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Master thesis

Intersectoral collaboration at the municipality level: a qualitative study of the experiences of public health coordinators in Norway

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Abstract

The aim: To explore and understand public health coordinators' experiences of intersectoral collaboration and Health in All Policies (HiAP). The research aims to shed light on the everyday reality of working to take forward the municipality's systematic public health work and reveal the constraining and enabling processes and factors.

Method: A qualitative cross-sectional study of eight public health coordinators from eight different municipalities on the East and West coast of Norway. The method of data collection was semi-structured individual interviews. The data were analyzed using a thematic analysis approach. Based on participants' experiences, processes were analysed with inductive reasoning and informed by concepts and literature on intersectoral collaboration.

Results: Nine themes were developed and further divided into two categories. Including category (i) professional capability, with themes 1) working across boundaries, 2) understanding roles and responsibilities, 3) understanding public health work, 4) public health as additional work, 5) team meetings as effective and meaningful. Category (ii) organisational structures, with theme 6) having a mandate for public health teams and overview document. Three themes were placed between the two categories, 7) purpose of public health teams, 8) overview document as a shared task and 9) collaboration as a long-term process.

Conclusion: Public health coordinators experiences of collaboration varied, for some, intersectoral collaboration was less present, while others seemed to have stable well-working public health teams. The findings indicate that public health coordinators had different preconditions and capabilities to work across boundaries to facilitate collaboration. The findings of this study suggest that public health coordinators in full-time positions, who can use boundary spanning processes have the potential to enhance the implementation of the principles of the Norwegian Public Health Act and achieve sustainable public health teams, that can ensure HiAP.

Norsk sammendrag

Målet med studien: Utforske og forstå hvordan folkehelsekoordinatorer opplever tverrsektorielt samarbeid og helse i all politikk. Studien tar sikte på å belyse den daglige virkeligheten med å jobbe for å videreføre kommunens systematiske folkehelsarbeid og få frem begrensende og muliggjørende faktorer og prosesser.

Metode: En kvalitativ tverrsnittstudie av åtte folkehelsekoordinatorer fra åtte forskjellige kommuner på Østlandet og Vestlandet i Norge. Semi-strukturerte intervjuer ble gjennomført, og data ble analysert ved bruk av en tematisk analysetilnærming. Basert på deltakernes erfaringer ble funn analysert induktivt og drøftes i lys av konsepter og litteratur om tverrsektorielt samarbeid.

Resultater: Ni temaer ble utviklet og senere delt inn i to kategorier. Kategori (i) profesjonelle ferdigheter som folkehelsekoordinator, med temaer 1) arbeide på tvers av grenser, 2) forstå roller og ansvar, 3) forstå folkehelsearbeid, 4) folkehelse som tilleggsarbeid, 5) team møter som effektive og meningsfulle. Kategori (ii) organisatoriske strukturer, med tema 6) mandat for folkehelseteam og oversiktsdokument. Tre temaer ble plassert mellom de to kategoriene, 7) hensikt med folkehelseteam, 8) oversiktsdokument som en fellesoppgave, og 9) samarbeid som en lagsiktig prosess.

Konklusjon: Folkehelsekoordinatorers opplevelser var varierende, for noen var tverrsektorielt samarbeid mindre til stede, mens andre så ut til å ha et stabilt og godt fungerende folkehelseteam. Funnene indikerer at folkehelsekoordinatorer har forskjellige forutsetninger og ferdigheter til å jobbe på tvers av sektorgrenser for å fasilitere samarbeid. Funnene fra denne studien antyder av folkehelsekoordinatorer i heltidstillinger som kan benytte «boundary spanning» prosesser har poteniale til å styrke implementeringen av folkehelselovens prinsipper og oppnå stabile folkehelseteam, som kan sikre helse i all politikk.

1. Introduction

1.1 The purpose of this master thesis

This master thesis seeks to understand the Norwegian Public Health Coordinators' (PHCs) experiences of intersectoral collaboration and HiAP in local municipalities. More specifically, this study has the potential to shed light on the everyday reality of working to take forward the municipality's systematic public health work as set out by the Norwegian government through the Norwegian Public Health Act (NPHA), and reveal the constraining and enabling processes and factors.

1.2 Background

Since the Ottawa Charter in 1986 under the leadership of the World Health Organization (WHO) a wide and new understanding of health promotion was developed and adopted. Health promotion as a concept was seen as shifting from focusing on individual risk factors to addressing the "context and meaning" of health actions and the determinants that keep people healthy (Dahlgren & Whitehead, 1991). This is because health and lifestyles are influenced by environments, e.g. where people live, work, eat, drink, move, and so on. These are not only individual choices, but they often have strong social, cultural, economic and environmental determinants. Therefore, improving and supporting people's health is often best influenced by actions beyond the health sector (health care, health services) (Ståhl, Wismar, Ollila, Lahtinen & Leppo, 2006).

The Ottawa Charter highlighted the importance of building healthy public policy. Over the last few decades, HiAP has been applied to multiple health topics and challenges and been linked and used in relation to concepts such as healthy public policy and intersectoral collaboration (WHO, 2017; Dubois, St-Louise & Veras 2015). HiAP and intersectoral collaboration share the core message of the need to integrate health considerations into all policies and sectors (Ståhl et al., 2006). In many parts of the world, influenced by the WHO, public health has become to be understood not only as an approach that moves beyond health care but also as a commitment to social reform and equity (Kickbusch, 2003). In order to tackle public health challenges, it is frequently argued that intersectoral collaboration among different professionals and sectors is required (Varda, Shoup & Miller, 2012).

There exist multiple terms on intersectoral collaboration and empirical articles often try to summarize the terms into one definition. Despite the different definitions of

intersectoral collaboration and different terms, the essence is that it allows for an expanded understanding of public health problems and possible solutions, where different disciplines or organisations are working together towards shared goals (National Association of County and City Health Officials, 2017; Willumsen & Ødegård, 2016). In this way, intersectoral collaboration is considered to be a process where HiAP is the goal (Corbin, Jones & Berry, 2018). HiAP stresses the importance of political choices and good governance including strong collaborations, shared leadership, dedicated capacity and resources, accountability and evidence (WHO, 2017, p. 6). There is a lack of evidence, however, about successful HiAP development and implementation. Further, while HiAP is a concept rather than a model, every HiAP initiative tends to be somewhat unique (Shankardass et al., 2018). This can be because every organization is different from each other, and there is not an empirical model of HiAP that can be followed.

1.3 Local public health work in Norway

As in many parts of the world, the Norwegian Government highlights the HiAP approach and the NPHA emphasises a high level of intersectoral collaboration in the municipalities, where every sector should be involved in public health work. The NPHA demands health considerations into policies to improve population health and reduce health inequalities (Fosse, Sherriff & Helgesen, 2019; Fosse & Helgesen, 2017; David et al., 2012; Lyshol, 2016). In Norway, the 356 municipalities have a dual role: on the one hand, they are agents for the welfare state through their responsibilities for implementing national policy goals. On the other hand, municipalities form independent local democratic areas that are able to decide how to use national funding in accordance with local priorities, preferences and needs, and are seen as primarily responsible for public health (Fosse et al., 2019; Lyshol, 2016).

The White Paper "Recipe for a healthier Norway" (Meld. St. 16. 2002-2003) presented back in 2003 the idea of a PHC-function. The White Paper states that «a coordinator for public health can contribute with local engagement, give a helping hand to local activities and intersectoral action, and coordinate different actors' efforts» (Norwegian Ministry of Health and Care Services, 2003, p. 76). A PHC works as a "glue" for the local public health work. The White Paper further presented an incentive scheme to ensure intersectoral organization based on a public health partnership deal, including a local and regional administrative coordination function (Norwegian Ministry of Health and Care Services, 2009). The aim of

the partnership deal and establishing PHCs in municipalities was to trigger engagement and give a helping hand to local activities and intersectoral action. The PHC-function was recommended to be placed central to the administrative level to be close to the policy level (Norwegian Ministry of Health and Care Services, 2009).

In 2011 a new division in time for Norwegian history of public health emerged when the Government established the NPHA. The Act is meant to ensure that municipalities implement and coordinate public health actions and facilitate long-term and systematic public health work (Norwegian Ministry of Health and Care Services, 2012). According to the Norwegian Directorate of Health, a PHC should work at a community- and society level with three points; 1) Overview of the public health, 2) goals, strategies and planning, and 3) intersectoral collaboration (Norwegian Directorate of Health, 2014, p. 105). The Government recommends that municipalities have a PHC-function to facilitate collaboration and coordination across all sectors, to get health into all policies and, furthermore, to fulfil the systematic public health work of the NPHA (Hagen, Øvergård, Helgesen, Fosse & Torp, 2018). The municipal response was overwhelming and in 2014 85% of municipalities had a PHC (Hofstad, 2018).

1.4 Public health coordinators in Norwegian municipalities

In Norwegian municipalities, the professionals with the main public health responsibility, sometimes have a PHC-title while others do not. However, often one person in municipalities is seen to have the function of a PHC (Norwegian Ministry of Health and Care Services, 2009; Lyshol, 2014; Helgesen & Hofstad, 2012). Acknowledging the Norwegian Government recommended and presented the PHC position for municipalities and uses this term, it is the term “PHC” that is used throughout this master thesis when referring to professionals working in Norwegian municipalities whose responsibility it is to manage the municipal statutory public health work. The PHC position is however not a statutory position for municipalities, furthermore, systematic public health work is statutory through the NPHA (Norwegian Directorate of Health, 2014). Research shows, however, that PHCs per cent of employment often declines with the municipality size and sometimes the budget. PHCs functions often are combined and located within service areas that belong to the health sector, or probably added on top of other disciplines (Hofstad, 2018). Helgesen, Fosse and Hagen (2017) discovered that only 23 per cent of municipalities had employed a PHC in a 70 per cent position or more; this might be due to the function not being statutory.

The HiAP approach alongside the Norwegian Government’s recommendation to

situate PHCs high in the political chain of command, such as the staff of the Chief Executive Officer, are designed to facilitate their involvement in setting the overall policy agenda, including municipal planning (Norwegian Ministry of Health and Care Services, 2009; Hagen, Helgesen, Torp & Fosse, 2015). After the NPHA was adopted, public health became a more explicit field within government policy. Statistics show that 72 per cent of Norwegian municipalities have established intersectoral working groups for public health-related questions. Still, it can vary when it comes to partners that are involved (Helgesen et al., 2017).

1.5 Objective of this study

While facilitating collaboration for public health sounds a reasonable recommendation with good intentions, at the same time, studies find that worldwide and nationally, intersectoral collaboration is challenging and complex (Gakh & Rutkow, 2017; Holt, Carey & Rod, 2018; Synnevåg, Amdam & Fosse, 2018a; Scheele, Little, & Diderichsen, 2018). However, studies have explored why intersectoral collaboration is challenging and discovered various factors that explain it. Nevertheless, relatively few studies have examined the Norwegian PHCs experiences regarding their role in intersectoral collaboration, which is the focus of this study. The reason for including the PHCs perspectives is because they often are the core persons to work across sector boundaries to facilitate collaborations, and their experiences can provide some insight into local intersectoral work as set out in the requirements of NPHA.

1.5.1 Research question

This study aims to shed light on the following research question: "*How do public health coordinators experience intersectoral collaboration?"*. The study aims to focus on the PHCs experiences concerning collaboration with other professionals across sectors to retain the policy perspective because the literature often argues that intersectoral collaboration should lead to HiAP. This study has the potential to provide a better understanding of intersectoral collaboration from the standpoint of PHCs. Considering the variations in how municipalities shape their PHC, this study selected PHCs from small, medium and large municipalities in different geographical location to give a varied range of experiences.

2. Literature review

There is an international body of literature on intersectoral collaboration, yet there is little evidence on how to practice intersectoral collaboration. Many local municipalities around the world have moved in the direction of the HiAP approach, along with facilitating intersectoral collaboration, with varying degrees of success (The Health Foundation, 2019). Public health is an inter-organisational field with a high degree of differentiation, meaning there are many different organisations involved in the pursuit of public health. This means that if the social determinants of health are to be adequately addressed then there is need for a HiAP approach. Intersectoral collaboration in public health is, therefore, often organised in the form of multidisciplinary teams. Such a team can be characterised as a small group of people, usually from different disciplines, who are working together across formal organisational boundaries to solve different public health challenges (Axelsson & Axelsson, 2006).

In order to get an overview of the current state of knowledge on the topic of, a literature search and review was carried out (appendix 1). The literature review found several indications, processes and factors that either promotes or inhibits intersectoral collaboration in local municipalities/authorities. The chapter begins by exploring the international literature before moving on to the Norwegian research on the topic.

2.1 Shared goals

The literature on intersectoral collaboration emphasises that the purpose of collaboration, shared visions and goals are widely agreed as essential factors in uniting collaborative partners (Corbin & Mittelmark, 2008). Axelsson and Axelsson (2006) discuss that there are different stages of developing a team. They express there is a forming stage, where members of the group are recruited, then usually comes a step of where there are conflicts of interests, values and goals due to the different professional cultures of the team members. If conflicts are resolved, the team members start to trust each other and can begin the process of formulating shared goals. The goals should be realistic, and everyone involved should agree on the goals (Corbin et al., 2018; National Association of County and City Health Officials, 2017). Collaboration for public health in general and HiAP, in particular, should be about everyone in a team having possibilities to identify health considerations in their work. Hence, this contributes to making sure health is “owned” by everyone involved, and the responsibility to identify public health challenges should be shared (Corbin, et al.,

2018; Hofstad, 2018). A scoping review found that clearly defined goals stimulated relevant sectors' ownership and involvement. Having shared goals made it possible for sectors to share economic resources and would not have been obtainable to accomplish if they did not have a common goal (Weiss, Lillefjell & Magnus, 2016). This study will examine the reality of developing shared goals as the literature finds essential when uniting different sectors for collaboration.

