BMJ Open

Collaboration between local authorities and civil society organisations for improving health: a scoping review

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To cite: Bäck A, Modin Asper M, Madsen S, *et al*. Collaboration between local authorities and civil society organisations for improving health: a scoping review. *BMJ Open* 2025;**15**:e092525. doi:10.1136/bmjopen-2024-092525

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (https://doi.org/10.1136/bmjopen-2024-092525).

Received 16 August 2024
Accepted 14 March 2025

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ABSTRACT

Objectives Cross-sector collaboration has been encouraged to improve population health. Both local authorities and civil society organisations impact population health, but less is known about *how* the actual process of collaboration is done. This scoping review aims to explore how local authorities and civil society organisations collaborate with the ambition to improve population health.

Design This scoping review was informed by the guidance of the Joanna Briggs Institute, and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews.

Data sources Medline, Web of Science, CINAHL and Sociological Abstracts were searched from inception to September 2022.

Eligibility criteria We included peer-reviewed empirical studies that describe the initiation, execution or sustainment of collaboration for health between local authorities and civil society organisations.

Data extraction and synthesis Two independent reviewers extracted data, which was summarised and analysed using inductive content analysis.

Results In the 79 included articles, collaborations between local authorities and civil society organisations entailed many different aspects, from exchanging knowledge, allocating resources, providing different types of support or human resources, training, forming different working groups, agreements and working plans to gathering data for needs analysis or evaluation. Few articles described how the collaboration had been initiated or sustained. Initiation was done through advocacy, needs assessments, making a request, creating a workgroup and conducting a pilot study. Sustainment efforts were continuous meetings, documents and tools, funding, and different plans and work structures. There were often additional actors involved in the collaborations. Information about study design was often not described in a clear and comparative manner.

Conclusions There is a need for more research on the details of initiating, executing and sustaining collaborations for health between local authorities and civil society organisations. Knowledge from this scoping review can be used to inform the planning of future collaborations between local authorities and civil society organisations.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The scoping methodology offered a thorough exploration of how collaborations have been characterised in the literature.
⇒ The scoping methodology allows for the exploration of a topic using both quantitative and qualitative methods.
⇒ A systematic process for conducting scoping reviews was used, and the scoping review protocol was registered in the Open Science Framework to ensure transparency (https://osf.io/vk3uc).
⇒ This scoping review deviates from the (Joanna Briggs Institute) guidelines by only including peer-reviewed literature to avoid a skewed inclusion of non-peer-reviewed literature (most often published in the language spoken in the setting where the efforts are undertaken) in English.

BACKGROUND

Collaboration between different sectors is increasingly encouraged to improve population health. The rationale is often that health is shaped by many factors outside the healthcare system,[1] and that health determinants are found across different types of sectors, such as welfare and city planning. Further, public health activities are performed by multiple actors,[2] for example, local authorities (LAs) and civil society.

Provided the nature of public health activities, LAs, that is, official organisations governing an area of a country,[3 4] are essential in setting up collaborative structures with other actors. LAs are responsible for providing public services[3 4] relating to several different sectors (eg, health and welfare). These authorities belong to different government tiers within a country and might be active on, for instance, county, city or municipality level.[5] According to the WHO, LAs are valuable actors in reducing health inequalities as they have knowledge about the local needs and problems in their areas.[6] LAs make important decisions regarding public

health prioritisation, including what they invest in, or discontinue investing in, for instance, choosing whether to prioritise universal or targeted health interventions.[7] The collaboration between LAs and other actors, such as civil society, has been pointed out as crucial for reducing health inequalities.[6]

Civil society can be viewed as a distinct sector, a social sphere, separate from the state and the market.[8] Civil society organisations (CSOs) are engaged in public issues[9] and could be, for example, charities, private voluntary organisations, foundations, religious organisations, support groups and sports clubs.[8] The involvement of CSOs in public health has been longstanding but has become more pivotal and visible as a response to discontentment with centralised authority, the quality of public services and policy decisions.[10] CSOs engage in public health matters on many levels, from influencing health policy to advocacy work or service provision to members of the public.[8] Further, when working together, organisations use a range of processes, from merely exchanging information to merging their operations. These processes can be categorised into levels of intensity that describe the degree of organisational integration and connection through certain activities, for example, sharing of resources, sharing responsibility, decision-making and risk-taking.[11] CSOs have an essential role in advocating for access to health services and the prioritisation of disadvantaged groups, especially in low- and middle-income countries.[12] They also provide significant services and support to underserved communities and groups,[8 13] for instance, providing immunisations in rural areas.[14] CSOs have therefore been pointed out as salient actors for outreach approaches targeting those most in need.[15]

