Building policy capacities: an interactive approach for linking knowledge to action in health promotion

ALFRED RÜTTEN* and PETER GELIUS
Institute of Sport Science and Sport, University of Erlangen-Nürnberg, Gebbertstraße 123b, 91058 Erlangen, Germany
*Corresponding author. E-mail: alfred.ruetten@sport.uni-erlangen.de

SUMMARY
This article outlines a theoretical framework for an interactive, research-driven approach to building policy capacities in health promotion. First, it illustrates how two important issues in the recent public health debate, capacity building and linking scientific knowledge to policy action, are connected to each other theoretically. It then introduces an international study on an interactive approach to capacity building in health promotion policy. The approach combines the ADEPT model of policy capacities with a co-operative planning process to foster the exchange of knowledge between policy-makers and researchers, thus improving intra- and inter-organizational capacities. A regional-level physical activity promotion project involving governmental and public-law institutions, NGOs and university researchers serves as a case study to illustrate the potential of the approach for capacity building. Analysis and comparison with a similar local-level project indicate that the approach provides an effective means of linking scientific knowledge to policy action and to planning concrete measures for capacity building in health promotion, but that it requires sufficiently long timelines and adequate resources to achieve adequate implementation and sustainability.

Key words: capacity building; knowledge translation; policy development; physical activity

INTRODUCTION
Since the late 1990s, there has been a growing debate on evidence-based medicine that stimulated further attempts to strengthen the evidence base of public health (Ham et al., 1995; WHO, 1998; UK Cabinet Office, 1999). Issues of ‘evidence-based policy’ and linking scientific knowledge to policy action became increasingly important for both public health policy and public health research. Many recent approaches for linking knowledge to action build on Carol Weiss’s (Weiss, 1979) early distinction of different models. Various authors agree that the linear rationality of traditional ‘knowledge transfer’ models (for example knowledge-driven and problem-solving models) is least appropriate (Black, 2001; Nutbeam, 2003; Davies et al., 2008). Instead, there is a broad consensus that research is ‘most likely to influence policy development through an extended process of communication and interaction’ (Brownson et al., 2009). This, they argue, requires an interactive model of knowledge to action (Nutley et al., 2007).

Different interactive models linking knowledge to action have been discussed in the last decade. For example, concepts of ‘knowledge brokering’ (CHSRF, 2003; van Kammen et al., 2006), ‘policy/social entrepreneurship’ (Drayton et al., 2006; Christopolous and Ingold, 2010) and ‘evidence-based advocacy’ (Brownson et al., 2009) have been recommended and applied to improve processes of linking knowledge to action in public health. The Canadian Institutes of Health Research (CIHR) have been particularly...
supportive in the development of an interactive approach to ‘knowledge translation’. They provided several casebooks with practical examples and ‘knowledge translation stories’ (CIHR, 2006a, 2006b, 2008, 2010).

However, the term knowledge translation has also come under criticism lately, among other things for being no more than a ‘nod towards aiding intelligibility’ to the knowledge transfer model and for limiting thinking to the field of medicine [(Davies et al., 2008), p. 188; Greenhalgh and Wieringa, 2011]. New terms such as ‘knowledge interaction’ and ‘knowledge intermediation’ have been suggested instead (Davies et al., 2008). Others have taken a social constructivist perspective [see also (Kontos and Poland, 2009; McWilliam et al., 2009)] or have employed nexus theories (de Leeuw et al., 2008; Jansen et al., 2010). In this article, we use the term ‘interactive knowledge to action’ to underline both the interactivity (knowledge exchange) and the intentionality (scientific knowledge to policy action) of the process but to avoid some of the problems associated with the term ‘knowledge translation’.

The importance of understanding the policy context as a prerequisite for understanding the conditions for the utilization of scientific evidence in policy-making was recognized early in the debate on evidence-based policy-making in public health (Lomas, 2000; Black, 2001). Several ‘influencing factors’ were identified, such as values and belief systems of policy-makers (Lomas, 2000; Bowen and Zwi, 2005; Exworthy, 2008). ‘Politics’ (for example the influence of public mood, interest groups and election results) and ‘policy windows’ were also highlighted as crucial contextual factors for research utilization in policy-making (Exworthy, 2008; Brownson et al., 2010).

However, if context is so important for the utilization of scientific knowledge, how can researchers interact with policy-makers in order to create more favorable contextual conditions for knowledge exchange, common knowledge creation and for linking scientific knowledge to policy action? There are few approaches that directly relate evidence-based policy-making to the idea of capacity building, that is enabling organizations to adopt (among other things) certain evidence-based policies. Examples include theories of diffusion of knowledge and organizational learning (Greenhalgh et al., 2004), organizational frameworks for ‘more effective knowledge transfer’ (Lavis et al., 2003) or Bowen and Zwi’s approach to an ‘evidence informed policy and practice pathway’ (2005). However, even theories that highlight the ‘capacities required for policy adoption and adaptation’ (Bowen and Zwi, 2005) rarely connect capacity building and interactive ‘knowledge to action’ in a truly systematic and theory-driven manner.