2.2 Leadership

In public health, the literature argues that intersectoral collaboration requires shared leadership because of different sectors and disciplines involved (Holt et al., 2018; Jones & Barry, 2011). It may, however, often be one person, such as the PHC, who facilitates and perhaps leads such intersectoral teams. These leaders must have the ability to promote openness, trust, autonomy, commit to cross boundaries and be inclusive of diverse partners (Corbin & Mittelmark, 2008). The scoping review of Weiss et al. (2016) found that those in a position of leadership improved chances for positively influencing local public health when committing to consistent and reliable advocacy and practical support of shared goals. Further, a knowledgeable leader with good communication skills, a democratic leadership style and innovative and visionary perspective proved to be beneficial. Also, a leader that has strong administrative support improved the chances of achieving policy objectives (Weiss et al., 2016). It is suggested that leaders of collaboration should be a translator by understanding the diverse meanings and aspirations of disparate constituencies: professions, cultures and sectors (National Health Service Wales, 2009). Baker, Wilkerson and Brennan (2012) identified that strong leadership and group management were important indicators of success in creating changes regarding partnership functioning.

Regular attention should be paid to how the leadership is perceived and to whether or not the current style of leadership is working, so adjustments can be made if necessary (Corbin, Fernandez & Mullen, 2015; Corbin & Mittelmark, 2008).

2.3 Co-benefits

A HiAP approach is built on the principle of co-benefits. This means all sectors that participate in collaboration should benefit from being involved (WHO, 2017, p. 4). Studies have concluded that it is crucial that HiAP approaches need to deliver co-benefits to non-health sectors since they often do not see how health or health equity implementation could

benefit their department. Co-benefits also have positive impacts other than improvements in health that occur as a result of efforts for collaboration for public health (National Association of County and City Health Officials, 2017). At the same time, a healthier population is likely to bring social and economic benefits to other sectors in the longer term. Furthermore, co-benefits offer a good reason for intersectoral investment (The Health Foundation, 2019).

2.4 Trust

Various studies have shown that trust among different partners is essential for productive intersectoral collaboration and for building sustainable relationships (Jones & Barry, 2011; O'Flynn, Blackman & Halligan, 2014). Furthermore, sustainable and long-term collaboration provides the opportunity to establish enduring relationships and trust (Buick, Blackman, O´Flynn, O´Donnell & West, 2016). However, trust takes time to build is a process may begin in the starting-phase of the collaboration, and further on can be systematically managed (van Rinsum, Gerards, Rutten, van de Goor & Kremers, 2017). Trust bears on the principle to secure an open flow of information and equal distribution of power within a team. A trustful environment makes it easier for everyone involved to reveal their interests, which can be important in developing shared goals (Axelsson & Axelsson, 2006; Mur- Veeman, Eikjelberg & Spreeuwenberg, 2001). Moreover, studies find that trust is often taken for granted and is recognised as being present, although it might not be (Jones & Barry, 2011; Williams, 2002).

2.5 Boundary spanner skills

There are many key factors and influences implicated in effective collaborative working; they involve the use of particular skills, abilities, experiences and personal characteristics (Williams, 2002, p. 115). In relation to this, several research articles about intersectoral collaboration mention the term “boundary spanners”, to explain a particular set of skills that is fundamental to successful collaboration (Chircop, Bassett & Taylor, 2015).

A scoping review of evidence on how to practice intersectoral collaboration for health equity by Chircop et al. (2015) found that a professional approach to collaboration should reflect abilities to engage in an open way with different sectors bringing their competency to the table depending on the issues. Moreover, to have people with boundary spanning skills, that can build relationships, can negotiate and solve conflicts and evaluate whether collaboration is required. However, the study of Williams (2002) aimed to identify, describe,

categorize and understand boundary spanning competencies and effective collaborative behaviour, and included people working in different policy areas, managing multi-agency partnerships. The participants in the study reported they may lack direct lines of authority over other partners. This may also be the case for PHCs, concerning the differences in how their role is shaped in municipalities. Moreover, what degree of authority they have over sectors when facilitating collaboration needs further exploration.

2.6 Roles, responsibilities and structures

Findings vary in the literature in this area, although several studies indicate the importance of clarification of roles in collaboration. A scoping review of facilitators for the development and implementation of health promoting policy programs, find the importance of taking time to define responsibility and roles for all central in the collaboration process. This was important for developing shared goals (Weiss et al., 2016). Furthermore, Cobin and Mittelmark (2008) found that vague structures and timeframes as well as unclear roles harmed productivity in collaboration. Corbin et al. (2015) found that informality in roles, flexibility in funding and a loosely defined purpose enables the recruitment of many resources, although this decreased productivity. However, it seems essential to balance formal and informal roles, depending on the purpose and goals of the collaboration (Corbin et al., 2018).

Within the public health field there are professions who have the role and responsibility to be a coordinator and facilitator. These roles are employed to mainly work with public health and are called various titles. Some are called public health practitioners, officers, officials, directors of public health, health brokers, and in Norway PHCs. A study presented a role with some similar responsiblities of Norwegian PHCs and boundary spanners, in terms of a “health broker” role in the Netherlands. Health brokers are defined as social entrepreneurs who can be characterised as change agents. They aim to create support and establish permanent collaborations and encourage knowledge exchange among politicians, policy-makers, private parties, health promotion practitioners and citizens to improve the health of the community (van Rinsum et al., 2017). Participants in the study of health brokers explained how stakeholders (persons with an interest or involvement in an activity) often do not realise that they can play a part in intersectoral collaboration for promoting health since this was not their core business (van Rinsum et al., 2017). The study also found problems with the use of language in collaborations. The participants in the study of health brokers indicated that using more appealing and favourable terms instead of “health” or “prevention” could facilitate agenda setting for health in different sectors. Although the

health brokers in the Netherlands were highly motivated to reduce health problems, their work was not very concrete or visible, which made it hard to keep focusing on the main goal and to enjoy their "successes". The health broker role requires multiple competencies such as being flexible, keeping up with the scientific evidence base in numerous fields, and maintaining contacts with different policy levels and sectors, especially communication skills (van Rinsum et al., 2017).

A study of ten Danish municipalities interviewed 49 civil servants from health and non-health sectors based on their experiences. The study concluded that it was time to dismiss the idea that intersectoral action for health can be achieved by rearranging organizational boundaries. Rather it may be more useful to seek to manage the silos which exist in any organization, by promoting awareness of their implications for public health action and by enhancing the boundary spanning skills of public health officers (Holt et al., 2018).

2.7 Evaluation

Research suggests it is important to evaluate partnerships for continuous improvement and to see whether collaborations are required or perhaps other forms of working towards a common goal through coordination (Chircop et al., 2015; Corbin et al., 2018). Also, research states that it can be helpful to monitor and evaluate how communication is perceived by collaborative partners and adjust if needed. Perhaps some individuals are not suited to collaborative practice; therefore, it can be important to clarify other motivation or reason for collaboration at the beginning of a collaborative process (Chircop et al., 2015). As reflected in the study of Jones and Barry (2011), they found that attitude to intersectoral working was seen as an important predictor of sustainable partnerships.

Evaluation is also an important stage of the systematic public health work in Norway (Norwegian Ministry of Health and Care Services, 2012), and therefore it is a requirement to evaluate the interventions of collaboration. Such evaluation gathers evidence on what works and why, and identifies challenges and best practises (Corbin et al., 2018).

2.8 Literature on public health coordinators in Norway

Scandinavian municipalities have been shown to generally lack the capacity to implement HiAP (Bekken, Dahl & Van Der Wel, 2017; Von Heimburg & Hakkebo, 2017). The ability to have well-working collaborations depends on both the professional and organizational capacity and opportunities for collaboration, for achieving HiAP (WHO, 2017,

p. 4). A study found that 83 per cent of PHCs consider coordination across sectors as an emphasized duty. Thus, regardless of per cent of employment, PHCs do not reduce ambitions to work intersectorally (Helgesen & Hofstad, 2012). Still, a report from 2019 states that PHCs may lack a clear work description in which responsibilities are described (Von Heimburg & Hofstad, 2019).

PHCs functions often are combined and located within service areas that belong to the health sector, or probably added on top of other disciplines (Hofstad, 2018). Helgesen et al. (2017) discovered that only 23 percent of municipalities had employed a PHC in a 70 per cent position or more; this might be due to the function not being statutory. Even though the HiAP approach and the Norwegian Government's recommend to situate PHCs high in the political chain of command, numbers from 2015 show that only 28 percent of PHCs were located near the Chief Executive Officer (Hagen et al., 2015, p. 599). In contrast, a study from 2018 indicates that PHCs experience and awareness of the municipal organization might be just as crucial as being placed nearby the Chief Executive (Hofstad, 2018; Hofstad & Schou, in press; Hofstad; 2016).

Statistics show that 72 percent of Norwegian municipalities have established intersectoral working groups for public health-related questions. Still, it can vary when it comes to partners that are involved (Helgesen et al., 2017). Most municipalities have a PHC, moreover Hagen, Øvergård, Helgesen, Fosse and Torp (2019) suggest the effect of PHCs on public health work may be questioned and needs further investigation and suggest the importance of detailed data on how PHCs understand their role and function. This is something this study will try to provide some insight into. This brief overview of the emergence of PHCs in Norwegian public health policy and practice raises several questions about the everyday reality of their work regarding intersectoral working.

2.9 Norwegian literature on intersectoral collaboration

Compared to the international arena, there has been little empirical research on local public health work in Norway. Nonetheless, what there is suggests that similar issues emerge. The Norwegian research on intersectoral collaboration and HiAP finds dilemmas that reveal the complexity and diversity of the public health field.

Similar to international literature, the Norwegian research finds dilemmas with getting public health as an overall target in all sectors. For example, a qualitative study back in 2016 aimed to discuss how public health professionals view their roles, and how these roles had changed as a direct consequence of the NPHA. The study included six PHCs, four public

health advisors and one municipal medical officer with responsibility for public health. The study found there was future hope for more intersectoral collaboration (Lyshol, 2016). NPHA makes it a duty to act on what is identified as the main challenges, in the municipality, so that crossing the municipal sectors can be done. Participants in Lyshol's study (2016) reflected that not all municipal sectors participated in the NPHA work. Further, findings revealed that public health professionals felt relatively alone in their work and may struggle to get the overall target of public health in all policies in all contexts (Lyshol, 2016).

Numbers from a survey found that 81 percent of municipalities find their PHC as the one who takes the most responsibility for their public health work (Helgesen et al., 2017). Possibly, PHCs should take the most responsibility, although it is important that PHCs are empowered by the administration and other sectors to coordinate and facilitate collaboration and perhaps delegate tasks for the overview document. However, a study finds that PHCs may not be empowered by the municipal administration and are often an unskilled part-time employee (Bekken, 2018). This is congruent with Hostad (2018) who suggested that public health professionals need training in collaboration competency. As the international literature express, it seems that facilitating collaboration is not an easy task, and can require a lot of different skills, for example, boundary-spanning skills, also having capacity for fulfilling the role as a facilitator. However, the research does not reveal much about the PHCs educational background, which this study will explore.

Lyshol (2016) reports that the use of municipal plans as a tool for change can make collaboration take place to make knowledge explicit. At the same time, a study from Norway found several dilemmas when using planning as a tool for implementing the HiAP approach. They faced the dilemma of whether to place public health at the forefront or to present these issues in more general terms (Synnevåg et al., 2018a). For example, integrating public health concerns into planning documents gives them focus, authority and status. According to some informants in the study, putting public health intentions and goals in plans and administrative procedures is very hard to do in principle (Synnevåg et al., 2018a) and this may not lead to intersectoral action. The study report that the development of a communicative planning procedure that facilitates dialogue and participation could promote meaning and reflection and was seen as essential for sectors' understanding and ownership to public health goals. The three municipalities that participated in the study reflected the difficulty in finding a good planning strategy for public health. The study found that PHCs should be facilitators who are available as discussion partners; their job is to promote finding common ground, not to define best practice (Synnevåg et al., 2018a).

In continuation of this, a mixed-method study of 30 public health leaders and employees with organizational, planning and policy responsibilities found that municipalities should identify relevant sources of knowledge, collect and analyze the best available knowledge in order to reach a common understanding of public health challenges (Lillefjell et al., 2018). Again, Synnevåg et al. (2018a) found that municipalities faced the dilemma of balancing the use of qualitative and quantitative knowledge as a basis for action and practice.

In contrast to much of the international literature, it seems that Norwegian municipalities have struggles with the public health term. A study from Norway identified dilemmas associated with using public health terminology when implementing an HiAP approach. Participants experienced the term as broad, complex, advanced and unnecessary. This is what has been termed "health imperialism" where health is seen as governing everything (Synnevåg, Amdam & Fosse, 2018b). Holt (2018) suggests that not "health" but "living conditions" might be the concept to be applied to achieve a stronger focus on how all sectors can contribute to reduce social inequalities by addressing the social determinants of health. However, Synnevåg et al. (2018b) found the term public health necessary for a systematic approach towards understanding public health and intersectoral responsibility. The dilemma was that health tends to dominate the development of the HiAP perspective in the municipal organisation. Making public health something special by placing it at the forefront can be perceived as some sort of attempt to use power by those within the public health discipline. Perhaps public health work is viewed as a threat to other disciplines, resulting in public health work being viewed with distrust (Synnevåg et al., 2018b). There is a need to explore how PHCs experience around the issue with the public health term, as it can perhaps be a barrier to facilitating collaboration.

Another dilemma for Norwegian municipalities is that reports indicate that many municipalities struggle to establish systematic, knowledge-based public health work, anchored in sectors besides health (Riksrevisjonen, 2015; Lillefjell et al., 2018). The systematic public health work reflects the NPHA, as presented in figure 1 where municipalities must follow the stages in order to possess a long-term systematic public health work. However, there is diversity in how Norwegian municipalities practise their systematic public health work (The Office of the Auditor General of Norway, 2015).

Figure 1. Illustration of the systematic public health work (Norwegian Directorate of Health, 2017, overhead 13).

Having a health overview is one of the manifestations of the HiAP principles (Hagen et al., 2015). This is because it is one of the most important tools to secure intersectoral integration of population health. This document shall lay premises for planning aims and priorities, development of local measures and finally, be evaluated (see Figure 1 above). The chief administrative officer is responsible for the conduct of health overview work. At the same time, the actual prioritization of which challenges to follow up in plans is up to local politicians to decide (Hofstad, 2016). There is, however, a reason to believe that who performs the day-to-day overview work varies from municipality to municipality (Hofstad, 2016). The Norwegian Directorate of Health and the NPHA states that PHCs should develop health overviews, so it is reasonable to believe that PHCs are involved in the overview work. Additionally, Hagen et al. (2015) found a significant association between having a PHC and developing health overviews.