Collaboration between government (on both national and local levels) and CSOs could be an important step in attaining the Sustainable Development Goals, as these organisations are put forward as key to achieving the goals.[16 17] CSOs' efforts in public health can concern topics such as access to clean water and sanitation,[18] health education,[19–21] or access to preventive or health service provision (eg, immunisation and nutrition supplements).[20 22 23] Efforts may also increase the demand for healthcare by reaching socially vulnerable groups (eg, building trust and referring to appropriate health services)[20 22 23] and reducing financial obstacles (eg, reduced out-of-pocket-payments through loans or insurance plans).[20 23] For instance, the advantages of collaboration between LAs and CSOs are the pooling of resources regarding economy, capacity and expertise,[24] which can lead to improved service quality.[25] However, these collaborations can also experience several challenges, including different objectives between actors, poor communication, unclear responsibilities[26] and power imbalance.[26 27]

In sum, both CSOs and LAs can impact population health.[28] However, details on how the collaboration process unfolds are generally lacking, as highlighted by several authors. There are gaps in knowledge about collaboration details, such as the varying types and intensities of collaborations, the information needed to understand what may work and why, and what the collaboration standards among participants entail.[1 29–31]

Given the potential for improving health through collaboration efforts, the study's aim is to explore how LAs and CSOs collaborate, with the ambition to improve population health.

METHOD

Scoping reviews are appropriate to identify types of evidence on a particular topic, clarify concepts, examine how research has been done, identify key characteristics concerning a topic, identify knowledge gaps or as a foundation for a systematic review.[32] The scoping review followed the updated Joanna Briggs Institute's guidance for conducting scoping reviews with the exception of including grey literature.[33] Further, the results are reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR).[34] See online supplemental file 1—PRISMA-ScR checklist. The study has been registered in the Open Science Framework (https://osf.io/vk3uc).

To achieve the aim of the study, the following research questions were posed:

- How have collaborations aiming to improve health been initiated between LAs and CSOs?
- How have collaborations to improve health between LAs and CSOs been executed?
- How have collaborations to improve health been sustained between LAs and CSOs?

Further, enablers and barriers for collaboration and evaluation of the collaboration process were explored.

Inclusion and exclusion criteria

Population

Articles were included if they described collaboration between two actors: (1) CSOs and (2) LAs. We excluded articles examining authorities on a national level only, and collaborations with solely private business enterprises.

Concept

All articles describing a collaboration to enhance population health, regardless of sector, are included. Collaboration is often described in terms of collective actions, involving more than one actor, with a mutual purpose,[35] here, achieving health outcomes specifically.[35 36] We included all articles describing the collaboration between these two actors, regardless of the terminology that was used to describe the process of working together.[37–39] We excluded articles that described pure financial support. Provided our interest in collaborations that focus on improving health, we also excluded articles that did not concern collaborations related to Sustainable Development Goal 3: to ensure healthy lives and promote well-being for all at all ages.[40] Articles that could not provide any data to either one of the research questions were also excluded.

Context

Articles could originate from any geographical location and any sector (eg, health and welfare, housing and planning, water, and sanitation), providing the criteria for population and concept were fulfilled.

Evidence sources

Articles were included if they were empirical studies, peer-reviewed and written in English. Excluded were non-empirical articles (eg, protocols, reviews, theoretical articles), non-English and not peer-reviewed.

Search strategy

The search for relevant articles was done from August to September 2022 by an information specialist at Karolinska Institutet Library. All four databases were searched from inception: Medline (Ovid), Web of Science (Clarivate), CINAHL (Ebsco) and Sociological Abstracts (Proquest). The search strategy encompassed MESH terms and free text terms related to the search concepts. See online supplemental file 2—Search strategies. Duplicates were removed using the method described by Bramer *et al*.[41]

Study selection

Titles, abstracts and keywords for all citations were screened using Rayyan.[42] First, all reviewers (ABä, MMA, SM, LE and ABe) independently and blindly screened 30 abstracts and compared the judgments. The inclusion and exclusion criteria were further discussed to ensure that the data obtained was relevant to the research aim. This process continued until the level of agreement was 75% or above.[43] In the next phase, all abstracts were screened by two reviewers blindly. Conflicts were discussed between the two reviewers, and any conflicts were resolved between them or within the larger author group. The full texts of the included abstracts were independently screened by two reviewers using Covidence.[44] Using the same principles as for the screening of abstracts, any conflicts between the two reviewers were first a subject for agreement within the pair, or if they could not reach an agreement, brought to the attention of the author group.

Data extraction

We created and pilot-tested a data extraction form prior to full data extraction, and some minor adjustments and clarifications were made (https://osf.io/vk3uc). The data extraction was done by two independent reviewers (ABä, MMA, SM and ABe), and any conflicts were resolved between them or with someone in the author group. The extraction form included items concerning publication data (eg, author and title of the publication), study characteristics (eg, country and study aim), collaboration actors, collaboration characteristics (initiation, execution, sustainment, duration, intensity, health issue), barriers and enablers for collaboration, and collaboration outcomes.

Definitions in the data extraction template

The countries were categorised into four categories depending on the type of country: *low-income*, *lower-middle income*, *upper-middle income* and *high-income* according to the classification by the World Bank[45] at the time of the study's publication.