This article attempts to address some of the gaps in the current debate on ‘knowledge to action’ and ‘capacity building’ from the theoretical level and the praxis of building policy capacities. First, we present an interactive model for engaging policy-makers and stakeholders from different sectors and organizations in a process of knowledge exchange with scientists, which aims to improve the capacities of participating organizations. In a second step, we introduce a regional-level physical activity promotion project involving NGOs from various sectors, a regional ministry and university researchers as a case study to test the potential of the co-operative planning process for capacity building. Section three briefly describes the methods used to assess the effects of the process, including (participant) observation, qualitative interviews and an online survey. Sections four and five present the results of the analysis and compare them to experiences from a similar project at the local level. We conclude that our concept provides an effective means for linking knowledge to action and capacity building in health promotion. However, the approach requires sufficiently long timelines and adequate resources to achieve adequate implementation and sustainability.

Conceptual framework: connecting policy ‘capacity building’ and ‘knowledge to action’

This section will outline a theoretical framework for an interactive, research-driven approach to building policy capacities in health promotion. We will illustrate how two important issues in the recent public health debate, ‘knowledge to action’ on the one hand and ‘capacity building’ on the other hand, could be connected to each other both theoretically and in practice.

The research project on which this article is based employed a concept of linking research and policy-making that shares some characteristics with models of ‘interactive’ or ‘integrated knowledge translation’, as put forth, for example,
by the Canadian Institute of Health Research (CIHR, 2008). One explicit goal of the project was to make scientific research on policy capacities ‘applicable’ to and ‘useful’ for policy development.

We recognize, however, that the term ‘knowledge translation’ has come under criticism lately, and we share some of the concerns regarding this concept. For example, Greenhalgh and Wieringa (Greenhalgh and Wieringa, 2011) argue that the ‘knowledge translation metaphor’ is too restrictive to adequately conceptualize exchange processes outside of medicine, and that it is based on the faulty assumption that knowledge is objective and can be separated from those who produce and apply it. Researchers from different backgrounds have proposed a number of alternative terms, including ‘knowledge exchange’ (Contandriopoulos et al., 2010), ‘knowledge interaction’ and ‘knowledge intermediation’ (Davies et al., 2008).

In particular, we agree that the term ‘knowledge translation’ may lead to the perception that the gap between research and policy-making is mainly a language issue that can be bridged simply by ‘interpreting’ between the different idioms. It may also support notions of a strict separation of the worlds and ‘cultures’ of science and policy-making, with the former ‘blessing’ the latter with its knowledge.

To a certain extent, we also endorse a social constructivist perspective on the interplay between research and policy-making. We agree that the link between knowledge and action may mainly reflect the ‘socially constituted patterns’ of social interaction. As such, it involves different actors (e.g. researchers, policy-makers) and deals with different contents (e.g. research evidence), contexts (e.g. belief systems of actors) and processes (e.g. knowledge to action interventions) [see also (Kontos and Poland, 2009; McWilliam et al., 2009)]. Among others, recent work on nexus theories should be mentioned here. It conceptualizes scientists, practitioners and policy-makers as equal partners and tries to identify ways to better connect them (de Leeuw et al., 2008; Jansen et al., 2010).

However, we do not support more radical constructivist points of view, in particular those that suggest that the entire knowledge to action approach is a misleading construct. As Nutley et al. [(Nutley et al., 2007), p. 122] point out, ‘postmodern accounts reject the conceptual separation of research from policy or practice. This means that it makes no sense to view research knowledge as something distinct from practice or policy knowledge’. Instead, the general role of knowledge is modified from ‘true representations of reality’ to a ‘functional fit’, to a means of adaptation to a given environment [(Glaserfeld, 2001), p. 9]. This perspective might be relevant in theory, but neither can it serve as an appropriate conceptual framework for ‘applied policy research’, nor does it provide a feasible strategy for improving the evidence base of policy-making in public health.

Against this backdrop, we would like to emphasize two elements of the ‘interactive knowledge to action approach’ that we use in this article. First, it focuses on aspects of social interaction and on the joint production of practical knowledge by researchers and policy-makers by means of a co-operative planning process. As a participatory action research approach, this co-operative planning process also reflects the interplay of contents, context and facilitation. Secondly, while we agree that knowledge does not simply follow a one-directional course from research into policy-making, the concept recognizes that one fundamental interest of scientists remains to make sure that the knowledge they have generated through their research gets incorporated into policy-making. The particular project discussed here intended to foster knowledge exchange between researchers and policy-makers by systematically focusing on the practical transformation of scientific evidence on building policy capacities into policy processes.