The Norwegian Board of Health Supervision (2015) perceives local health overview work to be putting extra pressure on local municipalities to step up their implementation of the NPHA. The overview describes the municipal health situation and positive and negative health determinants, hence it requires a board spectrum of knowledge and data and therefore individual and organizational capabilities (Hofstad, 2016). This can require coordination between different sectors and a close collaboration to support the overview work in a short and long term (Vedelt & Hofstad, 2014). In 2014, 39 per cent of municipalities reported that

they had made such an overview, while 48 per cent said they were starting the process. In 2017, there had been a significant increase, as 85 per cent reported they had made this overview (Fosse et al., 2019).

When it comes to using the health overview, the public health officials in the Lyshol (2016) study, expressed that some sectors were good at using the overview to be a part of their planning strategy. The public health officials expressed this as work in process. Also, they tried to educate their administration, different sectors and politicians, in ways to see the bigger picture and to ensure public health in an active part of all policies (Lyshol, 2016).

However, Hofstad (2016) discuss that having a PHC may not be enough for working across sectors, and to work intersectorally one has to unleash the competence and capacity of colleagues in other sectors. The challenge with the overview document is to have sufficient competence and capacity to locate, unpack and analyze statistical data, and for PHCs to do this alone can be challenging. Hofstad (2016) mentions the challenges at the municipal level is not about *having* relevant competence, but to *activate* this competence. If the PHCs engage in health overview work, and other sectors do not have the time and resources to undertake the work, their competence is not worth much (Hofstad, 2016).

Moreover, a health overview is a vital tool for identifying public health challenges, and can promote intersectoral collaboration in relation to implementation of shared goals. There seems to be a need for newer literature on how PHCs experience health overview work and will be explored in this study. Further, factors associated with how municipalities conduct the systematic public health work and PHCs view on this can be relevant in discovering how they experience intersectoral collaboration and needs deeper exploration.

2.10 The gap that this research aims to address

The literature review identifies that intersectoral collaboration can be difficult, both in local government internationally, but also in Norway. It is also known that to tackle complex public health challenges there is a need for collaboration between different professionals. Norwegian studies have found a significant association between collaboration with private and voluntary sectors and the employment and use of PHCs (Hagen et al., 2015). Therefore, this study will focus on how PHCs experience collaboration with other sectors within the municipal organization, also as relevant for developing and achieving HiAP. It seems there could be several barriers for PHCs to facilitate intersectoral collaboration, yet there is very little in-depth research about how PHCs themselves experience this, as core functions for

facilitating partnerships to get public health challenges into decisions. It is known that most of the Norwegian municipalities have intersectoral working groups for public health-related questions. What is less visible in the qualitative literature is how the collaboration is experienced in the everyday reality of PHCs, which is the gap this master thesis aims to investigate. This is an important phenomenon to explore, considering collaboration as essential for tackling municipal public health challenges, and this study could bring new knowledge into the topic.

3. Conceptual framework

3.1 Introduction

While there is no universally agreed-upon theory for intersectoral collaboration in public health, there is a growing body of research within this topic (Corbin et al., 2018). The literature argues that collaboration was best enabled using teams made up of professionals from different sectors (Weiss et al., 2016). Furthermore, collaboration for public health often requires a key driver to facilitate and connect different professions (Weiss et al., 2016; Hendriks et al., 2015), as in this study, PHCs. However, the literature review identified the concept of boundary spanners and long-term collaborations. These concepts brings together different dimensions that research suggests are important for effective local public health work involving intersectoral collaboration and will be outlined in this chapter, as the theoretical orientation of the study. How this conceptual framework was developed will be discussed in chapter 4.

3.2 The concept of boundary spanning

Boundary spanners have often been talked about in the organisational field as a role that works across multiple sectors, organisations and disciplines in governance, and, as a concept, have been imported into arenas such as public health (Sheikh, Schneider, Agyepong, Lehmann & Gilson, 2016; Hoffmann, 2012).

The ability to manage difference is particularly important in arenas where a process of collaboration happens. Here, a boundary spanner fosters a sense of shared ground, facilitates communication and connect processes and sectors across boundaries (Williams, 2002; Boston & Gill, 2019). The ability to get along with other people either individually or in groups, is a key feature of the most effective proponents of boundary spanning. This demands an investment in time to process an effective working relationship and visualize ‘reality’ from the perspective of others (Williams, 2002). Furthermore, different disciplines have different cultures, including what they view as important and less important, right or wrong and have different ‘world views’ as to the nature of problems and how these can be solved (Jones & Barry, 2011). Here, communication is seen to be especially influential because it helps to produce a shared interpretation of goals and agreement on roles and norms (Williams, 2010).

The concept of boundary spanners has been viewed in terms of ‘cultural brokers’. This term implies that they can understand another’s discipline and make efforts to emphasize and

respect another's values, motivations and perspectives (Williams, 2010). In this relation, people with boundary spanner skills have the ability to translate public health aims into relevant issues for every discipline, organization and sector and to value different motivations and perspectives (Holt et al., 2018). Considering these differences, it is important to frame this. Framing is a process of constructing and representing our interpretations of the world around us (Gray, 2003, cited in in Williams, 2010, p. 20). Stone (referred in Williams, 2010, p. 20) emphasizes the importance of casual ideas in this process. However, Schon and Rein (cited in Williams, 2010, p. 20) indicate there is a close relationship between frames and interest. This is because frames are based on people's background, history, interests and organizational roles. Benford and Snow (cited in Williams, 2010, p. 20) suggest key actors operate as "frame articulators" and function to put forwards ideas in an attempt to link their interest and interpretive frames. There is some evidence to suggest that boundary spanners perform this role (Williams & Sullivan, 2009).

Moreover, it seems as if boundary spanners should start a collaborative process of communicating a casual idea for people, to get to know their interest and lay the foundation for finding a shared ground. This can give information necessary for linking up different professions. This requires the boundary spanner to facilitate opportunities for communication to find out what everyone values as important. Perhaps three sectors are valuing and wanting the same thing, but they are just expressing it differently. Boundary spanner skills can bring these different perspectives and knowledge together, by recognizing opportunities (Mull & Jordan, 2014). Hence, knowing who needs to be involved in collaboration (Hoskins & Morley, 1991), as it is vital that boundary spanner have knowledge about "who knows what" (Williams, 2010, p. 120).

Boundary spanners might not be located at the top of the formal organizational hierarchy, but typically, has good access to it. In relation to this, boundary spanners are less *bound* by accepted norms of organizational behaviour and are encouraged or allowed to be unconventional. Their position and status within the hierarchy is such that they do not represent an explicit threat to top management but are tolerated in the expectation that they can deliver solutions to complex problems (Williams, 2010). Here, transdisciplinary knowledge can be a source of advantage to boundary spanners particularly as a means of heightening their legitimacy in the eyes of different partners. The competent boundary spanner has been marked with several skills. For example, having a personality that is reliable, tolerant, diplomatic, caring and committed (Williams, 2010).

Success in the implementation of HiAP is limited by the extent to which intersectoral

action of selected sectors can address improvement of health determinants on their own. For example, can a competent boundary spanner who is trying to ensure that children eat healthier food and have better nutrition, translate public health issues into relevant issues for every sector who can influence this. This can be policies that can use pricing mechanisms and labelling of foods, sectors who can restrict advertisements and provide more information and education for parents. However, at home parents' choices are dependent on other constraining factors, which depend on policies in other sectors and are not necessarily directly related to food, such as working times, employment conditions and requirements, availability of parental leave, and other measures influencing the scope and context in which parents can make choices (Ståhl et al., 2006, p. 13). The boundary spanner will view this as a process of negotiation and find opportunities to define the issue in relation to each sectors' values and interests.

3.3 Building substainable and long-term collaborations

The NPHA is among other built on the fundamental principle that public health work needs to take a long-term perspective to meet people's needs today while not compromising future generations (The Health Foundation, 2019). A necessary part of intersectoral collaboration involves building and sustaining effective personal relationships. This demands partners investment in time and is seen as a process that involves exploration, discovery and understanding people and what they present. It is a search for knowledge about roles, responsibilities, problems, accountabilities, cultures, professionals' norms, ambitions and underlying values. The quality of this information is allowing boundary spanners to identify potential areas of common interests and goals from different disciplines (Williams, 2002). Some factors are associated in the process of building sustainable collaboration:
1) communication; willingness and openness to be influenced by the views of other people. 2) personality; the best boundary spanners are considered to be easy and inviting, 3) understanding, empathizing and resolving conflicts; ability to manage conflict and criticism - the potential to fallout, but a willingness to move on without harming the relationship (Williams, 2002).

Trust is also an important factor associated in the process of building sustainable and long-term collaborations. Newell and Swan (2000) submit that different types of trust interrelate in particular ways depending on the motives holding sectors together in a team. Moreover, Vangen and Huxham (2005) describe building and sustaining trust as a process because each time partnerships act together, they take a risk and form expectations about the

outcome and the way others will contribute to achieving it. Each time an outcome meets expectations, trusting attitudes are strengthened. Further, the outcome of the collaboration becomes a part of the history of the partnership and can increase the chance that partners will have positive expectations about collaborating in the future (Vangen & Huxham, 2005).

Successful, stable and long-term multidisciplinary teams are characterized by members that trust each other; they are working closely together and have similar interests, values and goals. Decision-making in such groups is usually shared, and there is a collective team culture (Jones & Berry, 2018; Vangen & Huxham, 2005; Axelsson & Axelsson, 2006). Further, efforts by local PHCs or boundary spanners to build bridges and share knowledge with other sectors can help build trust and highlight opportunities for long-term partnerships (National Association of County and City Health Officials, 2017, 2017, p. 28).

Reducing health inequalities may require substantially different approaches than influencing health problems and implies maintaining a long-term policy perspective. This is because health impacts of policy changes are not necessarily direct and immediate but may only become evident much later. Sustainability and a long-term perspective are therefore of crucial importance in HiAP as well as ensuring that knowledge basis, human capacity and continuity of work are maintained (Ståhl et al., 2006, p. 14). Making this happen in practice is not simple. Working across sectors to solve complex problems require a coordination across departments and over time (The Health Foundation, 2019), as collaboration for public health can increase organizational and professional capacity (Hofstad, 2018).

In this study, the aim was to explore and understand PHCs experiences of intersectoral collaboration and HiAP. The concepts were employed for possible insight into the participants' experiences.

4. Research process

4.1 Research strategy and study design

This chapter describes the key steps of the research process from start to end. The purpose of this study was to explore and understand PHCs experiences of intersectoral collaboration and gain a deeper understanding of their everyday experiences working to take forward the municipality's systematic public health work. A qualitative approach is therefore the most appropriate research strategy, as qualitative data are rich and detailed (Bryman, 2016), and provides the basis for understanding PHCs perspectives and experiences.

A qualitative research strategy has constructionism and interpretivism paradigms. It is is based on the premise that the most appropriate way to study the social world and to generate knowledge is through people's understandings and hence to interpret humans through their subjective experience rather than viewing them objectively, as quantitative research can (Bryman, 2016). The aim is to interpret, understand and analyse PHCs experiences in detail, with an interpretive orientation of epistemology. This means that the focus is on understanding the social world through the interpretations of the participants' in their social context (Bryman, 2010). Including, a constructivist orientation of ontology, that asserts that social phenomena and their meanings are continually being affected by social actors (Bryman, 2012).

In terms of the study design, this was a cross-sectional study, including a snapshot of people's views at one point in time. The data collection was collected at a single point of time, entailing more than one informant, being interested in variation in respect of people, or in this case, PHCs (Bryman, 2012).

4.2 Sampling and process of recruitment

Sampling in qualitative research can be purposive and include people, organizations, documents and so on, with direct reference to the research question (Bryman, 2016). This research project used a form of purposive sampling of PHCs, that is to say, people whose main duty was public health work in the municipality, being aware that these professionals might have different titles in different parts of the country. The goal was to recruit participants who are relevant to the research question. There were two levels of sampling: first, selecting municipalities to invite into the study, and second inviting the specific employee in those municipalities.

The recruitment stage started in November 2019. Ten municipalities with varying size were selected based on classification of municipalities by population numbers from Statistics Norway (1998). This was to recruit PHCs from municipalities varying in size because this seemed relevant, considering the differences in how municipalities «shape» their PHC, and a strategy that could get a varied range of experiences.

After having obtained ethical approval in November 2019 (see Appendix 2), the researcher wrote an email to the ten chosen municipalities, by finding the municipal official email address for general questions. Five municipalities from both West Norway and five from East Norway were contacted and asked for contact information for the person(s) responsible for municipal public health work. The reason for including municipalities from both East and West Norway was because the size criteria were easier to meet, but also for practical travel reasons. This strategy also had the advantage of including municipalities from rural and urban areas which might be important for understanding PHCs experiences.

In December 2019, after retrieving contact information from selected municipalities, the researcher sent individual emails inviting all ten PHCs/persons working with public health. Five were positive to participate, so the researcher planned the date and time together with each participant. The remaining five were contacted by a follow-up call and asked if they had received the email. After this, two more persons agreed to participate, which means a total of six participants agreed to be interviewed. At the end of December, the researcher decided to recruit four more participants from different municipalities, considering six participants was perhaps not enough to provide richness and diversity in the data. The recruitment process was the same, with looking at the municipal size to get participants with variation. This was done as an effort to increase the sample to ten, considering this as a reasonable sample size as well as the time frame of this thesis. Of the four selected municipalities, two agreed to participate. One of them was excluded because the person did was not a local PHC but had a regional coordinator function. Eight of the 14 PHC contacted agreed to participate in the study, four PHCs working in municipalities in East of Norway, and four in West of Norway.

