The BeweegKuur programme: a qualitative study of promoting and impeding factors for successful implementation of a primary health care lifestyle intervention for overweight and obese people


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Background. The aim of the study was to identify promoting and impeding factors for successful implementation of a Dutch primary health care-based lifestyle programme called ‘BeweegKuur’. BeweegKuur aims to increase the physical activity and change the diet of people at increased health risk due to overweight or obesity.

Objective. To determine perceived promoting and impeding factors in the implementation of the BeweegKuur programme for overweight and obese people.

Methods. This study consisted of 3 focus group meetings with intervention participants, 15 interviews with health care professionals (HCPs) and 1 focus group session with dieticians. The interviews and focus groups were recorded and transcribed verbatim. The data were analysed with the Nvivo qualitative research software package.

Results. For some intervention participants, the invitation to participate in BeweegKuur came unexpectedly, as they had not been diagnosed with an illness. HCPs were aware of this and took time to explain to participants that the programme was appropriate and safe for them. Participants as well as professionals were generally positive about the feasibility of the programme for overweight and obese people.

Conclusions. HCPs as well as intervention participants were motivated to participate in the programme, and generally indicated that the intervention was in accordance with their needs. The multidisciplinary approach and the combination of physical activity and dietary behaviour change can make the BeweegKuur programme a success if potential impeding factors like those identified in the present study are overcome.

Keywords. HCPs, implementation, lifestyle intervention, overweight and obesity, primary health care.

Introduction

The number of people who are overweight or obese is increasing in Western societies. In the Netherlands, approximately half of the Dutch adult population was overweight in 2007, and 12% were obese. Obesity increases the risk of developing cardiovascular diseases, some types of cancer and psychosocial problems. Weight gain is the result of a positive energy balance, in which energy input through food consumption exceeds energy output, which is partly determined by physical activity. Lifestyle interventions focussing on both physical activity and healthy diet have proved effective in preventing weight-related morbidity in relatively controlled research settings. Because of the gap between theory and practice, the challenge is to make these interventions suitable for ‘real-world’ settings.

Primary health care has been suggested as a good starting point for lifestyle interventions, but successful
implementation of lifestyle programmes requires the intervention to be (i) in agreement with patients’ wishes and expectations and (ii) compatible with the structure and routines of primary health care. Thus, to make lifestyle interventions effective in primary health care, in-depth insight is needed into impeding and promoting factors of successful implementation. A number of characteristics have been argued to be essential for good implementation. These include the characteristics of the innovation itself. For example, does the innovation fit the organization? What are the impeding and promoting contents of the innovation? Also, the characteristics of the user are important. Does the user have a positive attitude towards the intervention and is he or she skilled enough? The factors which are crucial on the patient level include knowledge, skills, attitude and compliance. Furthermore, the characteristics of the organization are important. In lifestyle interventions, health care professionals (HCPs) work in multidisciplinary teams consisting of professionals from disciplines that have traditionally not been part of the HCPs work-related network. Finally, the characteristics of the social–political context are crucial, such as financial arrangements and policies.

This article reports on a qualitative study into the recently developed Dutch primary health care lifestyle intervention called ‘BeweegKuur’ (Dutch for ‘exercise therapy’), examining the crucial implementation issues. The objective of this study is to determine perceived promoting and impeding factors in the implementation of the BeweegKuur programme for obese and overweight people.

Methods

Background information on BeweegKuur
In 2008, the Netherlands Institute for Sport and Physical Activity developed BeweegKuur as an evidence- and practice-based intervention focussing on both dietary behaviour and physical activity. The aim was an effective and feasible primary health care-based intervention, which in time could be reimbursed under the Dutch basic health insurance scheme (for a detailed description of the intervention, see Helmink et al. 2008). The GPs refer patients for an introduction by a so-called lifestyle advisor (LSA), normally a practice nurse, who was trained prior to the implementation of the programme to coach and guide patients during the process of initiating and maintaining lifestyle changes. Based on the results of an endurance test, the LSA designs an individual exercise programme in close consultation with the patient and a physiotherapist and the LSA refers the patients to a dietician for individual assessment (see Fig. 1).

Pilot study
The BeweegKuur programme for obese and overweight people was implemented at the end of 2009 at five pilot locations across the Netherlands. In total, 36 HCPs started to work with the programme, and 87 patients participated during this period. Qualitative methods were used to assess the opinions of HCPs and patients regarding the programme’s feasibility in primary health care practice. Focus group sessions with a total of 16 patients were conducted at 3 locations. Participants were approached by the LSA and they received a gift voucher for their cooperation. Participants filled out an informed consent form and full anonymity was granted. The data were gathered between November 2009 and April 2010.

