Author’s response to reviews

Title: A toolkit with nine district types to support municipalities in taking an integrated approach to prevention

Authors:
Ilse Storm (ilse.storm@rivm.nl)
Nikkie Post (Nikkie.post@rivm.nl)
Antonia Verweij (Antonia.verweij@rivm.nl)
Karlijn Leenaars (Karlijn.Leenaars@rivm.nl)

Version: 1 Date: 21 Sep 2019

Author’s response to reviews:

Revision note AOPH-D-19-00129

A toolkit with nine district types to support municipalities in taking an integrated approach to prevention

Ilse Storm, PhD; Nikkie Post; Antonia Verweij; Karlijn Leenaars, PhD Archives of Public Health

Reviewer #1: General comments

R:

Dear authors, thank you very much for this interesting paper that describes a toolkit that aligns local district characteristics with available data and interventions.

A:

Many thanks for the positive feedback. Please see below our reaction on the comments.

Main manuscript:

R:
Methods, section 2.1b, page 10, row 107: You have performed a working session per district type. However, eight sessions versus nine district types means that one is missing. Please explain which district type was not represented and why?

A:

Indeed, nine work sessions were held to develop nine district types. Two sessions were combined on one day, but it makes more sense to count them as separate sessions. The sentence has been adjusted:

A total of nine working sessions were held.

Methods line 122-123

R:

Results, section 3.3, page 14: I would appreciate a bit more information if there is a specific approach that supports the initiators in contacting and involving stakeholders from other sectors. This is linked to two rather general question: Who is mainly using the toolkit or is starting the initiative? Are these public health authorities (on regional (or local) level)? On page 16 Dutch municipalities are described as users, can it be specified what kind of actors take the initiative?

A:

The toolkit is primarily intended to inspire policymakers on an integrated approach in both district health profiles and district plans, as described in line 78. The toolkit does not provide directions for organizing the collaboration, instead, it refers to other (collaboration) tools. It can be described more clearly who can take the initiative to use the toolkit and that working with various stakeholders requires more than just using the toolkit. The following sentences have been adjusted and added:

The aim of the toolkit is to enhance an integrated approach to prevent health problems.

Background line 76

A local process supervisor (e.g. a health policymaker, a health expert or professional community health services) is able to take the initiative to use the toolkit in practice. In order to collaborate successfully between domains the toolkit will not suffice, additional actions are required. For example, the establishment of a process approach and the organization of related networks on neighbourhood level, and more specifically: attention for success factors (e.g. governance, consensus and networks) [29, 30].Background line 81-87

R:
The interventions described in Table 2 have mostly a strong health focus. Please explain if it is planned that the interventions are extended by interventions from other resorts, e.g. social affairs, transport, work,...?

A:

Indeed, the toolkit contains more interventions on lifestyle than interventions from social affairs, transport and work. This has to do with the availability of recognized interventions from, for example, the physical and social domain (e.g. transport, social affairs). From various databases, mainly recognized interventions are included in the table, because the focus is on stimulating the use of recognized interventions. Of course there are also various environmental measures available to influence health, such as walking and cycling paths. The blocks ‘Physical and social environment’ and ‘Regulations and enforcement’ also include measures that focus on creating a healthy living environment (e.g. walking routes or availability of stimulants) and the enforcement of these measures. A sentence for clarification has been added:

In the toolkit most of the available recognized interventions from databases are for block 1 (information and education) and 2 (alerting, advice and support). Less recognized interventions are available for block 3 (physical and social environment) and 4 (regulations and enforcement). Any proven, recognized interventions out of these domains (that will get available in the future), could be added and made available through a new version of the toolkit.

Results Line 236-241

Reviewer #2: General Comments

R:

The authors of the article "A toolkit with nine district types to support municipalities in taking an integrated approach to prevention" describe the steps to develop a toolkit and the resulting product. The latter allows the target group, health policy makers and health experts in municipalities, to combine the analysis of health-related data at their district level with the selection of interventions that are presented as suited for an integrated approach to prevention according to the specific health problems within the certain district.

The article is interesting for researchers in the field of community health promotion and prevention. It gives a good description of the impressive approach that is taken by the Dutch national public health institute RIVM. The prevention toolkit seems an ambitious and logically developed digital instrument. The methods used for the development seem sound (minor amendments needed). However, it remains open how effective the prevention toolkit is as an approach compared to other approaches to foster the translation of evidence to action in prevention at the municipality level.

A:
We thank you for the feedback that the article is interesting for researchers in the field of community health promotion and prevention and also your directions for further improvement of the article are appreciated. In the section below, we’ll explain how we processed the comments.

