PHAC.18 - BeweegKuur: development of a combined lifestyle intervention and implementation in local settings

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Introduction: In 2006, the Ministry of Public Health presented its Prevention policy document stressing the relevance of prevention for public health improvement. It focuses on a local and neighbourhood oriented approach. Preventive and curative health care should act more closely together. Physical activity (PA) is seen as a tool to enhance health. Within this framework, the Ministry asked NISB to develop a – nationwide accessible- lifestyle intervention (LSI) for the primary care setting, focusing on increase in PA. This intervention, called BeweegKuur (BK), is now a combined LSI with a duration of 12 months, directed on PA enhancement by stimulating daily PA and guided transfer to suitable organized PA, on healthier eating habits, and on behavioural change. The target group consists of overweight and obese adults with weight related health risk, with insufficient PA, and who are motivated to change lifestyle. Different programmes are available varying in level of guidance on PA. The BK is carried out in the primary care setting with a role for general practitioners, physical therapists, dieticians, and a central role for the life style counsellor (LSC).

Activities undertaken: The BK is based on existing and evidence based LSIs. It started at a few locations in 2008. Concurrent development and implementation, guided by formative evaluation by means of forum discussions, questionnaires etc., was chosen as implementation strategy. Evaluations were carried out by independent scientific organisations among regional intermediate structures for collaboration in primary care (ROS), health care providers, PA providers, and participants, as well among regional and local networks. Topics were: role of stakeholders, time investment, rating of the intervention, needs and performance of professional education and (preliminarily) change in lifestyle. Results are used to adjust contents as well as the implementation process. In addition, scientific studies have been started on the process evaluations, (cost-) effectiveness, and on network development.

Results: BK is available at 160 locations. Adjustments in contents based on evaluations are a.o. employing physiotherapists as LSC next to practice nurses and the design of the diet programme. Health care providers value the BK on average with 7.3 out of 10, with a range of 1 to 10. Cooperation between these providers has improved markedly by the BK, and less with stakeholders outside care. Regional networks are developed further than local ones. Increase in unorganized biking and walking and in sporting at fitness centres leads to increase in total PA, more often than by activities at sport clubs and other organized activities. 50% of the participants maintain increased PA levels still one year after the end of BK, with motivation at start being a strong determinant. Registered health information shows a decrease in BMI of 3%, and 5-8% in blood glucose.

Conclusion: Concurrent and continuous development, implementation and evaluation is found to be very successful in the implementation process. The BK enhances cooperation between relevant stakeholders in prevention, at best at the regional level and between health care providers. Results suggest a positive effect on PA and health in motivated participants. Current actions are directed on improvement of local networks and on better accessibility to local PAs, supporting maintenance of lifestyle change.