the grassroots level.

- Being informed and prepared for the meetings: With better communication and information strategies, the community's perceived ability might be translated into active participation. This is because apart from knowledge and perceives ability to affect changes, attitudes, beliefs, and values underpin the effective operation of participatory mechanisms.

- People should work together as a partner rather than being control by groups or organizations.

- Develop resources for collaboration, such as topic-focused monthly meetings.

- Bring community and providers together as well as involve community in defining issues, gathering data and mobilizing resources.

4.10.2.2 In-depth interview

Kieng sub-district is located approximately 5 kilometers from Muang district to North. There are 11 villages, 1,634 households, and 6,291 population. The in-depth interview results from both Keing health center and Keing TAO are summarized bellow.

Kieng Health Center

Health personnel: There are 6 health personnel; 1 Head of health center, 1 Health academician, 2 Community health personnel, 1 Registered nurse, and 1 Technical nurse.

Primary health care structure: 55 Village health volunteers, 1 Tambon health volunteer's club with 65 members, 11 Health consumer groups, 11 Village primary health care centers, 3 School health consumer groups, 11 Drug funds. The in-depth interview results can be summarized as follow.

1. What are top five priority areas of health program for 2002?

- Primary Care
- Maternal and child care program
- Communicable Disease Control
- School Health
- Environmental Health

2. Of governmental agencies other than health organizations with which your organization collaborates, which agency is your most important partner overall?

There are many governmental agencies such as local school, police station, and TAO, that Keing health center collaborates with. However, the most important partner mentioned by the head of health center is local school. There are some reasons to say that such as, the location of local school is closest to the health center and with one of the top five priority areas of health program is school health program so that both school and health center work closely together.

3. Of the non-governmental organizations with which your organization collaborates, which is your most important partner overall?

The most important non-organization collaboration is community-based organizations such as religious organizations and village development groups.

4. How would you say about your organization's coordination and collaboration with local health providers and other local governmental and non-governmental agencies?

As cross-organizational collaboration is a complex undertaking, health center works with numerous people from diverse backgrounds who work at various levels in different organizations, the process which these relationships are promoted has a profound effect on the success of the collaboration. However, the head of health center also suggested that the process of collaboration must emphasize several common points:

- All partners should be involved in the program from the planning stage. This is because successful projects rarely are designed by one partner who, after all decisions are made, brings the other partners in.

- It is important to clarify each partner's roles and responsibilities clearly the beginning, specifying what each is expected to contribute and what each will get in return.

- It is extremely valuable to identify a neutral convener and a skilled facilitator who has the trust and respect of all partners.

- The process should be flexible and responsive to partners' needs, identifying ways to sidestep organizational bureaucracies.

5. What forum did the local health official discuss the problems?

The main forum for discussing about the health issues or community development will be sometimes hold at the TAO's or sometimes at village monthly meeting with expected full attendance of the people in the community.

6. To summarize, what do you think are the most important positive impacts of health development in your community?

The primary health care structure is said to be the most important positive impacts of health development in the community. That is, the capacity of village health volunteers is greatly strong. As can be seen from the study of HasroH (2001) on the Capacity of Village Health Volunteers in Primary Health Care Administration and Management in Keing Sub-district shows that the capacity is quite high (64.10%) and the most qualified skills was primary care; details shows in the following Table.

Table 4.26: Percentage of the capacity of village health volunteers in primary health care administration and management.

Capacity level	Educating others	Primary care	Surveillance	Management	Total (%)
Low	5/12.8	3/7.7	4/10.3	6/15.7	**11.54**
Moderate	15/38.5	3/7.7	7/17.9	13/33.3	**24.36**
High	19/48.7	33/84.6	28/71.8	20/51.3	**64.10**
Total	**39/100**	**39/100**	**39/100**	**39/100**	**100**

7. What do you think are the most important negative impacts of health development in your community?

The most important negative impacts can go to the difficulties in involving community members, leadership to develop an idea to a plan of action. Additionally, establishing concise communication policies, how to deliver messages in political times, and inadequacy of funding.

8. What changes would you like to see your community with respect to community health development?

The most critical successful collaborations require not only an adequate funds and in-kind contributions to support the administration and implementation of the project, but also necessarily need an adequate administrative and support as well as effective strategies for promoting understanding and communication. Good channel of communication at every level and phase of the collaboration is also needed; to foster trust and mutual respect; to support group decision-making; to keep partners fully informed about what is going on; to enable them to learn each others' concerns, values, and work; to compromise disagreements; and to provide them with avenues to respond to changes and emerging problems.

Keing Tambon Administrative Organization (TAO)

Keing TAO is located about 700 meters from health center. There are 31 members, 22 members were elected from 11 villages (2 persons for each village), and other 11 members by their position.