Main manuscript:

R:

1) "the aim of the toolkit is to encourage collaboration between different domains to prevent a health problem" (line 67): It is not well described which approach is taken to facilitate collaboration and what the scientific (also international) evidence is for the approach taken. From the existing text, the reviewer only understood, that interventions from different fields or sectors that are relevant to prevention are in the toolkit and that in the beginning of the prevention guide for a certain district, the necessity of collaboration is described. I am hesitating to believe that this is the most effective way to build capacity for intersectoral collaboration for health in municipalities.

A:

We have rewritten the purpose of the toolkit. The toolkit is primarily intended to inspire policymakers on an integrated approach in both district health profiles and district plans, as described in line 78. The toolkit does not provide directions for organizing the collaboration, instead, it refers to other (collaboration) tools. (see also reviewer #1). An important characteristic of an integrated approach is, of course, collaboration.

The following sentence has been modified to be more precise on the purpose of the toolkit:

The aim of the toolkit is to enhance an integrated approach to prevent health problems.

Background line 76

The following sentence has been adjusted to provide more explanation about collaboration between different domains, including international references (see also reviewer #1):

In order to collaborate successfully between domains the toolkit will not suffice, additional actions are required. For example, the establishment of a process approach and the organization of related networks on neighbourhood level, and more specifically: attention for success factors (e.g. governance, consensus) [29, 30].

Background Line 83-87

R:
2) The authors say that interventions are linked to certain district types (line 60). From what this reviewer understood, the interventions are rather linked by the target groups that they primarily have in focus (e.g. socially disadvantaged), and that also can be found more in certain districts. So the link is the target group, and not the district. Most of the interventions will not be district specific, and in most studies, context is not described in the form of certain districts. So the scientific evidence base and the factors, on which basis the interventions have been grouped to districts should be presented - not only the one example (line 215-219).

A:

During the process of developing the prevention guide, we have taken into account the fact that there are different prominent health problems of inhabitants of each of nine district types. We also took into account the demographic and other characteristics of each district type regarding interventions. For example, in a rural area it is suggested to incorporate the availability of the green environment in addressing obesity. While in a more urbanized area it is suggested to make use of the available facilities like gyms and urban parks. The underlying databases contain more information on how to implement interventions in the local context (e.g. finance, skills, constraints). The sentence is revised for more clarification.

An integral overview in which the available data about the health issues and characteristics for certain types of district is combined with proven, recognized interventions can provide support in the implementation of an integrated working approach in practice [24, 25].

Background line 62-66

R:

3) In the background section, the authors should describe how the target group of the prevention toolkit, namely health policy makers or municipality health experts, got information on health-related data at their district and found evidence-based interventions in the Netherlands before the toolkit existed. This is important to understand the context, in which the system of the prevention toolkit was developed and made sense. The only sentence describing the situation is far too vague (line 58: "fragmentary" - what does this mean? Do the authors think that their system is very context-specific and why? (should be part of discussion)

A:

We agree with the reviewer that this is too vague. The phrase 'The knowledge ... .to use "is adjusted.

This knowledge however, isn’t always coherently delivered in a way that the process of promoting district profiles to healthy district approaches is stimulated. An integral overview in which the available data about the health issues and characteristics for certain types of district is
combined with proven, recognized interventions can provide support in the implementation of an integrated working approach in practice [24, 25]. Studies revealed that policy advisors need guidance in their search for and selection of information [26, 27].

Background Line 62-67

R:

4) Through the whole article, there are inconsistencies in the use of the terminology: e.g. integrated versus integral. The authors first call an integrated approach "prevention focusing not just on individuals… but on surroundings" (line 11). In other parts of the text, integrated means intersectoral/interdisciplinary, i.e. bringing different sectors and disciplines together to promote prevention. Another meaning (line 24) is using intervention to tackle several (often clustered) behavioral risk factors at the same time with the same intervention set. The same inconsistency exists for "integral" versus "fragmentary". The authors should go through the whole text again, trying to define very much in the beginning what they mean by different terms, use international references to back their decisions on terminology and also differentiate their understanding of integrated from the WHO's health in all policies understanding.

A:

Integral has been replaced with integrated. The following sentences have been modified.

Integrated (instead of Integral)

Abstract, Line 46, 220, 256, 261, 262, 274, 281, 338

In the introduction, we have given a further explanation of the term integrated approach. Due to restrictions concerning the length of the article we have chosen not to explain in depth different terms like IA, HHP, HIAP and WOG. We have however added a reference to Kickbusch & Storm to address these concepts, terms and definitions. The following sentences have been revised and added.

In the Netherlands an integrated approach is often used interchangeably with the term Health in All Policies. Health in All Policies is a broader complementary policy-related strategy with a high potential for contributing to population health [7, 8]. In practice Health in All Policies is an integrated approach characterized by a mix of interventions and measures from various domains (e.g. care and the physical and social living environments) [9]

Background line 11-16

R:
5) Many of the references are Dutch references, which is not a problem per se. I see however several arguments where international references should be cited on top, to frame the prevention toolkit within the broader international research experience and results. One example is reference 22 in line 160.