The term capacity building has been used in a number of fields, including developmental aid (UNDP, 2007), administrative sciences (Walter Honadle, 1981; Cohen, 1995) and community development (Casswell, 2001; Craig, 2007). For health promotion, Hawe et al. (1999) define capacity building as ‘building sustainable skills, resources and commitments to health promotion in healthcare settings, community settings and in other sectors [to] prolong and multiply health gains many times over’. In 2005, capacity building was one of the five ‘required actions’ called for by the Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005). Apart from theoretical research on the topic (Crisp et al., 2000; Brown et al., 2001; Bowen and Zwi, 2005; Bates et al., 2006), there have also been attempts to provide practical guidance on how to build capacities in health
promotion (NSW Health Department, 2001). Laverack (Laverack, 2003) identifies nine relevant domains for ‘building capable communities’ and demonstrates how a four-stage approach was used to build capacities in two communities in Fiji.

Our own concept of capacity building is based on the ‘Analysis of Determinants of Policy Impact’ (ADEPT) model of policy capacities (Rütten et al., 2011) and an interactive approach of linking knowledge to action called co-operative planning (Rütten, 2001). ADEPT was originally developed to analyse the determinants of policy impact and is based on Georg Henrik von Wright’s (1976) model of the determinants of human action. It uses four basic categories to define organizational capacities in health promotion (see Figure 1): (i) the goals of an organization with respect to a certain topic, including the degree of their specificity, (ii) the obligations of the organization and the degree to which they foster or inhibit involvement in a certain topic, (iii) organizational resources, including finances, infrastructures and number and qualifications of staff and (iv) opportunities, which fall into three sub-categories: organizational opportunities that pertain to internal changes within organizations (such as new decision structures or actors), political opportunities that arise from external changes in political and inter-organizational settings (such as new contacts and increased networking) and public opportunities that emerge from external changes in public awareness, engagement of the population or mass media interest.

The ADEPT model has been applied and tested by various projects and research groups. Examples include the ‘Methodology for the Analysis of the Rationality and Effectiveness of Prevention and Health Promotion Strategies’ (MAREPS) project (Rütten et al., 2003), which conducted a statistical test of the model based on 719 interviews with policy-makers from six European nations, and the ‘European Network for Action on Ageing and Physical Activity’ (EUNAAAPA) project, which employed ADEPT for interviews with 248 policy-makers from 15 European nations to assess policy determinants in the field of physical activity promotion for older people (Rütten et al., under review). In addition, the model has been used to measure the extent of adaptation of HIV prevention programmes during the implementation phase (Bowen et al., 2010), to study determinants for the implementation of guidelines for chronic obstructive pulmonary lung disease in clinical practice (Cheung et al., 2011) and to assess determinants of the engagement of volunteer organizations in local health promotion (Simonsen-Rehn et al., 2006).

The second element of our capacity-building approach is co-operative planning (Rütten, 2001), which has been used to guide the development of inter-sectoral partnerships between researchers on the one side and practitioners and policy-makers on the other. The Prince of Wales Business Leaders Forum identified the co-operative planning process as one of seven models of good practice for building inter-sectoral partnerships to create policy impact and build capacity, calling it the ‘academia-driven approach’ (Tennyson, 1998).

Theoretically, our approach is based on at least three different strands of research: it builds on fundamental assumptions of (participatory) action research (Lewin, 1946, 1968; Foote Whyte, 1991; Green et al., 1995; Springett, 2001). It refers to some fundamental assumptions of applied social science (Merton, 1949; Lazarsfeld et al., 1975), particularly on a specific ‘policy orientation’ in this field (Lasswell, 1951; Coleman, 1972; Lindblom, 1980), which has recently also been recognized in public health research (de Leeuw, 2005; Breton and de Leeuw, 2010; Rütten, 2011). It also fits with some fundamental assumptions of key theories of policy processes and policy change, such as the Advocacy Coalition Framework (Sabatier, 2007).

The process of co-operative planning comprises three phases (Rütten, 2001):

(i) In the initial phase, a scientific institution teams up with a ‘political’ partner to select the members of the future planning group.
Potential candidates include community stakeholders, policy-makers from executive and legislative bodies, representatives of NGOs, other researchers, city planners and others.

(ii) In the planning phase, the planning group conducts a series of four to five sessions to develop specific measures. The fact that researchers are, by profession, perceived as neutral actors in the policy process allows them to take a leading position in co-operative planning and act as moderators of the process. A general brainstorming (session 1) is followed by a prioritization of ideas and a definition of goals (session 2). In sessions three to five, specific actions to reach these goals are developed. The result is a catalogue of actions with a clear time frame, allocation of resources and distribution of responsibilities.