All HCPs in the pilot locations were approached by the researcher for an interview or focus group. Due to logistics and time of the HCPs, most of the HCPs were interviewed individually [n = 15; 4 GPs, 6 physiotherapists (2 of whom acted as LSA), 4 practice nurses (3 of whom acted as LSA), and 1 dietician who acted as an LSA)]. Three interviews were done by telephone, the others face to face. In addition, a 1-hour focus group session with five dieticians was organized. The point of saturation was reached at the final interview. The interviews and focus groups were recorded and transcribed verbatim with the consent of the participants and transcripts were anonymized. Two researchers (JHMH and LCVB) interviewed the HCPs and led the focus groups and classified the interviews by theme, using the Nvivo qualitative research software package. The content analysis of the transcription was performed by two researchers (JHMH and LCVB). A codebook was developed before the interviews based on the interview scheme and the transcripts were systematically analysed by the principal investigator (JHMH). A second researcher (LCVB) verified the coding and made further suggestions. The themes discussed during the interviews and focus groups are...
systematically presented in Table 1. To facilitate the interpretation of the data, a thematic framework method has been used and the topics were categorized under the following themes: motivation and barriers for participation, physical activity, dietary behaviour, combination of physical activity and dietary behaviour and maintaining lifestyle changes.

Results

Motivation and barriers for participation
The main reasons for participants to take part in BeweegKuur were prevention of diseases and/or complications, losing weight and changing lifestyle. One participant stated 'I want to change my lifestyle, otherwise I’ll get diabetes'. Some participants were convinced by the LSA or GP to start the intervention, and for some participants the invitation to participate in the programme was unexpected because they were not aware of being at high risk of overweight-related morbidity as a result of their unhealthy lifestyle.

All HCPs had had 2 years of work experience with the BeweegKuur programme when it was still aimed at diabetic or pre-diabetic patients, but they shared the opinion that the further development of the programme for overweight or obese people was an essential improvement. A practice nurse stated: ‘It’s the target group that you hope will exercise more. With this programme, you can offer them something’. Another physiotherapist commented: ‘The participants in this target group feel that they have failed at different levels, at the level of exercise as well as that of dietary behaviour. It is a benefit to offer these people a programme’.

It is a new approach for GPs to identify potential intervention participants based on their overweight status, rather than on the diagnosis of a disease. HCPs noticed some differences between participants with diabetes and those with overweight or obesity. In the perception of HCPs, overweight or obese people were more embarrassed about their physical appearance (a practice nurse: ‘Physical appearance plays an important role’), while diabetes patients were more
aware of the fact that a healthy lifestyle could improve their health (LSA: ‘Diabetic patients are more aware that they can do something about their health’). These professionals thus indicated that the main reason for overweight and obese people to participate was to lose weight, while the diabetic patients generally appeared to participate to improve their health. The professionals reported that they needed more time to convince non-diabetic participants that it is good and safe to participate in BeweegKuur, since diabetic patients were already more used to seeing their GP or practice nurse regularly to discuss their lifestyle. A GP stated: ‘A diabetic patient is already a patient with a chronic disease and comes four times a year to the GP for a check-up. You talk about lifestyle with these patients more often. An overweight or obese patient is only too heavy and not sick yet. It is not always easy to start and talk about lifestyle and weight with these people’. All HCPs thought it was important that the participants consulted their GP before attending the programme, although in practice this did not always occur due to GPs’ lack of time. One HCP said: ‘I think it’s important. It can also be important for the participant to have the GP’s support’.

Most HCPs had attended the course on motivational interviewing provided to all professionals involved in the intervention; only some GPs did not attend. The HCPs thought that motivational interviewing was an important skill to motivate patients to participate in BeweegKuur. However, a barrier in this respect was lack of time for optimal use of motivational interviewing techniques. A practice nurse stated ‘I do not have enough time to apply Motivational Interviewing in the right way’.

HCPs stated that one important reason for patients to refuse participation was having to pay for the exercise programmes offered by the physiotherapists, which some were unwilling or unable to do. A physiotherapist said: ‘Paying for the exercise programme is a problem in this area. At first, we let them pay to exercise here, but a lot of patients refused to come. Now it is free and more people came’. Finally, time investment by participants or inability to come to meetings during working hours was also reasons to refuse. A LSA stated: ‘The people in the overweight and obese group are younger and have to work during the day when the meetings are planned’.

