Author's response to reviews

Title: 'People pull the rug from under your feet': barriers to successful public health programmes

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Author's response to reviews:

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Dear Sir/Madam

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People pull the rug from under your feet?: barriers to successful public health programmes

We note that the first reviewer has accepted all the revisions that we made in the previous version. We have now revised the paper, taking into account the comments made by the second reviewer. Below we set out our response to these comments.

1. The analysis does not lead to the conclusion that community programming is ineffective. This paper suggests that the program planning was not focused on community engagement. The actual failure of implementation appears to be a failure of management to invest in program planning.

Our response

We agree with this response. We hope that we have demonstrated that the indeterminate aspects of programme delivery meant that the goals of maintaining the original principles of community involvement were not maintained and thus led to a problematic implementation process. We have therefore included the following in the conclusion (page 12):

This analysis should not lead to the conclusion that community programmes, such as Breathing Space, are ineffective. Rather, the programme planning was
not able to focus fully on community engagement because of a failure by the programme leaders, both from the local community agencies and the external health board, to address these indeterminate aspects of the programme¿s implementation.

2. The methods in the abstract begin with the outcome evaluation. This paper, however, is not about the outcome evaluation. The first sentence of the methods should be omitted or replaced with ¿The process data will be presented to understand or explain the negative findings of the outcome evaluation of Breathing Space.¿

Our response

We feel it is important to contextualise the wider study design. We hope that we have clarified any misunderstanding with the inclusion of the following (page 2):

The overall evaluation of Breathing Space used a quasi-experimental design and incorporated a detailed process evaluation. The process evaluation aimed to document development and implementation of the programme using a range of qualitative methods, including observation, in-depth interviews, focus groups and documentary analysis. The paper draws upon 59 semi-structured in-depth interviews which were carried out as part of the process evaluation.

3. In the first paragraph rates are given for 1970 for the population at large. This data is then compared with age and SES specific data for 2003. The authors should either compare at-large data at both time points or age and SES specific data at both time points.

Our response

We now refer only to one point in time, as follows (page 3):

The most recent Scottish Health Survey found that 51% of men and 45% of women in the lowest household income quintile in Scotland smoke in comparison to 15% of men and 13% of women in the highest household income quintile [2].

4. On page 4 (4th paragraph) there is a sentence that states that ¿Typically, process evaluations use qualitative methods.¿ Actually, process evaluations can also use quantitative methods or both.

Our response

We accept the point. We have omitted ¿typically use qualitative methods¿ and state that in our study we only used qualitative methods, as follows (page 5):

The process evaluation focused upon the design, development, scope, intended purpose and implementation of the Breathing Space programme. To this end, a range of qualitative data collection methods was used, including: observation (at programme meetings and key events); in-depth interviews (with key stakeholders including programme managers and workers); focus groups (with programme implementers and young people); and examination of official documents (minutes, reports, budget statements, policy documents and key
correspondence) and monitoring of local newspapers and community publications.

5. Explain the term Carstairs score in the 5th paragraph.

Our response

We have decided to use the `Depcat¿ score as a marker of the deprivation within this community as it will be more easily understood by the reader.

We have inserted the following text (page 4):

(DepCat is a measure of social deprivation, widely used in Scotland, which is based on information gathered in the national census every ten years and describes the socio-economic composition of residents in a particular postcode sector. DepCat scores for each postcode area in Scotland are calculated from the percentage of unemployed males, over-crowded households, households without cars and people from social classes IV and V. The scale runs from DepCat 1 (most prosperous) to DepCat 7 (least prosperous) [31]).

6. It would be helpful to the reader if local agencies were defined or explained in the background.

Our response

We have further articulated that the local agencies were run by and for local people. We have also emphasised that it was the local people and local agencies who first asked for support from the health board in tackling smoking. Please note the following insert on page 4:

The programme was initiated in 1998 by the local health sub-group of the local urban regeneration partnership, both of which were solely managed by local people. The local groups contacted the Health Board for help in tackling the high prevalence of smoking in their local community. The management of the programme was undertaken by a partnership of the organisations run by local people, the Urban Regeneration Partnership (URP), and the community health agency (CHA) and the Health Board, between 1998-2001 (figure 1). The local agencies, while run by local people, did employ staff to undertake the community work.

7. In the 3rd paragraph the first sentence begins with ¿The programme was delivered¿. An explanation of the program would make the paper clearer.

Our response

Please note the insertion of programme activities in table 1 and the text on page 4:

The programme (the content of which is captured in table 1) was delivered in three phases over a three year period: first, the mapping phase (1998-1999), when existing community activity to tackle smoking was recorded and local participants were identified and recruited; second, the planning phase (spring
1999), when findings from the mapping exercise were disseminated to the local community led groups and when the interventions were developed; and, third, the implementation phase (Autumn 1999-Summer 2001). Programme funding was provided by the local health board, and the local community agencies gave contributions in time and local administrative support. Programme responsibilities were defined through the planning process, with an expectation that the local agencies would deliver the programme in collaboration with local people.

