Partner’s engagement in community-based health promotion programs: a case study of professional partner’s experiences and perspectives in Iran

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SUMMARY

Community-based health promotion requires effective participation and partnership of diverse and numerous stakeholders from community as well as external professional organizations. Although effective partnership of stakeholders is the key for success of health promotion practice and research, but this has proved to be a complex and challenging task. This study is an exploratory study to identify professional stakeholder’s perspectives and experiences toward the partnership’s engagement challenges in community-based participatory research conducted in Population Research Centers in Iran. A qualitative study design with in-depth semi-structured interviews as data collection method was chosen. Using purposeful sampling technique, policy-makers and managers (mainly academics) involved in community-based participatory research in these centers were invited to be interviewed. Data were collected to the point where no new information was forthcoming. All interviews were taped and transcribed. To provide answers for research questions, qualitative content analysis was employed to extract emerging main themes from numerous codes. Findings were categorized in three main themes as Partnership’s relationship and trust issues, Partnership’s individual issues and Partnership’s system issues. Although community-based participatory research in Iran benefits from more than a decade history and some physical infrastructures, but it seems that public health experts and researchers and other partner organizations are lagging behind in terms of capacities and competencies required to effectively utilize the available structure and opportunities. Hence, capacity development, both among professional partners and community may be the main way forward to tackling the future challenges for strengthening community actions but should include both levels of individuals and systems.

Key words: engagement; community-based health promotion programs; Iran

INTRODUCTION

Health promoters are increasingly involved in programs that require them to have the competency of empowering people by enabling individuals and communities to have greater influence over the determinants of their health (Laverack, 2004; Laverack and Keshavarz, 2011). Empowering individuals and community is based on effective mutual collaboration of professional stakeholders of the program with community level stakeholders. Strengthening community actions as the
third empowering health promotion action area is an integral component of health promotion practice as described in Ottawa in 1986 (WHO, 1986). Although it is generally agreed that health promotion projects need participation, but the quantity and quality of participation are the key issues. Passive participation may not lead to empowerment or action, and hence will not lead to improved health outcomes as expected (Rifkin, 2011). It seems that a reorientation of professional practice to strengthen community actions has not happened (Laverack and Keshavarz, 2011).

While sometimes the words such as involvement, engagement and participation are used interchangeably in the literature, some researchers consider them as different levels of taking part in community health promotion practice or research. For example, the Ladder of Community-Based Interaction framework by Laverack (Laverack, 2007) describes the levels starting from community readiness, to participation, to engagement, to organization, to development, to capacity-building, to collective action and finally to community empowerment. He considers participation as a form of involvement without commitment for action while considers engagement as a higher form of involvement. International Association of Public Participation (IAP2, 2013) describes these levels slightly different suggesting ‘participation spectrum’ starting from being just informed, upgraded to higher levels of to be consulted, to be involved, to collaborate and to be empowered. In this paper, we consider participation at engagement level (according to Laverack’s ladder) which seems equal to involvement level (according to IAP2 spectrum) which encompasses degrees of commitment that can lead to action.

STAKEHOLDER’S ENGAGEMENT IN COMMUNITY-BASED HEALTH PROMOTION PROGRAMS

Community-based health promotion programs have different stakeholders including community members and various professionals from different organizations and institutes.

Community engagement ensures that local agendas are accommodated within local and national programs (Laverack and Keshavarz, 2011). However, there have been many challenges to involving community and developing partnership between community and professional partners including issues of mutual trust, power imbalances, disparity in resources and capacity of partners (Mosavel et al., 2005; Freeman et al., 2006). In addition to the complexity of engaging communities, inadequate knowledge, and attitude towards and skills of working successfully with the communities among professional stakeholders makes the task of developing partnership with community a difficult task (Laverack and Keshavarz, 2011). Moreover, some researchers argue that more evidences are needed to show the efficiency and effectiveness of community engagement approaches in different contexts (Tse et al., 2010). In developing countries, compared with developed countries, there may be additional challenges such as lack of commitment by policy-makers and decision-makers to engage the stakeholders, literacy issues and cultural and communication barriers (Kobetz et al., 2009; Malekafzali et al., 2011, 2004).

