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TACKLING HEALTH INEQUALITIES: THE POTENTIAL OF SOCIAL COMMUNITY ENTERPRISES

JULIA HIDDINK

Wageningen University - Social Sciences
MSc thesis Chair Group Health & Society | HSO-80336

Tackling health inequalities: the potential of social community enterprises

Julia Hiddink | 950422338060
Communication, Health and Life Sciences - Specialization Health & Society

Supervisors: dr. ir. Lenneke Vaandrager & dr. ir. Jan Hassink

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Preface

Dear reader,

This thesis is part of my graduation for the MSc specialisation Health and Society at Wageningen University.

In spring 2018 I started working on this thesis. Working on the topic social community enterprises did not come ‘out of the blue’ for me: the practical experience I obtained with a ‘social gardening’ initiative in Arnhem I was involved in since a couple of years, stirred my curiosity to work with this topic on academic level as well. This thesis can be seen as a preliminary study of the research project ‘Addressing health inequalities in vulnerable urban neighbourhoods by social community enterprises’, a four-year research programme subsidized by ZonMW.

I really enjoyed the thesis process: the possibility to use your creativity to steer your research in certain directions, the challenge to get the words right on the paper, and the freedom to organise the time yourself. Working on an ongoing research project was very motivating, since it gives me the feeling that the research results are actually used. What I enjoyed most, although sometimes also most shocking, was to hear the stories of the long-term welfare recipients on the social community enterprises. They have their reasons to end up in a long-term welfare situation...

I would like to thank my supervisors Lenneke Vaandrager and Jan Hassink for their enthusiasm and constructive feedback during the thesis process, their help to find participants and their invitations to attend relevant meetings around this topic. I also would like to thank the initiators and participants of the six social community enterprises in the Netherlands, who were willing to share their sometimes sensitive stories. Finally, I would like to thank my family and friends who supported me in the past half year in the process.

I hope you enjoy reading this thesis.

Julia Hiddink

Abstract

BACKGROUND | In the Netherlands, there is a group of long-term welfare recipients whereby complicated health problems are seen. Municipalities do not always have a sharp picture, but globally this is the profile: for the most part 50+, long-term in the benefit, little work experience, low education, many language problems, physical and psychological complaints, debts, addiction, isolation, poor self-image - and all this in many combinations. It is often more difficult to motivate these people to participate, while they can have large benefit from it.

OBJECTIVES | To get insight in motivations of long-term welfare recipients to participate in social community enterprises, to connect these motivations to its perceived impact on individual health outcomes, and to get insight in effective strategies to involve long-term welfare recipients in social community enterprises,

METHODS | Semi-structured interviews with six initiators of social community enterprises in the Netherlands and with thirteen participants. Initiators were asked about strategies to involve long-term welfare recipients in their social community enterprise, and participants were asked about their motivations for participation and about their perceived impact on health as a result of this participation.

RESULTS | The most important motivations for participation were related to the atmosphere of the group, gaining social contacts, distraction from problems of daily life and meaning something for others and for society. The most important impact of participation was related to an increased physical and mental health, more social contacts, structure in daily life, recognition and gratitude and increase of competences. Using a personal approach and listening to the wishes and needs of residents is a strategy that comes back in all social community enterprises. An important boundary condition is that a community enterprise can only exist, and can exist well, if it is established from the neighbourhood and for the neighbourhood.

DISCUSSION | It stands out that many of the motivational factors for participation correspond with the health outcomes resulting from participation, and that many of the health outcomes are interrelated. These health outcomes can strengthen one's motivation to participate. Suggestions for further research are to study the potential of social community enterprises in reducing health inequalities in *rural* areas, and to use objective measures as well.

CONCLUSION | This study can be of value as a first step in the four-year research programme 'Addressing health inequalities in vulnerable urban neighbourhoods by social community enterprises', subsidized by ZonMW, providing input for which objective health outcome measures can be used.

Key words: health inequalities, low SES, participation, positive health, social community enterprises

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1. Introduction

1.1 Socioeconomic inequalities in health

Our society is characterised by heterogeneity, due to unequal distribution of material, knowledge and other resources among the citizens. Social stratification is a result of this classification of individuals into groups based on common socioeconomic conditions. This relative position on the social ladder is also called 'socioeconomic status' (SES). Indicators of SES are education, income, race and occupation, each addressing a different aspect of social stratification. These indicators of SES can reveal inequalities (Aarts, 2012).

Generally, people from lower socioeconomic groups have higher mortality and poorer health status than people with a higher SES (Mackenbach et al., 2008). This inverse association between health and SES has been discovered for almost all health outcomes and almost all indicators of SES. For example, people from lower socioeconomic groups have more fears, poorer self-rated health, have higher rates of morbidity and mortality from cardiovascular diseases, and live almost seven years less in the Netherlands (Aarts, 2012). The difference in life expectancy in perceived good health is even nineteen years (Poos, Nusselder, & Bruggink, 2014).

Health inequalities are often associated with inequalities in various other areas, such as educational level, employment, income, living and working conditions, accessibility of care services, and lifestyle (Storm, den Hertog, Van Oers & Schuit, 2016). For this reason, health inequalities are seen as a complicated health problem. In order to tackle health inequalities, it is essential that interventions aimed at the distal determinants involve not only the public health sector but also physical policy sectors (e.g. spatial planning, healthy neighbourhoods) and social policy sectors (e.g. education, integration).

Nowadays, there is a movement going on in society, in which citizens collectively take initiatives in areas in their neighbourhood or village where previously the traditional institutions, such as housing corporations and governments, were active. In this movement, these traditional parties leave more and more space for the citizen (Dijkema, 2015). In the last fifteen years, hundreds of citizen initiatives have arisen in the domains of care, mobility, energy, safety and public space. These initiatives manifest in a diversity ranging from community or village centers, local care cooperatives, libraries to civilian energy companies and neighbourhood buses. In the light of today's society, citizen participation may play a key role in reducing health inequalities, since its benefits such as gaining social contacts, contributing to society, continuing to learn and develop, being active and having a structured daily schedule (Bierbaum and Gassmann, 2016) may have a positive impact on health status.

1.2 Long-term welfare recipients and health

In the Netherlands, there is a group of long-term welfare recipients (in Dutch: mensen langdurig in de bijstand) whereby also complicated health problems are seen. Municipalities do not always have a sharp picture, but globally this is the profile: for the most part 50+, long-term in the benefit (in Rotterdam on average more than eleven years), little work

experience, low education, many language problems, physical and psychological complaints, debts, addiction, isolation, poor self-image - and all this in many combinations (Kremer, Van der Meer & Ham, 2017). In 2017, it turned out that this group, with a size of 225.000 people (Kremer & Van der Meer, 2018), has been 'parked' for help in the Netherlands (Box 1.1).

