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Peas in a Pod: The Process of Mutual Learning in Knowledge Exchange on Health Promotion Interventions Research

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ABSTRACT

Introduction: Knowledge exchange (KE) in health promotion research encourages the outcome of mutual learning between researchers and knowledge users. Researcher-practitioner partnerships (RPP) are an approach in health promotion intended to cultivate mutually beneficial research between different disciplines and sectors. RPPs have been found to improve intervention success and sustainability, including the bidirectional sharing of sector-specific knowledge, but how mutual learning occurs remains unclear. This paper analyses two examples of mutual learning in health promotion RPPs, as told by the practitioners and researchers involved.

Methods: During the Peas in a Pod virtual practice exchange, researchers and practitioners working in retail food environments came together to discuss KE. The event included a fireside chat with two retailers sharing their experiences collaborating with researchers. The primary author took notes from the discussion and led the writing of the case, which each practitioner reviewed for accuracy. After the fireside chat, researchers and knowledge users held small group discussions which were analysed into three themes to explore mutual learning within retail food environment research.

Results: Example one was a retailer-led hospital retail merchandising intervention study at an urban public tertiary hospital in Nova Scotia, Canada. Example two was a healthy merchandising strategy trial with an Australian Aboriginal-owned and governed not-for-profit store corporation in the Northern Territory and Queensland, Australia. Mutual learning involved (1) partnerships with both near and far-sighted vision, (2) negotiation and meeting in the middle and (3) leveraging policies and strategies to support interventions. Overall, KE bridged both knowledge and action.

Conclusion: This paper provides insight into how mutual learning occurs in health promotion research. Mutual learning within an RPP influenced research design and implementation. Our findings showed that knowledge exchange emerging through the

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intervention research also contributed to further changes in partnerships and policies. However, further study is required to understand how knowledge exchange and policies intersect.

So What? Mutual learning in knowledge exchange can contribute to health promotion intervention evidence and create pathways to new partnerships with retailers who are sceptical or hesitant about implementing retail interventions.

1 | Background

The aim of knowledge exchange (KE) in health research is the ‘collaborative problem-solving between researchers and decision-makers that happens through linkage and exchange’ [1]. An important assumption of integrated knowledge exchange is that such a model can facilitate two-way or mutual learning throughout the research process (e.g., planning, implementing and disseminating) [2]. Integrated knowledge exchange attempts to codify a process whereby researchers and knowledge users both benefit from the transfer of information through learning [3] and, ultimately, increase the likelihood of research being incorporated into practice [4–6]. This normative shift towards the outcome of bidirectional learning seeks to improve past efforts to incorporate research into practice through one-way knowledge ‘dissemination’ but which often overlooked the knowledge and practice concerns raised by practitioners in the process [7].

A distinctive form of bidirectional knowledge exchange in health promotion intervention research has been the cultivation of long-term partnerships between health researchers and practitioners in the specific field, community, or setting of inquiry. Researcher-practitioner partnerships (RPP) are mutualistic collaborations between partners of different disciplines and sectors, developed and sustained over time, that explore practice-based solutions to real-world health problems [8]. RPPs are acknowledged across disciplines, sometimes called participatory action research or knowledge co-production, and in health promotion have been more recently called learning communities [9]. During these partnerships, researchers and practitioners collaborate throughout the process to identify research objectives, decide on a design and methods and determine how results or information generated can be owned and used for future research and practice [10]. Some of this research employs an ‘action-research’ stance, whereby researchers themselves are invested in social-action or political imperatives in the communities where they work. It has also been observed that partnerships can support joint efforts to address research agendas emerging from both academia and real-world settings [7, 8, 11].

How mutual learning occurs in RPP has been explored in research areas outside knowledge exchange, such as health education [12], health policy [13] and international development [14, 15]. These studies have tended to highlight the importance of entrepreneurial individuals who play key roles ‘brokering’ the knowledge exchange. Features of partnerships that support an outcome of mutual learning include identifying areas for improvement together, engaging in co-design processes and researchers sharing and interpreting findings [8]. An important insight from these otherwise disciplinarily distinct studies is that mutual learning does not naturally result in, or equate to, equal learning, meaning that there could be risks of creating new power imbalances during the process of mutual learning.