4.3 Data collection method

The method of data collection was semi-structured individual interviews. This method is characterized as an open interview where the interviewer is exploring the participants' perspectives and views to understand their everyday experiences (Bryman, 2016). The questions in the semi-structured interview guide were developed on the basis of the research

question and to cover the areas that were relevant in order to shed light on the research question from the perspective of the participants (Bryman, 2016). The guide contained five open questions that gave opportunities for the researcher to ask follow-up questions outside from the guide to get more details of the informants' responses (Kvale & Brinkmann, 2015; Bryman, 2016). In order to ensure that all topics of interest were considered throughout the interview, the researcher made some key words in the guide, to keep the interview conversation going, and as a safety net for the researcher if she found it difficult to come up with follow-up questions and keep the structure.

This open and flexible data collection method invited the participants to speak openly and in a detailed way about their everyday experiences of the municipal public health work and intersectoral collaboration in their work position. The interview guide was also informed by the criteria list of the successful interviewer by Kvale (1996), including open, clear and structured questions. This was to ensure getting rich and detailed information from the participants, furthermore, to become familiar with how it is recommended to act as an interviewer, including how to use follow-up, probing and introducing questions, among other practical advice (Bryman, 2016; Kvale & Brinkmann, 2015).

Some changes in the interview guide was made after conducting the two first interviews. The question was changed from: "Could you start by saying something about your role on a day to day basis?" to "Can you tell me about your role as a PHC? This was because the question was confusing because they were not sure to talk about their role as a PHC or their combined role. Two other questions were deleted after the two first interviews, because this was something the participants brought up anyway. This resulted in the guide going from seven to five questions. This resulted in an interview that offered short probes from the researcher and more detailed data from the participant for the analysis, and to use time to og in-depth to what the participants responded. The interview became more conversation-like over time although sometimes the researcher. The semi-structured interview guide can be found in Appendix 3 and appendix 4 in Norwegian.

The people who are interviewed in qualitative are not meant to be representative of a population, instead, the findings of qualitative research are to generalize to theory, rather than to populations (Bryman, 2016). The aim of this study was, therefore, in the sense of working inductively, to theoretically generalize from the data, by using theoretical concepts to say something about intersectoral collaboration for public health in Norwegian municipalities.

4.4 Pilot study

Before collecting the data for the main study, the researcher conducted two pilot interviews. Piloting has a role in ensuring that the research instrument functions well, especially when the interview guide is self-developed (Bryman, 2016). The researcher met two people who worked as a PHC. The interview guide was piloted on these two persons during November 2019. This provided some experience for the researcher when it came to preparing the interview process and the semi-structured guide for the main study. This included the use of the interview guide, and how it felt interviewing and coming up with follow-up questions and what questions to keep or remove, in order to have relevant questions for the main study. The researcher also became more familiar with using "Nettskjema dictaphone" app to take recordings and to transcribe afterwards. After getting feedback from the pilot participants and transcribing the recordings, the interview guide went from 12 to seven questions. After listening to the tape recordings of the pilot study, some questions were changed because they were difficult for the pilot participants to understand, and viewed as less relevant in order to include questions that seemed to provide in-depth data.

4.5 Interview setting

The interviews were conducted in January 2020 and took place where the participants worked each of whom was asked in advance to book a quiet room for the interview. The researcher and the participants were alone during the interviews, which lasted between 60 to 90 minutes. Before the interviews, the participants retrieved information about the study with an informed consent form which they could choose to sign before meeting the researcher, or right ahead of the interview, appendix 5, shows the informed consent form. Ahead of the interviews, they were reminded that they could withdraw at any time, to make sure they did not feel committed or forced to carry out the whole interview. The researcher also pointed out to the participants that there were no right or wrong answers to the questions asked, and that the interview was about their views and experiences. All interviews were audio recorded in line with participants consent using the required processes (Nettskjema diktafone). During the interviews, the researcher strengthened respondent credibility. This means that the researcher made small summaries with her own interpretation of what the participants said, to check if she had understood the respondent accurately (Bryman, 2016).

Over the course of interviewing, the researcher got more experienced being a research instrument and took some learning from every interview. For example, getting the informants

to really open-up was difficult initially. The informants tended to be very pleased to tell about projects and measures and talked very generally. As the interviews went by, the researcher got more experienced and was able to get in-depth data about their own experiences and views of intersectoral collaboration in the municipality. The researcher plays an essential part in the interview situation. Developing rapport with the participants and creating an atmosphere for the conversation to float naturally is an important influence on the quality and richness of data generated. This required that the researcher felt confident about talking to the participants and being used to talking with new people. The researcher experienced this to go well and was able to ask follow-up questions and was comfortable with silence to give the participants time to think. Often the participants added something more to say after remaining silent.

4.6 Data analysis

During the data collection process, each audio-recording was transcribed verbatim and this went in parallel with each interview. During the process of transcribing the researcher tried not to have too much focus on analysis while still doing fieldwork in order not to rush to premature conclusions. However, repressing analytical insight may mean losing them forever (Patton, 2002, p. 436). Therefore, the researcher wrote some keywords and reflections after each interview but did not spend too much time interpreting what they said. This was to capture initial ideas and thoughts and helped to orientate ideas towards the data analysis but did not dictate the process. The data were analyzed using a thematic analysis approach. This approach provides systematic procedures for generating codes and themes from the dataset (Clarke & Braun, 2016). The main purpose of the analysis was to discover significant ways of understanding how PHCs experience intersectoral collaboration and contribute to the existing literature of the topic (Bryman, 2012). The analytical process is meant to organize, elucidate and telling the story of the data (Patton, 2002). The aim is not simply to summarize the data content but to identify and interpret, key, but not necessarily all features of the data (Clarke & Braun, 2017).

4.6.1 Coding, categories and discovering concepts

The process of analysing the data started by reading through all transcripts and field notes while listening to the tape-recordings one more time, to become familiar with the data. In the process of becoming familiar with the data, the transcripts were marked with three different colours, where red was direct talk about how they experience intersectoral collaboration; yellow was data that could be important for how they experience it; and blue

was other important sayings and metaphors. Parallel to this, each transcript was fractured into smaller pieces and labelled with initial codes and notes. Codes are the smallest units of the analysis that capture interesting features of the data, and are building blocks for themes, patterns and meaning (Clarke & Braun, 2017). After coding the data, a search for themes started by collecting codes into potential themes, in order to gather all relevant data to potential theme. In order to so in the most systematic way, important parts of each transcript were put into table 1. This was inspired by Charmaz (2014) and illustrates an example of the process where pieces of the transcript were put into a table that included columns of 1) quotations, 2) initial codes and further transformed to higher-order analytic 3) themes and 4) categories.

Table 1. Example of coding and categorization of the data.

Quotation	**Initial codes**	**Theme**	**Category**
"I think that the intersectoral public health work in this municipality has been a challenge because we had no continuity in the public health team"	Collaboration best viewed when having continuity the team	Collaboration as a long-term process	Organisational capacity
"There is no point to drag someone in (public health team) that don't have time or interest, we get much further if we have people that are passionate"	People being passionate about public health made it easier for PHCs to produce better teamwork Authority of PHCs	Working across boundaries	Professional capability

Moreover, themes were developed through interpreting each transcript with codes and was a search for repetitions, patterns, metaphors, similarities and differences in the participants' experiences (Bryman, 2016). Furthermore, looking for extraordinary deviations and underlying causes, especially in terms of identifying the crucial details that could give new insights into the phenomenon (Clarke & Braun, 2017).

The process of going from initial codes to emerging themes went over a long time and included crucial interpretations and reflections. In this process, two mind maps were made to try to make sense of the initial codes and notes. At the same time, the tables with initial codes from each participant were printed out to look for patterns and repetitions and were also a part of the development of themes. This was not a linear process but involved moving between the data, field notes and the literature. Interpreting the data offered explanations, conclusions, making inference, bearing in mind to not describe but try to interpret the findings, in order to make sense of the data (Patton, 2002; Bryman, 2016). At the end of this process, the initial codes and the mind maps were reviewed and further transformed into themes. After the themes were made, two categories were developed, as themes showed different patterns.

The literature turned out to be helpful in the development of the themes and categories. This was done by comparing the existing literature with the emerged themes, to see if the themes made sense or if the themes could be inspired by similar themes in previous research. A qualitative approach works primarily in an inductive way, which allows the analysis to emerge from patterns found in the empirical data of the study, without presuppositions in advance of what is important for understanding participants (Patton, 2002, p. 56). This is especially related to the desire to allow categories and themes to emerge naturally from the empirical data during analysis (Dunne, 2011). Interpreting the findings while reading existing literature, involved looking for logical ways of organizing the data and was a search for alternative theoretical concepts (Patton, 2002). More specifically, the literature on intersectoral collaboration helped to develop a conceptual framework. The process of developing the concepts was not linear. It first started out with a broad outline of concepts, called sensitizing concepts, and gives a very general sense of the phenomena and a useful guide to empirical enquiry (Bryman, 2016, p 383). Further, the concepts were revised in connection to what came to sight through reflections in the process of data collection and analysis. The concepts were then narrowed to the researcher's synthesis of what was meaningful for conceptualizing the research question of the study. This is because theory is the outline of this study when working inductively (Bryman, 2012).

4.7 Description of the participants

The participants were eight PHCs or other persons who had the main responsibility for municipal public health work, seven women and one man with varying ages. To maintain participants' anonymity the municipal size is divided into three different categories. Table 2

presents participants' job title, size of the municipality, per cent of employment and place of position.

Participants educational background also varied, including 1) Kindergarten teacher, 2) Masters in public health science, 3) Store management, 4) Political scientist, 5) Occupational therapist and political science, 6) Nurse and masters in interaction and management, 7) Bachelor of social geography and masters in change management, 8) Master of public administration and management.

Table 2. The participants' job title, size of the municipality, per cent of employment and place of position.

Job position	**Municipal size**	**Percent of employment**	**Place of position**
Healthy life supervisor	2000 - 4999	60%	Right below the Chief Executive Culture sector
Public health coordinator and drug and crime preventative coordinator (SLT-coordinator)	2000 - 4999	100%	Right below the Chief Executive
Municipal chief of culture and adolescence	2000 - 4999	100%	The leader group of the Chief Executive
Municipal chief of living conditions	2000 - 4999	100%	Right below the Chief Executive
Head of the unit for culture and sports	2000 - 4999	100%	Community development sector
Area planner	4999 - 19 999	100%	Sector of area use
Advisor development and strategy	19 999 - 49 999	100%	Below the Chief of development and strategy
Municipal planner	19 999 - 49 999	100%	Municipal Chief of Community development, below the Chief Executive level

4.8 Ethical considerations

Ethical considerations were clarified at an early stage of the research project. In general, ethical aspects of research involving people are not so different from ethical considerations in everyday interactions with people (Oliver, 2010; Bryman, 2016). The researcher received NSD approval on 21st November. When recruiting the participants an information sheet was sent out by e-mail to each, to deliver as much information as needed to make an informed decision about whether to participate in the research project or not (The Norwegian National Research Ethics Committees, 2016). This includes information about their right to withdraw from the study at any time, also during the interview. The document also included information about how the data would be managed and that the interview would use audio-recordings (Bryman, 2016; Oliver, 2010). The participants received written information and oral information when the researcher met the participants, in order for the participants to ask questions if they had some. A consent form was signed by both the researcher and the participant when they met in person. Each received a copy.

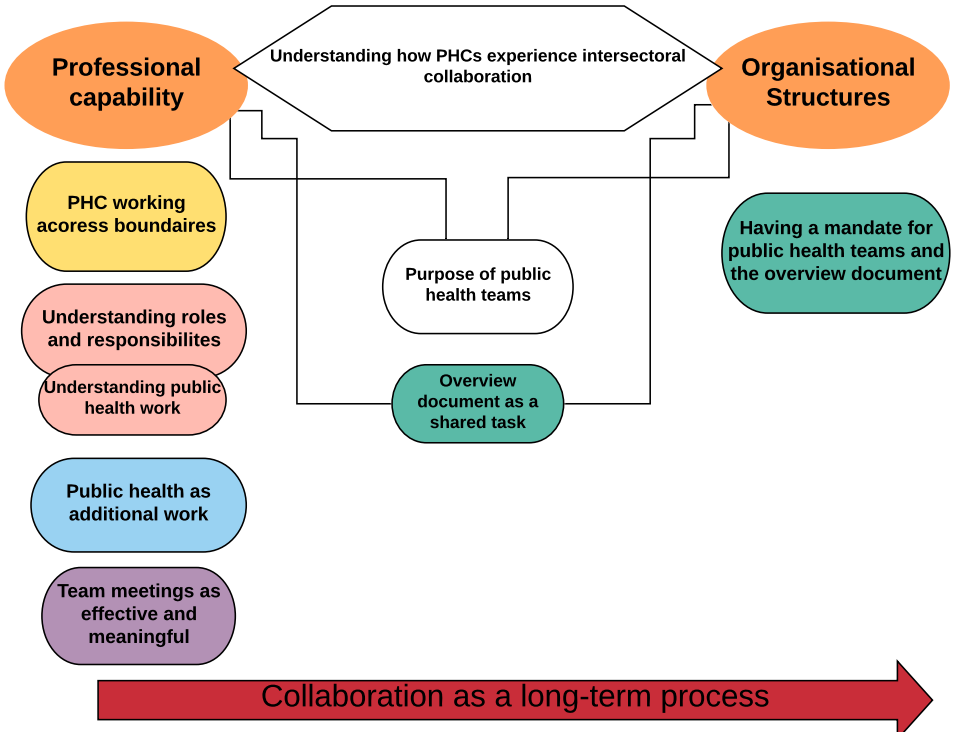
To record the interviews the app "Nettskjema-Dictaphone" was used on the researcher's own phone. This was to prevent intermediate storage on the phone but stream audio directly to a secure storage area (Nettskjema) (Inland University Norway, 2019). When taking quotations from the transcript, an ethical principle is that all participants remain anonymous in order to avoid doing harm to people. This means that private data that can identify participants is not disclosed (The Norwegian National Research Ethics Committees, 2010). To keep the participants' anonymity "participant 1, 2…" were used. Further, all quotations used were translated from Norwegian to English, which also could have contributed to remaining the participants anonymity, however, this is also a limitation and will be discussed in chapter 6.