A:

We agree with the reviewer that more international references could be added. This has been done. See the section ‘literature’.

R:

6) In addition, a summary of the international evidence on what we know about the factors that can facilitate translation of evidence into action at the municipality level should be given in the background, to legitimize and frame the approach which was taken with the prevention toolkit.

A:

We agree with the reviewer that this could receive more attention. The following sentences have been added (see also point 3):

Hereby we have been borne on previous (international) studies with regard to tools and use of knowledge for evidence-informed health policymaking (such as making decisions based on the best available research and using systematic data and information and development of integrated plan tailored to the local situation) [17, 19, 28].

Background line 70-73

This knowledge however, isn’t always coherently delivered in a way that the process of promoting district profiles to healthy district approaches is stimulated.

Background line 62-63

Studies revealed that policy advisors need guidance in their search for and selection of information [26, 27].

Background line 66-67

R:

7) In the conclusion, I would expect some information on how the quite impressive and work-intensive approach that is taken with the prevention toolkit will be evaluated and against what other approaches, in order to prove its superiority. This seems important to
me as the development and constant update requirements are comparatively intense. Some data on costs and effects might be very worthwhile to come to a scientifically sound result.

A:

The toolkit is currently applied and has not been evaluated yet. We certainly don’t want to imply that the toolkit is superior to other available tools. When it comes to implementation, other (stand-alone) tools have shown to be quite valuable. The added value of the toolkit consists of integrating existing knowledge and tools. The following sentences concerning other available tools and strategies have been added.

In order to collaborate successfully between domains the toolkit will not suffice, additional actions are required. For example, like the establishment of a process approach and the organization of related networks on neighbourhood level, and more specifically: attention for success factors (e.g. governance, consensus and networks) [29, 30].

One of the benefits of the toolkit is that it brings together existing knowledge and tools (compared to stand-alone tools). However, it is recommended to evaluate this perceived benefit.

Discussion line 302-304

R:

8) I wonder whether the authors have indication that the system supports the feeling of ownership in the municipalities. In my experience, the local stakeholders have a high need of being the owner of their interventions, being the ones that decide. The presentation of predefined integrated approaches, that might have less flexibility, might hamper the motivation to use the toolkit.

A:

The toolkit is no blueprint but is meant to inspire local stakeholders to develop their own process approach for a healthy district. The feeling of ownership only occurs when local stakeholders, like municipalities, develop their own process and when there is sufficient support on policy and governance level. The following sentences have been revised for more clarification.

The toolkit is not a blueprint but is instead aimed at inspiring municipal policymakers or professionals and providing them with concrete tools about data, themes and interventions to start working on their own district or municipality. Municipalities are enabled to extract available knowledge for their own context.

Background line 78-81

For example, methods for getting the residents involved or generating broad (financial) support or ownership of the integrated approach.
Discussion line 284-286

R:

9) Which criteria were used to choose the source data bases from which interventions were drawn (line 144)? Why were only dutch data bases taken? Is this associated with the necessity of linking to districts?

A:

In the Netherlands a recognition system for interventions is in place. This recognition system assesses the quality, effectiveness and feasibility of a wide range of interventions. A condition to be acknowledged is that the intervention must be executed in the Netherlands. Also foreign interventions can be acknowledged provided that they are executed in the Netherlands. So, these databases are a good source for interventions because these interventions have been executed in the Netherlands and information about the interventions is available for professionals who are interested in implementing these interventions. We added a sentence (169-172) for more clarification:

A condition to be acknowledged is that the intervention must be executed in the Netherlands. Also foreign interventions can be acknowledged, provided that they are executed in the Netherlands.

Methods line 171-173

R:

10) Line 109: the snowball sampling of stakeholders is perhaps not the best method when a nation-wide use of the toolkit is envisaged, and may also be a reason why only 10% of municipalities are interested (are these belonging to those that were part of the working sessions?). Maybe this should be mentioned in the limitations.

A:

The stakeholders who participated in the work sessions are not necessarily the ‘end-users’ of the toolkit. For example, the municipalities that use the toolkit are participants in national programmes (e.g ‘Get Prevention Started in your Municipality’). Since the toolkit is relatively new, dissemination is still ongoing and it is too early to draw conclusions from the 10%. Information has already been given about the use of the toolkit. We already stated that an increase in dissemination and support is needed to stimulate the use of the toolkit. Therefore, no additional additions have been made.

R:

A:

The word is replaced in the sentence. It’s about the decentralization which offers opportunities.

Delegated tasks from national to local (instead of devolved).

Background Line 30