The intensity of collaboration between LA and CSO was categorised according to the types of collaboration described by Bailey and Koney[11]; *cooperation* (eg, information exchange, support, using combined resources for own tasks, independent decision-making), *coordination* (eg, aligning activities, contributing staff to the shared effort, decision-making and resource integration is task-specific, often short-term), *collaboration* (eg, formal work plan, pooled resources more frequently include funding, tasks are undertaken in an integrated manner, shared decision-making and risk-taking, often long-term) and *coadunation* (eg, the combination of two or more organisations into a single organisation).

Descriptions of collaboration outcomes were extracted, focusing on the operational and organisational levels,[46 47] that is, the processes and relationships among the actors in the collaboration. Distant outcomes, such as reduced maternal mortality or increased uptake of screening for HIV, were not extracted. Further, when and how empirical data about the collaboration process was gathered was also extracted.

Analysis

Descriptive information such as the country where the collaboration took place, type of CSO and LA actor was directly gathered from the articles and presented in text, tables and figures. Items containing more information, and therefore requiring examination, were either summarised or analysed through inductive content analysis.[48] The inductive content analysis had the following steps: extracts from items relevant for inductive analysis were read through, the text extracts were then condensed into smaller text units, and assigned a code. For each item (for instance, *collaboration initiation*), codes from the condensed text units were grouped, representing categories of meaning within the items (for instance, the category making a request as one of the ways to initiate collaboration). The analysis was performed by four authors (ABä, MMA, SM and ABe) and discussed by at least two authors to ensure an agreement on the data synthesis and to enrich the qualitative analysis. Discussions around the analysis and summaries were also held in the larger author group in several meetings for the same purpose.

Patient and public involvement

Patients were not involved in the design or completion of this study.

RESULTS

The search strategy generated 5017 articles. After removing duplicates (n=5), 5012 titles and abstracts were

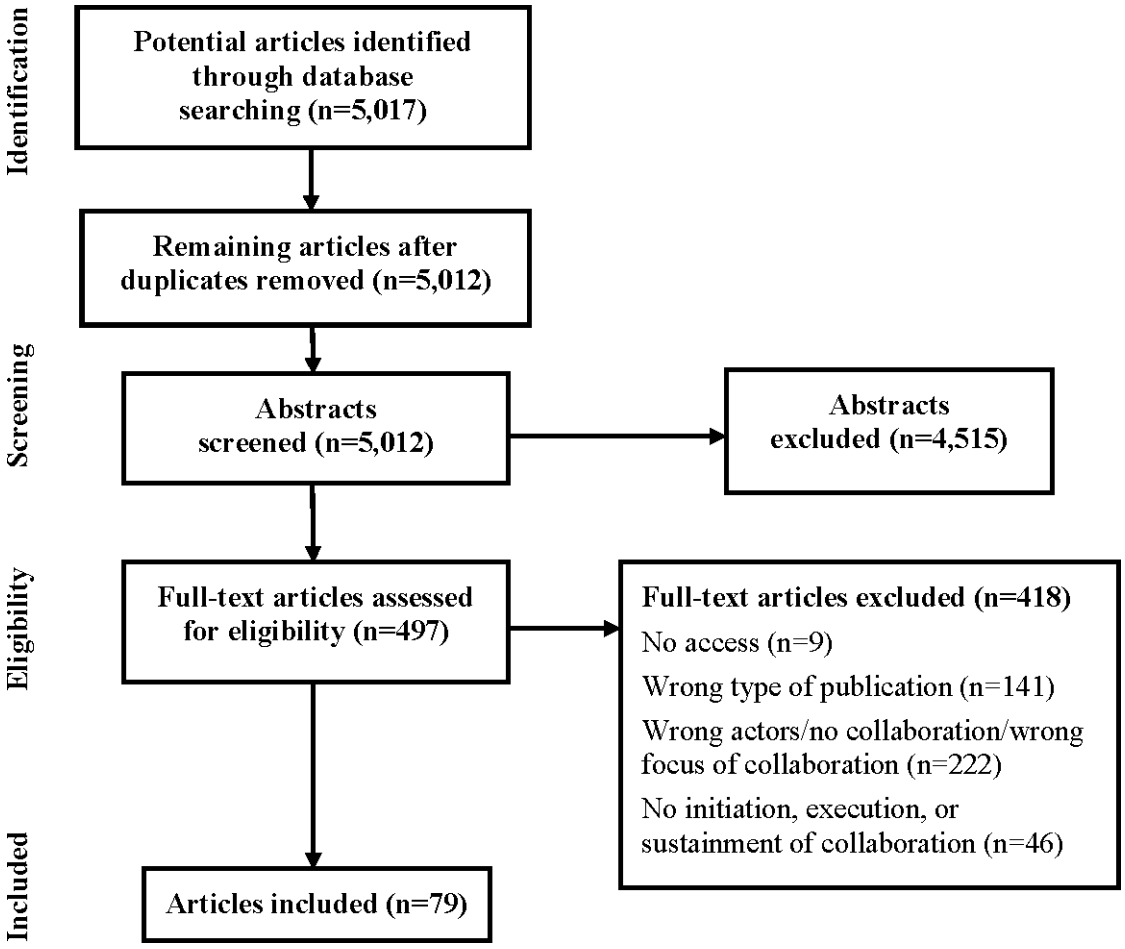

Figure 1 Flow chart.

screened out of which 4515 were excluded. Thus, 497 full texts remained for assessment. During the full-text assessment, 418 articles were excluded, resulting in a final sample of 79 articles.[49–127] See flow chart in figure 1.