1. What are your TAO's top five priority program areas?

- Environmental health
- Communicable disease control
- Coverage of households' latrine use
- Water supplies and sewage disposal
- Child care

Table 4.27: Kieng TAO's Financial allocation for sub-district development

Programs	Fiscal year				
	2541	2542	2543	2544	2545
Public Health					
1. Healthy child contest	-	1,500	1,500	1,500	1,500
2. Preparation for dengue prevention					
- Mosquito spray machine	-	46,000	-	-	-
- Mosquito chemical spray	6,000	8,500	8,5000	8,5000	8,500
- Sand abet	-	9,000	9,000	9,000	9,000
3. Environmental health					
- Cleanliness contest	-	3,3000	3,300	3,300	3,300
Economic					
1. Support village organizations	-	85,000	85,000	85,000	85,000
Social					
1. Support cultural conservation activities	-	5,000	5,000	5,000	5,000
2. Youth sport competition (1 per year)	-	32,000	32,000	32,000	32,000
3. Human resource development	-	5,000	5,000	5,000	5,000

Source: *Keing TAO, Five years plan budget report*

2. Of governmental agencies with which your organization collaborates, which agency is your most important partner overall?

Regarding to community development, health center is said to be the most important partner in dealing with community problems.

3. Of the non-governmental organizations with which your organization collaborates, which is your most important partner overall?

Overall, the non-governmental organization that the TAO work collaboratively with is business agencies and religious organizations.

4. How would you say about your organization's coordination with local health providers and other local governmental and non-governmental agencies?

Even though in the current environment many organization seemed to work together more than ever before, such as in addressing challenging health problems, responding to economic and performance issues, collaboration is tough.

5. What forum did the local health official discuss the problems?

The monthly meeting will be hold at the TAO to concern about the progress of work and the occurrence of community problems. Since two-third of the members of TAO are elected from each village (2 elected persons per village) attend the meetings. Then these members will deliver the message through the village meeting to further plan together to get work done. This is can be said that it works through the original political framework. That is, it is well known that issues concerning political culture are not easy to change among institutional actors and citizens in spite of transformations in the political framework.

6. To summarize, what do you think are the most important positive impacts of health development in your community?

Working more closely with health providers also facilitates the translation of public health knowledge into mainstream political practice, providing effective community development to a much broader population. However, some areas also need to be reconsidered as well.

7. What do you think are the most important negative impacts of health development in your community?

It is important to point out that while cross-organizations entering into collaborative relationships are commonly concerned about *losing* control over their professional destinies. This seemed to be the most important negative impact for community health development.

8. What changes would you like to see your community with respect to community health development?

The new policies and legislation for local governance or decentralization are apparently seen; however, the challenges that remains is how to actually implement the goals and principles of that policies into workable institutional mechanism and realized their potential benefit. This is because to encourage community to participate in community development, it is a complex process involving belief, customs, ways of life, and power relations". Therefore, to establish a closer relationship, a clear understanding of whether cross-organizational collaborations can work as well as how they work in the real world. This is may worth noting for better community development.

4.11 Discussion

Through this study, it was able to determine levels of partnership synergy in Muang district, Maha Sarakham, and thus ascertain the degree to which partnerships make the most of their collaborative potential. Data collection from 30 individual partners in Kieng sub-district, Munag district, Maha Sarakham, suggested that the majority of these partnerships have relatively successful at combining the perspectives,

resources, and skills of the partners to strengthen the thinking and actions of the group and the partnership's relationship to the broader community. Nonetheless, there is room for improvement, particularly in certain aspects of partnership synergy. Findings suggested that, in order to make the most of collaboration, these partnerships need to build more effectively on their partners' strengths and capabilities to document the impact of the partnership's actions, clearly communicate how the partnership's actions will address problems that are important to people in the community, and develop common goals that are understood and supported by all partners.

Another key outcome of the study was the identification of partnership synergy in the six main areas, it can be discussed as the following paragraphs.

Leadership: Results suggested that achieving high levels of synergy required a certain kind of leadership – leadership that facilitates productive interactions among partners by bridging diverse cultures, performing boundary-spanning functions, and revealing and challenging assumptions that limit thinking and action. The 30 samples in the study, on average, have fairly effective leadership; nonetheless, the partnership clearly need to do some work to improve certain leadership capacities. Specifically, findings suggested that the leadership in these partnerships tends to be weakest in its ability to resolve conflict among partners, develop a common language within the partnership, and empower partnership participants. Descriptive results also indicate that the leadership in these 30 samples is frequently shared; over two-thirds of respondents reported that they play a formal or informal leadership role in their partnership. Consequently, the capabilities of many people in a partnership can be drawn upon to build more effective leadership. However, the prevalence of shared leadership also suggested that for leadership to be effective, the capabilities of multiple people need to

be coordinated, which present an additional challenge to partnerships. Ultimately, in order to maximize synergy, a partnership's leadership must develop and coordinate key leadership capacities that enable a partnership to effectively leverage the involvement and contributions of its partners.