Reviewing community-based programs and also participation and partnership literature, it seems that often the focus of studies has been on community part of the participation and partnership rather than professional and organizational part of the mutual collaborations. Successful community-based programs and research needs motivation and competency in both sides, community and professional stakeholders of the program and at both levels of individuals and systems.

This paper reports part of a PhD study about community participation in health promotion programs. It focuses on challenges of participation by exploring experiences and perspectives of different professional stakeholders of Community-Based Participatory Research (CBPR) projects conducted by the Population Research Centers (PRCs) in Iran. This paper tries to identify what factors concerning quality, quantity and sustainability of community participation in base health programs influence policy-makers and managers (mainly academics). It does not investigate the factors influencing participation from members of the community. Successful community-based programs and research need motivation and competency by both community and professional stakeholders of the program and at system and individual levels of participation.

COMMUNITY-BASED PARTICIPATORY RESEARCH

CBPR as one form of participatory research is defined as ‘a collaborative approach to research,
which equitably involves all partners in the research process and recognizes the unique strengths that each brings’ [(Minkler and Wallerstein, 2003), p. 3]. It begins with a research topic of importance to the community and assumes that participants have much to suggest and that they should be collaborators in the research process. Based on a broad review of the literature, Israel et al. (Israel et al., 2003) have recognized key principles of CBPR: CBPR identifies community as a unit of identify; facilitate equitable engagement of all partners in all phases of research; promote co-learning and capacity building; integrates knowledge and intervention for mutual benefit of all partners; disseminates findings and knowledge gained to all partners and involves them in the dissemination process. CBPR reinforces community capacity building and engagement of the community in all phases of the research (Israel et al., 2005). This method aims to shift from the professionals’ control on decision-making power to a shared relationship with community representatives to achieve priority setting mechanisms, and so more successful health interventions and community-sustaining changes (Leung et al., 2004). Collaboration of different partners increases their understanding of health, social and cultural community issues and helps to integrate knowledge gained with action for improving community members’ health (Minkler and Wallerstein, 2003). CBPR has been conducted in many countries on many aspects of public health (El Ansari et al., 2002; Meyer et al., 2003; Puoane et al., 2004; Schneider et al., 2004; Keshavarz et al., 2009).

**PRCs IN IRAN**

Iran, a Middle Eastern country, with >76 million people is the 17th largest country in the world (Statistical Center of Iran, 2011). It is estimated that 92.4 of the Iranian adult population are now literate (Statistical Center of Iran, 2011). The territory is subdivided into 31 provinces and 402 cities. Regarding the health system, at the national level, Ministry of Health and Medical Education (MOHEME) is responsible for planning, monitoring and supervision of health-related activities for public and private sectors. The ministry delegates its power to medical universities across the country. Therefore, at the provincial level, the universities of medical sciences and health services are the most significant government institutes in charge of health. Iran has made remarkable progress in the health sector with much improvement in various health indicators (Movahedi et al., 2008). According to WHO report (WHO, 2013), the life expectancy was estimated to be ≏73 in 2011. Currently, cardiovascular diseases and road injuries are the main causes of mortality (Mehrdad, 2009).

Engaging communities in public health programs, especially in rural areas have more than three decades history in Iran. Currently, trained and paid community members (male and female) work in primary healthcare networks in Iran as community health workers. They run ‘Health Houses’ in rural areas (Tavassoli, 2008). In Urban areas trained women from the community contribute to the health systems as community health volunteers (Ansarifar, 2009). Community-based initiatives as an approach to developing healthy cities and villages also have a long history in Iran (WHO, 2008). Currently, community-based drug abuse prevention also is implemented in many cities (Keshavarz et al., 2009). But, involvement of community in research started from just more than a decade ago. In 2001, MOHME established 13 PRCs, which over time increased to >30 centers across the country. After establishing PRCs, these centers and their missions were introduced to the community through lectures in local community settings such as mosques. The vision of PRCs consists of three parts: (i) to enhance community involvement in health promotion activities toward the ultimate goal of human development; (ii) to adopt community participation and empowerment strategies and (iii) to lead research for development. These centers adopted CBPR as an approach to tackle health-related issues of local communities through capacity development and empowerment of the beneficiaries with human and social development goals (Majdzadeh et al., 2009).

