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An analysis in the context of intersectoral health policymaking in 34 Dutch projects of the governmental program Gezonde Slagkracht

Kimberly M. Grêaux

SUMMARY

Problem statement

Globally, countries face major public health problems due to non-communicable diseases. These diseases are mainly caused by unhealthy behaviors such as poor diet, sedentary behavior, and alcohol and drug abuse. Intersectoral health policymaking, addressing various interacting personal and environmental behavioral determinants simultaneously, is considered essential to improve public health. Intersectoral policymaking requires diverse and multi-sector involvement in the policy networks that decide on the implementation of integrated health promotion packages, and in the partnerships that ensure the implementation of these packages. Such packages include complementary methods of change (e.g., education and regulation), situated in various local settings (e.g., schools and public places), and targeting both personal and environmental behavioral determinants. In practice, however, intersectoral policymaking tends to result in small-scale interventions targeting mainly personal determinants rather than broader initiatives addressing structural environmental determinants. Several challenges due to the complexity of involving a variety of partners have been identified, such as selecting the right partners, incorporating leadership, developing a shared mission and building trust among partners. In addition, problems with the implementation, i.e., the actual use of health promotion interventions, have been highlighted as a reason why the interventions included in integrated health promotion packages do not achieve their potential public health impact. Intermediate users do not adopt or implement available evidence-based interventions, use them only on a small scale, or do not implement them as intended by their developers. In the Netherlands, evidence-based practice in health promotion is supported by the Dutch Recognition System (DRS) which includes a health promotion intervention database on the website of the Centre for Healthy Living of the National Institute for Public Health and the Environment. Adoption and implementation of recognized interventions from this database might however be hampered by contextual mismatches, such as the perceived lack of information and support on whether these interventions can be adapted to fit the unique implementation context of the intermediate user. Implementation can be seen as the introduction of an intervention in a specific context with which it should interact in order to perform its "function" in terms of the intended health outcomes. Such an intervention-context interaction may require either adaptation of the intervention, or capacity building in the context. In addition, the presence of this intervention-context interaction could mean that, depending on the nature of the intervention features and the context features, specific key interaction points might arise. The identification of such "bottlenecks for implementation" could create opportunities to predict implementation problems and develop implementation strategies specifically for a type of intervention and context.

Aim, study setting, and conceptual framework

The aim of this dissertation was to contribute to optimizing the implementation of integrated health promotion packages in local intersectoral health policymaking.

All four studies included in this dissertation were conducted in the context of the governmental program Gezonde Slagkracht on intersectoral policymaking in Dutch municipalities. The program offered 34 municipalities or alliances of municipalities (referred to below as projects) the opportunity to experiment with the development and implementation of intersectoral health policy on various health themes by means of financial and professional support. The program required the appointment of a project leader who had a coordinating role in the establishment of local policy and implementation partnerships consisting of partners from the health and non-health sectors, private partners and citizens. Health promotion packages had to include different types of health promotion interventions implemented in different local settings, addressing both personal and environmental behavioral determinants, and preferably from the DRS database.

The studies in this dissertation depart from the Determinants of Implementation model (DIM model), which includes the *implementation stages* of adoption, implementation and continuation of interventions, four categories of *conditions* influencing the implementation process, i.e., characteristics of (co-)implementers, the intervention, the organization of the (co-)implementers, and the socio-political context, the moderating role of *the implementation strategy (* i.e., the actions taken to enhance the adoption, implementation and continuation of interventions), and the notion of '*contextual fit*'.

Included studies

The observational longitudinal multiple-case study in **Chapter 2** examined whether the involvement of more *and* more diverse partners in the implementation partnerships would result in more integrated intervention packages. Questionnaire data were collected among 31 project leaders and 152 intervention implementers in 31 projects. Results indicated that a variety of partners from multiple sectors was involved, during both adoption and implementation of the packages. However, these were primarily partners from the health, welfare and educations sectors. Almost all packages integrated multiple methods of change, but mostly education, facilitation and case finding, in multiple, but mostly health and public settings. They targeted diverse behavioral determinants, but typically personal and social environmental determinants. More partnership diversity, especially during implementation, was associated with more integrated health promotion packages. It was concluded that investment in diversely composed partnerships seems worthwhile for implementing integrated health promotion packages. However,

investments in conditions like framing health issues and network management, are also needed.

The observational cross-sectional multiple-case study in **Chapter 3** examined under which conditions (levels of active networking, active participating and trust) the involvement of more sectors in policy networks would be associated with the implementation of more integrated health promotion packages. Data for a fuzzy-set qualitative comparative analysis were collected from policy networks in 29 projects using questionnaires. A multisectoral policy network was neither a necessary nor a sufficient condition. In multisectoral networks, additionally required was either the active participation of network actors or active networking by the project leader. In policy networks that included few sectors, a high level of trust was needed – in the absence though of any of the other conditions. If the network actors were also actively involved, an extra requirement was active networking by the project leader. It was concluded that the multisectoral composition of policy networks can contribute to the implementation of integrated health promotion packages, but not without additional efforts. Policy networks that include only few sectors are also able to implement integrated packages, under the condition of trust among partners though.

Chapter 4 examined the role of the DRS in supporting and achieving evidence-based practice. In an observational cross-sectional mixed-method study, interview and questionnaire data were collected among 34 project leaders and 158 implementers of interventions. The results indicated that the database of the DRS was not frequently visited by most projects. However, most projects implemented at least one intervention that originated from the database, and about half the projects submitted at least one intervention for inclusion in the database. The number of adopted, implemented and continued DRS interventions, and submitted interventions, were a minority of all interventions. In several projects, the use of the DRS was stimulated by the Gezonde Slagkracht program's required and supported use of the DRS. Factors hindering the use of the DRS related to the perceived low user-friendliness of the database, the limited availability of interventions for certain themes, target groups, and behavioral determinants, the limited availability of adaptable interventions and local capacity for adjustments of DRS interventions to their own implementation context, the time-intensive development and submission process, and a general lack of awareness of the importance of evidence-based practices among project leaders and implementers. It was concluded that the role of the DRS was limited but certainly not negligible in supporting and achieving evidence-based practices.

Chapter 5 examined the presence of - and regularities in – intervention-context interactions or 'bottlenecks for implementation' in an observational cross-sectional multiple-

case study. The study assessed whether similar intervention systems i.e., that address the same health theme with an identical change method in a comparable setting, would come across a similar set of bottlenecks for implementation. Bottlenecks were identified by the implementers by rating the presence and importance of conditions for implementation in a range of intervention systems. Questionnaire data about 243 interventions was collected among 120 implementers in 30 projects. Bottlenecks occurred in all categories of conditions, e.g., relating to the implementer, the intervention, and political and administrative support, and often connected with intersectoral policymaking, e.g., relating to the co-implementer and the co-implementer's organization. Both hypotheses were supported: (1) Each intervention system came across a unique set of – a limited number of – conditions hampering implementation; (2) Most bottlenecks were associated with the characteristics of the system in which they occurred, i.e. with its health theme, change method and/or implementation setting. However, bottlenecks also appeared when there was no such association, or did not appear when there was an association. It was concluded that intervention-context interactions in intersectoral health policymaking may lead to both regularities and variations in bottlenecks for implementation.

General discussion

Chapter 6 contains the general discussion of this dissertation and starts with a summary of the main findings, followed by a discussion of methodological considerations regarding, among other things, the real-life context and the observational character of the study. The chapter closes with the conclusions and implications of the research, leading to the final statement that the research has helped to substantiate several directions that the improvement of the implementation of health promotion packages can take, and has generated some new directions that could ultimately raise the impact of health promotion.