5. Findings

5.1 Understanding how public health coordinators experience intersectoral collaboration

In this chapter, the findings will be presented in order to shed light on the research question, which is: How do public health coordinators experience intersectoral collaboration?. They focus in particular on the constraining and enabling processes at a local level. All the municipalities in this study had, or have had multidisciplinary teams for public health, driven by the PHCs, but with varying degrees of success. Proffesionals placed in sectors that were involved in public health teams varied but was for example sectors like health, culture, area, technical and other. A few pointed out having well-working public health teams. Two indicated a failed attempt at collaboration, while some participants reported hope for the future development of collaboration. Figure 2 presents the categories and themes in line with the principles of the analysis: nine themes emerged. The themes showed different patterns; therefore, they were divided into two inter-related categories.

Figure 2. Categories and themes about understanding how public health coordinators experience collaboration.



Categories are those marked in orange with themes below. Professional capability relates to themes about individuals working in the municipality, for example, what professions have the power to do and ability to do. For example, PHCs capabilities to work across boundaries and for various sectors to understand public health work and their role in it.

The category organizational structures relates to the theme about municipal structures that are mandated and may play an important role in the pursuit of intersectoral collaboration. The themes «purpose of public health teams», «overview document as a shared task» and «collaboration as a long-term process» can relate to both categories. This will be explained further below in this chapter.

5.2 Wokring across boundaries

This theme was developed as participants had differing experiences about working across boundaries that were seen to exist in the municipalities. Participants mentioned they had worked in the municipal organization for many years, which they saw as a strength because they knew how things worked. However, many of the participants lacked a clear job description where responsibilities were described so that their role as a PHC was diffuse and up to each one to interpret, what they could, or should do. Some requested a clearer work description, while others felt like the NPHA was their description, including the overview document. However, overall, this meant that PHCs had a lot of discretion about how they could work.

At the same time, 7 of the 8 participants had the PHC role responsibility added to their original position. This was not necessarily seen by PHCs as a limitation for facilitating intersectoral collaboration. However, some indicated that they felt as if they had to accept the responsibility for public health, on top of their original discipline. In a way, it was just something they could not decline, only accept. Consequently, this made it difficult for PHCs to cross their own and other boundaries considering they had other tasks additional to the PHC role. Many PHCs felt relatively alone in their role, and this made it even more important to get commitment and support from those in their public health team. This was viewed as empowering when they felt alone in their work, as participant 4 put it:

> *Ehh it has been frustrating, when you are alone as a PHC, then it is important to have a team around you that views it as their task and not a team that thinks it's me running the public health work.*

However, crossing boundaries was seen as important for the public health team's success. In this regard, it was judged to be important for the PHC to show particular kinds of leadership skills, as participant 7 expressed it: *" Eh I think it is a little bit about my personality and education… There is a little bit of leadership skills in it, and how to deal with different types of people* ". This participant stood out from the other PHCs. This was because the participant found it beneficial not being placed in any sector but alone, right below the Chief Executive. It was explained that this meant that other colleagues then saw that s/he had no other sector associations or obligations in terms of belonging to, for example, the health sector but rather was a neutral person who was available for everyone to contact. This also helped facilitate meetings, moving across boundaries and making conversations with everyone to retrieve knowledge about what sectors had on their agenda. This was seen as a key factor for making team meetings effective and meaningful for everyone involved.

Most participants talked about working across boundaries to facilitate collaboration as difficult, especially when they got the impression that people in different disciplines lacked interest and ownership of public health. This made it also difficult to have sustainable public health teams. Some participants mentioned that it was about sectors attitudes not to give it less priority. As they had the impression that sectors were not motivated for being a part of a public health team. Moreover, they described how sectors might feel a strong "pull" towards their own discipline, which meant they were most interested in working within the field of their own competence and speciality and, for whatever reason, were reluctant to be stretched beyond that. Participant 4 expressed it thus: *"Uhm it is clear that these intersectoral tasks are not so easy, they often get in conflict with the core tasks, it is a competition about the attention and resources".*

In a way, it was challenging for PHCs to get sectors to go beyond the boundaries of their own sector. On the other side, those people who was committed, enthusiastic and passionate towards public health work made it easier being a PHC. For example, participant 2 explains: *"There is no point dragging someone in (to the public health team) that doesn't have time or interest, we get much further if we have people that are passionate".*

One way of trying to increase interest in public health work was offered as an example by one participant who had experienced a successful process of developing sectors involvement in public health work. This was done by making sure everyone in the team had some autonomy in what they wished to contribute within the team's public health work. Making sure everyone was asked during team meetings what was important for them regarding public health work in their own sector was a part of creating involvement. By

asking this, it could also lead to increased interest and ownership. For example, participant 7 explained:

> *If you can feel ownership to it, then it is better to work with public health.... It is up to each unit to choose what to collaborate about. There are plenty of intersectoral measures but sectors must have ownership of them; it is wrong for me to choose (what they should contribute with), because they should get a sense of ownership to public health work being their responsibility.*

Participants talked about the term ownership relating to interest in public health work, as if sectors sensed ownership then it was easier to get everyone around the table to talk about public health and achieve positive outcomes. For some PHCs it was important to value sectors different motivations and views on how they thought about public health. Also, it was thought that professions themselves should identify what was essential for them when taking action on public health challenges.

PHCs understood that intersectoral work had more chance of happening if people were interested in public health and passionate about it, as this could lead to collaborative public health teams, and generate commitment. In contrast, PHCs who experienced less interest and commitment thought the reason was that sectors already had a powerful interest in their own discipline and did not understand their role in public health teams.

5.3 Understanding public health work

Overall, PHCs recognized the public health field as broad and challenging to handle. This theme was developed to reflect the way in which participants talked about different sectors' understanding of public health work, as well as when talking about their use of the public health term. Participants talked about an increased focus on public health and that the field had significantly received more attention since the NPHA was passed into law in 2011. Participants perceived that most people working in the municipal organization were aware that public health was not only the health sector's responsibility. At the same time, participants also had an impression that this understanding still varied among different professions. For example, participant 2 said: *"I think some when they hear 'public health' still think health… but it has become better, and I think people are more familiar with the it now".*

There might still be associations from professionals that public health is related to the health sector, which could make it challenging working with people who had little

understanding that public health is much more than health service or health care. For example, participant 6 explained:

> *I think the term is really important and I wish we used it more, and I see that when colleagues absolutely should have a conscious relationship to public health. When my closest colleagues heard that I was going to become a PHC, they said: "yes you're gonna become some health stuff". Then they don't have much knowledge of what public health work is... They have good competence in their own discipline, but it is disappointing that they do not have more knowledge about public health.*

As far as PHCs saw things, it was reasonable to expect that people from other professions knew a little more about public health and even their role in it, as well as it is so much more than 'health stuff'. The reason for not using the term more often was because people were not familiar with it and lacked an understanding of public health work. Participant (6) was working in a middle-large municipality, where collaboration in the past had some struggles and was still in the starting-phase of re-organizing a new public health team. It is worth noting that this participant was relatively new in the role of a PHC and had this role added onto the original working role.

In contrast to this, participants were optimistic about the future development of public health understanding among members of the team and the need for intersectoral collaboration. At the same time, some indicated there was still a need to improve people's understandings of public health, to get everyone in the same direction of working intersectorally and for the municipality to work systematically with public health. For example, participant 3 explains: *"When people really think, then I think they view it (public health work) as important... although not everyone has a big awareness of it, then they are quick to give it less priority".*

The importance attached to a better understanding of public health within the municipality in general, and the public health team more particularly was seen as making it more likely that people would prioritise it in their work. It was therefore really important that people understood it was work that went way beyond the health sector.

5.4 Understanding roles and responsibilities

A specific way in which understanding public health work was talked about was in relation to the roles and responsibilities of those in various sectors. For the PHCs, it was essential, if collaboration was to work well, that sectors understood how their work had

implications for public health. Hence, it was important for sectors to understand their role in public health work. In contrast, some PHCs indicated that not every sector understood what they could offer the team and therefore were unclear about what their role could be and what they could be responsible for. There was, however, some understanding that this was part of an ongoing process and would not happen overnight. For example, participant 1 shared experiences from previous attempts at collaboration and had suggestions for adjustments: *"The next step with the group is to have a dialogue, where everyone can ask themselves "what is public health for me, and how do I interpret it?.* Ideally, such a dialogue should be done in the starting phase of the public health team and give space for sectors to explain their understanding of their role in public health work. For example, participant 4 puts it this way:

> *It is more about getting it (public health) up for discussion, to get more knowledge and understanding about your own role in public health, with public health glasses on.*

Moreover, participants voiced it was important to use team meetings to discuss how everyone interpreted public health in their own work. However, participants explained that the issue with public health work was that it had been fronted as everyone's responsibility, but that this led to everyone giving public health teams less priority. A critical step in success was for sectors to go from knowing that public health was everyone's responsibility to developing a concrete understanding about what this responsibility actually meant. This, however, seemed challenging for both PHCs and sectors to put into practise because PHCs indicated it should not be necessary for them to tell people what role and responsibility they have. Rather, this was up to each sector to find out themselves. In line with this, participants wished sectors themselves could be more enthusiastic about developing their role understanding. Most PHCs requested more engagement and willingness from sectors, as it was seen as sectors own responsibility to find out their role and responsibilities in systematic public health work and in a public health team.

5.5 Public health as additional work

This theme was developed to reflect participants expression that collaboration in public health work was viewed as additional to everything else sectors should do. At the same time, systematic public health work was also talked about this way. For example, participant 4 talked about systematic public health and described it as: *"I have experienced a limited*

amount of knowledge among some persons… increase this knowledge about systematic public health work in general so it becomes just as systematic as any other planning processes…. everyone should contribute".

Because public health work was viewed as additional to everything else, as a process it was therefore given less priority and viewed as having less value. Public health work was thus viewed as needing more legitimacy in the sense of having more authority. The argument from PHCs was that the planning process for systematic public health work should be prioritised just as any other planning process in the municipality. This was seen as a way of integrating public health work more fundamentally into all the work of the municipality.

PHCs indicated sectors did not understand the point of attending public health team meetings. This made it difficult for the PHCs because they felt like they were adding, something which sectors also perceived as additional work for them. In a way just telling sectors what to do, for example, requiring them to attend team meetings, or bring information to the overview document was seen as giving them something additional to their everyday work.

Another aspect of this theme relating to perceptions of public health work being additional was that other sectors looked at public health as not being urgent work, in that it was not something that had to dealt with within a short timescale, with a specific deadline. This was also seen as a part of the explanation for why people did not attend team meeting; not attending was perceived by others – including PHCs themselves to some extent – as not having any damaging consequences, at least in the short term. Participant 2 expressed it thus:

> *It is clear that because public health work is not a time-critical work, it has been sometimes challenging to get everyone to the team meeting. And it is very easy for me included to down prioritize the collaborative meeting over an urgent case. There have been meetings where I said we have to tighten up, eh because we don't get progress. No one has a specific time set off to this, but it is about attitudes to not give it less priority, but it is very easy to not prioritize it because there is no damage done if we don't meet the other month.*

However, PHCs felt as if down-prioritizing team meetings could easily happen over time. They were aware that sectors had their own tasks to fulfil and that collaboration could get in the way of these tasks as everyone was busy enough. Additionally, PHCs recognised that sectors had limited capacity themselves, which was likely to strengthen their feeling of

public health being additional work. That public health had been promoted as everyone's responsibility, was percieved as an unintended consequence, that meant that others could step away from public health work when things were very busy. Participant 8 expressed it in the following way:

> *Public health where no one has the responsibility alone, yet where everyone has the responsibility …, it is like that with tasks in general. It could fall aside and be put on hold if we experience other things that are more urgent.*

Overall, public health work was perceived by the PHCs to often conflict with other work that sectors had to do. In this regard, PHCs were frustrated that there seemed to be little understanding of the potential benefits of coming together to increase capacity for their municipal public health work.

5.6 Team meetings as effective and meaningful

PHCs experienced a varying degree of effectiveness during meetings with the public health team, which meant that PHCs found it difficult to get sectors engaged in team meetings. In contrast, PHCs who experienced good collaboration, reported that having a clear agenda for each team meeting could lead to an effective meeting where everyone perceived it as meaningful and everyone had something to bring up for discussion. For example, a participant wanted to keep an update on what every sector was planning, by contacting them, but also got them taking contact. Therefore, the PHC was able to get a sense of what they valued as important in relation to making a clear agenda for the public health team. By doing this, the PHCs were creating a process for including people in a meaningful way. For example participant 7 explained:

> *I have worked tactically with knowing what everyone is working on, then I know some have a wish to do this, then I see others wanting that but they just view it differently, then there is a third who wishes something else. Then I can say; I have heard that this is a challenge in three different places and I will arrange a meeting for us to talk about it.*

In contrast, those who experienced unclear agendas for team meetings indicated that there was no point at having the meeting with no reasonable outcomes. PHCs often found the

team conversations to be about what each sector is already doing instead of what they can to together as a team.

5.7 The purpose of the public health teams

This theme emerged as a condition of both organisational structures and professional capability. This is because it involved the capability of professions to identify the purpose, but also because many had mandated public health teams in a partnership deal with the County, or had one because it was stronly recommended by the Government and the NPHA. When asking PHCs what the purpose of having a public health team was, the responses varied.

Some emphasised the concrete outputs they were responsible for, such as the overview document. Others mentioned that public health team meetings were an important process that could lead, over time to a better understanding of local public health work and their part in that. In reality, given the challenges of working intersectorally at a local level the value of a process of meeting together was rarely if ever realised. This meant that meetings became a forum for updating and more substantial issues such as developing shared goals tended to be side-lined. Some PHCs mentioned they had to ask themselves what the purpose of their team was and acknowledged that team meetings just happened in the principle of having a team. For example, when asked what the purpose of their public health team was, participant 6, replied:*"Hmm, eh, that is a really good question that we have to ask ourselves because we end up meeting just to meet, and in the best case, updating each other about what we are working on, and it is random, and it becomes unconnected from a clear objective".* The participant was not sure why this tended to happen, although the participant explained that there had been some disagreements in their public health team, because people had differing perceptions of what public health work was. The expectations about the purpose of collaboration to tackle inequalities in health and get health in all policies that had been highlighted in the NPHA, was not present for all municipalities.