The power dynamics of RPPs have been studied in various forms. For example, a qualitative study by McCabe et al. [16] discovered multiple types of power, including resource, structural and normative power dynamics, all of which can interfere with the learning processes between researchers and practitioners. Managing these imbalances can be crucial to researcher-practitioner collaborations success [17, 18].

However, mutual learning as a process is itself less understood. Does the establishment and sustainment of an RPP equate to eventual mutual learning? Or does a concrete practice change (intervention) in the community need to occur and be sustained? Are specific forms of knowledge generation and transfer required, such as evidence of findings being incorporated into co-designed research grants or co-authored publications? How do RPPs negotiate power relations from different facets of the research (e.g., research funding administration) and practice (e.g., concrete implementation of an intervention within a community)? A study of how KE occurs, with particular attention to mutual learning, could help us understand how best to facilitate this type of learning to foster more effective partnerships.

The following paper examines two health promotion interventions, one in a Canadian urban public tertiary hospital and the other in an Australian Aboriginal-owned and governed not-for-profit remote retail corporation, to explore mutual learning between researchers and retailers actively engaged in research partnerships to promote health in retail food environments. Specifically, we will describe and synthesise lessons learned from a Canada-Australia knowledge exchange forum, referred to as a ‘practice exchange’. A growing body of literature has examined how the success and sustainability of health promotion in retail settings may be contingent on productive RPPs between researchers and amenable retailers or store owners [19–21]. Food retailers appear to have mixed views regarding healthy retailing interventions [22, 23]. Some studies exploring retailer priorities found that profitability was prioritised over selling healthy items [22, 24, 25]. Researchers and retailers who partner to study food environments appear to be equally knowledgeable about the potential risks of healthy retail interventions, including competition and resource allocation factors [26] or the embeddedness of retailing in larger food supply chains and systems [22]. It has also been observed that certain kinds of retailers, such as those offering publicly-funded services (e.g., hospital, school) or in socially-driven not-for-profit sectors (e.g., cooperative, community store), may hold a dual revenue generation-health promotion mandate and in the uptake of health evidence, face a duality; at times, they must prioritise health and, at other times, business outcomes [27, 28].

The objective of the paper is to examine the bidirectional nature of learning during an RPP-led research process. This includes how practical knowledge from real-world industrial sectors (food retailing) is incorporated into research questions and vice

versa—how health promotion evidence is integrated throughout the research process into the retail environment.

2 | Retail Food Environments: Australian and Canadian Cases

2.1 | Methods

Participation in the Peas in a Pod practice exchange was organised through a snowballing approach in the multisectoral network of a mid-career academic's research lab (senior author), established in the sub-field of social and structural research in food environments. Members of the coordinating research lab extended invitations to current peer research collaborators. For about 5 years, the network had undertaken conventional forms of science collaboration, such as preparing joint research funding proposals based on shared research objectives. At the same time, each researcher had developed practices for fruitful RPP development in local contexts with retailers. For Peas in a Pod, each participating researcher was asked to invite the retailer they had often partnered with in an RPP; hence, the name peas in a pod, an idiom describing partners who are similar to one another or, in this case, work in similar fields. The Peas in a Pod exchange was conceived just prior to COVID-19 as an in-person initiative, to strengthen research and practice translation about RPPs. With the onset and continuation of the pandemic it became evident that an in-person exchange would not soon be feasible. Therefore, the event was reorganised into a virtual format to adhere to travel and other public health restrictions during the COVID-19 pandemic, and an accompanying asynchronous process was organised to collect and analyse learnings. The event was held via Zoom on 22 September 2021. Participants were asked to review a draft discussion document ahead of time, introducing questions about mutual learning in RPP.