One of the articles[127] described five different collaboration projects. Further, four of the articles described the same two collaboration projects.[64 69 70 120] Hence, the total number of collaborations projects included were 81. Articles describing collaborations undertaken with the same actors, activities and collaboration subjects but undertaken in different locations were considered as one collaboration.

Study and collaboration characteristics

Information about the study and collaboration characteristics is provided in table 1 (information about the individual studies are available in the online supplemental file S3—Characteristics of individual studies).

Of the 81 collaboration projects, the majority (n=44) took place in high-income countries. When LAs and CSOs collaborated, additional actors were often involved. This was the case in 70 of the 81 collaboration projects. Additional actors beyond LAs and CSOs were grouped into seven categories. *Government agencies* (eg, national/state/federal government agencies and departments within government agencies), *actors within research and academics* (eg, researchers, universities), *service providers* (providers in education, social care and healthcare), *additional civil society organisations* (development organisations, aid organisations, NGOs and community organisations that were not the main CSO actor in the study), *companies* (business enterprises and companies), *community representatives* (eg, community leaders, politicians and other influential members in the district, that either represent parts of a community as an individual or as a representative of a group) and *other actors* (stakeholders such as citizens, and programmes and networks which are presented as an actor in the collaboration).

Of the 61 articles that stated the aim of the study, less than half (n=26) reported that describing the collaboration was part of the article's aim, while the majority (n=35) did not mention collaboration in the aim.

The magnitude of the collaboration projects varied greatly among the articles. The scope of the projects ranged from the implementation of large national programmes to the development of specific interventions in a local context. They also varied in form, encompassing a range of projects such as policies, plans, services, activities and models, which were developed and/or implemented. The collaboration subjects (health topics) were sorted into six categories: *infectious diseases* (eg, HIV,

Table 1 Characteristics of the included collaborations

Characteristics of studied collaborations	Number of collaboration projects, total n=81 (%)
Type of country	
Low-income	8 (10%)
Lower-middle income	22 (27%)
Upper-middle income	7 (9%)
High-income	44 (54%)
Additional actors	
Government agencies	38 (47%)
Academics/research	23 (28%)
Service providers	36 (44%)
Additional civil society organisations	27 (33%)
Companies	10 (12%)
Community representatives	15 (19%)
Other actors	36 (44%)
Collaboration subject	
Infectious diseases	18 (22%)
Maternal, adolescent, reproductive and child health	17 (21%)
Living conditions/lifestyle habits	19 (23%)
Non-communicable diseases	7 (9%)
Mental health	4 (5%)
Other	16 (20%)

Table 2 Characteristics of activities, intensity and duration of collaborations

Activities, intensity and duration of collaborations	Number of collaboration projects, total n=81 (%)
Collaboration activities	
Allocate resources	65 (80%)
Adopt agreements/contracts	19 (23%)
Establishing strategic and operational groups	34 (42%)
Establishing working plans	35 (43%)
Gather data	50 (62%)
Support	19 (23%)
Exchange information/knowledge	73 (90%)
Train	36 (44%)
Intensity of collaboration among local authorities and civil society organisations	
Coordination	26 (32%)
Cooperation	19 (23%)
Collaboration	17 (21%)
Coadunation	0 (0%)
Not possible to judge*	19 (23%)
Collaboration duration	
Not reported	36 (44%)
Less than 1 year	4 (5%)
1–3 years	24 (30%)
4–10 years	14 (17%)
More than 10 years	3 (4%)

*In one of the articles, different intensities of collaboration were identified in two municipalities; therefore, it was categorised as 'Not possible to judge'.

COVID-19), *maternal, adolescent, reproductive and child health* (eg, child and maternal mortality, adoption, adolescence sexual and reproductive health), *living conditions/lifestyle habits* (eg, health promotion, social prescribing, air pollution), *non-communicable diseases* (eg, cancer and diabetes), *mental health* (eg, psychological first aid or general mental health) and *other* (eg, geriatric care and health services/information).

How was collaboration initiated?

The actor who initiated the collaboration was reported in 37 projects. It was roughly as common that LAs (n=11), CSOs (n=11) or additional actors (n=15) had initiated the collaboration. Most of the projects (n=44) did not state who initiated the collaboration.