Partnership efficiency: By making good use of partners' time, in-kind resources, and financial resources, partnerships are likely to increase their synergy levels as well as the likelihood that partners will continue to contribute to the partnership. Results showed that, on average, the 30 samples in the study tend to be strongest in their used of partners' in-kind resources and weakest in their use of partners' financial resources and time. Data collected through the study further suggest that using partners' time efficiently is particularly important to partners, since the work of a partnership frequently not a partner's primary responsibility.

Administration and management: Analysis results showed that the effectiveness of a partnership's administration and management also has an important on partnership synergy. That is, administration and management activities, such as coordination of communication among partners and partnership activities, and the preparation of material that inform partners, can make it possible for multiple, independent people and organizations to work together. These activities can provide important support for partners' efforts and interactions and, as findings suggest, help them maximize synergy. The data indicated that the 30 participants in the study tend to perform well on some administration and management activities. On average, the partnerships are strongest in their ability to coordinate partnership activities; they also appear to be fairly effective in their ability to manage and disburse funds, coordinate

communication among partners, and perform secretarial duties. However, findings suggested that the partnerships in the study need to work on their ability to effectively provide orientation to new partners, evaluate the progress and impact of the partnership, and coordinate communication with people and groups outside the partnership. As with leadership, the data indicated that many partners tend to work with the partnership coordinator to perform administration and management activities in the partnership. Nonetheless, assistance from partners with these tasks does not appear to be sufficient; the majority of coordinators reported that their partnership does not have the funds and in-kind resources it needs to adequately support its administrative and management activities.

Non-financial resources: Like administration and management, non-financial resources, such as skills and expertise; information; and connections to target populations, play an unique role; synergy is largely built from these resources, and it is only by combining them in various ways that partners can potentially create something new that enables them to accomplish more than they could on their own. Results suggested that the partnerships in the study have generally not been able to obtain all of the non-financial resources they need to do their work effectively and maximize partnership synergy. This lack of resources may be due, in part, to inability of the partnerships to recruit and retain essential partners.

Partner involvement challenges: The partners involvement challenges most troublesome for the 30 respondents is recruiting essential partners. Recruiting partners is challenging yet critical for partnerships. As one responded stated "We have somehow

failed to attract key community stakeholders and power brokers. The board requires new partnership – it needs revitalizing through some new members with assorted talents".

Community-related challenges: The 30 respondents in the study, on average, are not encountering the community-related challenges to the extent that they are encountering challenges with partner involvement. However, the community-related challenges that the partnerships reported encountering most often is lack of incentives in the community to motivate people to participate. This result is consistent with the finding that the partnerships are having difficulty motivating partners to participate.

Decision-making process: Inclusive decision-making process that make the most of what different partners have to offer are likely to facilitate partnership synergy. Data collected from the majority of the 30 respondents in the study suggested that at least some decisions were made based on the input of all partners. The data also indicated that the partners in the study support all or most of the decisions made by their partnership and are satisfied with their influence in their partnership. Nonetheless, data suggested that some partners felt disengaged from the process, and almost half of the respondents reported that they are less than "very comfortable" with the way decisions are made.

Benefits and drawbacks: Through the study, it was also able to gather valuable descriptive information about the benefits and drawbacks that respondents from the 30 samples experienced as a results of their participation. Findings discussed in this study support the idea that partner involvement in a partnership, whether in the form of

providing leadership, management, or other financial and in-kind resources is of great importance for synergy. Consequently, it may be possible for partnerships to facilitate synergy by maximizing participants' benefits and minimizing their drawbacks. Study data revealed that the benefits most often received by respondents include developing valuable relationships; having the ability to contribute to the community; gaining useful knowledge about services, programs, or people in the community; and acquiring new knowledge and skills. The two drawbacks of participation most frequently experienced by partners are diversion of time and resources away from other priorities or obligations, and frustration or aggravation. Frustration or aggravation stands out as a particularly serious drawbacks for the partners. Additionally, almost half of the respondents in the study reported experiencing the drawback of being associated with partners that have negative images.

From this data exercise, it suggested that for collaborations to succeed, partners must perceive a compelling *need* to work with professionals and organizations in other fields and be *willing* to do so. To some extent, the willingness to participate in a collaborative enterprise depends on whether potential partners give it a high priority. That decision, in turn, relates to whether the expected benefits appear to be worth the investment and commitment, and whether the project is likely to be feasible and well run. Moreover, to sustain a collaborative partnership, confidence and trust in the leaders are potential.