(iii) In the third phase, the catalogue of actions is implemented step by step under the supervision of the planning group. The scientific institution monitors the implementation process, identifying obstacles to a successful implementation of the catalogue and proposing measures to remove them.

The co-operative planning approach has been empirically tested in various studies. For example, it was used in a local health promotion action research project aimed at improving access to sport facilities for socially disadvantaged women (Rütten et al., 2009), empowering them through a co-operative planning process to become co-workers and co-deciders in the project (Rütten et al., 2008; Rütten et al., 2009; Frahsa et al., 2011). Most recently, Frahsa et al. (2014) have analysed to what extent participation in co-operative planning enables policy-makers and public health practitioners for health-promoting action and policy change.

While previous public health debates have independently stressed the importance of both capacity building and interactive knowledge to action approaches, it is also essential to connect them to each other in a meaningful way, both theoretically and practically. Interactive concepts concerning the interplay of science and policy might be useful for investigating the interrelationship of capacity building and linking knowledge to action. Co-operative planning is such an approach. It systematically fosters a knowledge exchange between researchers, policy-makers and other stakeholders, thus providing multiple opportunities for mutual learning. In particular, co-operative planning facilitates a practical transformation of scientific evidence on policy capacities into policy processes by addressing all four dimensions of the ADEPT model: (i) it specifies goals of participating organizations; (ii) it creates new obligations in the form of responsibilities and timelines; (iii) it re-allocates existing intra-organizational resources and identifies new funding sources; and (iv) it creates new political and organizational opportunities in the form of increased involvement of staff as well as intensified contacts and co-operation between organizations and sectors. Capacities may be built either directly, for example by using the planning process to develop measures directly targeting one or more of the four dimensions, or indirectly by working on pilot projects that affect certain capacity dimensions. In addition, capacities may be built through the planning process itself, when the skills (resources) of participants are improved as a result of the collaboration with others.

Putting the concept into practice: the case of the PASEO project

The ‘Building Policy Capacities for Health Promotion through Physical Activity among Sedentary Older People’ (PASEO) project was funded by the Health Programme of the European Union from 2009 to early 2011. It used the co-operative planning process to foster the link between knowledge and action and to build capacities for health promotion in 15 European nations, thus contributing to improved physical activity promotion for older people. In each country, a scientific partner teamed up with a political organization to recruit relevant organizations for national or regional alliances that would develop specific measures to build capacities. This article reports the experiences of the German PASEO alliance, which was established at the regional level in one of the 16 Federal States.

Figure 2 illustrates the overall design of PASEO, which involved four main project phases based on the co-operative planning process. Each phase targeted specific capacities to be built. Likewise, each phase involved different kinds of knowledge to be exchanged between researchers and policy-makers. As the
project was based on an interactive, non-linear model of linking knowledge to action, it was assumed that the relationship between academia and policy would vary in each of the four phases of the process.

In Phase 1, the scientific partner teams up with a large NGO or governmental organization. In the second phase, both partners approach relevant organizations from the sport, health care, social care and other sectors in order to engage them as partners for the planned alliance for physical activity promotion for older people. In Phase 3, the newly formed alliance conducts a planning process (as outlined above), thus building capacities in all four dimensions of the ADEPT model. In the final phase of the project, alliance partners move on to implement the measures developed in the planning phase.

**METHODS**

The investigation of capacity building and the linking of knowledge to action in the PASEO Project generally followed a case study approach. As existing models and theories were tested, one could speak of a ‘theory-confirming case study’ (Lijphart, 1971) or an ‘explanatory case study’ (Yin, 2009). The design could also be described as a ‘quasi-experiment’ (Collier, 1993) that applies a certain intervention (the co-operative planning process) to a natural or field setting.

In line with Yin’s conclusion [(Yin, 2009), p. 101] that ‘a good case study will […] want to use as many sources as possible’, a mix of qualitative and quantitative methods was used, including observation, document analysis, interviews and an online survey. Such a combination bears certain similarities to approaches of ‘policy ethnography’ (Travers, 2001; Flick, 2002; Willis and Trondman, 2002). In the past, several case studies have used this method to investigate the details of policy-making (Exworthy et al., 2002; Wiesner, 2003; Pritzlaff, 2006). We considered other designs (in particular a pre-post design) but rejected them due to the interactiveness of the PASEO approach.