Many of the participants expressed specific measures or projects that they were implementing, but few were in relation to collaboration in the public health team. Collaboration for public health was thus happening somewhat randomly rather than systematically. For example, participant 5 got asked how collaboration was experienced, and explained: *"It is not challenging for me to go up to people and say "hello, we have to..." ehh but it happens a little bit randomly".*

5.8 Collaboration as a long-term process

This theme was experienced as a matter of capacity of the public health teams to work together over time, furthermore the importances of leadership, and for the development of role understandings. In connection to this, PHCs viewed collaboration as best when it became a long-term process. It required ongoing interaction, dialogue and working together to develop and confirm shared understandings of local public health work. PHCs expressed that these collaboration teams would not just happen because everyone thinks it is a good idea or because it was mandated by the NPHA.

In contrast, most PHCs experienced it was the opposite. PHCs talked about failed attempts to create long-term collaborations. PHCs thought collaboration was something that should happen, and believed sectors also recognised that fact. Everyone knew that they had to follow the guidelines from the County and the national Government in order to report having 'done' intersectoral collaboration. However, sustained involvement of the same people was viewed as important. Participant 2 mentioned: *"I think that the intersectoral public health work in this municipality has been a challenge because we had no continuity in the public health team".*

However, PHCs viewed collaboration for public health as a long-term process, where taking actions on the public health challenges was not fixed during one meeting. Further, PHCs who achieved a long-term collaboration and continuity in teams indicated it was fundamental for team members to understand each other better, develop role understanding, and create shared goals.

5.9 Overview document as a shared task

PHCs highlighted the overview document as a challenging and time-consuming task. The overview document was time-critical work in that the material for it, must be done by a specific month of the year. Therefore it was placed below both of the categories, as it is a something mandated and requires proffesional capabilities.

Overall, participants echoed it was challenging to get the overview document to become a shared task, hence, to get sectors to bring information into it. Regarding this, the PHCs viewed the document as everyone's responsibility to deliver relevant information into it, with the PHCs' responsibility being to collect and finish the overall document. Often PHCs experienced working on the document with the local medical officer and writing most of the document alone, because they found it difficult to get information for it without getting the feeling of adding more work upon sectors. It was described as a matter of sectors'

understandings and knowledge with the document. Further, the challenge to make it a shared task was also expressed as a matter of each sector's capacity to contribute. PHCs acknowledged that the time for them to be asking for information was necessary, considering sectors had other urgent tasks to fulfil in their work.

The process of retrieving information for the document seemed in other words as a matter of PHCs' authority to get it. Some mentioned they had requested this information in the public health team but ended up disappointed by the response. Meanwhile, PHCs who had a mandate to delegate tasks for the overview document experienced this as empowering in a way of adding more authority to the request for information from each sector. At the same time, the consequence was that the quality and quantity of received information varied. For example, participant 2 explained:

> *When the analyses with the overview document are done, we write the goals and the target areas together, but no, that is not how it is, and I know it won't become like that either… No, because they might not be familiar with the tool (overview document), where you receive the information. People should maybe do some research themselves, it is me who has delegated the whole process, it is my document... I have asked can you please make an overview of the resident structure?"... It was very little to get from them, and I felt like a secretary who had to do all of the work, and that's how it ended.*

The consequence for the PHCs was more work on the document and that it might lack important information. The consequences for the local municipal public health work was in terms of being unable to identify public health challenges adequately. Ultimately this meant that systematic public health work in a long-term perspective was very difficult. These findings were in line with the three other themes in the findings: team meetings as meaningful and effective, the purpose of public health teams, and understanding roles and responsibilities. Participants experienced the overview document is a tool that needs to become a shared responsibility and for professions to become more knowledgeable about it.

5.10 Having a mandate for public health teams and the overview document

Some participants had a mandate for their public health team, including a mandate for delegating tasks for the overview document. This mandate meant that PHCs have a formal authority to have a public health team and for various sectors to attend meetings. Further, that PHCs can delegate sectors to bring needed information to the overview document. This mandate is signed by the Chief Executive of the municipality.

Having a mandate for a public health team was talked about in both a positive and a negative way for collaboration to take place and function well. The positive way was that PHCs experienced that having a mandate for their public health team, as well as for the overview work, could give them the formal support to be calling into meetings, alongside sectors having a formal duty to appear and contribute to the overview document. Hence, it provided PHCs authority to get everyone around the table and talk about public health in the context of everyone's work and responsibilities. The negative was that PHCs felt that team meetings could be "forced" upon sectors when having a mandate. In other words, they expressed a feeling being perceived as pushing public health onto other sector's agendas in a way that becomes something they just had to be a part of and fulfil. In other words, it could mean that sectors were not included in a meaningful way. Participant 5 who had a mandate for their team talked about it in this way:

> *The challenge is when you need others… the leaders that are in the public health team it can be hard because I experience that for them it is something that is forced upon them… a lot of them I think are so busy that public health becomes like something they just have to be a part of, right.*

6. Discussion

6.1 Introduction

This study aimed to understand the Norwegian PHCs experiences of intersectoral collaboration. Understanding the PHCs' perspectives also contributed to revealing the constraining and enabling processes and factors within their everyday reality of working to take forward the municipality's systematic public health work. Furthermore, previous research has focused on many different aspects of intersectoral collaboration and little in-depth research on PHCs, which this study add to the existing literature.

The findings chapter presented the different themes and categories, but this chapter will present the core findings. This chapter starts with presenting the limitations of the research. It further discusses the findings in comparisons with previous literature presented earlier in this study to illustrate what this study has added in terms of understanding how PHCs experience intersectoral collaboration. Furthermore, through detailed and rich data of PHCs perspectives along with the conceptual framework, this study provided some explanations of constraining and enabling processes and factors. This will be done further below, as the main theoretical supplement for understanding PHCs experiences. Implications for policy and practice are also discussed.

6.2 Limitations

This research project has some limitations which are important to discuss in order to consider the limits of validity and integrity of the research. In contrast to quantitative research, the sample in qualitative methods is relatively small but can provide detailed data about a much smaller number of people (Patton, 2002). The most important issue in qualitative research is that the selected participants provided information richness (Patton, 2002), so that a valid understanding of PHCs social reality could be developed based on their perspectives. The researcher sent out invitations to 14 PHCs but ended up with a total of eight participants. With this sample size, it was possible to identify patterns in the data that provided valid findings saying something about the everyday reality of PHCs and their experiences with intersectoral collaboration. The sample was also varied in terms of PHCs' backgrounds and the kinds of municipalities they were working in. This means that the findings can also be related to many different kinds of circumstances within municipalities.

The aim was to theoretically generalize, in this case, use theoretical concepts to say something about intersectoral collaboration for public health in Norwegian municipalities.

This can have the potential to explain why things are the way they are in terms of enabling and constraining processes in a general way beyond the specific sample used in this study. However, it must also be said that if the sampling had been expanded to include a larger number of participants from different kinds of municipalities additional patterns and insights might have been developed. Nevertheless, within the timeframe and resources available for the Masters' dissertation a cut-off point had to be identified.

A human being is the instrument of qualitative methods (Patton, 2002, p. 64). The limitations of this study concern the researcher being inexperienced with being a research instrument. However, a small pilot study helped the researcher become aware of the challenges that would need to be managed in conducting the study in general and in organising and carrying out the interviews in particular. Furthermore, as the researcher got more experienced in the main study she was more able to generate in-depth data as the interviews went on. It is acknowledged that a lack of skill and confidence could have limited the generation of in-depth data in the two-three first interviews.

In order to strengthen the credibility of this study, throughout the whole research process, the researcher reflected on the process by critically self-questioning. This meant that reflecting on different steps, from the very start on the project description to every little step of the process was an ongoing learning process, for example, by asking "what shapes and has shaped her perspective and how does she know what she knows?" This included reflecting back and forth on the learning outcomes of the research. The supervision was really helpful in this process, it provided several reflections and thoughts that pushed the researcher to reflect in different perspectives on the stages.

Another limitation of this study is that the interviews were carried out and transcribed in Norwegian but the analysis involved translating quotations into English so that they could be discussed as part of supervision as well as presented in the final thesis. It may be the case that some of the meaning in the quotations might have been misplaced because they were translated from Norwegian to English.

During the process, the researcher got the opportunity from Rogaland County to attend "partnership for public health seminars". More specifically Rogaland County has "partnerships agreements for public health" with all the municipalities in the county. They arranged seminars for PHCs where the goals are to share experiences and discuss different topics concerning the municipal public health work. Rogaland County asked the researcher if she wanted to attend seminars to talk about her research into inhibiting and promoting processes regarding intersectoral collaboration, as the seminars were about this topic. The

researcher got to attend two of these seminars lasting a whole day, where PHCs talked about their experiences with collaboration for public health. Although this was not a part of the research process bearing on the principle of integrity in the analysis it is important to note because the researcher attended the seminars in the starting-phase of the analyses process. The information that was retrieved and interpreted at the seminars might have influenced the data analysis in some degree and might be a limitation. At the same time, the researcher could evaluate if the interpretations from the seminars could support alternative explanations of the data (Patton, 2002). This helped to increase the researcher's confidence in the original explanations of the data that were developed in this study. For example, the information retrieved at the seminars might have overly influenced the interpretation in a way that gave less weight to the participants in the study.

The validity, meaningfulness and insight from this study reflects the researchers' analytical capabilities (Patton, 2002). What is important in qualitative thematic analysis is letting the participants' words speak for themselves, but also attempting to interpret them and seek hidden patterns (Clarke & Braun, 2013). The validity lies in the deep exploration of themes in providing a "thick description" that strives to let the reader see what is going on and to understand the underlying meanings of the participants (Braun & Clarke, 2006). That is to say, there is no "correct way" of interpreting the data. The researcher tried to see if the findings reflected the experiences of the participants in a believable way and to double-check this by looking over the transcripts in line with the interpretations, as an attempt to reveal the meaning of the data (Whittemore, Chase & Mandle, 2001). However, the methods of qualitative inquiry stand on their own as a reasonable way to find out what is happening in human settings (Patton, 2002), in this case, relating to the everyday experiences of PHCs trying to facilitate intersectoral public health work in municipalities.

6.3 Discussion of main findings

The main findings of this study show that although PHCs varied in their individual views, overall they all experienced intersectoral collaboration differently from what is advocated in the NPHA. Attempts were made to facilitate action for collaboration across sectors, but with varying degrees of success. This be may be linked to the diversity and complexity in how Norwegian municipalities practise their systematic public health work (The Office of the Auditor General of Norway, 2015; Hagen et al., 2015; Lyshol, 2016). These findings confirm that facilitating collaboration is not a straightforward process, but

occurs over time, where the ability to have well-working collaboration depends on communication alongside professional and organisational capacity (WHO, 2017).

6.3.1 Public health coordinators' different preconditions of their role

An important finding is that PHCs have very different preconditions in relation to how their role is shaped. Much of the Norwegian literature on PHCs has focused on these factors (Hofstad, 2016; Von Heimburg & Hofstad, 2019; Hagen et al., 2015), however, the findings of this study agrees with Hagen et al. (2018) and Hofstad (2018) suggesting to have PHCs in positions close to full-time. This is because PHCs who were flexible in their time spent on coordination, also experienced having capability to work across boundaries. Previous research alongside the Norwegian Government recommends placing PHCs nearby the Chief Executive Officer to get the overall policy agenda (Norwegian Ministry of Health and Care Services, 2009; Hofstad, 2018). In addition, Hofstad (2018) indicated that PHCs experience and awareness of the municipal organization might be just as crucial as being placed nearby the Chief Executive. The findings of this study additionally found that it seems essential that PHCs have authority and support of the Chief Executive and colleagues, to lead a public health team to influence HiAP (upwards and sideways), and less important where they are situated. Similar findings are found elsewhere, in Bekken (2018), and Lyshol (2016) for example, where public health officials felt that they lacked time to do their job and missed support from colleagues.

Another constraining factor related to PHC preconditions to work across boundaries, relates to the role being added to professionals' original work. Although not all PHCs in this study viewed this as a limitation, this is in line with the findings of Helgesen and Hofstad (2012) stating that regardless of per cent of employment, PHCs did not reduce their ambitions to work intersectorally. At the same time, PHCs seem to have much discretion about how they should work. This is in line with previous research reporting PHCs may lack a clear work description in which responsibilities are described (Von Heimburg & Hofstad, 2019). The concept of boundary spanners recommends being knowledgeable about one's own organization (Williams, 2002). On one side, PHCs seemed very knowledgeable and had worked there a long time before getting the PHC role. On the other side, working there a long time can perhaps explain why they found it difficult to work across boundaries taking on a different role than their original. This is because working across boundaries requires different ways of working than what they were used to, rethinking traditional methods of managing relationships (Varda et al., 2012), and at the same time having discretion about how they

should work. In relation to this, the concept of boundary spanners is described as less bounded by normal and accepted norms of organizational behaviour and can be unconventional (Williams, 2010). It may be the case that it is difficult to cross boundaries for those who get the PHC role added on top of their original, traditional *bounded role*. Stepping out of established norms of their work behaviour is limited because they already have an attachment to their original role and to their main work tasks. This can explain why crossing boundaries is a difficult, and further why PHCs experienced a lack of role understanding among various sectors. Therefore, if boundary spanning processes can be possible for PHCs, it seems important to not have two different roles in the municipality. Another argument for PHCs to not have another role is that this limits the opportunities for getting knowledge about what other disciplines can contribute in solving complex public health challenges. Having transdisciplinary knowledge can also be a source of advantage as a means of heightening PHCs legitimacy in the eyes of different sectors and further connecting them (Williams, 2010). Moreover, it is important for PHCs to know who to include in the public health team, as one factor in making team meetings meaningful for everyone.