Box 1.1: Current status of welfare recipients in the Netherlands

Kremer, Van der Meer and Ham (2017) have shown that at least half of those entitled to social assistance are specified to paid work. They no longer have to apply for work, they do not get help to work. For them, the assistance has changed from a temporary safety net to a permanent facility. This is striking since the previous government has tightened up the rules surrounding assistance. Nowadays, everyone needs to be guided towards a job. People who do not actively seek employment can be cut back on their benefits. Municipalities may also request a social return from them. Now it appears that these rules are therefore not retained for all social assistance recipients.

The Dutch cities Amsterdam, Utrecht, Rotterdam, Leeuwarden and Tilburg all distinguish between welfare recipients who are and are not promising. Due to budget cuts, they cut their client base in two. With the budget that they have, they only help the ones who are promising. This means that the underprivileged welfare recipients are parked. This concerns about half of the dossier. When registering for a social assistance benefit, the municipalities immediately classify the people on their job opportunities. In doing so, they look at age, education, work experience, language-knowledge, health and social circumstances. If the municipality thinks that it takes more than two years to help someone find a job, then he or she is too expensive for a trajectory towards work.

But what to do with the consideration included in the Participation Act? This obliges everyone to do a socially useful activity to keep their benefits. The five municipalities in this group handle this smoothly. They think it is already a good thing for underprivileged social workers if they are working on their health or on getting rid of their debts. To this end they are invited to participate in coffee drinking, sports, computer lessons or gardening.

In the Dutch cities Amsterdam, Utrecht, Rotterdam, Leeuwarden and Tilburg, rehabilitation to work is not necessarily the goal for the long-term welfare recipients. They especially hope to make the people more independent or happier. In Rotterdam, welfare recipients do not come under the civil servants of the work & income department, but they are assigned to the social development department.

For labor participation, welfare recipients are driven by very human motivations and motives. The available research suggests that negative incentives work better for labor participation (sanctions, finiteness of the benefit), where positive incentives in social participation are more effective (certainty, attention, few obligations) (Lub, 2017). The question is how social participation and labor participation must relate to each other. How can both the resilience of work and the social participation of welfare recipients be increased?

1.3 The potential of social community enterprises

Participation in social community enterprises seems promising to fulfil these needs. Social community enterprises are located between charity organizations and commercial companies and thus form a new sector (Nyssens, 2007; figure 1).

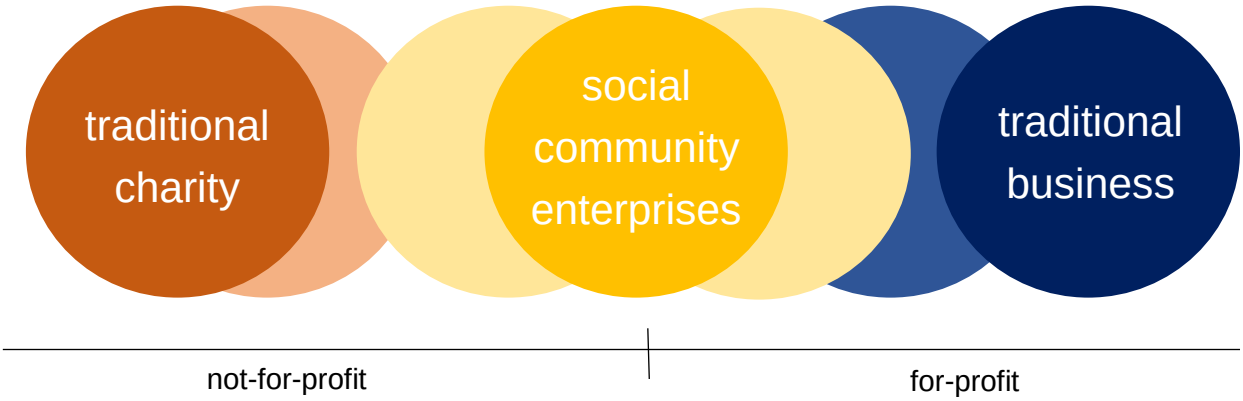

Figure 1: The place of social community enterprises in the business model spectrum (adapted from Sosense, 2013).

The term community enterprise is derived from the English concept of *community enterprise* or *community-based enterprise*. In a community enterprise, the residents of the neighbourhood and the activities they undertake themselves in the district or neighbourhood are central. Community enterprises can be considered as a specific form of citizens' initiative, often focused on citizens' own living and working conditions and the living conditions in the district or neighbourhood (Denters et al., 2013).

In the British development practice, a large diversity of organizations on different scale levels is indicated with the term community enterprise (Bailey, 2012), such as community centers in self-management, community development trusts and partnerships around urban renewal, which are known under the name *New Deal for Communities*. It is important to note that this diversity also can be found in community enterprises in the Netherlands. In order to give more insight into the different types of social community enterprises and the practical issues they entail, some fictional examples of these different types are given in Appendix I.

The National Partnership Active Residents (LSA, in Dutch: *Landelijk Samenwerkingsverband Actieve Bewoners*) uses a different name for a neighbourhood enterprise: resident company (in Dutch: *bewonersbedrijf*). The term 'Resident company' is first introduced by the LSA, after an organized study trip to London in 2011 where they visited a number of development trusts. Impressed by the possibilities and experiences in the United Kingdom, LSA has put the residents' companies on the map in the Netherlands. In essence, a resident company is the same as a community enterprise or development trust.

The resident companies are usually affiliated with the National Partnership Active Residents (LSA).

According to the LSA, a resident company is “a company in residents' hands to improve their neighbourhood on physical, economic and social level”. Resident companies are characterized by the following assumptions:

1. Works on economic, physical and social development in an area in which residents recognize themselves;
2. Is independent, self-sufficient and profit flows back to the neighbourhood;
3. Originates from residents, is owned by residents and is controlled by residents;
4. Is focused on cooperation with residents' associations, local government, institutions and companies.

In addition to the terms ‘community enterprise’ and ‘resident company’, the Dutch development practice also uses terms such as community centres in self-management, care cooperatives and ‘breeding places’. These initiatives are similar to community enterprises and resident companies and are mainly public-oriented and capital extensive.