At the event, a facilitated 'fireside chat' was then held between two retailers (authors TN and KS), one a dietitian and foodservices manager at a Canadian Atlantic provincial health authority operating its own retail foodservices locations, and the other,

a public health nutritionist at an Australian Aboriginal-owned and governed not-for-profit remote food corporation operating in the Northern Territory and Queensland, Australia. Although its origin is somewhat debated [29], 'fireside chat' is a colloquialism of management fields that refers to a form of communication between senior decision-makers, with a high degree of informality and intimacy of conversation, and without formal rules of order [30]. The moderator for the fireside chat (author RH) was selected in advance from among the invited participants, for their strong oral communication skills, being at a similar career stage to the retailer speakers, and work experience across sectors. Each practitioner was asked reflexive questions by the moderator about mutual learning and knowledge exchange within their fields. The primary author (not a moderator or fireside speaker) took notes from the discussion and led the writing of the case, which each practitioner reviewed for accuracy. After the fireside chat, researchers and knowledge users held small group debriefing discussions, which were analysed into three themes to explore mutual learning within retail food environment research.

3 | Results

The two RPP intervention examples examined during the exchange were *Snacking Made Simple* (Canada) and *Healthy Stores 2020* (Australia). This section outlines each example (see Table 1) and is then followed by a description of the components of mutual learning (Table 2).

3.1 | Snacking Made Simple: A Hospital Retail Intervention

The *Snacking Made Simple* intervention was implemented in an urban public tertiary hospital setting in Halifax, Nova Scotia, Canada. Nova Scotia Health is the health authority that runs the public hospitals in the province and is responsible for delivering healthcare services to approximately one million provincial residents [31]. Unlike many other public hospitals in Canada whose

TABLE 1 | An overview of the two examples (Canadian urban public tertiary hospital and Australian Aboriginal-owned and governed remote retail corporation) included a description of the retail intervention, key partners involved and organisational supporting documents.

| | Canadian urban public tertiary hospital | Australian Aboriginal-owned and governed not-for-profit remote retail corporation |
|---|---|--|
| What sparked the need for the intervention? | High prices of healthy food/beverage options identified as a barrier | Community wanted to address high sugar consumption in light of high rates of diabetes |
| Intervention | <i>Snacking Made Simple</i> —a health promotion intervention targeting the price, promotion, placement and products of 5 healthier and 5 less healthy snack items | <i>Healthy Stores 2020</i> —a merchandising strategy to reduce promotions of food/beverages high in salt, sugar and saturated fat, e.g., reducing their placement in high traffic areas (e.g., front of store) and no buy one get one free, bundle deals, or giveaways |
| Key partners | Food services manager and director, researchers, dietitians | Aboriginal community leaders (store board directors), researchers, nutritionists, retailers |
| Did you have organisational support? | Yes Healthy Eating Policy | Yes Nutrition and health strategy |

TABLE 2 | Lessons learned about mutual learning across examples.

| Main findings about mutual learning | Key points | |
|--|---|--|
| Timeline—near and far-sighted vision | Partnerships existed before the study in each example. Research grants, including those designed for RPPs, do not typically support the scope of time and resources necessary to form trusting partnerships with retailers. Researchers in both examples led the research; retailers led the intervention implementation. All members of the RPP brought both near-sighted (e.g., short term goals) and far-sighted vision (e.g., larger grants, organisational priorities). | |
| | <i>Canada</i> | <i>Australia</i> |
| | Retailer-led intervention with input from researchers Supported expanded study of quality improvement retail intervention | Co-designed between retailers and researchers and community Supported pragmatic randomised trial of retail intervention |
| Meeting in the middle | Active negotiation was necessary (e.g., prioritising affordability of products, supporting point-of-sale staff). Researchers and retailers must both be flexible and willing to adapt certain aspects of the intervention or research design that may not consider in their practice alone. Retailers examined in this paper were unique in holding a dual role of health and fiscal responsibility to communities (public and not-for-profit). Researchers incorporated this into intervention planning and design and future funding (e.g., grants). Researchers often provided in-kind resources where retail practitioners were more constrained. Retailers provided context to support analysis and interpretation of research findings. Retailers used study evidence to expand and scale health promotion activities in their organisations outside of the original study context. | |
| | <i>Canada</i> | <i>Australia</i> |
| | Data collected for administrative analysis of sales but analysed by researchers. | Data collected for research purposes. Study adapted based on feasibility. |
| Policies as part of mutual learning | Existing organisational policies reinforced the research and KE processes. Retailers provided insight about what policies meant and how they were actioned every day. Organisations operating foodservices from a publicly funded or not-for-profit model may have social responsibility more aligned with healthy eating than similar organisations in the for-profit sector. Organisations both had high-level healthy eating or nutrition policies that were able to encompass the intervention research. | |
| | <i>Canada</i> | <i>Australia</i> |
| | Dietetic/nutrition professionals involved in the RPP were publicly funded health authority permanent employees. | Dietetic/nutrition professionals involved in the RPP are organisational staff funded through store revenue. |