6.3.2 Public health coordinators capabilities to work across boundaries

Findings of this study are consistent with the findings from the Danish study of Holt, et al. (2018), concluding it is time to dismiss the idea that intersectoral action can be achieved through structural rearrangements. Instead, they concluded that focusing on promoting awareness of each profession's relevance for public health action and enhancing the boundary-spanning skills of public health officers. Also, that forming intersectoral teams is based on the assumption that bringing sectors together with the mandate to implement policy across sectors, will improve knowledge sharing and information flows and intersectoral commitment. In the same vein, the findings of this study revealed that having public health teams does not necessarily entail possibilities to provide shared goals and HiAP. Furthermore, this study indicated that organisational structures have less significance even though the emphasis in Norwegian policy is given to the structural organisational aspects of intersectoral collaboration. This study reveals that for PHCs the most important dynamics relate to the people in their public health teams, and their colleagues out there in different sectors.

This findings indicated that it seems critical for PHCs to have specific capabilities to work across boundaries, especially professional skills of a key person (the PHC) who can unite different sectors by enhancing their understanding of their role in a public health team. This concerns several of the themes developed, that are connected to PHCs' capability to make necessary changes in order to achieve productive working collaboration for public health challenges. Similar findings have been outlined in previous research but with an assumption that PHCs may need training in collaboration competency (Hofstad, 2018). Holt (2018) additionally discussed that enough time for PHCs to fulfil their role might not be sufficient to ensure the desired results given how important it is for PHCs to possess the competencies and skills required (Holt, 2018).

The findings indicate that PHCs struggled to produce a shared interpretation of goals and agreements on roles in the municipal public health work. One reason can be because people are placed in their sector and the communication to produce a shared interpretation of goals and agreement on roles gets lost (Williams, 2010), especially if people do not attend team meetings.

In the same vein, if there is little continuity in teams, developing a coherent inclusive vision is difficult. A further constraining factor related to how hard it was to include and get commitment from their team when they were perceived as less interested in public health. PHCs seemed to accept that some were more interested and passionate than others. It might be important for PHCs to secure sectors' motivation for being a part of a public health team in terms of wanting to and needing to. Furthermore, for PHCs the key challenge is to function as a key person who can make public health challenges into relevant issues for every discipline, which is an enabling skill of boundary spanners, and in so doing value their different interests and motivations (Williams, 2002; Varda et al., 2012). This helps team members better understand their role in the public health team, so that shared goals can be made. This is also supported by Synnevåg et al (2018a), who state that PHCs should be facilitators who are available as discussion partners. In this way, facilitating dialogue could promote meaning and reflection, which was seen as essential for sectors' understanding and ownership of public health goals. This can explain why having a mandate for public health teams had little value if PHCs do not have the capability to trigger sectors' ownership of public health work and help them to understand their role in a team. At the same time, this requires that PHCs have the competence to address improvement in health determinants and find opportunities to define the issue in relation to each sector's own values and interests. In contrast, some PHCs looked at developing role understanding and ownership as sector's own responsibility. However, if

sectors operationalize public health work into something suitable for them, perhaps the wider public health context can be missed. For example, Carey and Crammond (2015) experienced the need to break down the social determinants of health, communicating this information in suitable ways within the different government department. On the other side, PHCs should consequently make sure everyone in the team has at least a degree of autonomy to talk about their different perspectives on public health challenges. This can promote openness, autonomy and trust and is fundamental for sectors to reveal their interest, and for PHCs to find a shared ground and further for teams to develop shared goals (Axelsson & Axelsson, 2006; Williams, 2002). This means that it is important to find a balance between breaking down the social determinants of health for each sector, but at the same time making sure sectors interests and goals of their work remains.

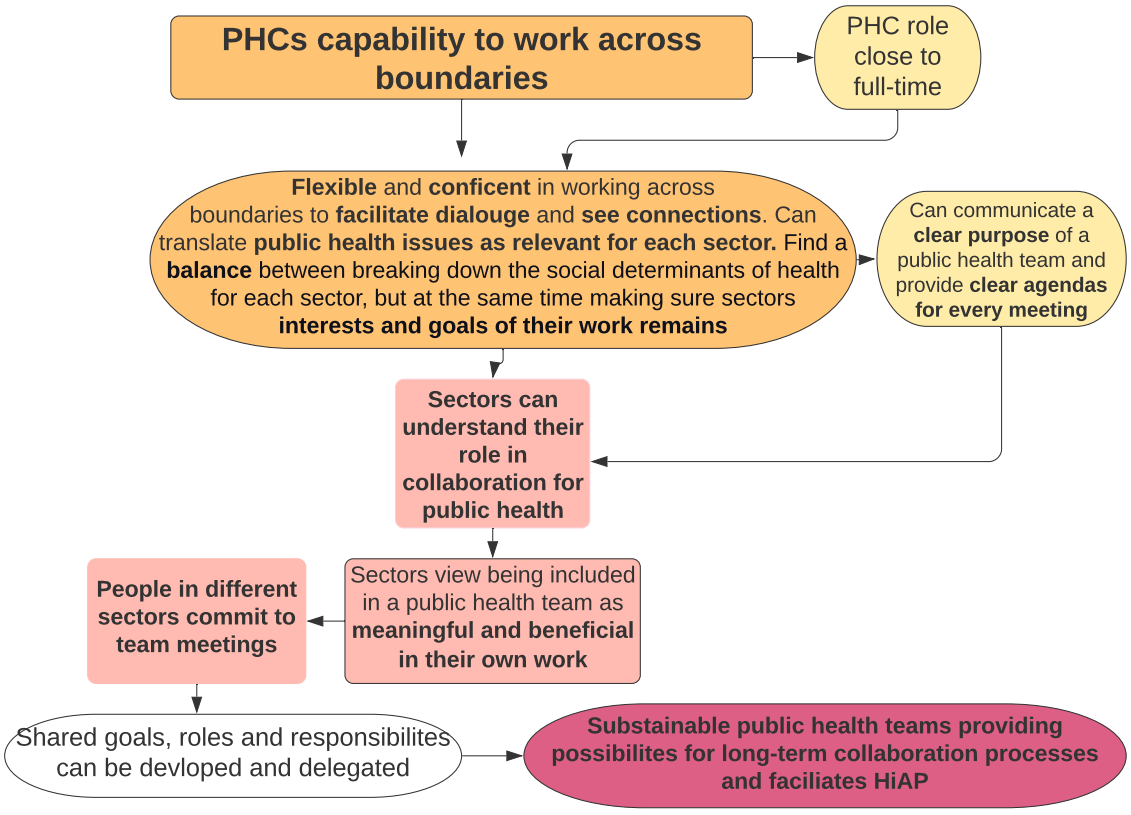
In relation to meaningful team meetings, the findings indicated that an important factor for getting commitment to public health teams was sectors attitudes towards public health. Here, Jones and Berry (2011) found that attitudes to intersectoral collaboration was seen as an important predictor for sustainable partnerships. PHCs mentioned that it was not every sector that understood that public health is work that goes beyond the health sector, and therefore not their responsibility. PHCs got impressions that sectors could view the public health team, as less important in relation to their own work or even additional work. Linking this to the concept of boundary spanning, PHCs could benefit from retrieving knowledge about sectors 'frames' and attitudes towards collaborating, to reveal important information before connecting different sectors to a public health team (Benford & Snow, cited in Williams, 2010). Another interesting finding is that few PHCs underlined the importance of evaluation. This concerns evaluation about how communication and leadership is perceived in the public health team, which might have led to a lost opportunity for PHCs to adjust after needs, and their opinions whether the public health team is functioning in line with their expectations (Chircop et al., 2015; Synnevåg et al., 2018a).

Overall, not many participants talked about their education background as beneficial. To understand an enabling processes from PHCs perspectives, an example from one participant can be explained. This participant mentioned his/her education in store management as useful in the PHC role, as well as retriveving knowledge about sectors' attitudes towards collaboration, besides triggering sectors to reveal what they viewed as important in regard to the municipal public health work. A good illustration of what this PHC talked about was getting people to collaborate being comparable to selling a product and explaining the benefits of buying the product, in this case, benefits of collaboration (co-

benefits). It also involved listening carefully to what the customer (sectors) wanted and viewed as important. This PHC had the perception that this contributed to being good at crossing boundaries and communicating with different people in sectors. An important factor, was that this PHC did not work in any sector but was placed right below the Chief Executive, which might also be important in making the PHC role appear neutral. The PHC used negotiation skills, finding opportunities to define issues in relation to each sector's own values and interests.

As the findings of this study have revealed and discussed above, there are a lot of constraining factors and processes for PHCs working across boundaries to faciliate intersectoral collaboration. However, based on PHCs' experiences and the concept of boundary spanning, figure 3 is a theoretical model that was developed to bring together enabling factors and processes to show what needs to happen for intersectoral collaboration in Norwegian municipalities.

Figure 3. Theoretical model to explain enabling factors and processes of facilitating intersectoral collaboration at the local level.



6.3.3 Long-term collaboration and the overview document

Trust is an important factor that underpins the process of building sustainable and long-term collaborations. PHCs did not indicate a lack of trust among the memebers of the team. This is however congruent with findings revealing that trust is often taken for granted and is recognised as being present (Jones & Barry, 2011; Williams, 2002).

However, the findings indicated that outcome expectations of the public health teams was to be negatively loaded, in a way that people in various sectors might not expect achieving excellent results of such teamwork. At the same time, municipalitites lacked a clear purpose of having a public health team. This can explain why teams did not achieving long-term substainable collaborations, and might be because the culture of teamwork is not well-established. Overall, trust interrelates in ways depending on the motives holding sectors together in a team (Newell & Swan, 2000). It is therefore essential for PHCs to ensure that the purpose and motivations of keeping a team together is perceived as understandable and accepted by everyone involved. Ensuring this, is particularly important in the starting-phrase of uniting sectors, concerning the purpose of collaboration is widely agreed as an essential factor in uniting collaborative partners (Corbin & Mittelmark, 2008). A clear meaning of a public health team, that holdes it together, seems therefore crucial in order to achive substainable teams and positive outcomes, where building trust happends over time, and is strengthened each time an outcome meets expectations (Vangen & Huxham, 2005). This can possibly fade sectors' perceptions of public health as additional work. Furthermore, boundary spanner skills becomes essential for everyone involved in the team to realise how they can play a part in intersectoral collaboration, and look at the teams challenges as relevant for their work. This, along with a clear purpose increases the chances of a long-term collaborative team and HiAP.

An important factor related to how PHCs experienced intersectoral collaboration, was linked with the overview document. Even if attempts were made to make this document a shared task, PHCs found in many cases that this work remained a narrow task for themselves. Not getting others involved in the overview document can explain why it was challenging to develop shared goals, as it is a tool for identifying public health challenges. It can also tell why the planning process of the systematic public health work, was not, from the perspectives of PHCs where it should be. The overview document requires a broad spectrum of knowledge and data, and this documents needs to become a shared task for the whole municipality. This is because the NPHA requires municipalities to understand the social determinants of health and health inequalities by developing a health overview (Fisher, 2018; Norwegian Directorate

of Health, 2017). Previous research on PHCs and their experiences with the overview document has not been done, however Vedelt and Hofstad (2014) suggested the document to be a task for everyone in the municipality.

From PHCs perspectives, this study add that people might lack knowledge about how to use the document, and why it is a necessary tool. Another issue that arise is that when PHCs engage in health overview work, sectors do not have the time and resources to undertake the work. In contrast, if everyone involved in a public health team can put time and effort on information to it, it can perhaps promote ownership and interest to collaborate to tackle challenges identified. This is supported in Lyshol (2016) reporting that the use of plans as a tool for change can make collaborations take place as it makes knowledge explicit.

6.4 Implications for public health policy and practice

Collaboration for public health can be seen as a process where HiAP is the goal. The findings of this study indicate that Norwegian municipalities struggle to establish sustainable long-term public health teams, where various sectors are involved so that getting HiAP can be achieved. However, participants did not talk much about the policy perspectives of intersectoral collaboration. The reason for this might be because of the culture or norm that Norwegian municipal organisations perhaps have, which is to take distance from politics, in the way of letting the policymakers do their job, and they do theirs. This study did only focus on collaboration within the municipal organisation (professions in sectors and units), and future research could explore how municipalities involve and collaborate with their citizens and possible effects on achieving HiAP. This is because, in collaborations for public health, municipalities have a role of engaging the private sector, the voluntary sector and citizens (WHO, 2015, p. 98; Norwegian Ministry of Health and Care Services, 2019).

At the same time, many participants mentioned that their municipality had implemented a “consequence for the public health” point, in their saksmal, this is a layout that professions use when presenting different issues for the policy makers. Having this on the ‘saksmal’ was a relatively new initiative. However, it underlines the importance of different professions’ knowledge about public health consequences and ability to adress the social determinants of health. Perhaps not everyone is able to ensure the bigger public health perspective is developed but PHCs have a central role in so doing. Further research could focus on the implications of having a consequence for public health in municipal ‘saksmaler’, as this can be an important tool for achieving HiAP.

The findings suggest that Norwegian municipalities could benefit from having PHCs

with boundary spanning skills in a full-time position, concerning implementing the principles of the NPHA and achieving sustainable public health teams. A PHC in full-time with boundary spanner skills has the potential to promote awareness of sectors role and implications in the municipal public health work. Moreover, can move around boundaries to facilitate dialogue to see connections, identifying peoples 'frames' and valuing professions' different motivations and interests. Furthermore, it seems crucial that PHCs can enhance sectors' knowledge about the overview document to get this a shared task and increase awareness of this document as an essential starting point for systematic public health work.

Suggestions for future research should focus on all the public health teams that exist in Norwegian municipalities. More specifically, a qualitative study of members in public health teams could be undertaken to reveal their point of view on collaboration for public health, as this study only focused on PHCs, and did not consider other perspectives.

7. Conclusion

The purpose of this study was to understand the Norwegian PHCs' experiences of intersectoral collaboration and reveal constraining and enabling processes and factors of their everyday reality of working to take forward the municipality's systematic public health work. This study adds, to some extent, the understanding of the PHC role and how they experience intersectoral collaboration, and builds on the existing literature of the complexity of collaboration for public health.

PHCs everyday reality of working to take forward the municipality's systematic public health work and experiences of collaboration varied. Some found intersectoral collabortion to be less present, while others seemed to have stable well-working public health teams. PHCs indicated that dynamics related to people in their public health teams, and their colleages out in different sectors was more important than organisational structures. For example, how important it is for PHCs that people understand their role in public health work, to get commitments to teams in order to achive stable and long-term collaborations.