**Physical activity**
The focus group participants who had been allocated to the independent exercise setting had started various physical activities, such as walking, cycling, Nordic walking, swimming, and dancing. Participants allocated to the start-up and supervised exercise settings were positive about the physiotherapy programme. A respondent stated: ‘The physiotherapist sees everything, even when it doesn’t go well’. Supervision by the physiotherapist was perceived as valuable and some participants wanted to stay with the physiotherapist after the three months of training. This option was indeed offered at two locations, at a price which was almost equal to going to a gym. Some participants preferred to exercise alone, while others preferred group exercising. A patient stated: ‘I rather exercise in a group, we have a nice group’. Another patient preferred to exercise alone: ‘If you go for a walk you can do it whenever you want, whereas in a group you have to be there on time’.

HCPs perceived the three exercise settings to be appropriate for this target group, though they also reported that some participants were disappointed about being allocated to the independent exercise setting. Some participants had expected that the programme would consist of 3 months of training with a physiotherapist, rather than having to exercise on their own. One LSA stated: ‘Some patients are enthusiastic because they think they can go to the supervised exercise setting. If we refer them to the independent exercise setting, they’re really disappointed’.

**Dietary behaviour**
Respondents were satisfied with the dietary programme offered to them. They indicated that it was important that the content and goals of the dietary programme were made clear from the start. Attendance at individual consultations with dieticians varied, partly because of costs, the expectation that it would not add much to the group meetings or negative experiences with past visits to a dietician. As one respondent expressed it: ‘In the past I went to a dietician and she told me what I was allowed to eat and what not. If you have a consultation with the dietician she focuses on you. Now I am in a group, so the attention is not only focused on me, and for me that works better’. Other respondents thought they would benefit more from individual consultations: ‘I think that you can make better arrangements with the dietician during an individual consultation than during the group meetings’. The majority of the respondents were willing to participate in the group education meetings. A reason not to attend the meetings was a fear of showing dietary behaviour and emotions in the group. For some respondents, the information in the meetings was not new; nevertheless, they felt that the meetings were useful as a back-up to prevent an unhealthy lifestyle. A respondent stated: ‘The information in the meetings is not new, but now I have a back up so I will improve my behaviour sooner’. Another perceived advantage of the group meetings was that participants could compare themselves with others. Some respondents had wanted more information about the combination of their diet and their increased exercise behaviour.
Some LSAs were of the opinion that they ought to be present at a patient’s first dietary education meeting, to lower the threshold. Since participants already knew the LSA, this could increase their willingness to go. An LSA stated: ‘Patients think it is nice if we are there’. It was perceived as important by HCPs that LSAs explained to participants that BeweegKuur consisted of both an exercise and a dietary programme and that they should try and convince participants to attend the first session to see ‘that it’s not so bad’. Some dieticians saw that participants were very negative at the start, but became more positive during the meetings. A dietician: ‘One participant was very sceptical and didn’t know what to do before the meeting. During the meeting, she was talking the most’. A disadvantage of the individual consultations is that Dutch health insurance does not cover the full costs. People consulting a dietician have to pay part of the cost themselves, which made some participants decide not to attend individual consultations. A dietician stated: ‘The payment really plays a role. One participant cancelled the BeweegKuur when he heard he had to pay’.

Combination of physical activity and dietary behaviour
The respondents thought the exercise programme was the most attractive part of BeweegKuur, although they all regarded the combination of exercise and dietary behaviour as necessary. One respondent said: ‘It isn’t possible to do the one without the other’. The combination of the exercise and dietary programme was perceived as a considerable burden, especially for those in the supervised exercise setting, and particularly in the beginning.

HCPs were also convinced of the necessity of combining the dietary and exercise programmes. However, most of the dieticians aimed their educational efforts solely at improving dietary behaviour. A dietician stated: ‘I only aim at an improved diet and not at more physical activity’. Only one dietician took the participants’ increased physical activity behaviour into account in their dietary advice.

Maintaining lifestyle changes
The focus groups revealed that participation in BeweegKuur was perceived as a success by the participants when they lost weight, and that continuation of a healthy lifestyle was also an important aim for the participants. Some respondents doubted whether they would be able to maintain their healthy lifestyle after the programme: ‘I think it’ll be hard to keep up the healthy lifestyle’.