Note: Mutual learning involved (1) partnerships with both near and far-sighted vision, (2) negotiation and meeting in the middle and (3) leveraging policies and strategies to support interventions.

foodservice outlets are run by external contractors, Nova Scotia Health has shifted its organisational policies and procedures over the last decade towards a return to delivering its own foodservices. In 2018, Nova Scotia Health adopted an authority-wide Healthy Eating Policy, upholding them as a leader in creating supportive food environments in both retail and inpatient services. In the policy, Nova Scotia Health agrees to ‘walk the talk’ and model evidence-based healthy eating policy [32]. The policy provides guidance on food pricing, promotions, fundraising, breastfeeding and innovation.

Snacking Made Simple was initiated in response to staff healthy food affordability concerns and under the auspices of the Healthy Eating Policy. Two hospitals had disseminated a staff feedback survey to determine why healthier items were less popular. High prices were identified as a key barrier. In August

2018, they implemented *Snacking Made Simple*, with the goal to increase the purchasing of healthier snack items and simultaneously decrease the purchasing of less healthy snack items. Details about the intervention and an evaluation of its effects on consumer purchasing have been published elsewhere [33]. Briefly, the intervention included price decreases for healthy intervention items (ranging from 13% to 25%) and price increases for less healthy intervention items (ranging from 26% to 54%), implemented in four retail sites with slight variations depending on layout and customer preference.

This RPP was comprised of a retailer-led intervention, and the evaluation was researcher-led. The RPP implementation team comprised food services managers, communications, point-of-sale staff and researchers. Researchers who were members of the Healthy Eating Policy Steering Committee (HEPSC), a

committee providing strategic direction to the health authority on the implementation of its policy, evaluated the purchasing outcomes of the intervention.

3.2 | Healthy Stores 2020: A Community Co-Designed Pragmatic Randomised Trial

Readers are referred elsewhere for full details of the *Healthy Stores 2020* pragmatic randomised trial, including the study protocol [34], main outcomes paper [35] and an implementation study [36]. Briefly, community leaders had long raised concerns about high sugar consumption and its impacts on nutrition and health. Existing research collaborators had led several prior health promotion studies in rural and remote stores. These led to researchers, retailers and community leaders discussing the need to design a study that included restrictions on the placement and promotion of unhealthy food and drinks.

Together, these longstanding discussions prompted the design of a two-arm, parallel pragmatic randomised trial to evaluate the effect of the *Healthy Stores 2020* merchandising strategy that would restrict the promotion and placement of unhealthy foods and beverages (classified as ‘red’) in 10 stores throughout remote Australian retail stores, with a further 10 stores serving as the control group that would adhere to usual retail practice. To accomplish the study, an RPP was established between researchers and the Arnhem Land Progress Aboriginal (ALPA) Corporation, the largest Aboriginal-owned and governed not-for-profit remote food corporation [37] in Australia, throughout the Northern Territory and Queensland. ALPA adopted its own organisation-wide Nutrition Policy and the *Healthy Stores 2020* strategy was viewed as aligned with policy implementation.