Findings show that PHCs have different preconditions based on how they are shaped (role being added onto their original work, place of position and clarity of their role). It seems critical for PHCs to have clearity of their responsibilities and have specific capabilities to work across boundaries to unite different sectors. The findings of this study add to the previous literature that PHCs in full-time position who can use boundary spanning processes, have the potential to enhance implementation of the principles of the NPHA and achieving sustainable public health teams, that can ensure HiAP. More specifically, this seems important in order to meet the Norwegian Government's expectations for this role.

The findings also go some way to explaining why intersectoral collaboration as a process and HiAP as an outcome often do not occur. Even though the NPHA became a law eight years ago, it does not necessarily follow that suddenly everyone works in a direction of collaboration. Furthermore, it can not be assumed that there is a broad and deep understanding of systematic public health work. This also explains, in part, how public health work continues to be strongly associated with the health sector as being the prime 'mover and shaker' in local public health work.

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Appendices

Appendix 1: literature search strategy

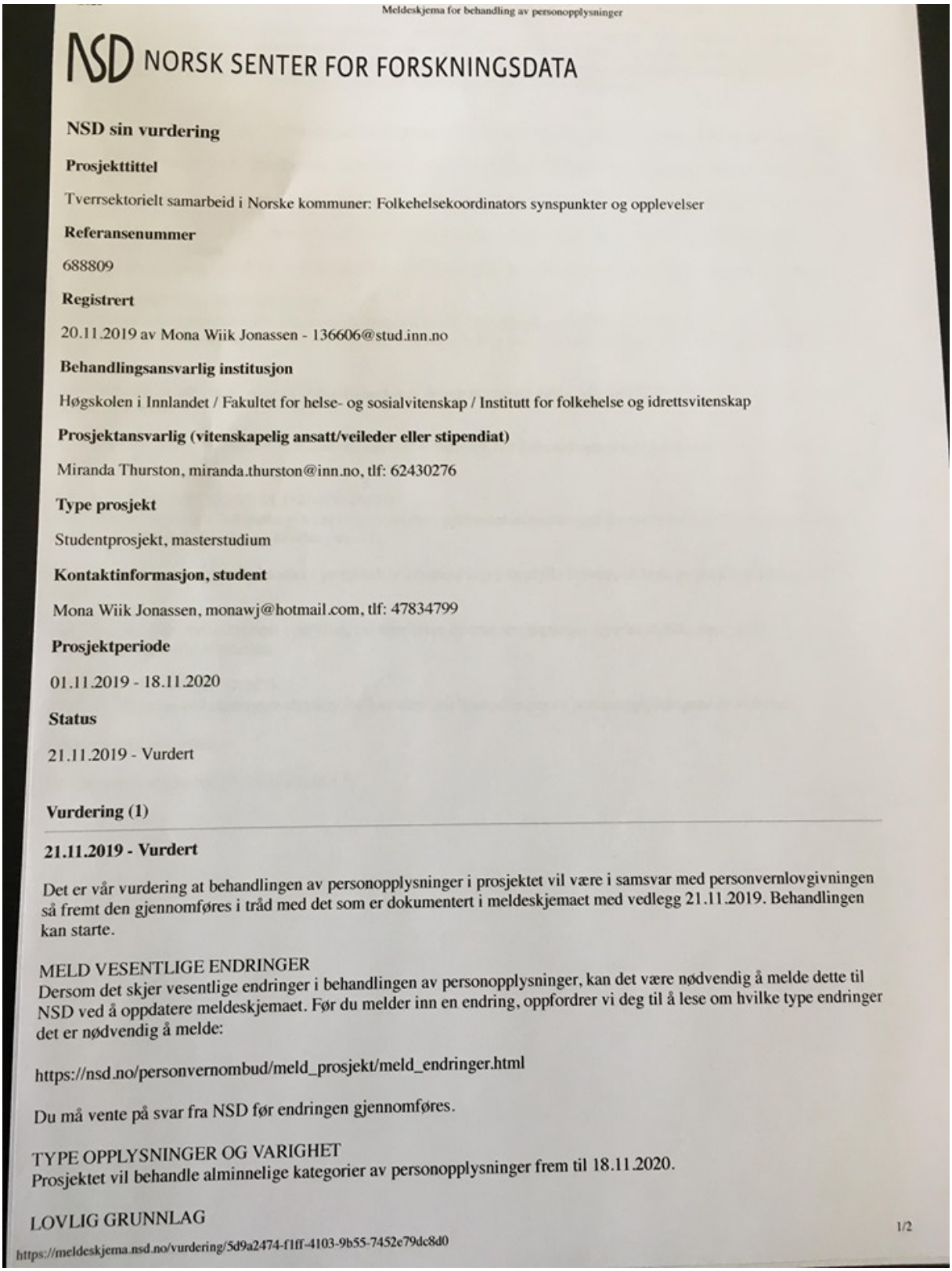
The literature search focused on local public health work and intersectoral collaboration both from Norwegian and international literature. The review found that intersectoral collaboration is a topic that has a rich tradition of research. The search was performed systematically in a table that included:

Authors and year	Database and date	Keywords	Overall results	Articles read in full text	Articles included*	Summary of findings

Inclusion criteria: Scientific publications (articles, books, reports). Within the public health policy field. **Keywords that was used:** Intersectoral collaboration, health in all policies, local public health, partnerships, cross-sectoral, public health officials, public health coordinators, health promotion partnerships.

The systematic literature search was done in databases like **Oria, google scholar, PubMed, Idunn and CINAHL.** After reading abstracts or full-text of relevant literature, a snowballing approach was used to find relevant articles from the articles that were found. Throughout the research process reading and finding relevant literature continued. Substantial revisions of the literature review were made towards the end of the research process.

Appendix 2: approval from NSD - in Norwegian



Meldeskjema for behandling av personopplysninger

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Tverrsektorielt samarbeid i Norske kommuner: Folkehelsekoordinators synspunkter og opplevelser

Referansenummer

688809

Registrert

20.11.2019 av Mona Wiik Jonassen - 136606@stud.inn.no

Behandlingsansvarlig institusjon

Høgskolen i Innlandet / Fakultet for helse- og sosialvitenskap / Institutt for folkehelse og idrettsvitenskap

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Miranda Thurston, miranda.thurston@inn.no, tlf: 62430276

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Mona Wiik Jonassen, monawj@hotmail.com, tlf: 47834799

Prosjektperiode

01.11.2019 - 18.11.2020

Status

21.11.2019 - Vurdert

Vurdering (1)

21.11.2019 - Vurdert

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet med vedlegg 21.11.2019. Behandlingen kan starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde:

https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html

Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige kategorier av personopplysninger frem til 18.11.2020.

LOVLIG GRUNNLAG

1/2

https://meldeskjema.nsd.no/vurdering/5d9a2474-f1ff-4103-9b55-7452e79dc8d0

Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse som kan dokumenteres, og som den registrerte kan trekke tilbake. Lovlig grunnlag for behandlingen vil dermed være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a.

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke behandles til nye, uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

NSD vurderer at informasjonen om behandlingen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

Dersom du benytter en databehandler i prosjektet må behandlingen oppfylle kravene til bruk av databehandler, jf. art 28 og 29.

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og/eller rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!

Tlf. Personverntjenester: 55 58 21 17 (tast 1)

Appendix 3: interview guide – in English

Checklist before the interview:

- **I want to thank you for participating in this interview. You are helping me complete my master thesis at the University of Innlandet.**
- **Sign the informed concent____**
- **I want to remind you that you can withdraw from the research at any time, including during the interview. Please remember there are no right or wrong answers to the questions I am asking as I am interested in knowing about and understanding your experiences and views on topics relating to your role.**
- **I will be starting asking some general questions about your role, and further about intersectoral collaboration and themes relating to this.**
- **Before we start, do you have any questions?**

Participant: _____ Municipal size_____

Job title _____ Percent of emplyment:_____ Length of position as PHC: _____ Length of position in the municipality:_____ Combined with: _____ Placement: _____ Closest leader:_____ Education:_____	
1. Can you start to describe your role as a PHC? Important tasks, work description	
2. During the last month, who in relation to work, have you talked the most to? **2.1 What was the purpose of talking to this person(s)**	
3. How do you experience collaboration with other sectors in the municipalities? Challenges, work environment, PH term, improvements, dream scenarios, a concrete experience that you remember really well. Intersectoral team? A typical meeting Leader Purpose	
4. What do you think about the meaning of collaboration in relation to getting healthy in all policies?	
5. Other	

Appendix 4: interview guide – in Norwegian

Huskeliste før intervjuet:

- **Signere samtykkeskjema ____**
- **Jeg vil takke deg for at du deltar i denne studien, og at du hjelper meg å fullføre masterstudien ved høgskolen i innlandet.**
- **Jeg vil minne seg på at du kan trekke deg når som helst gjennom intervjuet.**
- **Også vil jeg bare si at det finnes ingen rette eller gale svar. Gjennom intervjuet er jeg bare ute etter dine tanker, opplevelser og synspunkter.**
- **Jeg kommer til å spørre om litt generell informasjon om din stilling. Videre om tverrserktorielt samarbeid og relaterte temaer spesielt rundt din rolle.**
- **Før vi starter, er det noe du lurer på?**

Informant: _____ Innbyggertall_____

Stillingstittel: _____ Stillingsprosent:_____ Lengde stilling som FHK: _____ Lengde jobba i kommunen:_____ Kombinert med: _____ Plassering: _____ Nærmeste leder:_____ Utdanning_____	
1. Kan du starte med å fortelle om din rolle som FHK/____? Viktige arbeidsoppgaver, stillingsbeskrivelse	
2. I løpet av den siste måneden, hvem har du i jobbsammenheng ofte snakket med? **2.1 Hva var formålet med å snakke med denne personen(ene)?**	
3. Hvordan opplever du samarbeid med andre sektorer i kommunen? Utfordinger, arbeidsmiljø, FH begrepet, forbedringer, drømme senario, konkrete opplevelser som du husker godt **Tverrsektorielt team?** Typisk møte Leder Hensikt	
4. Hva tenker du om betydningen av samarbeid i relasjon til å få helse i all politikk?	
5. Annet	

Appendix 5: consent form

Vil du delta i forskningsprosjektet

" Folkehelsekoordinatorer og folkehelseansvarlige sine synspunkter og opplevelser om samarbeid for folkehelse"?

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å utforske folkehelsekoordinatorer og folkehelseansvarlige i kommuner om deres synspunkter og opplevelser relatert til tverrsektorielt samarbeid. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål
Formålet med denne masteroppgaven er å få et innblikk i folkehelsekoordinatorer/folkehelseansvarlige opplevelser relatert til samarbeid for folkehelse. Problemstillingen som ønsker å besvares er «Hvilke synspunkter og opplevelser har folkehelsekoordinatorer om tverrsektorielt samarbeid»

Hvem er ansvarlig for forskningsprosjektet?
Høgskolen i Innlandet er ansvarlig for prosjektet.

Hva innebærer det for deg å delta?
For å kunne fullføre masteroppgaven har jeg behov for å gjennomføre intervjuer med folkehelsekoordinatorer/folkehelseansvarlige i ulike kommuner. Varigheten på intervjuet vil ligge på cirka 30-60 minutter Det vil foreligge en semistrukturert intervju som vil bli ført som en samtale mellom intervjuer og den intervjuende. Intervjuet ønsker å bli tatt opp med lydopptaker på egen mobiltelefon. Opptakene sendes direkte til skylagring som er sikret for uvedkommende, det er kun forsker som har tilgang. Lydopptakene blir dermed ikke laget på mobiltelefonen. Underveis i intervjuet ønsker intervjuer å ta notater.

Det er frivillig å delta
Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger
Vi vil bare bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

- Opplysninger som blir gitt under intervjuet vil kun være tilgjengelig for meg (student) og min veileder ved Høgskolen i Innlandet etter opplysningene har blitt anonymisert.
- Navnet, kontaktopplysningene og eventuelt annet som kan identifisere deg vil bli lagret elektortonisk i «Nettskjema» som er et dataoppbevaringsverktøy anerkjent av Høgskolen i Innlandet, Personvernsombundet og Regionale Etiske Komiteer.

I det ferdige resultatet vil det ikke være mulig å gjenkjenne deg ut ifra opplysninger som kommer frem under intervjuet. Det vil nevnes i publikasjonen utvalget er folkehelsekoordinatorer og/eller folkehelseansvarlige fra kommuner i Vest-Norge og Øst-Norge. Det vil benyttes opplysninger som «Informanter» og «kommuner», dette skal gjøre at deltakerne ikke er mulig å gjenkjenne i publikasjonen.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?
Prosjektet skal etter planen avsluttes 18.mai 2020. Intervjuopptakene og personopplysninger vil bli slettet ved prosjektslutt. Personidentifiserbare opplysninger fjernes slik at anonymisert data vil bli oppbevart seks måneder etter prosjektslutt. Dette er hvis det forekommer at Høgskolen krever bevis om at forskningen har foregått.

Dine rettigheter
Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,
- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Høgskolen i Innlandet har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- Høgskolen i Innlandet ved **Student:** Mona Wiik Jonassen, mail: monawj@hotmail.com telefonnummer: 47834799. **Veileder**: Miranda Thurston, mail: miranda.thurston@inn.no
- Vårt personvernombud: NSD – Norsk senter for forskningsdata AS, på epost (personverntjenester@nsd.no) eller telefon: 55 58 21 17.

Med vennlig hilsen

Prosjektansvarlig
(Forsker/veileder)

Student

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet «***Folkehelsekoordinatorer sine synpunkter og erfaringer om tverrsektorielt samarbeid***» og har fått anledning til å stille spørsmål. Jeg samtykker til:

- ☐ å delta frivillig i studiens intervju
- ☐ at opplysninger om meg kan brukes i publiseringen (anonymt)
- ☐ at mine personopplysninger lagres etter prosjektslutt og deretter anonymiserte opplysninger frem til 23. november 2020.

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca. 18.mai 2020.

(Signert av prosjektdeltaker, dato)