In this thesis the term ‘social community enterprise’ is used. Based on the text above, the following definition of social community enterprises is formulated for this study:

An enterprise of and for local residents, which is often captured in the management and/or ownership structure, which works on sustainable economic, physical and/or social improvement of the neighbourhood, small-scale and local, and creates value in and adds to the neighbourhood.

In other words, many of the social community enterprises not only have a social added value for the neighbourhood, they also contribute to the economic growth and social potential of the neighbourhood (Rijksoverheid, 2014). Social community enterprises function as a meeting place in the neighbourhood and promote familiarity with each other and with others (Dijkema, 2015). Research from Stickley and Hall (2017) in the UK has shown that clients of occupational therapy valued participation in social enterprises with routine, employment, social relationships, and developing a sense of identity, especially outside a medical context. Social enterprises have proven to reduce drudgery (in Dutch: *‘geestdodend werk’*) of the poor and excluded by offering innovative and creative solutions for long standing social problems (Kummitha, 2017). These innovative and creative problem solving mechanisms offer a place for people with different cultural backgrounds and local dynamics.

Difficulties of social enterprises are that they quite often do not reach their intended goals, particularly when they do not succeed to understand the local contexts and adapt themselves to such dynamism (Kummitha, 2017). Another difficulty lies with the poor access to funding, which remains a major challenge for social enterprises to grow and become sustainable (Sdrali, Goussia-Rizou, & Sarafi, 2016). Because a profit objective is often lacking in community enterprises and it is not always a well-established organisation that has developed the initiative, it is sometimes difficult to find financing to start up the initiative (Rijksoverheid, 2014).

2. Background and theoretical framework

2.1 The place of participation in the Netherlands and participation defined

In the Netherlands, participation is high on the political agenda: 'everyone must participate', is the adage (RMO, 2008). Politicians and policymakers want citizens to take more responsibility in all kinds of areas - instead of leaning on the government - and participate more intensively in society. For example, the Social Support Act *(Wet Maatschappelijke Ondersteuning; WMO)* introduced in 2007, and the Participation Law of 2015, are based on these aims. These aims are referred to as the transition from a welfare state, aimed at protecting citizens, to a participation society in which citizens are activated and their participation is supported.

The general idea behind participation is that society can only function properly if everyone contributes to it. Not the government, but citizens themselves are responsible for welfare and prosperity. That is why it is of great importance that everyone participates according to their capacity (RMO, 2008).

Participation as a concept refers to participation in social life. This is still a broad concept. Many specifications exist, such as self-reliant *('zelfredzame')* participation, social *('maatschappelijke')* participation, socio-cultural participation, labor participation, citizen participation, client participation and political participation (Putters, 2014). Participation can refer to full participation in society, but also to a very focused activity, such as sport, work or volunteer work. Social participation can be considered as a clustering of work, volunteer work and informal care. Participation can also be classified according to purpose and types of interaction with the environment, for example when the activity is carried out with others and whether it involves a joint goal or a contribution to society.

2.2 Problem statement

Today's participation society asks citizens to be more self-reliant, and on the other hand, to participate through care, work or voluntary activities (Putters, 2014). Citizens are seen as co-producers of services. However, too much focus on citizens as co-producers can also strengthen social inequality and lead to displeasure when it are always the same citizens who determine what happens in a neighbourhood, for example because of their education, ethnicity or age (Putters, 2014). As Graaf, Van Hulst & Michels (2015) describe, participation is especially problematic in those areas of cities that are labelled disadvantaged neighbourhoods. In such neighbourhoods both the participation of citizens in their direct environment and the participation in formal policy-making are often limited. In particular, minority groups and young people are heavily underrepresented in participation processes.

Organisations at the neighbourhood level have weak structures because of difficulties in finding funding, especially in times of austerity. To put it bluntly, many people have a hard time making ends meet and lack the resources or interest needed to participate. Over the past 15 years, new government programmes for disadvantaged neighbourhoods have confirmed this. Part of what makes the participation problems worse in these areas is that

natural participation of citizens in their own environment is often a precondition for participation on the higher 'rungs on the ladder'.

However, participation in disadvantaged neighbourhoods requires more than the standard invitation to meet with civil servants, street-level bureaucrats or politicians. Getting citizens in disadvantaged neighbourhoods to participate demands innovative, non-standard activities that have a positive influence on the conditions under which participation flourishes. Activities of this kind are often developed by individuals or small groups of practitioners (Graaf, Van Hulst & Michels, 2015).

Considering the health outcomes of participation and the current status and needs of welfare recipients in the Netherlands, the setting of a social community enterprise might offer a meaningful place for health promotion. Unfortunately, surprisingly little literature is available on strategies to involve lower socioeconomic groups in social community enterprises. To obtain knowledge on these strategies, first knowledge is needed on motivations of long-term welfare recipients for their participation in social community enterprises. In addition, there is little empirical research on the functioning and impact of social community enterprises (Bailey, 2012; Pierre et al., 2015). The lack of empirical research makes it very relevant to study the actual and potential contribution of social community enterprises to reduce health inequalities.

As such, the central objectives of this research are in line with crucial demands of the social community enterprises. The objectives are aimed to support (potential) social entrepreneurs and to provide them with relevant information to enhance the chance on a successful social community enterprise. The **two main objectives** of this thesis are:

1. To get insight in motivations of long-term welfare recipients to participate in social community enterprises, and to connect these motivations to its perceived impact on individual health outcomes.

2. To get insight in effective strategies to involve long-term welfare recipients in social community enterprises, in order to develop a tool for initiators of social community enterprises to support them involving long-term welfare recipients.

2.3 Theoretical framework and concepts

In order to understand the motivations of long-term welfare recipients to participate in social community enterprises and to relate these motivations with the perceived impact of social community enterprises on health of long-term welfare recipients on individual level, the following theoretical framework has been composed (figure 2).