HCPs commented that it was important that the list of available local exercise facilities was complete and up to date, to sustain lifestyle changes. An important prerequisite for sustained engagement in physical activity is a smooth transition of the participants to local facilities. The five pilot locations had worked with the BeweegKuur programme for almost 2 years, and their lists were now sufficiently complete. During the first year of the programme, however, the list had been incomplete, which had hindered the transition. All professionals intended to discuss the BeweegKuur programme with participants when these patients returned to their practice after completing the programme, in order to follow-up on the process of lifestyle change. Practice nurse: ‘I always talk about their lifestyle with the patient when they return at a check up’. A GP stated: ‘I only see the participants once a year and there is not always time to talk about the programme. But I always try to talk about lifestyle’.

Discussion
A new aspect of lifestyle interventions such as BeweegKuur, at least for primary health care in the Netherlands, is that the selection of potential participants is based on risk factors for diseases, rather than on actual diagnosis of a disease. This approach implies a shift towards a more preventive attitude for all professionals concerned. For some participants, the invitation to participate in the programme was unexpected, as they were not diagnosed with a disease. HCPs were aware of this and indicated they needed more time to explain to patients that the programme was appropriate and safe for them. In this study, participants as well as HCPs were generally positive about the feasibility of the programme for overweight and obese people. Referral by a GP was perceived as important by both participants and professionals. A study by Schmidt et al.18 showed that being motivated by a GP can be important for patients and provides a strong incentive to exercise. Attractive features of our intervention are the multidisciplinary approach and the combination of physical activity and improved dietary behaviour. However, our study also identified some potentially impeding factors for the implementation of BeweegKuur, as outlined below.

An important skill to motivate participants is motivational interviewing, and all HCPs had been trained to use this. Previous studies showed that motivational interviewing is effective in coaching lifestyle changes.19–22 However, these techniques are not easily applied in routine practice and require intensive training and practice support by specific feedback.19 The fact that motivational interviewing takes more time than traditional counselling techniques could be a barrier for HCPs to implement it in the BeweegKuur programme. In our study, they did indicate lack of time, as was also reported in other studies.12,23–25

The BeweegKuur programme was perceived as a success by the participants when they lost weight or reached their target weight. However, weight
reduction results from a consistently negative energy balance over a prolonged period, and exercise will lead to an increase in muscle tissue, resulting in better physical condition but not necessarily in weight reduction for all participants. HCPs in particular should explain this to the participants, and discuss realistic objectives.

The majority of the participants were referred to a dietician. Some respondents had found that dieticians’ advice had not helped them in the past, and therefore no longer wanted to consult a dietician. It is crucial that the dieticians’ counselling adds to previous experiences and fits in with the BeweegKuur lifestyle approach. This implies, for example, that dietary advice should be adapted to the increased physical activity in the patients’ daily routines.

An impeding factor for individual dietary consultations in BeweegKuur was that health insurance did not fully cover the costs. A similar financial impeding factor was identified for the start-up and supervised exercise sessions. Some people were unable or unwilling to pay their share of the cost (a relatively small amount of money: 15 Euros a month) of exercising with a physiotherapist, and in some cases refused to participate in the programme.

Some participants were disappointed when they were referred to the independent exercise setting. These respondents had expected that the BeweegKuur involved three months of exercising with a physiotherapist, while in fact they had to exercise on their own, without supervision. The different exercise settings thus need to be explained in more detail to participants before they start. Some participants were not convinced they would be able to maintain their healthy lifestyle after the programme. A complete list of available local exercise facilities was perceived as crucial by the HCPs, as well as giving attention to lifestyle during follow-up meetings after completion of the programme.

Strength of this study is the qualitative study methodology that incorporated both HCPs and patients. The results of this study have been directly used to inform practice; the gathered information has been used to improve the nation-wide implementation of the BeweegKuur programme. The majority of the participants were referred to the independent exercise setting. Some respondents had expected that the BeweegKuur involved three months of exercising with a physiotherapist, while in fact they had to exercise on their own, without supervision. The different exercise settings thus need to be explained in more detail to participants before they start. Some participants were not convinced they would be able to maintain their healthy lifestyle after the programme. A complete list of available local exercise facilities was perceived as crucial by the HCPs, as well as giving attention to lifestyle during follow-up meetings after completion of the programme.

To conclude, both HCPs and participants were motivated to participate in the programme, and they generally indicated the intervention to be in accordance with their wishes and needs. If the various potential impeding factors identified in the present study are taken into account, the multidisciplinary approach and the combination of physical activity and dietary behaviour advice can make the BeweegKuur programme a success.

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