According to the MOHME guideline (Bahraini, 2005), PRCs were established within urban communities with low- to middle-socioeconomic status and stable population turn over and also with the history of social participation and volunteer activities. Each PRC covers 1200 household. The communities covered by PRCs are homogenous in terms of ethnicity and access to health centers. Centers have similar organizational structure, and are formally connected and supervised by local universities of medical sciences (Majdzadeh et al., 2009).

Each PRC is directed by a faculty member of the local university and a steering committee.
with participation of community members and program managers and/or their representatives from different local organizations including academic researchers from universities, managers of health sectors and representatives of social organizations (Bahreini, 2005). The roles of steering committee include coordination and communication across social organizations involved in the center’s affiliated projects, mobilizing resources, reviewing the CBPR projects and also capacity building in the communities but by academic members of the committee. Although all members of the committee have the decision-making right, but leadership power of the committee belongs to the researcher from the university. For example, in case the committee could not reach an agreement, the researcher from the university will make the final decision. The centers are staffed by a general practitioner, a public health officer and a nurse with master degrees. An office in the Ministry of Health, manages the overall function of all centers across the country. Recently, they have been renamed to Social Development and Health Promotion Research (SDHPR) centers (Bahreini et al., 2005).

The first step after establishment of the center and forming the steering community is conducting a participatory need assessment with involvement of local community representatives to determine the type of issues any PRC should be focused on, or at least to start with. After identifying community health issues, participatory projects are developed and implemented. However, in practice, some of conducted projects did not meet required principles of participation and partnership. In other words, the level of community involvement was not satisfactory in different phases of the participatory research as expected and demanded.

METHODS

The study partially reported here was a qualitative study with explanatory nature aimed at identifying professional stakeholder’s perspectives and experiences toward the partner’s engagement challenges in CBPR community-based participatory research conducted in PRCs in Iran. Sampling population was CBPR projects conducted by PRCs across the country. A purposeful sampling methodology was adopted. In this study, we focused on those projects that met the following criteria: (i) they involved partners in all stages of the programs (conducting a participatory needs assessment) (ii) they developed the research proposal in a participatory manner (iii) the names of local people were listed in the initial proposals and final reports of the project. (iv) They had to be started 6 months before the beginning of this study. Accordingly, five projects from three cities of Tehran, Zanjan and Kashan were chosen (see Table 1) (Golami et al., 2007; Jamshidi et al., 2008; Kamal et al., 2008–2009; Khorsanifar et al., 2008; Under Secretary for Research of Zanjan Medical University of Medical Science, 2008). The focus of these projects included recycling, rubbish disposal, reproductive health, motorcyclist safety and women’s sport (see Table 1). Ethics approval was granted by the University of the Medical Ethics Committee of the Ministry of Health and Medical Education and the Ethics Committee of the Putra University of Malaysia.

The participants in this study were recruited using purposeful sampling. As the experiences and challenges of professional partners’ participation at the implementation level may vary significantly with the top managerial level, professional stakeholders were selected at two levels. The first level was the local level, including professional stakeholders of selected projects that entered this study. The second level was the national level including mangers and decision-makers in charge of managing PRCs in Research and Technology Assistant Office of the Ministry of Health (key informants people). The sampling process contributed to the diversity of the participants including university researchers working with the centers, directors of the centers, the research deputies of the medical universities which the center was affiliated with and representatives of social organizations working with the centers. Sampling was ceased with 17 participants from the centers and 4 individuals from the Ministry of Health when the interviewer fund out that saturation had been achieved (Strauss and Corbin, 1998).

Among qualitative methods for data collection, semi-structured interview methodology was chosen as the most appropriate approach. This offered the required flexibility of enquiry to examine the experiences and perspective of participants toward community engagement (Minichiello et al., 2004). During the data collection and analysis, ethical considerations were observed by written consent letter, considering privacy of the information as well as the name of the interviewee in all stages of the research.
Table I: Selected projects and participant’s information