The different data collection methods were used according to their appropriateness and feasibility in the different phases of the project.
Ten semi-structured qualitative phone interviews with select organizations were conducted in Phase 2 of the project in order to obtain an overview of existing capacities. The interviews lasted 60 minutes on average and employed a semi-structured interview guideline with both open-ended and more 'targeted' questions (Hsieh and Shannon, 2005). Targeted questions were based on the ADEPT model (Rütten et al., 2011), assessing capacities in terms of four dimensions: goals, obligations, resources and opportunities. After the planning, all participants of the process (n = 22) were invited by e-mail to take part in a quantitative online survey. Fourteen participants responded (response rate 63.6%). Survey questions were based on concepts of quality management (Donabedian, 1966; Ruckstuhl et al., 2001). There were four questions on the setup and facilitation of the planning process, two on the outputs of the planning (catalogue of actions and its implementation) and three on the perceived outcomes with respect to capacity building. In addition, e-mails, notes of phone conversations and various documents produced by participating organizations during all phases of the project were collected for analysis.

Finally, researchers used observational methods throughout the entire planning process. Minutes were taken of several meetings with the political partners in Phases 1 and 4, including a one-day conference in Phase 4. Notes were taken of more informal meetings and conversations, for example during coffee breaks. A special template was used for all meetings of the actual planning group in Phase 3, recording participants, time frame, most important topics, general atmosphere, relations between participants and potential unexpected events. The observation approach employed shows several features of ‘participant-observation’ [(Yin, 2009), p. 111f], as researchers were not only external observers but played an active role in the planning process as both moderators and experts. However, the method lacked certain features considered characteristic of participant-observation: for instance, researchers did not attempt to join any of the organizations for an extended period of time to study their internal operations. During the planning group meetings, the research team conducted ‘direct observations’ [(Yin, 2009), p. 102] whenever possible. One researcher would serve as moderator, while another would take notes.

The analysis of the data closely followed the central propositions of the underlying theories [Yin, 2009, p. 130ff]. The central categories for the analysis were provided by the ADEPT model (goals, obligations, resources and opportunities) and by the concept of interactive knowledge to action. Likewise, the main phases for the analysis were derived directly from the cooperative planning process. The approach used also bears certain similarities with the concept of ‘process tracing’ by George and McKeown [George and McKeown, 1985; also see (Collier, 1993)]. More precisely, it resembles their idea of ‘process verification’, where researchers gather evidence to assess if the processes they observe in their particular case match the predictions of the theories underlying the study.

As a consequence, each phase of the planning process was analysed separately, using the different sources of evidence outlined above. In the initial step, two researchers independently analysed the notes of the phone interviews to identify relevant sections referring to the capacities of the ADEPT model. The participating researchers then met to discuss the results and consolidate the findings. This method resembles the concept of ‘directed content analysis’ (Hsieh and Shannon, 2005), which identifies relevant categories prior to the analysis and confirms or refutes theories rather than generating them. In a second step, the documents, meeting minutes and observation notes relevant for each phase were discussed by the participating researchers to assess when and how knowledge had been exchanged or capacities had been built, or where this had failed to happen. In a final step, the results of the quantitative online survey were used to back up or, where necessary, adjust the findings made in the analysis of the other sources of evidence [(Yin, 2009), p. 103].

RESULTS

Phase 1: team building

Prior to the formal start of the project, the ministry of health in one of the German federal states signalled support for PASEO to the university acting as German project partner, suggesting a subordinate agency of the ministry, the regional health promotion agency, as formal collaborator. Between January and June 2009, three preparatory meetings between the university, the ministry and the health promotion
agency took place to establish the cooperation and to prepare further project work. Phase 1 contributed to capacity building on various dimensions as conceptualized in the ADEPT model. In particular, it created political opportunities by initiating a new cooperation between the university and the health promotion agency. The participation of the ministry and its agency provided the project with resources that researchers alone could not have mustered. These resources included political support and project infrastructures (such as mailing lists, newsletters and venues). In turn, PASEO helped the health promotion agency fulfill some of its external obligations under the German National Action Plan on Diet and Physical Activity (IN FORM), which obliges it to become active in the field of physical activity for older people.

In terms of knowledge exchange, the political organizations provided valuable insights on the physical activity promotion ‘landscape’ in the state, particularly concerning the activities of the most important organizations involved and their relations with each other. Meanwhile, the scientific partner focused on providing knowledge related to the capacity-building process of PASEO.

Phase 2: alliance building
In the second phase of the project, relevant regional-level public-law institutions (such as sickness funds) as well as NGOs from the sport, health care, social care and other sectors (for example tourism and education) were approached for participation in the future alliance. Out of 54 organizations invited, 13 agreed to take part, mainly from the sport and healthcare sector. The scientific PASEO partner conducted qualitative interviews based on the ADEPT model with representatives of participating organizations to assess existing capacities. In addition, a focus group with older people to inform future alliance work about their special needs and wishes for physical activity was organized.

