On the importance of reporting public health programmes

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Published online: 2 June 2011
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This issue compiles a selection of recently completed disease prevention and health promotion (DPHP) programmes funded under the German Ministry of Education and Research's national prevention research initiative focussing on new evidence and implementation-oriented research processes. Sixty projects are to be funded with 20 million Euros from 2004–2012. The objectives are to explore new intervention concepts and access paths, evaluate effectiveness and cost-effectiveness, develop methods of prevention research, and support quality assurance and networking. Target groups include children, adolescents, and elderly and socially disadvantaged people. The initiative enables close cooperation of research and practice in planning and conducting these projects to ensure the practical usability of all results.

The government initiative is coupled with the Cooperation for Sustainable Prevention (KNP) meta-project editing this issue. KNP's mission is to connect DPHP stakeholders disseminating the results of German prevention research to users and decision-makers, and to consolidate research

methods. Its platforms include a scientific advisory committee, annual strategic meetings for all project teams and users and other stakeholders and decision-makers, and regular task forces for research translation. KNP was established in 2009 by the Hannover Medical School, the University Medical Center Hamburg-Eppendorf, and the Federal Centre for Health Education in cooperation with the DPHP agency of Lower Saxony, the Bavarian Health and Food Safety Authority, and the German Society for Social Medicine and Prevention.

The main purpose of this issue is to promulgate health intervention programmes developed and tested in Germany while at the same time providing a foundation for more detailed reporting of evaluation results. A frequent flaw of effectiveness studies is the lack of a clear and sufficient description of the intervention. Usually there is a dearth of space for research articles, forcing authors to restrict programme portraits to slim sketches. As a consequence, it is often impossible for reviewers to assess programme fidelity well enough to exclude low intervention integrity as a possible source of low effectiveness. This is the reason why the authors of meta-analyses frequently implicate insufficient information on intervention procedures, even on core subjects of evidence-based medicine such as pharmacotherapy, as a major obstacle to the assessment of public health intervention results (Strech et al. 2011).

A considerable number of guidelines on reporting standards for different trial designs and purposes have been established around the world in the last few years (Meerpohl et al. 2009). For DPHP, the TREND statement applies in many cases and will help surmount some typical difficulties of RCT designs (Des Jarlais et al. 2004). Like almost all other protocols, TREND emphasises the importance of depicting interventions in adequate detail. Adher-

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ence to adequate reporting standards is urgently recommended for all authors of future DPHP publications.

Still, the editorial policies and reviewer preferences of most scientific journals allow almost no room for a thorough depiction of evaluated interventions, although these descriptions would be immensely beneficial to practitioners. Misled by a culture of effectiveness in a scientific relevance structure emphasising quantitative data, reviewers frequently press for findings before the intervention has been reconstructed and described attentively. Therefore, KNP is all the more grateful to the editors of this journal for the invitation to publicise promising and proven German DPHP programmes for children and adolescents.

The interventions were implemented in different settings day nurseries and pre-schools, schools, families, rehabilitation clinics, and the Internet. All of the programmes have passed extensive tests of feasibility, and some are already widely implemented. They address a wide range of health issues, from deficiencies in life skills, problem-solving and communication skills, emotional disruption and hyperactivity, eating disorders, depressive symptoms, sedentary lifestyle, and obesity to substance abuse and behavioural problems. Most include cognitive behavioural intervention and training modules. Some integrate parents, and some train teachers as expert facilitators and local contact persons (e.g., Fit for PISA).

All of the programmes have some favourable features in common: All programmes introduced in this issue are based on explicit theoretical approaches. All have been manualized. They are characterised by high-quality evaluation designs: most are RCT or cluster randomised trials, depending on conditions in the specific settings. Considerable effort has been invested in safeguarding quality assurance (e.g., in PALME parents' training). For example, there were quality criteria and monitoring instruments for all steps as well as user training and supervision. Some of the programmes used formalised protocols for that purpose (e.g., PriMa for primary prevention of anorexia nervosa).

Generalising the results, the contributions suggest that there are some common experiences:

- The integration of family members (parents) makes sense, but not in all settings and target groups (e.g., adolescents and body-related topics). Some programmes gain efficacy by addressing sociocultural risk factors (e.g., body image or culturally determined concepts of beauty in the media).
- Systematic adaptation is a promising method of international transfer that can be highly efficient if all modifications are accompanied by theoretical reflection

and empirical pre-tests and evaluations. Otherwise, transfer to a different setting or target group may diminish efficacy, even if the programmes are transferred from one school grade or school type to another. In particular, interventions for socially disadvantaged groups (e.g., low-income families) require careful consideration of intervention usability and effectiveness. Other factors to consider in the adaptation process include the organisational and professional culture (e.g., the skills of facilitators and users) and sociocultural differences (e.g., international transfer requires much more than dealing with language translation problems).

- Local modification is a central problem. Broad dissemination and implementation are usually accompanied by substantial local modifications, which are sometimes arbitrary and sometimes useful for addressing new target groups. All of these “homemade” adaptations are difficult to monitor and control. Furthermore, decision-makers sometimes demand adaptations that do not always make sense in terms of efficacy and effectiveness (e.g., revision of sexual topics, reduction of programme costs, or implementation by insufficiently trained or motivated professional groups).
- There may be many equally effective ways to deal with specific health risks (e.g., eating disorders may be addressed either by integration of family members in the programmes or by school-based, teacher-supported training).

Finally, some programmes become widespread because of their advantages and favourable research results and user reports, whereas other similarly effective programmes do not. This is a central yet delicate problem. If DPHP is to reach its full potential in the interest of public health, decision-makers, funders and users must learn to pay more attention to effectiveness and efficiency.

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