<table>
<thead>
<tr>
<th>Project name</th>
<th>Main social organizations involved</th>
<th>Groups of community involved</th>
<th>Affiliated participants</th>
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<tbody>
<tr>
<td>The Effect of the Community Involvement and the Collaboration of the Organizations on Recycling the Rubbish from its Source in District 3 of Kashan City</td>
<td>SDHPR Center of Kashan Medical science university of Kashan Municipality office of Kashan</td>
<td>Women volunteer, Students, local Housewives</td>
<td>$n = 4$ (an academic researcher, one researcher and one staff member of PRC and the head of PRC)</td>
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<tr>
<td>The Role of Making a Health Path for the Motorcyclists through Community Involvement from the Ata Entrance to the Basij Square in Reducing the Motorbike Accidents in Kashan</td>
<td>SDHPR Center of Kashan Medical science university of Kashan Driving and Traffic Office of Kashan</td>
<td>Local community members, Basij (a social organization)</td>
<td>$n = 4$ (an academic researcher, one researcher and one staff member of PRC and the head of PRC)</td>
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<tr>
<td>Improving Participation of Local Female in Exercise Program through intersectoral Collaboration in Women living in the District Covered by the SDHPR Center of Kashan</td>
<td>SDHPR Center of Kashan Medical Science University of Kashan Physical Education Organization of Kashan</td>
<td>Local community members, women volunteers</td>
<td>$n = 3$ (an academic researcher, one researcher and staff member of PRC and the head of PRC)</td>
</tr>
<tr>
<td>The Effect of the Adolescents’ Involvement on Organizing and Promoting the Proper Culture of Rubbish Disposal in the District of Islamabad in, Zanjan-Iran</td>
<td>SDHPR center of Zanjan Medical Science University of Zanjan Municipality office</td>
<td>Local community members, local students</td>
<td>$n = 3$ (an academic researcher, one researcher and staff member of PRC and the head of PRC)</td>
</tr>
<tr>
<td>Preparing Multimedia Packages on the Reproductive Health with the Involvement of the local Adolescents in District 17 of Tehran</td>
<td>SDHPR center of Tehran Municipality office of Tehran</td>
<td>Local adolescents</td>
<td>$n = 3$ (an academic researcher, one researcher and staff member of PRC and the head of PRC)</td>
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Activities performed by community in all selected projects:
- Participation in defining the research goals and activities
- Participation in writing the research proposal and final report
- Participation in committee meetings
- Participation in mobilization of resource
- Participation in implementation (collecting data, designing, preparing, presenting and distributing educational materials and . . .)
processes and voluntary participation in this study. All participants were interviewed individually by the first author; each interview lasted from 50 to 70 min. The interviews were audio-taped and transcribed verbatim into textual data by the first author. Interview transcriptions provided a rich source material for analysis.

The Qualitative content analysis method then was performed on transcription by using the Graneheim and Lundman’s content analysis approach (Graneheim and Lundman, 2004). By line-by-line study of the transcriptions, the meaning units (codes) were identified and labeled. Then categories were constructed by categorization of the codes based on differences and similarities into categories (Krippendorff, 2004). To establish credibility, the researcher considered member checks, peer examination and data or sources triangulation (Denzin and Lincoln, 2000). To ensure transferability, firstly, the sample was clearly and adequately defined through determining the inclusion and exclusion criteria, and secondly, the researcher endeavored to collect deep and thick description through creating an interview guide with open-ended questions. Moreover, an independent rechecking of the transcription, codes and emergent categories was employed to achieve dependability and conformability of the data simultaneously.

The sections below summarize the results as a means to better understand ways in which effective participation of partners in participatory efforts could be enhanced in Iran. Quotes from participants were selected to provide an example of the type of responses we received, and/or to illuminate a general theme emerging from the analysis. The quotes are not intended to provide a fully representative description of the interviews.

RESULTS

The study identified several perspectives and experienced challenges in regards to stakeholder’s participation in community-based health promotion projects as factors which could affect the nature, sustainability and success of the programs. In all five projects that constituted the context of this study, there were a number of challenges that faced developing true partnership between professional partners and community members. There were some similarities and also differences between experiences and perspectives of two levels of stakeholders and also among different individuals from different research centers which will be highlighted in following section. The main difference between the top managerial level and implementation level was the interviewees’ perspectives and experiences regarding the degree of complexity of developing partnership in CBPR projects. Those working in the field much more often talked in details about the practical challenges and barriers. Here, the results of the study including the experienced challenges and applied solutions (summarized in Table 2) are presented in three main categories as, partnership relationship and trust issues, partnership’s individual level issues and partnership’s systems level issues.