Policy capacities were mainly built in this phase in the form of political opportunities through increased networking (particularly at the working level) between the project partners and the regional NGOs recruited in the alliance. In addition, informational resources were created, both by disseminating information on PASEO to a large variety of organizations and through the qualitative interviews, which allowed researchers a direct insight into existing policy capacities. Analysis of the interviews indicated considerable heterogeneity among the different organizations with respect to resources, goals and obligations. Networking and the implementation of programmes at the local level were identified as most promising areas to build capacities. A notable problem with capacity building in this phase was that no organizations from the social care sector (organizations with a particular focus on ageing) could be engaged.

As a result of the knowledge exchange process, the scientific partner was able to acquire new knowledge on existing capacities, while policymakers received research-based knowledge on the needs and wishes of the target group.

Phase 3: planning
The planning phase in the German PASEO alliance took place between February and July 2010. Due to limited time frames and tight schedules, the group decided to conduct the planning process in four sessions. Each of these sessions lasted ~3 h. Between 15 and 19 individuals were present, representing 8–13 organizations. The regional ministry acted as patron of the alliance, while the health promotion agency provided the venue. Sessions were moderated by the scientific partner.

At the first planning meeting, the scientific partner introduced the project and briefly reported the results of the ADEPT interviews and the focus group. A brainstorming session was conducted to collect ideas for potential measures to improve policy capacities, which yielded five suggested actions for further discussion. The second meeting served to set priorities and to select measures to be actually implemented. Of the five actions originally suggested, two were chosen: a local-level pilot project for ‘green prescriptions’ for older people (general practitioners referring older people to previously identified physical activity offers in their community) and a one-day event to motivate older people to become more physically active. Two workgroups were formed, which then discussed ideas for the design and implementation of the two actions. At the third meeting, the two workgroups continued to specify the measures and discuss organizational details. This included the concept and design of the green prescription forms, co-ordination of the pilot projects at the
local level, timelines and financing. At the final planning meeting of the alliance, the catalogue of actions was finalized: both workgroups decided to file grant applications with the regional government’s health promotion funding programme and specified responsibilities for preparing the applications, required funding and preliminary timelines. The scientific PASEO partner officially transferred responsibility for further alliance activities to the regional health promotion agency.

With respect to capacity building, the planning phase helped specify the goals of the alliance by discussing potential measures and selecting two pilot projects as a start for further activities in the field of physical activity promotion for older people. New obligations were created for the organizations involved through the successful development of a catalogue of actions specifying responsibilities and timelines in the pilot projects. Organizations agreed to re-allocate some of their existing resources to contribute to the project (such as staff time, printing and distribution costs). In addition, the acquisition of new resources for the pilot projects was planned for by filing grant applications with the ministry of health. With respect to non-material resources, an important achievement was that organizations learned to develop measures by themselves instead of following prescriptions by the scientific or political partners of PASEO. Finally, both political and organizational opportunities were created: leading organizations in the field of physical activity and ageing showed commitment for the alliance throughout the entire planning phase, with individual staff members allotting more time to the issue of physical activity and ageing than before. The online survey conducted after the end of Phase 3 indicated that most participants also had a positive or very positive opinion of various aspects of the planning process, including the composition of the alliance (70% positive opinion, 10% very positive opinion), the representation of relevant sectors (70% positive, 0% very positive), the experience of the participants (60% positive, 10% very positive) and the moderation (64% positive, 18% very positive) and organization (45% positive, 18% very positive) of the planning process.

However, some problems were encountered in the planning phase. With respect to organizational opportunities, there were continuous scheduling problems for some organizations, particularly for the smaller ones with limited staff in the field of physical activity and ageing. The large organizations, by contrast, tended to send different representatives to the different meetings, which hampered the continuity of the process. The planning phase uncovered some long-standing conflicts between organizations, some within the same sector (namely between the large-scale organizations in the healthcare sector) and some between sectors. This included conflicts over resource distribution and fear of losing clients between the health care and sport sector. These conflicts inhibited the buildup of political opportunities and proved difficult to overcome in the short time frame of the planning process. In the online survey, most participants were rather skeptical concerning the commitment of the partners to the alliance (with 40% giving a neutral rating and 10% giving a negative rating) and their willingness to co-operate (60% neutral rating, 10% negative rating). The catalogue of actions received mostly neutral ratings (64%).

The university provided knowledge for this phase in three ways: by feeding the results of the qualitative interviews and the focus group into the planning process; by moderating the planning process as facilitators and by contributing expertise on specific topics of physical activity promotion for older people to the development of the two pilot projects. One of the central problems encountered in the planning process was the expectation by alliance members that researchers would play a much more active role and suggest specific measures to be implemented.