Of the 81 collaboration projects, 24 described *how* collaboration was initiated. The analysis resulted in five categories describing ways to initiate a collaboration. The first was using *advocacy* to engage actors in an initiative or a specific issue.[57 87 110 124] Another way was to conduct a *baseline study or a needs assessment* through, for example, focus groups, surveys or workshops.[87 94 101 109 124] Others were *making a request* or receiving a request. The motives varied but included different needs and intentions when releasing a request or when approaching the actor in mind, for example, presenting ideas, asking for support or extending invitations.[51 56 58 61 63 72 77 97 98 107 109 110 126] Finally, two additional ways to initiate collaboration were to *create a working group* with the purpose of engaging in, for example, the establishment of plans, and sharing of resources and expertise,[51 56 61 63 86 98 121] or to generate a *pilot project* with the intent to provide care or improve a specific type of health service.[51 82 97 107]

How was the collaboration executed?

The collaboration activities that took place in the 81 collaboration projects have been categorised into eight different categories, see table 2 (information about the individual studies is available in online supplemental file 3—Characteristics of individual studies).

The most common level of intensity of collaboration among LA and CSO was coordination, categorised in 26 of the 81 collaboration projects.

When collaboration duration was reported, the most common duration was between 1 and 3 years (n=24).

Table 3 Categories of activities describing the execution of the collaboration

Main categories	Subcategories (in italics)
Exchange information/ knowledge	Providing and receiving information and knowledge was an essential part of most collaborations. *Meetings* were used, for example, for programme/intervention development, progress reports or strategy planning. *Consultations* were used to, for example, harness knowledge and expertise and receive advice. *Forums and networks* for discussions and *workshops* were also described to gain feedback and make better planning. *Other activities* were also described, such as presentations of projects, sensitisation visits and providing printed information
Adopt agreements/contracts	One collaboration activity was adopting formally and legally binding contracts and agreements, such as *memorandums of understanding*, *letters of agreement* and *contracts*
Allocate resources	The allocation of *funding and grants* was the most common resource that was noted, with emphasis on fuelling collaboration efforts. Efforts in planning, establishing and providing *health facilities* were presented as an important part of, for example, delivering health services. Actors were engaged in giving and receiving *technical support* or expertise within the collaboration projects. The distribution of *equipment and materials*, for example, office space, educational materials and essential physical tools like computers and medicines were mentioned as a resource. The provision and delegation of *human resources*, such as staff or volunteers with specific expertise, were vital for the projects. A representative from either actor was sometimes appointed/delegated to act as the point of contact in parts of the collaboration for *coordination* purposes
Establishing strategic and operational groups	A common category was the establishment of strategic and operational groups. Groups were assembled to be collectively involved in *the decision-making and steering* of the collaboration project. The groups could be involved in both *the development* and *the implementation* of the collaboration project
Establishing working plans	The purpose of a working plan could be to define the scope of work and clarify the relationship among the collaborators. These plans vary, offering formal, informal or detailed, yet brief, descriptions of the plan. The working plans could, for example, include detailed tasks, project timelines, work structure, logistics and management of the collaboration projects
Gather and analyse data	The purpose of gathering and analysing data was to *identify gaps and conduct needs assessments*, to follow and improve the process through *evaluation and feedback* and finally, *monitoring* to maintain effective programme coordination and ensure the standard of healthcare services. This was conducted through, for example, conducting workshops, performing action visits or round table discussions
Support	Some studies described actors providing or receiving support, and it was reported as *endorsement or unspecified support*
Train	*Training for members in the collaborations* involved preparing actors in health practices, in using, for example, advocacy strategies, psychological first aid or different communication tools. *Training for outreach* involved training providers (eg, healthcare staff) to enable them to carry out activities in the projects, for example, data collection

However, in the majority of collaboration projects (n=36) duration was not reported.

Table 3 outlines the analysis of *how* the collaboration activities have been executed. Included are 68 collaboration projects having a description of the actions performed by LAs and CSOs.

How was collaboration sustained?

A total of 20 articles reported undertakings to sustain the collaboration. The most common were different kinds of *meetings* that occurred regularly with varying intensity.[56 63 72 92 97 106 126 127] *Documents and tools* have also been used, such as a checklist tool to sustain contact between actors or using legally binding documents for collaboration sustainment.[82 95] *Funding* was mentioned to sustain the collaboration. For example, receiving funds could enable coordination, and funding commitments enabled the continuum of activities within a programme.[61 89 106]

Finally, *different plans and work structures* for sustainment have also been reported, such as the creation of networks or planning agendas for further collaboration, the creation of a new association or the planned transition of responsibility between the actors.[64 77 78 83 105 118 120]

What were collaboration barriers and enablers?

A total of 27 articles described barriers for collaboration and 29 articles presented prerequisites and actions that were described to support collaboration. The categories created are presented in tables 4 and 5.