4.12 Limitations

1. The sample size of this study was small and may have something in common such as personality traits, therefore outcomes can not be generalized for the people in Maha Sarakham.

2. The findings of this study are relatively limited. For example, the quantitative data, there is no sample size calculation for acceptable error.

3. Since the researcher has very little research experiences, personal bias and some of critical areas may be missed out or did not covered.

4. Some respondents did not understand the meaning of words or vocabularies in the questionnaire. However, since this data exercise was self-administrated conducted by well trained interviewers, some of difficult terms used were explained during interviewing. Therefore, definitions of specific words or vocabularies used should provided.

5. Due to this data exercise was cross-sectional, a causal relationship between the dimensions of partnership and synergy has not been demonstrated. To show that effectiveness of leadership and partnership efficiency actually predict levels of synergy over time; therefore, a longitudinal study would have to be conducted.

4.13 Lesson learned

There are numerous lessons that can be learned throughout this study that will be further useful for future improving skills and works. Those lessons learned include:

1. Assessing a partnership's level of synergy can provide people in partnerships, and researchers with a valuable indicator of how well the collaborative process is working – a way of determining the degree to which a partnership is making

the most of collaboration long before it is able to see visible results. A meaningful intermediate outcomes, such as synergy, is critical for partnerships because of the delay in realizing population-level health goals and the difficulty documenting a partnership's effectiveness due to valid indicators.

2. Additionally, the study established the content validity and internal reliability of six scales that measure the partnership synergy.

3. The introduction made at the beginning of the interview served reasonable efforts. This is because the questionnaire is the subjective instrument that there is no right or wrong answer; however, the respondents were, sometimes, showed fear to give a wrong answer. Therefore, a clear introduction and questionnaire instruction should be provided before interviewing is essential. Additionally, the scales of measurement are difficult to answer, such as very poor, poor, neither poor nor good, good, and very good, sometimes it could cause some errors in data collection.

4. The in-depth interview guidelines needs to be tested before actual data collection. In addition to gain more experiences in how to approach the respondents, privacy is considered to be more concentrated as well as good relationship and trust are needed. This is because, the key informants should feel free to tell and to answer the questions.

5. The results of the data collected should not be interpreted the meaning of the mean of the respondents. Under this circumstance, the data collector should pay attention in every word that the respondents given.

6. Furthermore, with regard to the choice of Keing sub-district, Muang district as a target area, the district has a particular well developed infrastructure; therefore, a similar survey conduct in other districts within the province may produce different results.

7. Interviewer bias was seen through this study. That is, since the appointed for the in-depth interview was arranged with the great cooperation from the Vice-Provincial Medical Chief Officer. Furthermore, he was the one who facilitated for the in-depth interview process. Therefore, cooperation for giving and participating in the study was greatly high.

8. Above all, although partnerships are becoming an increasingly prevalent way to address complex health issues and many have great strengths, they often encounter difficulties and many do not reach their full potential. As one respondent in the study wrote, "We have a lot of good influence, but have a long way to go". Ultimately, for partnerships to be able to assess and strengthen their collaborative potential, they need information specific to their partnership.

4.14 Expected outcome

All recommendations from respondents would be seriously considered in order to improve and develop the new strategic tool to help people to make the most of collaboration. The results also will be necessary to validate any judgment about the effectiveness of the community partnership as well as it will be used as baseline data for future comparison and to set up the intervention programs.

4.15 Ethical considerations

Some of ethical issues were considered throughout this study, including:

Voluntary participation: The participants' involvement in this study was voluntary. That is no one was forced to participate.

No harms to participants: The participants were free to answer or skip some questions that they do not want to answer.

Confidentiality: All participants were informed about the objectives and the process of study. Although information given in focus group discussion was recorded, the participants' names were not mentioned or written and all gathered information will be confidentially kept.

4.16 Conclusion

In conclusion, as a result of the study, it can be seen that apathy, resignation and fear of retaliation, politicization of community leaders and distrust of both public institutions and democratic mechanisms were mentioned in the group discussions as impediments to people's involvement. However, the measurement of partnership synergy and the identification of factors that influence the ability of partnerships to achieve high level of synergy may help partnerships assess and strengthen their capacity to realize the full potential of collaboration. Additionally, the results of the study may be useful providing an empirical basis for the development of practical tools in order to give people involved in partnerships and the researcher the specific skills needs to heighten the partnership's levels of synergy as well as help partnerships leverage their resources and involve partners in a way that enables them to maximize their collaborative potential.

Overall, the respondents to the survey reported being dedicated, committed and enthusiastic about partnerships participating in health activities. Most believed that the community should be involved in health. Additionally, satisfaction working relationship with a valuable indicator of how well the collaborative process is working as well as a way of determining the degree to which a partnership is making the most of collaboration long before it is able to see visible results are also important.

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