**Phase 4: implementation and monitoring**

The catalogue of actions envisioned both pilot projects to start in the fall of 2010 with the filing of grant applications. While preparations were undertaken by a large healthcare NGO and the regional health promotion agency, respectively, neither application was filed. Two reasons for this were a conflict over doctor’s remunerations in the case of the first pilot project and a temporary shortage of federal government funding for the health promotion agency in the case of the second. A further alliance meeting was scheduled for late 2010 but did not take place due to scheduling problems. However, the health promotion agency organized a one-day conference on physical activity promotion for older people in February 2011, in which several alliance members took part.
As the measures designed to increase capacities were not implemented, no capacities were built in this phase of the project. Likewise, the alliance did not continue to operate, at least not in the same fashion as before. However, the health promotion agency recently increased its effort to schedule new alliance meetings, and the conference might also be a harbinger for further activities in this field in the future, suggesting that some capacity building in the field of political opportunities took place in the implementation phase. This is also supported by the results of the online survey: while only 22% of respondents were sure that the alliance had so far paid off for their organizations (with 44% answering ‘maybe’, 22% ‘no’ and 11% ‘don’t know’), a large majority (78%) stated that they planned to continue their involvement in the alliance.

While the university provided some of its knowledge to help alliance partners prepare the grant proposals for the two pilot projects, it largely withdrew from its leading project role to focus on monitoring the implementation process. This was also done in order to give the alliance a chance to develop a sustainable leadership structure after the end of the EU funding period. This, however, turned out to be difficult. The transfer of responsibility to the health promotion agency was problematic, partially due to the above-mentioned funding problems. In addition, most alliance members continued to expect researchers to play a leading role in the implementation process.

**DISCUSSION**

The experience of the PASEO project illustrates that interactive ‘knowledge to action’ approaches such as co-operative planning are potentially promising approaches to building policy capacities. The case study has successfully shown that linking knowledge to action is not a linear, unidirectional process from researchers to policy-makers, but that in some phases of the interaction, the knowledge flowing from policy-makers to researchers may exceed the knowledge ‘transferred’ from researchers to policy-makers. In addition, researchers play a multitude of different roles in the capacity-building process, sometimes being equal partners, sometimes leading parts of the process and sometimes restricting themselves to the role of external observers. Interestingly, policy-makers tend to have difficulties accepting these multiple roles and expect researchers to act mostly as advisors on policy content (most importantly on specific interventions to be implemented). This indicates that it might be advisable to discuss these issues prior to the start of the process. All in all, we believe that PASEO is vivid proof that ‘knowledge to action’ and capacity building are closely linked in projects involving researchers and policy-makers. In many cases, the knowledge exchanged also led to an increase in generic policy capacities, such as the practical implementation of scientific evidence on policy capacities into policy processes.

We are aware that several aspects of the study presented in this article may meet with criticism. Some might argue that the concepts used put too much emphasis on ‘organizations’ and neglect the people who act on their behalf. This critique partially reflects the long-standing dispute in the social sciences between structuralist and agentic approaches. As we have argued at length elsewhere (Rütten and Gelius, 2011), we share Anthony Giddens’s (1984) view that structure and agency are inseparable from each other, and that their complex interaction should be considered in health promotion research, too.

The main interest of the PASEO project was to build organizational capacities, but the co-operative planning process relies on the close interaction of one or a few representatives per organization. Likewise, measuring the capacities of a multi-member organization in a parsimonious way requires identifying a small number of people in key positions that can give a realistic assessment of the entire organization (Rütten et al., 2010).

We are aware that such a ‘pars pro toto’ approach poses several challenges. One or a few individuals can never fully represent the full spectrum of an organization. In addition, organizations are more than just the sum of ‘equal’ individuals, with rules, hierarchies and power relations playing an important role in their collective decision-making. Finally, when surveying individuals, it is sometimes difficult to distinguish between individual and organizational capacities.

On a theoretical level, the ADEPT model reflects at least some of these issues by using categories that are directed at the organization level (such as the specification of organizational goals) and others geared more towards the individual (such as feeling personally obliged to do...
something about a certain issue). Concerning the practical aspects of the co-operative planning process, the PASEO project tried to ensure that all participants came from the ‘working level’ and were actively involved in physical activity promotion for older people. We agree that a more in-depth study of the interplay of (organizational) structure and (individual) agency would have been desirable. However, this would not have been feasible in the framework and time frame of this project.