Collaboration evaluation

In general, the explicit evaluation of the collaboration process was rare. 14 articles reported *how* empirical data about the collaboration process was collected, through qualitative, or a combination of quantitative and qualitative methods. Qualitative data was most often

Table 4 Barriers for collaboration

Category	Subcategory	
Barriers	Lack of resources	The most common barrier in collaboration efforts was a lack of resources. These barriers were related to a lack of stable and sufficient funding, lack of time for collaboration efforts, staff turnover or staff shortage and competing demands from other interventions.[60 64 66 78 80–82 85 95 98 106 108 110 112 116 120 121 127]
	Structural factors	Structural aspects could also hinder collaboration through different organisational obligations and jurisdictions among collaboration partners, bureaucratic long decision processes, lack of leadership or lack of clear and supportive policies for collaboration with clear role descriptions.[62 64 80 81 83 106–109 112 120 122 124 127]
	Differing missions and motivations	Challenges within this category concerned diverging organisational missions (not all organisations are health-oriented), conflicting expectations on, for instance, project outcomes, and lack of enthusiasm among certain collaboration actors.[55 64 66 78 80 106–108 112 120]
	Lack of trust	There were examples in which LAs were suspicious of the political agendas of the CSOs or saw the CSOs as policy critical. Likewise, there were depictions of CSOs being sceptical about the intentions of LAs and perceiving them as authoritarian. Lack of trust could also be regarding the financial contributions of the collaboration partners.[55 106 107 120 124 127]
	Problems with communication	These communication problems were due to, for instance, challenges in communicating effectively among several partners in the collaboration, reluctance to share information or diverging cultures regarding ways of working among the partners, making communication more difficult.[55 106 107 115 122 127]
	Political changes	Political events could negatively impact collaboration efforts. For instance, a change in political leadership could lead to diminished political interest and changes in priorities. Political budget cycles could affect the possibility of funding collaboration projects.[66 98 106 113 124]

CSOs, civil society organisations; LAs, local authorities.

collected with individual or focus group interviews, followed by observations. Quantitative data was most often collected with surveys, and sometimes with checklists.[55 64 72 73 80–82 106 107 111 112 115 120 127] One article described using a pre-existing qualitative instrument.[64]

Ten articles reported *when* the data on collaboration was collected.[55 64 81 106 107 112 115 117 120 126] Six of these reported that the data collection occurred during the collaboration project, and one reported having it done 3–12 months after the collaboration ended. Further, another three of the ten reported a date for when the data collection took place, but it was not possible to determine when in relation to the collaboration.

A total of 23 articles presented outcomes of the collaboration on operational and organisational levels. However, only 11 explicitly mentioned that they had collected empirical data about the collaboration process.[64 72 73 81 82 106 107 112 115 120 126] The outcomes described in the 23 articles were similar, regardless of whether they reported having examined the collaboration or not. Five categories of outcomes were created.

The first was increased capacity in the form of *knowledge and resources* among the collaboration partners through knowledge sharing and pooling of resources, which could make expansions of programmes, etc in the collaboration possible. Knowledge gains regarded both awareness about the collaborating partners, their strengths and weaknesses, and awareness about the health issue or intervention at hand.[72 74 77 81 83 106 107 112 115] *Strengthened partnerships* were also achieved through improved relationships between actors, increased trust and opportunities for new partnerships to emerge.[67 72 78 81–83 90 96 110 120 122] *Management-related outcomes* were also reported, such as increased leadership, more effective management and possibilities to transfer responsibility for different initiatives between actors to sustain them. Some also found a need to clarify the different roles within the collaborations.[53 83 90 112 114 126] Another category described *better outputs*, such as better access to existing services, avoidance of duplicate efforts and new pathways for referral.[81 84 112 114 120] A final category was *giving civil society a voice*, describing that the collaborations had increased civil societies' possibilities to be involved in health promotion programmes and interventions and influence decisions.[64 81] One article briefly mentioned the satisfaction with the collaboration between the actors,[73] although there was also an example of a negative outcome where collaboration led to tension between the actors, with some LA representatives feeling threatened by the CSO.[107]

Table 5 Prerequisites and actions described that support collaboration

Category	Subcategory	
Pre-requisites and actions described that support collaboration	Common goals	One essential enabler brought forward was the need to have common, compatible and clear goals and objectives of the collaboration.[82 90 112 119]
	Pre-existing relationships	Pre-existing relationships and a good track record of collaborations between the partners or other partners (including the community that was often the end beneficiary of collaborations) were mentioned as important enablers. Part of this category also included personal and informal links and relationships that enhanced collaborative efforts.[51 62 83 90 92 106 124]
	Selecting the right partners	The notion of selecting the right partners for the collaboration where issues relating to engaging trustworthy partners and requiring them directly were brought up.[64 82 90 114 127]
	Equality among partners	Collaboration was also described to be enabled by recognition of equality among partners, which was linked to the importance of trust and relationships but emphasising the importance of recognising the needs of the engaged partners to partake in the collaboration and having joint decision-making and shared credit of efforts.[61 64 65 82 125]
	Investing in trust	Investing in trust and relationships between the partners included aspects of mutual trust and adopting a collaborative philosophy.[82 83 108 112]
	Commitment	Committed leadership and local ownership were brought forward as an important enabler.[52 54 66 108 119 124]
	Facilitation	It was also considered important to have people within the collaborating partners that facilitated the collaboration, for example, a champion.[61 64 81 82 108]
	Recognition of competencies opportunities for reach	This included aspects of having wide networks and the ability to negotiate with different actors outside the collaboration.[52 60 64 73 108 114 127]
	Formal agreements and processes	The presence of required formal agreements and processes outlining roles and responsibilities as well as the adoption of structured tools was also brought up as enabling for collaboration.[64 67 72 110 112 114 127]
	Sharing relevant information	The need to share relevant information among actors and adoption of agreed communication channels.[54 66 72 83 92 106 125 127]
	Resources	Allocation of required resources (including funding, time, snacks for meetings, technical support and training materials).[61 74 76 82 90 106 119 127]