**Partnership’s relationship and trust issue**

Many interviewees acknowledged the difficulty of development and sustaining of effective communication between different partners involved in CBPR. They affirmed that there is not adequate and conceivable communication between academician and community: ‘We don’t speak to people in a way that they can understand us . . . and don’t make them informed of the issues related to their health and society’ (Key informant from MOHME). One of the interviewed researchers from a PRC mentioned, ‘We still need to have a discourse between the people and us in order to reach a mutual understanding of the health issues’. Some of participants believed that working with community required certain communication skills that they had not already developed in their academic training. A GP who was staff of PRCs and worked as a research assistant said: ‘In the training period at General Practice, I got familiar with participation to some extent, but I did not have any applied course regarding the communication skills in community partnership . . . . I as a physician did not know at all how to speak to the community with their own language’.

Many of participants believed that inappropriate communication led to ineffective relationship and also inadequate or even lack of ‘trust’ between partners. They believed the quality of relationships influenced the quantity, quality and sustainability of engagement of community members as well as professionals. Majority of interviewed researchers and representatives of social organizations emphasized that lack of trust between partners especially at the beginning of the project was an important challenge that without solving it, to start a participatory project
<table>
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<tr>
<th>Themes</th>
<th>Partnership relationship and trust</th>
<th>Partnership individual issues</th>
<th>Partnership systems level issues</th>
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<tr>
<td>Challenges</td>
<td>Inadequate mutual trust</td>
<td>(1) Inadequate capacity of community members: Inadequate capability for collective activity Inadequate belief the in value of working with experts Inadequate communication skills Inadequate special literacy related to civil rights and health issues associated with the project Inadequate knowledge, attitude, motivation and skills Previous negative experiences (2) Inadequate capacity of professionals: Inadequate knowledge regarding CBPR methods Inadequate skills for working and communicating with community Inadequate belief in value of engaging community and participatory work</td>
<td>Management high speed changes Top-down management style Lack of certain organizational structure for intersectoral collaboration and engaging communities Inadequate value and priority for participatory work with community and/or other partners institutional Lack of supportive evaluation system Lack of shared responsibility and accountability by social organizations for community health Conflict of organizational or individual interests and priorities of professional partners with those of community</td>
</tr>
<tr>
<td>Solutions</td>
<td>Developing communication skills</td>
<td>(1) Capacity building for community members: Running workshops Involving experienced volunteers (2) Capacity building for professionals: Developing required individual capacities (training, motivation and opportunities) Running participatory research Monitoring the implementation of projects by experts of national office of CBPR in Ministry of Health</td>
<td>Developing required systems capacities for all organizational partners including development of: Participatory management style Supportive value system Shared accountability and responsibility Stability of organizations Organizational structure for participatory planning and intersectoral partnership Value system for participatory research and programs training opportunities Better communication through dialogue and developing projects based on common needs of community and social organization</td>
</tr>
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</table>
could be impossible. Participants stated that ‘trust’ between partners was itself influenced by the community members’ attitudes toward researchers and the organizations inviting them to get engaged in research projects. This sometimes was influenced by their previous experiences. One participant with master degree in nursing working in PRCs stated: ‘The community’s distrust in us was a barrier towards their engagement. Because (in past) some of the researchers had collected information and blood samples for the project of Healthy Heart, and local community had not observed the result of their engagement’.

To solve the issue of ineffective relationships and to develop trust, academic partners explained that they had utilized some techniques such as running short-term projects before conducting main projects, developing active interactions with community through meetings, hiring community volunteers. One participants who was the head of one of PRCs stated: ‘I trained voluntary women in the local health center and used them to teach the local community because the local people knew them and trusted them… well this group got along with the people very well.’

**Partnership’s individual issues**

The findings showed that most of participants believed that for the success of partnership in CBPR projects, some kind of capacities, both within the community members and as well as professional partners of the programs were required. Absence of these capacities was considered as challenges in partnership. For community members, capacities such as ‘capability for collective activity’, ‘belief the in value of working with experts’, ‘communication skills’ and ‘special literacy related to civil rights and health issues associated with the project’ were identified by some participants as necessary. One participant who was an academic staff stated: ‘We shouldn’t leave the door of the SDHPR center open and offer everybody to come in and participate… Well, it is necessary to have certain abilities… I don’t think we can invite the people who have just passed needs assessment workshop and a research methodology course to come and involve in CBPR project. I believe that people must be of the team work type’.