The programme was delivered in four health promotion settings (community, schools/youth, primary care and workplaces) and comprised a range of activities, such as training health workers, young people’s videos, health fairs in the shopping centre, newspaper features, and innovative smoking cessation and well-being programmes (table 1).

8. The methods section also needs more clarification and should be explained plainly and in an organized fashion. On page 5 the 1st sentence beginning with “A comprehensive description of the intervention was undertaken” Why? It is unclear why or what the description was used for.

Our response
The introduction to the ‘Methods and analysis’ section has been rewritten (page 5). See our response to point 4 above.

9. First paragraph remains unclear. What is meant by the phrase “Breathing Space far exceeded any contingency provision?”

Our response
We have rephrased as follows (page 5):

While change is an anticipated component of community based programmes, the level of change associated with Breathing Space far exceeded resource provision.

10. Edits should be made to the length and organization of the findings section.

Our response
We have shortened the findings section from 1778 words to 1598 words. In doing so we hope that we have achieved a greater degree of clarity and reduced the amount of repetition. We have also re-ordered the presentation of the findings.

11. It seems that one of the most important findings from the Process Evaluation is that it should have been used as a Formative Evaluation. The authors do not make this point and it is the strongest reason for the paper.

Our response
We have added the following text (pages 9-10):

The findings of our analysis clearly indicate that the Breathing Space programme may have benefited from a formative evaluation which enabled programme
participants to reflect on and respond to challenges (particularly concerning community involvement) arising through implementation. While a formative approach would have been difficult to incorporate into the overall quasi-experimental design of the Breathing Space evaluation, in retrospect some feedback to programme implementers might have been possible without compromising the study.

We also added the following to the conclusion of the abstract conclusion:

Evaluations of innovative community development initiatives may benefit from a formative approach.

12. The first sentence of the discussion is unclear. Why would the fact that the programme took place in a disadvantaged area have anything to do with successor failure? This appears as though it is a bias. The authors should reconsider the phrasing.

Our response
We have rephrased as follows (page 10):

A limitation of the process evaluation is that it is not possible to know the extent to which the findings might reflect the experiences of programme intervention in other types of communities (e.g. less socio-economically deprived).

13. The lack of specific programme objects and programme planning seems to be the reason for the failure of the programme. Typically we think of this a Type III error: failure to implement the programme as planned. The process evaluation in innovative community programming should be formative. A formative evaluation would allow programming changes to occur during the life of a program.

Our response
Importantly, it was the loss of key stakeholders, as we argue, that had a significant impact on the possibility of achieving the programme objectives. It is more problematic conceptualising this as a type III error when working in a community development programme, since the intention is to work with the community to develop the intervention, without necessarily having a clear idea at the outset of what the intervention will eventually ‘look like’. We have, however, included the importance of a formative evaluation in our discussion (see point 11 above).

14 This does not appear to be a community intervention. Rather this appears to be a coalition of local agencies. Please clarify how this program was conceived as a community intervention. The programme as described appears to have been very management or bureaucratic and not built on the principles of community participation.

Our response
The programme was conceived originally as a community driven intervention.
The health board agency was asked by the community run groups to help them tackle smoking. The original planning was based on community development principles. We refer in the paper to another published paper that explores the use of these principles more fully in this project (Ritchie et al 2004). It was the indeterminate aspects that eroded this original conception of a community driven programme based upon community development principles. We would therefore claim that this was a community intervention that did not work because of the failings of the partnership to form successfully between the local people, the local group and the Health Board. We have also stated clearly the origins of the programme and the community setting approach from health promotion theory.

See our response to point 6 above. See, also, the following text (page 4 and 11, respectively):

The conception and design of Breathing Space was grounded in the principles of community development, including shared participatory decision making and consensus. It was intended that intervention activity would be planned and driven by the local community, with leadership for the programme nurtured from within the community [28]. A previous paper explored the tensions and contradictions in implementing these principles in practice [19].

Moreover, it must be acknowledged that those partnership organisations, that are run by and for local people, which traditionally are perceived (and perceive themselves) as the least powerful players in an intervention partnership will have most to lose in this respect. The importance of indeterminate knowledge to programme success is clear in the case of Breathing Space, because loss of the knowledge and understanding which underpinned the original community based ethos of the programme served to undermine participant ownership and programme direction.

We hope that you will find the revised paper suitable for publication, and look forward to hearing from you in due course

Yours sincerely,

Deborah Ritchie