DISCUSSION

In this scoping review, we extracted 79 articles describing how 81 collaboration projects between LAs and CSOs for improving population health have been performed and studied. A main finding was a lack of substantial descriptions of how these types of collaborations have been initiated, executed and sustained. For example, only 24 of 79 articles described how the collaborations had been initiated, and the details on initiation efforts were often sparse. In 19 of the articles, the information on how the collaboration had been executed was so scarce that no judgement could be made regarding the intensity of collaboration between the LAs and CSOs. Many different activities were identified, but there was often a lack of information concerning how the activities and the collaboration actors were chosen and how these actors and activities were supposed to contribute to the goal of the collaboration. Similarly, only 20 articles described factors affecting the sustainment of the collaboration.

The lack of detailed information could be due to several factors. For instance, only 26 of 79 articles included an aim that related to describing the collaboration. Thus, collaboration was given less attention than other matters, such as the project itself or the projects' outcomes on population health. Furthermore, in 70 collaboration projects, several additional actors were involved in the collaboration. Hence, collaborations aiming to improve health often involve a multitude of actors doing different activities, making it complex to illustrate what activities are actually done in collaboration, by whom, and in what way the activities are collaborative. Concerning the lack of information in the included articles about the sustainment of collaborations; it is possible that some of the collaborations were intended to be short-term, and therefore were not focused on sustainment.[11] Some collaborations are made to simply exchange information and support with no intention of any organisational integration.[11] The lack of information about sustainment could also imply that the sustainment of collaborations for health between LAs and CSOs is not given much practical attention, increasing the risk of collaboration failure. For instance, initially successful collaborations could fail

to produce long-term effects if too little attention is paid to relationship- and trust-building among the actors to develop sustainable working relations.[128]

The most common intensity of collaboration identified between LAs and CSOs was coordination. Coordination is often short-term, and involves the exchange of information or using combined resources for one's tasks.[11] This type of collaboration involves the least 'meshing' between the collaborating actors. At the same time, there were examples of conflicting expectations and motives being barriers to collaboration, implicating differing views on what type of collaboration was desired. Discussing expectations for the collaboration at initiation among the actors could make such tensions less common. An example of this was how needs, assets, roles and expectations among collaborating members were discussed in an initial meeting in the collaboration described by Wynn *et al*.[56]

Despite the lack of detailed description of collaborations, a great variety of activities were mentioned. These included exchanging knowledge, allocating resources, providing different types of support or human resources, training, forming different working groups, agreements and working plans to gather data for needs analysis or evaluation. There were, however, also articles in which the collaboration process was described in a more detailed and informative way, for example.[56 63 64 67 92 94] These findings provide new knowledge on *how* collaborative processes have been done, which had been lacking previously.[30 31] This scoping review can provide inspiration on activities to consider when planning collaborations between LAs and CSOs. However, the exact planning needs to be considered at local level and here, the findings concerning enablers and barriers could be helpful. The barriers and enablers identified matched well with the factors presented in Marek *et al*'s model[129] for successful collaboration between community agencies. We found barriers and enablers in all of the seven factors: context, members, process and organisation, communication, function, resources, and leadership. The findings in this scoping review regarding enablers and barriers thus seem to be in line with previous research on collaboration in the public sector, including NGO collaboration.[1 26 29 129] A reflection is that several of the enabling factors identified in this scoping review can be significantly influenced by the collaborating actors, such as common goals, selecting the right partners and investing in trust. Using this knowledge in the planning of collaborations might mitigate encountering some potential barriers.