The RPP that initiated the *Healthy Stores 2020* intervention was a collaboration between Aboriginal community leaders, academic researchers and retailers, including both researchers and retailers who held health practitioner qualifications as medical, dietetic, or nutrition practitioners. Similar to the *Snacking Made Simple* intervention, the intervention was retailer-led and the research trial to evaluate the intervention was researcher-led.

Front-line retail managers and staff operating individual stores were initially hesitant about whether or not *Healthy Stores 2020* would ‘work’. Even if it worked, there were concerns it would divert business from ALPA stores. The nutritionists communicated concerns back to researchers and vice versa. However, in the end, many of the intervention stores felt confident about *Healthy Stores 2020*, and some expressed interest in trialling other interventions to reduce sugar consumption. Another outcome of *Healthy Stores 2020* was a policy action series—co-designed using research and evidence from store owners and retailers [38]. The Policy Action Series included activities to increase the acceptability and feasibility of actions within retail settings (e.g., 4P’s), such as best practices for product, placement and promotion of healthy and unhealthy food and drinks. This Series was co-designed for retailers by retailers to support them in their future retail endeavours. Similarly, at ALPA, the

initiative was primarily led by a front-line retail manager, with considerable input from point-of-sale staff [39].

3.3 | Exploring the Dimensions of Mutual Learning Across RPPs

1. The timeline for partnerships involves near- and far-sighted vision.

Members of both RPPs expressed that their projects required both near- and far-sighted vision, meaning partners frequently identified opportunities in front of them (near) and down the road (far). In both RPP examples, partnerships between researchers and retailers had existed long before the research was conducted. The researchers involved in *Healthy Stores 2020* had completed prior research with ALPA and were familiar with their Healthy Eating Strategy and organisational history. In the RPP partnership between Nova Scotia Health and researchers, the researchers had membership in the health authority’s HEPSC. This meant there was a preexisting level of trust as well as formalised interaction and a variety of forms of professional cooperation between the partners before the interventions proceeded.

During Peas in a Pod, several researchers mentioned that the time relationship-building takes in RPPs is often unacknowledged by research grants but increasingly is necessary to receive these grants from national funding agencies. Therefore, researchers must invest in-kind and alternative resources in partnerships long before the academic grant process begins. Researchers’ process of involvement in each case study varied. *Healthy Stores 2020* was coordinated around an external grant funding competition by a national research funding agency in Australia. *Snacking Made Simple* was a quality improvement intervention and the research component was unfunded (in-kind).

Healthy Stores 2020 was a co-designed intervention with frequent bidirectional input from both partners. ALPA saw the benefits of involving researchers as contributing legitimacy to the results, providing expertise for the intervention and adding scientific rigour to the study design. ALPA admitted they did not have time or resources for a research study. In turn, the researchers saw the benefit of collaborating with [name removed for peer review] to advance an emerging and potentially impactful area of research inquiry. ALPA provided insider knowledge that contributed to the adaptation of the interventions based on context. This adaptation contributed to the study’s success since the interventions were tailored based on the needs of the retailers and community. This back-and-forth of research and design benefited both partners by contributing to an intervention that was successfully implemented, relevant and sustained.

On the other hand, *Snacking Made Simple* was a retailer-led pricing intervention designed by Nova Scotia Health. The intervention was a quality improvement initiative to iteratively improve practice, and only routine monitoring and evaluation had been anticipated. Although this intervention was retailer-led, research input came from the opportunity for academic researchers to participate in the HEPSC where aspects of the

intervention design could be discussed. Researchers identified important research gaps that this real-world intervention raised and sought organisational views on whether the retailing strategy behind the intervention could be studied in a structured way on a larger scale. Researcher in-kind resources were provided (e.g., trainees, analysis and academic dissemination) as well as sharing of evidence on methodology (e.g., time series analysis) to inform the organisation on its routine approaches to quality improvement. In turn, Nova Scotia Health saw the benefit in being able to provide further research and evaluation metrics back to their leadership to demonstrate the potential benefits of trialling pricing interventions. This process ultimately contributed to other quality improvement interventions within the health authority's facilities.