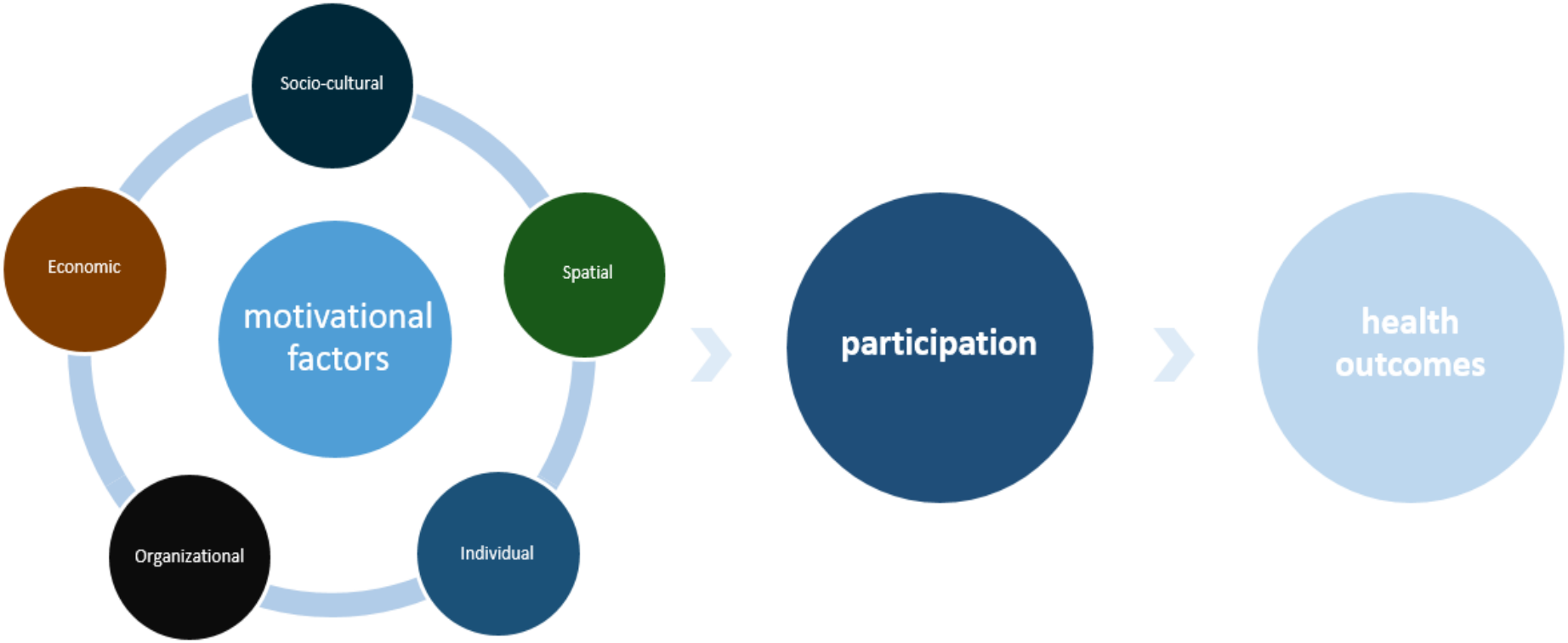

Figure 2: Theoretical framework (based on Dahlgren & Whitehead, 1991)

This theoretical framework is inspired by Dahlgren & Whiteheads' earlier developed socio-ecological model of health (1991). The socio-ecological model of health takes different levels into account when analysing health issues: individual factors, social and community factors and general socio-economic, cultural and environmental factors; and the interactions between those levels. Its holistic approach allows to tackle health inequalities in multiple areas, such as on neighbourhood level, on education level or on integration level.

In order to explain the different motivational factors that determine participation in social community enterprises, and the health outcomes associated with this participation, the following conceptual framework has been composed (figure 3). This conceptual framework is used as a hypothesis for this research, as it is only based on literature study. In this research, the hypothesized factors and health determinants of the conceptual framework will be tested empirically by conducting interviews among long-term welfare recipients involved in Dutch social community enterprises. When referring to participation, both participation in *activities* of social community enterprises is meant as well as being involved in the *establishment* and/or *organization* of a social community enterprise.

Figure 3: Conceptual framework

Based on the available literature, **socio-cultural factors** are expected to play an important role in one's motivation to participate in a social community enterprise. In a Dutch study of Bierbaum and Gassmann (2016) on the motives on welfare recipients for participation, it has been shown that certain "attractive aspects" of having a job also apply to volunteering or participation; such as gaining social contacts, increasing their own network, meaning something for others and being appreciated for that and making a contribution to society. However, the researchers emphasize that such effects mainly occur when the voluntary activities are in line with the interest and experience of the participants, and take into account individual limitations. This finding reflects an interaction with the factors on **individual level**. In the conceptual framework, the individual factors are based on the three concepts of the Theory of Planned Behaviour *attitude*, *subjective norm* and *perceived behavioural control* (Ajzen, 1991). *Attitude* holds that only specific attitudes towards the behaviour in question can be expected to predict that behaviour. Regarding participation in social community enterprises, attitudes could be: expected utility for own health or for society, or expected pleasure to participate. *Subjective norm* refers to people's beliefs about how people they care about will view the behaviour in question. For example, if participation in social community enterprises, or participation in society in general, is very uncommon or is disapproved by the social environment of long-term welfare recipients, one may be less likely to participate. Knowing these beliefs can be as important as knowing the person's attitudes to predict someone's intentions. *Perceived behaviour control* refers to people's perceptions of their ability to perform a given behaviour. The three predictors *attitude, subjective norm* and *perceived behavioural control* lead to *intention.* Generally, the more favorable *attitude* and *subjective norm* and the greater *perceived behavioural control*, the stronger person's intention to perform the behaviour in question. Next to the concepts of the Theory of Planned Behaviour, the concept of *health* belongs to the individual factors. One's health status, either physical and/or mental, will influence one's motivation and ability to participate.

Other factors that play a role in one's motivation to participate, are those on **economic** level. A lack of participation, or even exclusion, is often associated with a lack of work, income and health (Putters, 2014). Here, an interrelationship between the individual- and economic factors can be found: a lack of health can result in an inability to work. A **spatial** factor that facilitates participation is accessibility: when (potential) visitors experience places in a neighbourhood as accessible, hospitable, open and inviting, residents actually come - this visit resulting in an increase of residents' quality of life (Huygen, 2011). An **organizational** factor that plays a role in one's motivation to participate, is the way the work is managed. De Graaf, Van Hulst & Michels (2015) discuss the role of practitioners on enhancing participation in disadvantaged neighbourhoods. They investigated that when practitioners who either start projects that connect people in their own life world or connect policy-makers and policy to initiatives on the ground, an opportunity for many is created to develop their citizenship and become a more active participant in their local communities, by relating to- and forming a bridge between the life world and the world of formal policy-making. Another organizational factor is the kind of work that is offered: for example, it has been found that green urban citizens' initiatives mainly attract higher educated people (Van Dam, Salverda, Hassink, Vaandrager & Wentink, 2017).