To deal with community’s inadequate capacity, some of researchers ran workshops for the community or they involved experienced volunteers as a capacity building strategy in community as one of the academic staff stated: ‘In my project (women’s sport), I chose the Women Volunteers because they had years of experiencing such shared activities and they had a series of abilities to get in touch with the society’.

For professional partners, capacities identified necessary to be able effectively engage in participatory community-based projects included ‘enough knowledge regarding CBPR methods’, ‘skills for working and communicating with community’ and ‘recognition the value of engaging community and participatory work’. Participants argued that inadequacy of these capacities had root in inadequate academic training which had led to applying inadequate or inappropriate strategies for encouragement of the community. One of the participants who was head of PRCs said, ‘For lack of enough experience and knowledge of CBPR, I resorted to inappropriate financial persuasion to improve the local youth’s engagement, which I could not continue. This resulted in the community’s distrust in me’. One of the participants who was Key informants from MOHME stressed on the importance of manager’s attitudes toward participatory work ‘If the manager did not have a positive attitude towards the participatory project, there would not be enough support of the project and the support would be always temporary’.

Although participants refereed to some existing strategies to improve capacity of professional partners (mainly academic researchers) such as running participatory research methodology workshops, monitoring the implementation of projects by experts of national office of CBPR in Ministry Of Health, but they considered these strategies to be inadequate. Most professionals at the level of centers believed that they needed more formal training in CBPR and more visit of projects field in which true CBPR approaches were in place.

Recognition of community members by researchers and other professional partners was an important factor that had affected the level of the community member’s engagement and also partnership between community and other professional stakeholders. Moreover, results showed that the value attributed to the level of the community’s recognition by the stakeholders was different at different stages of the project and according to the diverse perspectives of different professional stakeholders. Some of the professionals believed that the community can and should engage mainly in the implementation stages of the project as administrative work forces, not in proposal writing.
and in the publication of research findings. But those stakeholders, who had specialized in health science disciplines, believed that community should also participate in the stages of needs assessment, planning and the implementation of the participatory project and so, they had engaged community in all stages of their project.

**Partnership’s systems issue**

According to the findings, in addition to capacity of individuals, systems level capacity or organizational capacity for partnership with community or other organizations also was an important issue that was believed to have influences on developing the collaboration between partners and also the continuation of developed collaboration. They believed these capacities did not exist adequately. The most frequently mentioned issues included ‘lack of certain organizational structure for intersectoral collaboration and engaging communities’, ‘institutional evaluation system’, ‘Inadequate value and priority for participatory work with community and/or other partners’, ‘lack of shared responsibility and accountability by social organizations for community health’, ‘management high speed changes’, ‘top down management style’ and ‘conflict of organizational or individual interests and priorities of professional partners with those of community’. Head of one PRC stated ‘Sometimes the organization cooperated with us, and... sometimes it didn’t... It takes time to attract the organizations for cooperation... Sometimes we have to go to the organization several times to follow our letters. I see no place for the people in the system of decision making in health care system,... we don’t receive the full support of the managers’. Other researcher working in a PRC explained ‘The cooperation of the organization was based on the interest of the managers and not on the organizational duty... Most of the time, the cooperation was temporary’.

Lack of a certain organizational structure for community participation within the governmental organizations was identified as the reason for discontinuation of established relationship beyond the projects as one participant who was researcher and staff of PRCs explained ‘As the our project (devising multimedia packages) was over, our cooperation with municipality was over, too. There is no regulation for the sustainability of cooperation’. As mentioned above, fast rate changes in the structures and the management of the organizations was also identified as a significant challenge ‘When the managers are replaced, to justify the new ones for cooperation takes time, and sometimes it lasts for days and weeks, this results in the obstruction in the project administration’.