2. Problem-solving, meeting in the middle and negotiation contribute to mutual learning.

KE practice involves bidirectional, or mutual, learning between researchers and knowledge users. ALPA saw one of their strengths as communicating real-world context in an ongoing way. The financial viability of the ALPA stores has a significant impact on food security in remote communities, as they are the major food source. Thus, practitioners at ALPA helped researchers adopt the retailer's perspective in designing the study, and the design of the final intervention implemented within the store was ultimately a complex negotiation conducted at multiple levels: the RPP, community leadership, front-line store management. Stores receiving *Healthy Stores 2020* that were near other competitor stores (e.g., in the same small community) were left room to adapt or opt-out of the most potentially commercially sensitive part of the study, removing certain sodas from the fridge altogether. Several stores and communities indeed did not opt for that part of the strategy due to the potential loss of revenue, and this tailoring of the intervention was then integrated into the study methodology including the statistical design for outcomes analysis. This learning occurred bidirectionally between researchers and practitioners through one nutritionist who served to broker between and translated retailer and researcher needs to the other constituencies and individuals impacted by the intervention (e.g., community members, suppliers and point of sale staff). Throughout the study, the ALPA nutritionist continued to communicate expectations to corporate stakeholders, acting as translators or knowledge-brokers between researchers and other knowledge users.

In addition, retailers were knowledgeable about the feasibility of interventions, in ways researchers without day-to-day experience could not anticipate. For example, *Healthy Stores 2020* required changes to store layouts and substantial day-to-day upkeep, which had potential cost and human resources implications (e.g., orientation for new staff). The ALPA nutritionist advocated for in-kind researcher assistance to help retailers since implementing the intervention without additional support was unrealistic in the eyes of retailers. As a result of this exchange, researchers adjusted the intervention design for feasibility.

Point-of-sale employees were identified as critically important partners in both examples. At Nova Scotia Health, employees tended to receive the brunt of complaints when implementing something new, and changes to pricing of items would be

potentially contentious. Organisational decision-makers took particular care in facilitating the uptake of front-line knowledge into the intervention design and made sure researchers were also frequently informed of where front-line staff take risks by deviating from their usual practice.

Researchers used hospital point-of-sale purchasing datasets for a retrospective time series analysis following *Snacking Made Simple*. This data was originally collected for food services administrative purposes, to inform purchasing orders and weekly menu scheduling. During the interpretation of preliminary research findings, discontinuities and variations among outlets in the longitudinal sales analysis were presented to the hospital team. Retailers immediately noted that although all food outlets were open to inpatients, visitors and staff and were located only a few minutes from each other, each retail outlet was unique and tended to serve different customers, including at different times of the day. For example, the café near the parking garage served daytime ambulatory patients, while the café in a building for rehabilitation services tended to serve mainly proximally located staff on break and residents, similar to long-term care. The contextual knowledge led the researchers to ask other questions about space utilisation and to incorporate these nuances into further analysis of the study.

3. Leveraging policies and strategies.

In both examples, specific high-level organisational policies consistent with the goals and research objectives of the intervention study supported collaborative and effective RPPs. Health-promoting policies are often difficult to implement in both healthcare and private sector industry settings [40] but can support research activities, as well as organisational priorities (e.g., sustainability) and then, within those activities, guide intervention research that aligns with organisational values.

The Nova Scotia Health Healthy Eating Policy emphasised innovation and evidence-based practice, hence the inclusion of researchers in the HEPSC. In contrast to research being done 'off the side of the desk' at the health care organisation, external researchers were sought for their interest in researching practice concerns.

Policies guided both the research objectives and the tailoring of the interventions. One of the focuses of Nova Scotia Health's policy was providing affordable options, shifting the responsibility from the employee to the employer for creating an affordable healthy food choice environment. The intervention, once implemented and evaluated at a few central locations, was then scaled outwards across the organisation into procedures focused on making healthier options more affordable by offering a discounted price across the province.