Interestingly, some of these motivational factors for participation are also considered as health outcomes resulting from participation. For example, several studies show that

participation contributes to social inclusion, by gaining new contacts and getting a larger social network (Bierbaum & Gassmann, 2016; Fuller et al., 2008; RMO, 2008).

At the same time, health outcomes of participation can strengthen one's motivation to participate. For example, research from Jehoel-Gijsbers (2004) shows that participation leads to self-development: people acquire knowledge through education or provide for living through work; increase their competences through activities such as sport, holding a board position in an association or attending a course and furthermore, participation leads to self-confidence. To be able to participate, people often need knowledge, self-confidence and, last but not least, income, and this is also acquired through participation. In this way, a mutual reinforcing effect of participation can be seen.

Other health outcomes that are associated with participation are contributions to wellbeing, an increase of self-worth and feelings of autonomy, and having a structured daily schedule. In Norway, Ohls (2016) explored the effect of activation on wellbeing of (long-term) welfare recipients. For this, 20 participants of the so-called Qualification Program (QP), a national activation programme focused on labour market reintegration and a strengthening of the 'overall life situation'. Ohls concludes that activation programmes such as QP can significantly contribute to the personal well-being of welfare recipients, and therefore reducing their former physical- and mental health problems, and social shame. To put it differently, Jehoel-Gijsbers (2004) explains that people who are structurally outside the established social frameworks often have a greater demand for professional care. Non-participation has an adverse effect on their sense of well-being and health. People who do not perform paid work, do voluntary work or provide informal care, often feel that they do not count in society. The various forms of participation do not differ much from each other and even seem to reinforce each other. Those who do paid and unpaid work least often have the feeling that they do *not* count. Fuller et al. (2008) found in his Canadian study on the experiences of single welfare mothers with activation policy that according to the mothers' experiences, active citizenship and volunteering worked status enhancing; because they undermine the negative self-image of the "parasitic assistance receiver". In other words, their contribution to the welfare of the community turned out to bring about a strong sense of self-worth for the welfare mothers (Fuller et al. speak of "*social worth*"). Autonomy is considered to be an health outcome given the fact that participation indicates a certain degree of self-determination. One is not on the side, but actively participates as a full citizen and therefore has an influence on events (RMO, 2008).

In the conceptual framework, the health outcomes are structured based on the six domains of positive health: bodily functions, quality of life, social and societal participation, mental functions and perception, spiritual/existential dimension, and daily functioning (Huber et al., 2016). In short, the concept of positive health approaches people as more than their illness and focuses on their strengths rather than weaknesses.

The conceptual framework is used for answering the following **research questions** of this research:

1. What are motivational factors of long-term welfare recipients to participate in social community enterprises?

   A. (How) are the mentioned factors related to each other?
   B. How important are each of the factors for participants' involvement in a social community enterprise?

2. What is the perceived impact of participation in social community enterprises on health of long-term welfare recipients on individual level?

3. Which strategies are used to involve long-term welfare recipients in social community enterprises?

   A. To what extent are these strategies effective in involving long-term welfare recipients in social community enterprises?

When there is more insight in the (importance of the different) motivational factors for participants' involvement in social community enterprises, a tool can be developed for initiators - supporting them on which motivational factors their strategies should focus.

3. Methods

3.1 Study design and sample selection

A multiple case study design was applied for conducting this research. To compose a sample, selection took place by initially identifying social community enterprises in the Netherlands who are successful in involving long-term welfare recipients. Initiatives were selected through **convenience sampling** by approaching experts (Pharos -a Dutch expertise centre on health differences-, GGD Rotterdam and LSA) and by **snowball sampling**. The recruitment of the social community enterprises occurred through selecting initiatives in the Netherlands having long-term welfare recipients in their target group, and preferably located in a disadvantaged neighbourhood. Besides, it was tried to select a variety of social community enterprises, regarding the kind of activities they offer and the geographical location. Initiators of social community enterprises were approached by e-mail or telephone and were explained the research objectives and the research procedure.

The **target group** of this study consisted of long-term welfare recipients in the Netherlands, participating in a social community enterprise. Inclusion criteria for the study sample were having a long-term social assistance benefit (i.e. people with a large distance to the labor market), participation in a social community enterprise (participation: either in activities and/or on organizational/management level), and living in the Netherlands. Exclusion criteria were not having a long-term social assistance benefit, and not being active in a social community enterprise.

3.2 Data collection

To answer the operational research questions, semi-structured interviews were conducted with initiators of the selected social community enterprises and their participants. This type of interviewing gives room to the interviewer and the respondent to delve deeper into certain topics, while there are a number of fixed topics in every interview in order to compare them (Berg & Lune, 2012). For these interviews, **two different semi-structured questionnaires** were composed; one for the initiators, and one for participants of social community enterprises (appendix II). The questionnaires were developed by using the conceptual framework (chapter 2). The questionnaire for initiators contained general questions about the enterprise; such as questions about the start of the enterprise, the role of the initiator and the activities that take place. Other parts of the questionnaire were about strategies they use to involve long-term welfare recipients and their effectiveness, motivations of their target group to participate and their perceived impact on health. The questionnaire for participants contained general questions such as age and work experience, questions about motivations to participate and perceived impact on health. For the questions about motivations to participate, **'participant interview cards'** were used: cards with words that could play a role in participants' motivation. These words were based on the socio-cultural, spatial, individual, organizational and economic factors of the conceptual framework. Examples of these cards were 'structure', 'social contacts' and 'accessibility' (appendix II). Participants were asked to rank these motivational factors from most important to least important and to explain this ranking. The goal of using these interview cards was to probe the interviewee to generate further explanation, and to get insight into the weight of these different factors. Besides, from experience of other research projects, it is known that these interview cards give more

interaction and that respondents like this method (Byron, 1988). For the questions on perceived impact on health, the main outcome measure concerned the six domains of positive health: bodily functions, quality of life, social and societal participation, mental functions and perception, spiritual/existential dimension, and daily functioning.

Next to the interviews with the initiators and participants of the social community enterprises, the researcher participated in the activities offered at the community enterprise if that was possible. It was expected that this **participatory approach** would have various benefits. It might facilitate the interview process with the participants: they might feel more comfortable with the researcher and might be more willing to share (sensitive) information, because they got to know the researcher in an informal way. In addition, in this way the researcher got a better understanding of the culture that prevailed on the initiative and of the way people interact. This participatory approach might have been beneficial for the interpretation of the results. All interviews were conducted by the same interviewer. Each interview lasted about half an hour and was recorded by telephone.