A total of 14 articles described collecting data on the collaboration process, out of which only one mentioned using a specific model for data collection. Sjögren Forss *et al*[64] used empowerment and power relations models to guide the planning of the collaboration, along with a specific model for evaluating partnerships. This approach provided a detailed description of the collaboration and the outcomes identified. Evaluating collaboration may be challenging. Marek *et al*[129] suggest that the reasons behind these challenges relate to both lack of validated tools for measurement as well as the dynamic nature of collaborations in community settings, undefined outcomes and the time needed before seeing effects. Further, there are several questions to consider regarding the evaluation of collaboration efforts, such as how it should be measured, what should be measured, when and why. These questions may have different answers among the collaborating actors and need to be discussed among the actors involved.[47] Silvia[47] argues that a collaboration's evaluation should include establishing clear goals, developing measures together during the collaboration (as this may require negotiation), using innovative ways to find measures of effectiveness that are agreeable to all collaborating partners and comprising measures on several levels (operational, organisational and environmental). Thus, more research is needed focused on the evaluation of the process of collaboration, not only evaluating the potential effects of the project on the target group, such as increased service delivery. There were, however, descriptions of outcomes of the collaboration on operational and organisational levels. Some of these outcomes, such as strengthened capacity in the form of increased knowledge and resources, as well as better relationships and processes have been highlighted in previous research.[24 130] More systematic ways of evaluating collaboration on operational and organisational levels could be beneficial for understanding these descriptions of outcomes, as well as understanding effective ways to execute these collaborations. Marek *et al*[129] have developed an evaluation tool which could help uncover reasons behind why collaborations are successful or not, which could be used in future studies examining collaboration efforts in the public sector among different actors. Most collaborations in this scoping review had been executed in high-income countries. Given the expectations of intersectoral collaboration involving LAs and CSOs to achieve SDGs,[16 17] the lack of detailed information on how to best collaborate is especially troubling, as intersectoral collaboration could have the most impact in low- and middle-income countries.

Methodological considerations

This scoping review fills a research gap since it includes many examples of how collaborations between LAs and CSOs have been done. However, a limitation is that this review only included peer-reviewed articles. Although the Joanna Briggs Institute's guidance for conducting scoping reviews stipulates the inclusion of grey literature, the skewed inclusion of such literature (most often published in the language spoken in the setting where the efforts are undertaken) to only include countries where English is the official language seemed not appropriate. In contrast, peer-reviewed empirical evidence is generally communicated in English and therefore provides an opportunity to learn from much more diverse contexts. Further, we excluded collaborations that were not primarily focused on health-related to Sustainable Development Goal

3. Including grey literature and/or articles focused on Sustainable Development Goals beyond number 3 would have provided a greater amount of included literature and could have rendered other results than those presented here. We did, however, have an inclusive definition of empirical articles that made research notes, etc eligible for inclusion, thereby broadening the scope of articles. Another limitation of this study is that the literature search was conducted over a year ago. This means that any new studies on the collaboration between LAs and CSOs to improve health since then are not included, although they could have provided further insights into how these collaborations have been initiated, executed, and sustained.

Only outcomes focusing on the processes and relationships in the collaborations were extracted for this scoping review. This means that more distal outcomes such as service outcomes for the specific project and effects on population health were not included. The reason for this was mainly that the articles did not report on research powered to study these types of outcomes. We opted not to present how the authors of the included articles described 'study design' (although it was part of the extraction template) as we found this information not to be presented in a clear and comparative manner (some presenting their design in terms of the type of data that was collected, ie, as qualitative or quantitative, while others presented that their design was a case study). Only including articles like randomised controlled trials would allow for studying effects on population health but would necessitate a different review methodology, namely, a systematic review. However, a systematic review would not be suitable for exploring how collaborations are conducted. Further, we have chosen not to present the purpose of the collaboration (although it was in the extraction template), as we perceived that the extracted data on the purpose of the collaboration, the aim of the studies, the collaboration subject and the collaboration initiation was often intertwined and thereby captured in the other extracted items. Finally, the inclusion criterion that articles needed to provide data to either one of the research questions was added after the publication of the study protocol.

A strength is that this scoping review was executed systematically, informed by the Joanna Briggs Institute's guidance for conducting scoping reviews.[33] For instance, screening, assessment of full texts and extraction were made independently by two reviewers. The systematic process increases the reliability of the results and might aid in replications of the study. Further, a protocol was also published prior to data extraction to ensure transparency in the review process.

CONCLUSION

Collaborations between LAs and CSOs ranged in their intensity and entailed many different types of activities. Our understanding of collaborations is still, however, limited since the articles often lacked detailed information about how collaborations were performed and what outcomes were obtained. There is a need for more research on the details of initiating, executing and sustaining collaborations for health between LAs and CSOs. Evaluating collaboration processes using standardised measures is also prompted. Knowledge on collaboration activities and enabling factors from this scoping review can be used to inform the planning of future collaborations between LAs and CSOs.

Acknowledgements We would like to thank Sabina Gillsund and Emma-Lotta Säätelä at KI University Library for their assistance in developing and conducting the search strategy for this scoping review.

Contributors ABä, ABe, LE, HH and VAC developed the study design and search strategy. All authors have been involved in refining the details of the study selection and data extraction. ABä, ABe, MMA and SM conducted the analysis, which was then continuously discussed among all the authors. ABä prepared the manuscript draft, with assistance from MMA and SM. All authors have been involved in revising the manuscript and have approved the final version of the manuscript. ABä is the guarantor.

Funding Supported by funding provided by Region Stockholm (ALF funding). The involvement of the sixth author was partly funded by a grant from the Swedish Research Council for Health, Working life and Welfare (FORTE; 2023-01085).

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information.

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