Policies provided common ground between researchers and practitioners. ALPA is a not-for-profit corporation; funding for ALPA retail positions (e.g., including nutritionists on staff) comes from the revenue generated by ALPA-owned stores. Researchers acknowledged the value of financial independence of partner organisations within study designs and accounted for potential revenue losses on the commercial side of RPP projects. These priorities and values are reflected in the ALPA

organisational nutrition and health strategy, which provided researchers with a perspective on organisational values which could be integrated into the *Healthy Stores 2020* intervention.

4 | Discussion

This paper describes and synthesises lessons learned from a Canada-Australia knowledge exchange forum, specifically a ‘practice exchange’, to discuss the concrete details of mutual learning between researchers and practitioners working in retail food environments. It draws from two examples of RPPs to focus on where the ‘mutual’ in mutual learning originated from and how it was cultivated and sustained. Commonalities across the two RPPs were the capacity of all members of the partnerships to bring both near and far-sighted vision, negotiate expectations and leverage organisational policies and context. However, some distinctive partnership features emerged, such as the intervention research designs (retailer-led vs. codesigned) and quite distinct retail settings (e.g., hospital vs. community). These partnerships offer illustrative concrete actions of the ‘how’, or practice of, bidirectional exchange and learning between researchers and knowledge users, as well as some of the key challenges and where they tended to arise (e.g., grants, time and resources).

Knowledge exchange research has highlighted the concept of ‘bridging’ worlds in establishing a mutually beneficial partnership [41]. The findings in this paper reinforce the evidence on specific roles for knowledge brokers, for instance, nutrition professionals who can ‘speak the language’ of academic research and retail organisations and re-balance what is considered expertise [42]. For instance, some scholars have critiqued the longstanding ‘silencing’ that characterises the health and community sectors and identify partnerships as one way to ‘bridge’ knowledge and action in a structured way (e.g., further influencing partnerships, policies and food culture) [43]. In some ways, this literature considers the practice work in various sub-sectors to be ‘mutual’ in reinforcing specific health promotion goals, but functionally distinct.

In contrast, our exchange process highlighted similarities in practice across varied sectors and practice settings. Indeed, the mindset and vision of the researchers and retailers who partnered on the initiatives examined were in many ways alike. Key commonalities were found within both parties of the RPP, for instance, where they shared near- and far-sighted vision. Partnerships with far-sighted vision saw potential future opportunities to investigate retail food environment interventions on larger-population level scales. In contrast, near-sighted vision saw organisational/sector-specific opportunities within reach.

Past evaluations of health promotion interventions and how they address sensitivity to the local context have examined how long-term partnerships for research purposes require trust, time and dedicated funding [7]. Trust is critical to establishing and maintaining partnerships and, ultimately, developing mutualism since partners need to believe and trust that their interests are being upheld [44] in the short and long run. Material interests must often align between partners; as evidenced in our examples, both partners held similar goals for promoting healthy eating in society (e.g., dietary sugar reduction; food affordability).

The RPPs examined in this study also broadly accepted the goals of improving population diets by creating supportive food environments [21]. Despite these common aims, negotiation was required and reinforces existing literature demonstrating how trust can be built and maintained by supporting sector-specific benefits such as retailer-led interventions or feasibility adaptations in intervention designs [28, 44].

The practice exchange reinforced existing literature on how RPPs work in relation to the academic grant process (e.g., timing, process), which may not support the time and resources it takes to form the necessary partnerships [45, 46]. It has often been argued that researchers may need to take into account practitioners’ acute organisational demands in terms of how nimbly analyses and dissemination occur [46]. Yet in the RPPs examined in this paper, it was also observed that the greater research freedom and timeline discretion afforded academic researchers in the partnerships enabled the production of larger-scale and perhaps more complex or analytically demanding analyses that were ultimately influential in other retail practices and policy domains.

Our second finding highlighted the need to meet in the middle and to actively negotiate. Existing research on organisational behaviour for health promotion has explained how knowledge-brokering activities often occur through diplomatic efforts [47]. Mutual learning relies on networks of people to develop a mutual comprehension of sometimes distinct contexts [15]. Clarifying what is meant by context is essential, as context is dynamic and changing [48]. For instance, the RPPs in the practice exchange discussed multi-level physical (layout of stores), organisational (policy and strategy values) and structural-relational (food sovereignty) factors. Objectively measuring context can be furthermore ambiguous and difficult to define [49]. Food environments may contain multiple retail settings, as is the case for hospitals. Therefore, practitioners and researchers may need to consider methodologies to capture or ‘adjust’ for context as settings-within-settings in the study of health promotion interventions [50].