3.3 Data analysis

After conducting the interviews, the interviews were transcribed in Dutch in a Word file. The transcriptions were read through to discover certain patterns, similarities and differences between the interviews. After this, the codes were constructed. The Word files were saved in ATLAS.ti 8.0; a programme for data analysis. The files were coded by using this programme. Coding was done by labeling sentences or phrases. The codes that belonged to the **first research question**, which was about the motivational factors of long-term welfare recipients to participate in social community enterprises, corresponded to the motivational factors of the conceptual framework: socio-cultural, spatial, individual, organizational and economic. These codes were only applied in the interviews with the participants. Sometimes, multiple codes were assigned to the same phrase, which helped the researcher to get insight in the interlinkages between the mentioned factors. To get insight in the importance of each of the factors in participants' involvement in a social community enterprise (subquestion 1b), the interview cards were analysed by assigning the code 'interview cards' to the text that belonged to this small exercise.

The codes that belonged to the **second research question**, which was about the perceived impact of participation in social community enterprises on health of long-term welfare recipients on individual level, corresponded to the health outcomes of the conceptual framework: bodily functions, quality of life, social and societal participation, mental functions and perception, spiritual/existential dimension, and daily functioning. These codes were applied in all interviews.

The codes that belonged to the **third research question**, which was about the strategies to involve long-term welfare recipients in social community enterprises, were the following: financial incentives, personal approach, innovative, wishes and needs of residents, via network, via (welfare)organisations or municipality, via social service, and via newspaper or media. The codes for the subquestion about effectiveness of strategies, were: opportunities, barriers, effectiveness and boundary conditions. These codes were applied in both the interviews with the initiators and with the participants of the social community enterprises.

3.4 Ethics

For the participatory research and the interviews with the participants of social community enterprises, permission was asked from Wageningen University's Social Sciences Ethics Committee, because of the involvement of a vulnerable group. Respondents might run an emotional risk, as the questions on motivational factors and perceived health impact of participation on social community enterprises requires the respondent to talk about his/her life. This might have lead the interviewee to recall painful or distressing memories. Therefore, the participants were assured that they did not have to tell something that caused them discomfort; the interviewer tried to identify early signals of stress during the interviews in order to avoid any moments of difficulty. If those moments arose, they were tackled with empathy and comprehension, and the researcher would offer the participant a break and/or the possibility to immediately conclude the interview.

Before the start of each interview, respondents were asked in person to sign an informed consent (appendix IV). With this informed consent, respondents were informed about the research objectives and about the content and duration of the interview. In addition, respondents were asked permission for recording the interview and for using their quotes in the report. Respondents were guaranteed that their information is kept anonymous and not shared with third parties.

4. Results

4.1 Introduction

Initially, seventeen initiatives were selected for participation. Several initiatives were not willing to participate for the following reasons: two initiatives considered a cost-benefit analysis for participation – much work, and only long-term benefits for the initiatives (one of these even asked a financial compensation for participation in the research). One initiative was willing to participate, but did not have the manpower to speak to someone. One initiative believed that its mission and vision did not fit this research and another initiative turned out not to exist anymore. Six initiatives no longer contacted the researcher after a first telephone or e-mail contact.

Generally, it was quite difficult to get in contact with the initiatives. Examples of difficulties are: an e-mail that is not working, different people who answer the phone, other priorities, or lack of clarity about the contact person on the website. At the same time, these aspects might be characteristic for social community enterprises. However, once in contact with the initiatives, they were very enthusiastic and willing to share their experiences.

Eventually, the selection process resulted in **six initiatives** who were willing to participate in this research (see appendix V). Five interviews were conducted with initiators of social community enterprises, one interview with a civil servant who was involved in a social community enterprise and thirteen interviews with participants of social community enterprises. Regarding the latter, a focus group with about twelve participants was included. The choice for a focus group was based on advice of the group leader of the participants of that particular initiative. According to the group leader, many of the participants had experience with justice. This given caused the participants to fear that the information the interviewer would obtain would end up in the wrong place. The participants were therefore quite suspicious to share information. It was expected that in the setting of a focus group it would be easier for participants to share information, rather than they would have been interviewed individually. Still, there were only three of the twelve participants who really said something during the focus group.

The reason that at one initiative only a civil servant is interviewed and not the initiators and the participants, was that the civil servant thought the initiators and participants would lack the time. Therefore, only the involved civil servant was interviewed for this initiative.

Five semi-formal conversations were held with participants outside the target group, like with group leaders or with participants who were not in a long-term welfare situation. These semi-formal conversations have not taken place in an interview setting, but during coffee breaks or during activities, for example. In these conversations, extra information was obtained about the initiative and about the involvement of participants and its related difficulties.

4.2 Profile of the researched social community enterprises

The six researched social community enterprises offered a variety of activities: from catering service, green maintenance, growing crops for the Food bank to organizing activities for the neighbourhood. Four social community enterprises were located in a **disadvantaged neighbourhood**, characterized by residents having problems such as addiction, language problems, loneliness, and psychological and physical complaints. Most of these residents were in a (long-term) welfare situation. One social community enterprise was founded in a time when the neighbourhood was in a disadvantaged position, regarding resident composition. However, due to housing policy of the municipality, the profile of the neighbourhood has changed in the meantime so that more wealthy families came to live there, such as young two-income households. Another social community enterprise was not located in a disadvantaged neighbourhood. Unlike the other social community enterprises, the main goal of the latter initiative was to offer learning workplaces for people with a distance to the labor market. This place was meant as a stepping stone towards a regular job, whereas the other social community enterprises merely focused on participation in itself. Most social community enterprises have between 20-50 active volunteers. Four initiatives had a **business model** and were financially independent. Their earnings came from the projects they carried out for clients, such as green maintenance for the municipality; or from events that were organised, such as marriages or network meetings for companies. At one initiative the volunteers received a volunteer allowance of up to 63.50 euros per month. Another initiative worked with an innovative business model, which they called a 'social mortgage'. The municipality has advanced a sum of 200.000 euros to build a neighbourhood center, and the mortgage is repaid by the efforts of volunteers. A model was used in which volunteer hours were equivalent to certain allowances. The last initiative depended on annual subsidies from the municipality.