PASEO illustrates that the four categories of the ADEPT model can successfully be employed to conceptualize capacities and capacity building. With respect to the capacity-building process, the project achieved many of its goals. Three project phases were successfully completed as planned: The scientific project partner successfully teamed up with governmental institutions; the alliance was successfully established; the planning was successful and yielded a specific plan to conduct two pilot projects after a comparatively short period of time. In Phases 1 and 2 of the project, one focus of capacity building was on creating political opportunities in the form of new or increased co-operations and networking. In Phase 3, all four dimensions of the ADEPT model were tackled. However, the catalogue of actions was not put into practice, and consequently no capacities could be built via the implementation of measures. While the conference on active ageing organized by the regional health promotion agency may be a positive sign, no further alliance meetings have taken place so far.

Why did the project encounter problems with respect to implementation and sustainability? Some potential answers can be found in the specific characteristics of the German PASEO project, such as resource problems and some long-standing conflicts between participating organizations that were difficult to overcome in the context of a single project. Other points, however, are of a more basic structural nature and become visible if we compare PASEO to another project we have conducted using a similar design. The ‘Bewegung als Investition in Gesundheit’ (BIG, German for ‘Movement as an Investment for Health’, Rütt et al., 2008; Rütt et al., 2009; Rütt et al., 2010) project employed the ADEPT model and a co-operative planning process to promote physical activity among women in difficult life situations in a medium-sized German municipality.

The BIG project took place on the local level, while the PASEO planning process was conducted on the regional level. This led to more ‘politicizing’ between organizations than in a local setting and to less work on the issues themselves. In addition, the working level of organizations was farther removed from the decision-making level: some participants had hardly any power to make decisions on their own and had to refer every issue back to their superiors, which made planning more difficult. In addition, many organizations sent different representatives to different planning sessions, causing further problems. Most importantly, the target group had hardly any chance of becoming directly involved. While older people were ‘represented’ via the focus group meeting and some organizations with a special focus on older people, they did not take part in the planning themselves. Pressure on the PASEO group to actually implement measures was therefore considerably lower than in our local level project.

The time frame in PASEO was considerably shorter than in BIG. In particular, the planning and implementation phases were shorter due to time limitations imposed on the project by the funding agency. This directly impacted on the implementation of the catalogue of actions and the transfer of responsibility for the alliance from the scientific partner to the regional health promotion agency. It was also difficult to communicate to the alliance members that the role of the scientific partner had changed from practical alliance work to scientific monitoring.

Finally, the resources available for PASEO were considerably lower than in BIG. PASEO only provided financial resources for a part-time position, which also had the task of coordinating the project at the EU level. As a consequence, there was not enough time to maintain contact with alliance members between meetings, leading both to logistic problems and to a lack of trust. Moreover, it was impossible for the scientific partner to assist in the implementation of the catalogue of actions and to monitor the process at the same time. In addition, the part-time position at the regional health promotion agency that dealt with PASEO was jeopardized by funding cuts by the national government.

Drawing lessons for future projects, it should be noted that there will always be difficulties connected to working at the regional or national level. More complex organizational setups, reduced participation of the target group and a
trade-off between a greater political reach and more ‘politicking’ occur in this context. The most promising changes to improve chances of implementation and sustainability might include more resources for project staff and longer timelines, especially in the implementation phase. The lessons learned from PASEO are consistent with Nutley et al.’s (2007) observation that interactive approaches can be quite effective but tend to be costly and face challenges with respect to competing and conflicting agendas.

CONCLUSION

This article has outlined a process of interactive ‘knowledge to action’ that uses co-operative planning to initiate capacity building and a knowledge exchange between policy-makers and researchers. We have discussed the PASEO project as a case study to illustrate how this concept can be put into practice to build policy capacities for physical activity promotion among older people on the regional level in a German state.

The results presented here support the theoretical connection between ‘knowledge to action’ and capacity building. They demonstrate the diverse relations of researchers and policymakers and the various kinds of knowledge exchanged throughout such a project and thus make a strong case for interactive models of linking knowledge to action. The case of PASEO also illustrates how researchers can actually effect change at the policy level by building capacities through knowledge exchange with policymakers. On a theoretical level, it makes a strong case for the explanatory power of the ADEPT model in conceptualizing capacity and capacity building.

While alliance building and the planning phase were successful, substantial problems regarding implementation and sustainability cannot be denied. Comparison with a similar project (BIG) at the local level revealed that these problems can at least in part be attributed to the more difficult political and organizational environment at the regional level.

Future research might want to test regional and national level policy capacity building using interactive ‘knowledge to action’ approaches with improved resources and longer timelines. In addition, it would be interesting to compare the experience of the German PASEO project to some or all of the 14 other countries that took part in the project. We hope to conduct such a comparative analysis in the near future. If some of the other countries have managed to implement their catalogues of actions and maintain their national alliances, this might provide valuable insights as to how regional and national level processes of capacity building and knowledge exchange could be optimized in the future.

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