The institutional evaluation system in organization, particularly in universities was identified as an influencing factor on motivation of faculty members to engage in community-based projects. Participants who were faculty members explained that the current evaluation system for their promotion was mostly based on publications which was harder to make by participatory research. One of the academic staff said, ‘To give me a rank, my boss asks me a paper. I should be looking for a project from which I can more quickly extract a paper based on its results... but you see, CBPR projects are very time consuming and, sometimes, impossible to be published easily’. Other participant who was a researcher and staff member of the PRC said, ‘When our center (SDHPR center) ranked the second in the development of the participatory projects based on CBPR, I felt no feeling of honor...the heads of our university didn’t show any sign of appreciation of my colleagues and me’. To develop collaborative projects, from participant’s point of view, it was identified necessary that institutional evaluation system value their participatory research activity.

Most of participants realized that it was not possible to address all institutional challenges in short term, especially in the context of centralized, top-down organizations. However, some of the participants suggested that steering committees of CBPR could bring about more accountability on the part of the organizations if organization’s representatives with full responsibility be members of these committees. Moreover they pointed out that developing better communication through dialog and developing projects based on common needs of community and social organization were effective to deal with institutional issues and lead to greater support from organizations as one of the academic staff said ‘You know this project (recycling projects) has somehow touched the shared needs of the community and the organizations. It was like the municipality had some contribution to determining the financial sources’.

**Limitations of the study**

This study only explored perspectives and experiences of professional partners in some
community-based research centers in Iran, hence our findings cannot be (and were not to be) generalized to all professional partners of CBPR in Iran. The findings of this study need to be further tested both using qualitative and quantitative methods to identify other type of experiences and perspectives and also measure the frequency of each type of perspectives and experiences if it is to form the base of future interventions. However, yet the findings of this study have the potential to lead us to better understanding of the importance of the need to develop professional partner’s individual, organizational as well communicational capacities which not only influence on the quality of their engagement, but also on the success and sustainability of community engagements for health promotion.

DISCUSSION

Table 2 summaries the main themes which emerged from findings of this study as experienced challenges in partners’ engagement from professional perspectives and suggested or experienced solutions.

The current international data suggest that quantity and quality of collaboration between partners and the nature of their engagement can be influenced by various factors. As previously noted in the literature, ‘trust’ and developing ‘communication’ were acknowledged as important factors that influenced the partners relationship (Israel et al., 2001; Shiu-Thornton, 2003; Avis et al., 2007). Trust is a bi-directional issue based on experience and relationship (Ahmed et al., 2004). It seems that when people, whether as community member or professionals, achieve what expected from their partnership in an acceptable timeframe, they can trust better. These expectations may include information, money, services, respect, commitment, recognition or some kind of feedback. One of the factors negatively influenced trust building process in many community-based programs in Iran (Bahreini et al., 2005), including those entered this study, was previous negative experiences of unmet expectations, whether realistic or unrealistic. So, it is important to develop strategies to make sure unrealistic expectations are not developed among the partners, and produced realistic expectations are met. In addition, it appears that unfamiliarity with people, program or the nature of participatory work also prevents developing trust. Hence, it is very important to pay attention to the way of introducing programs and building good relationship between partners. Selecting community members with strong interpersonal skills and knowledge of the community as a strategy for trust building and facilitating relationship among the partners have proved to be effective (Reid and Viana, 2001; Strickland, 2006). This study showed that in Iranian context, this strategy was also effective. The other issue in trust building process, regardless of the level of familiarity or trust in people and program, is partner’s trust in ‘partnership’ as an effective way of solving community health problems. If people believe there is no benefit or outcome in partnership for a specific issue, trust building would be more time consuming and difficult.

As dominant management style in many organizations in Iran is a top-down approach, professionals are more used to or encouraged to apply top-down program planning and implementation, even when they work with community and are to work participatory. In addition, the lack of adequate training regarding to community based and bottom-up and participatory programs among researchers and program managers has contributed to the challenge of working effectively and participatory with communities (Keshavarz et al., 2009).