4.3 Interviewed participants and their motivations to participate in a social community enterprise

Thirteen interviews were conducted with participants of social community enterprises. All thirteen participants were in a long-term welfare situation. Five participants were 55 years and older, the remaining participants were aged 34-50. Most of the respondents followed secondary education, although two respondents followed higher education and one even university. Most respondents have had many different jobs, ranging from administrative, care, cleaning, gardening, catering, and supermarket work to construction, marine and car assembly work. Reasons that participants ended up on welfare were reorganisations or dismissals, physical and psychological complaints, addictions, experiences with justice and language problems. Most respondents were active in the initiative 2-3 times a week, although some respondents were active one day a week and other respondents every day. Table 1 below gives an overview of the activities that are offered by the initiatives and the activities that participants perform.

Table 1: Overview of activities offered by initiatives and performed by participants

Initiative #	Activities offered by initiative	Activities performed by participants
1	Catering, delivery van, hall rental, library, maintenance, repair service.	Cleaning work, memory training (elderly), 'open entry' (*in Dutch: 'open inloop'*), having lunch, preparing lunch.
2	Children's activity week, cleaning work, cooking meals, green maintenance, 'pocket money project' for children.	Cooking meals (n=1), green maintenance (majority of participants).
3	Singing; yoga.	'Open entry', where participants can do the activities they initiate themselves, such as card games, bingo or 'just' drinking coffee; singing; yoga.
4	Still in establishment phase.	
5	Meeting place for local residents, place for events (marriages, theatre, network meetings), renting rooms as office space.	Catering, preparing lunch or dinner for guests, maintenance on terrain or building, vegetable garden.
6	Work in vegetable garden.	Preparing coffee and cleaning work (n=1), work in vegetable garden (majority of participants).

In response to the questions on participants' motivations for participation, it stands out that all interviewees mentioned aspects related to the atmosphere of the group, gaining social contacts, distraction from problems of daily life and meaning something for others and for society. A distinction can be made between motivations to *start participating* in a social community enterprise and motivations to *stay involved* in a social community enterprise. Motivations to start participating are often related to gaining social contacts, getting out of isolation, distraction from problems of daily life, a financial incentive, and meaning something for others; while motivations to stay involved are often related to the atmosphere of the group and to the perceived health impact of participation. The results of the questions on motivations for participation are described and structured on the basis of the following factors: socio-cultural, spatial, individual, organizational and economic.

4.3.1 Socio-cultural factors

Analysing participants' socio-cultural factors shows that all interviewees mentioned aspects related to the atmosphere of the group, gaining social contacts, distraction from problems of daily life and meaning something for others and for society. Four participants mentioned they feel comfortable in the group involved in the initiative. They are *'happy to be here'* [I#2], feel *'like home'* [I#6] and *'the group feels like family to me'* [I#5]. One participant with a non-Western background and language problems mentioned she feels accepted within the Dutch group, and socially supported to learn Dutch. She gets calm in this group. The **atmosphere in the group** facilitates participants to get involved in the initiative. An initiator clarified this

aspect by bringing forward the phenomenon that participants sometimes flow out to other or regular work, but sometimes return to the initiative because they miss the atmosphere, the cosiness [I#2].

In response to the question whether the motivations of the participants have changed since the beginning of their participation, generally it is seen that participants' motivations have not been changed. Only one participant answered: *"They have only become stronger"* [I#2]. As an explanation the participant stated that she felt more and more familiar with the participants involved and has built a relationship with them.

Gaining **social contacts** was another socio-cultural factor that was mentioned by four participants. Meeting people one would never meet, and meeting people from the neighbourhood. Where people were at home all day long previously, by participating in the social community enterprise they are activated to 'do' something - which leads to feelings of **meaningfulness**. Related to this activation, is the **distraction from problems** of daily life that comes with it. One interviewee saw participation as a way to combat boredom and another interviewee mentioned that participation was also a way to get out of her isolation at home: "*If you are single and you are at home all day long: that does not make you happy. And when you are here again, and you are surrounded by other colleagues and people: what could be more fun than sitting at home, right?*" [I#3].

4.3.2 Spatial factors

Meaning something for the neighbourhood was a spatial factor mentioned by three participants. One participant was annoyed and irritated by the litter in the neighbourhood. With the adage *'I can annoy me, but I can also see what I can do about it'* [I#2], he started to get involved in the enterprise. Volunteer work in the neighbourhood and for the neighbourhood, is his adage. Another participant benefited of the literally close location of the social community enterprise to his home. This participant could not handle too many environmental stimuli. The fact that the enterprise was located close to his home was essential for him, because he should not be too long on the streets: too many stimuli, too much distraction. For the green social enterprise in particular, the participants mentioned working in an outdoor environment and working in nature as a motivational factor [I#6].

4.3.3 Individual factors

Individual factors are classified into perceived behavioural control, subjective norm, attitude and health. Four participants mentioned **perceived behavioural control** as a motivating factor for their participation. One participant found it important to develop herself and to learn things, and to become independent [I#6]. Another participant related her perceived behavioural control to an improved self-confidence [I#6], and for another participant a motivation was to show other people the abilities of younger people; to show them that younger people are also able to do things [I#3]. Another participant mentioned her attitude towards the initiative explicitly: "*I just go here with pleasure."* [I#2] Three participants mentioned health and physical activity as a motivating factor: *"I like to be physically active"* [I#2,5,6].

4.3.4 Organizational factors

Organizational factors are classified into 'management of work', 'kind of work' and 'structure'. Three participants referred to the **management of work** during the interviews: they appreciated the prevailing culture on the workplace, which was often associated with informal and open. One participant put it like this: "*My boss here is also very serious and nice. She says everything she wants to say, but she says it open in my face. She does not say: 'you MUST do this and this and this...'"* [I#6]. According to an initiator, this openness also works the other way around: participants feel comfortable enough to share, for example, their financial problems [I#2]. Another participant associated the workplace with safety and freedom, without 'hassle of the bigwigs' *(in Dutch: 'gezeur van de hoge heren)'. "In that respect: here you learn to develop yourself. Without being tapped on your fingers of 'you're doing it wrong'. If you do it wrong, you just go over it. That is how it works."* [I#5] Another participant referred to the empathy on the workplace: *"if something does not go well, you just sit down for a moment"* [I#3]. This prevailing culture is underlined by an initiator: participants do not have to work for three hours in a row, they can smoke a cigarette, drink a cup of coffee or have a chat in between [I#2].

Two interviewees referred to the **kind of work** as an attractor: they appreciated the practical nature of the work, rather than doing office work [I#3]. Two interviewees indicated that the kind of work in itself did not really matter to them: whether they would be in the office or would do cleaning work, did not really matter. What is important to them is just that they are active [I#2,5].