Additionally, studying how these interventions actively change the context where they are implemented is essential [51]. As in the examples explored through our practice exchange, both sets of interventions were kept in place after the study finished and ultimately influenced other aspects of organisational practice. Thus, context is dynamic and not static [52]. Increasing the understanding of integrating context into health promotion could highlight vital measurements and lead to a longitudinal study of context or study of context in different phases of development (e.g., adoption, implementation and evaluation) [53].

Our third finding was that researchers and practitioners leveraged existing organisational policies to build common ground. In a way, both examples covered in this paper were ideal situations in that overarching health promotion policies provided a foundation for more in-depth and novel intervention research work. Policies have been identified as effective tools for improving diets and altering the environments and conditions where people shop for food [54]. However, health promotion policies do not always consider specific retail contexts, and this can present challenges. This was investigated by Law et al. [55] in

their qualitative study of retailer perspectives on implementing a nutrition policy in public healthcare settings. One of their main findings was that the policy was incongruent with the retailer's local contexts. One of the policy requirements restricted certain products (red light or unhealthy products) within certain areas of the retail store (e.g., a certain distance from the cash register). Retailers were perplexed by this, as the space and size layout of some stores hampered this requirement. In response, they wanted real-life examples of how other stores had accomplished this policy objective. Researchers may need to develop a relational understanding of 'how a policy means' in practice for the retail organisation and its corporate stakeholders [56].

The goal of integrated KE is often to contribute to organisational culture change, where research and changes to practice are welcomed and lead to the adaptation of policies or incorporation of findings into policies. For the organisations we examined in this paper, policies were the start, not the outcome, of KE. Our findings showed that knowledge exchange emerging through intervention research also contributed to further changes in partnerships and policies. However, further study is required to understand how knowledge exchange and policies intersect.

5 | Limitations and Strengths

This paper comprised a synthesis of discussions catalysed by a virtual knowledge exchange event. A key strength of this article comes from the extensive applied KE experience of the participants who have worked in a variety of sectoral retail food environments across Canada-Australia. Another strength of this paper is that it addresses a health promotion gap in synthesising the 'how' of knowledge exchange outcomes, including linking knowledge products published elsewhere. The examples varied in geographical location, organisation type and customer base. Their similarities in KE, however, potentially show the consistency across the field of retail food environments intervention research and the transferability of research from one setting to another.

This paper is subject to several limitations. While the two overarching research project contexts were well established, the paper was based on findings derived from a one-time KE event held within that context. Alternative data collection methods might shed light on other aspects of mutual learning as well as the sustainability of RPP and interventions [57]. Another limitation is that participation in the event occurred through a snowballing approach. The participants thus represented at least part of an existing knowledge network. Future studies involving a wider range of participants may unearth additional aspects of mutual learning. In addition, the knowledge during this event was co-created and captured using non-traditional methods, where participants might have felt they could speak more candidly than other data collection methods. However, since partners were present at the event, they might not have spoken more openly (response bias) [58].

6 | Conclusion

This paper explored mutual learning within retail food environments using two examples of RPPs. There was evidence of

mutual learning as practitioners provided context to intervention design and researchers provided research and scientific rigour. Partnerships are necessary to build up the evidence base of retail intervention effectiveness; however, simply working together did not produce mutual learning. RPPs need to negotiate their interests and build trust in several ways over time to advance the scientific study of health promotion in retailing. Building up the evidence could create pathways to new partnerships with retailers who are sceptical or hesitant about implementing retail interventions. KE appears to have been supported by organisational policies and, in turn, influenced the development of new policies and strategies. KE, as examined in this paper, was found to have organisational outcomes beyond bridging the knowledge-to-action gap.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analysed in this study.

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