The present work further showed that, from professional partner’s perspective, not only individual capacities such health literacy, team work attitude and skills and communication skills are required by both side partners in participatory community-based programs, systems level capacities are also needed to support initiation, sustainability and effectiveness of partnerships for promoting community health. Among the identified important capacities was stability of organizations, organizational structure for participatory planning and intersectoral partnership, existence of value system for participatory research and programs, training opportunities, accountability. To employ the participatory approach, researchers require additional skills such as strong communication skills, organizational skills, team development, conflict resolution, capacity to operate within different power structures, power sharing and modesty (Garwick and Auger, 2003; Barker and Klopper, 2007). Several other studies in Iran, also suggest that many of such capacities are not adequately developed in many community-based programs in Iran (Khadivee and Khosrvi, 2004; Behdjat et al., 2009; Keshavarz et al., 2009).
et al., 2009; Moshki et al., 2009). Some international research have also reported lack of adequate capacity of partners as a barrier for effective collaboration in community-based research (Balcazar et al., 1990; El Ansari et al., 2002) or community health programs (Delgado-Gallego and Vazquez-Navarrete, 2006). Communication skills, as one of main required capacities for partners in CBPR, have also been highlighted in the international literature (Jones and Wells, 2007). For example, Mosavel et al. (Mosavel et al., 2005) while exploring the CBPR in South Africa, found that the communication difficulties between community members and professional stakeholders negatively affected partner’s participation. Similar findings reported by Strickland (Strickland, 2006); Avis et al. (Avis et al., 2007) and Viswanathan et al. (Viswanathan et al., 2004).

Inadequacy of above-mentioned capacities, such as top-down planning approaches (Blackburn and Holland, 1998), inadequate organizational structure, process, policies and value system for participatory research (Polanyi and Cockburn, 2003; Seifer et al., 2003), organization’s inflexible structure for power sharing (Shoultz et al., 2006), have been experienced in other countries as negative factors with significant impact on professional participation in community-based programs.

In case of Iran, it should be noted that, perhaps unlike to many countries, some important national level capacities, such as funding and infrastructures including place, staff and policies for community-based programs, have been developed by Ministry of Health. It seems that, as a review of community-based health promotion programs in Iran showed (Keshavarz et al., 2009), the need for a participatory bottom-up approach has been more a perceived need of few national top managers of Ministry of Health, especially within the deputy for research, rather than collective perceived need or demand by communities or even public health practitioners or academic researchers. As a result, professionals have been lagging behind, not fully prepared to take up the opportunities (Keshavarz et al., 2009). After a decade, still there is limited official training or academic courses in regard to required competencies for working and partnering with community to pursue health. So, many programs suffer from theoretical or methodological weaknesses which limit the success of partnership and its outcome, no matter how enthusiastic are both side partners to work with each other. This, as discussed before, may produce negative experiences and, unpleasant previous experience of partnership which negatively influences future collaborations. Another point to take into account is that these infrastructures including policies and resources for community-based programs have been developed in few organizations such Ministry of Health and not all other organizations which their partnership is essential for community health. Hence, professionals from other organizations face more challenges and have much less individual and organizational capacities for effective partnership. This, in its own turn, will negatively influence on satisfaction of health professionals from their collaboration with external agencies and partners.

Laverack and Keshavarz (Laverack and Keshavarz, 2011) suggest four key challenges still remains for the future of strengthening community actions programs: (i) engage communities to share priorities; (ii) build community capacity; (iii) mechanisms for flexible and transparent funding and (iv) being creative in order to expand or replicate successful local initiatives. The key to this is to use standardized approaches for community engagement during the planning process. It is obvious that competent, committed, ambitious and supported professionals can achieve more success in difficult task of engaging community in collaborative efforts to promote health by using standardized, evidence informed approaches.

CONCLUSION

Studying the perspectives and experiences of professional stakeholders involved in the CBPR projects conducted by PRCs in Iran, provided useful information about the challenges and potential solutions for identified challenges they experienced during collaborative research partnerships with the community. Challenges in most part related to the issue of communication and capacity, both at individual and systems levels as prerequisites of developing effective partnership among partners in a participatory and community-based health promotion program. Although CBPR in Iran benefits from more than a decade history, and some infrastructures, but it seems that for a variety of reasons, public health experts and researchers and other partner organizations are lagging behind in terms of capacities and competencies required to effectively utilize the available structure and opportunities. Hence, capacity development, both among
professional partners and community, with a holistic perspective may be the main way forward to tackle the future challenges for strengthening community actions but should include both levels of individuals and systems.

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