Five participants stressed the importance of **structure** in their daily life. For one participant who was striving towards regular work, structure was important to get back in his daily routine, in order to get back to work normally [I#5]. For him, structure was also important to know where he stands. Another participant was looking forward the whole week until it was Wednesday: the day when she volunteered in the community garden [I#6]. One participant mentioned she already had structure in her family with children [I#3]. The importance of having structure is illustrated by an initiator who saw the participants 'growing' in that respect: where the participants first stayed in bed up to 10 AM, now they are motivated to be on time at 9 AM every day – which is the basis for regular work in the future. They stay in the rhythm then [I#2].

4.3.5 Economic factors

Economic factors are classified into 'a stepping stone towards work', 'income' and 'social service'. Four interviewees declared they see their participation as a **stepping stone towards regular work** [I#1,2,5]. One participant was striving to get regular work at the municipality, and with participation in a social community enterprise he aims to show that he is able to work and that he is willing to work [I#2]. One initiator indicated they supported participants towards regular work, by giving feedback about the participants to the municipality and other organizations, or by advising them to have the participant to follow a course or something similar [I#1].

Two participants mentioned volunteer allowances as a motivational economic factor for participation [I#2; **income**]. According to the initiator of this enterprise, some participants really have the need to earn these 63.50 per month, next to their welfare. They even need

this for their groceries, for their basic expenses. According to her, some participants initially are attracted to the social community enterprise by this financial incentive, and discover non-tangible values of participating in a later stage, such as the cosiness and social contacts.

Three participants are (partly) driven by the **social service** to participate. Since they are in a welfare situation, they have to do volunteer work as a compensation. One participant put it like this: *"Instead of being pushed by the social service, you can better take it in your own hands and take the initiative yourself to do volunteer work"* [I#3].

4.3.6 The importance of the different factors

The exercise with the interview cards, whereby participants are asked to rank the cards from most important to least important for their participation, revealed that all interviewees who are asked for the exercise (n=6) ranked the cards more or less on an equal level. They could not attach a particular importance to a specific card, but believed that everything related to the whole picture. One participant commented later that 'health' would be the most important for him: *"if you are not healthy, you cannot work. Then I actually think health is the most important, because that also stimulates the rest"* [I#5].

4.4 Strategies of social community enterprises to involve participants

In the six interviews with the initiators and the involved civil servant of the social community enterprises, several strategies to involve participants came forward: via municipalities/(welfare) organizations, via own network, through a personal approach, via media, through financial incentives and several innovative strategies. More information on these strategies is given below, introduced by a paragraph describing why it is so difficult to involve long-term welfare recipients in social community enterprises. This aspect would initially not be questioned, but came forward during the interviews and is considered important information as a basis to understand how to involve long-term welfare recipients. This information can be seen as an extension of the paragraphs in chapter 2.2.

4.4.1 Explanations for difficulties involving long-term welfare recipients in social community enterprises

According to two initiators, the civil servant and two participants – not in a welfare situation - of social community enterprises, there are several explanations for the difficulties that are experienced with involving long-term welfare recipients in social community enterprises.

The first explanation lies in the group of people who are 'used to' receiving a welfare, that they are familiar with it. This group is also referred to as **'generational welfare recipients'**; people who have been receiving welfares for several generations. In terms of feeling, these people often seem to have the idea of "we do not get out of the welfare situation that easily", and a form of **lethargy** develops. It seems to be very difficult to motivate those groups. The civil servant illustrated this lethargy like this: *"I can live well with a welfare, why should I work so hard and achieve the same end result?"* There are people with a regular job, who, in terms of disposable income, have a much more complicated situation than people in a welfare situation. *"That people say: if I can also sit at home and I do not have to do much for it, and I earn twenty euros more, yes, why should I make an effort?"* Next to that, they seem to have the idea of **'I cannot do volunteer work'** [for bureaucratic reasons, next to their

welfare]. As stated by the civil servant, for this reason the residents are explained what is allowed and what is not allowed [I#4]. That they also get a volunteer contract, and that they do not have to be afraid for the loss of their welfare. Another aspect the civil servant referred to was that receiving a welfare might have become 'normal' from the past. That you are used to the fact that you are taken care of, and that receiving a welfare is seen as **a form of 'right'**. Instead of having to think of *'it's a kind of safety net, and actually I have to give something in return'*. And that 'something in return', working to capacity, that everyone can do something, that is something we see more and more in recent years – compared to the time of the welfare state. The self-evidence *(vanzelfsprekendheid)* should be taken off, and people should take the initiative themselves to contribute to capacity if they are healthy: "*If I am healthy, and I can make a contribution to society somewhere, even though I'm going to get groceries for the neighbours, then I'm still useful".* According to the civil servant, we should ask the question 'what can you do yourself?' much more.

According to two participants, **shame** also plays a role in the difficulty to involve long-term welfare recipients [I#1,6]. Since they participate less in the regular labour process, they develop an inferiority complex: *'I've been in this position for so long, I don't have the capacities to do anything anymore'.* It is something that people impose on themselves: *'I don't have the capacities, I am no longer worth anything'.*

One of the participants also referred to the **multiple problems** that long-term welfare recipients already face [I#6]. They often have such worries that they are finally stuck. They already have so many problems on their mind that they do not even think about coming here to work. *"If you already have applied eighty times, and it does not work, then you become depressed. And then you do not come here to work here for a while, because then you need your 'hands and feet' to stay upright. And it does not always have to be due to your own fault". "And then they are often wrongly advised by clever people who think they know something, and then they get even further in the shit".*

Another initiator speaks about the '**own pride**' of various ethnical groups living in the relevant neighbourhood: people with a Turkish, Moroccan, Antillean, Cape Verdian and Somalian background [I#6]. They want to show that they can make it themselves with what they have. What she also noticed is that these various groups have contact with each other, but that cooperation is difficult. Since they do not discover that these cultural differences are actually minimal. Because they all have the same problem: talking and adjusting to Dutch.

4.4.2 Strategies

Using a **personal approach** and listening to the **wishes and needs** of residents is a strategy that comes back in all social community enterprises. However, this can take many different forms. At the community garden, a **'chat at the fence'** could sometimes already be enough to involve long-term welfare recipients [I#6]. In another initiative, **door-to-door conversations** with residents to map their wishes and needs, were really the basis of the initiative [I#3]. Their aim was to ask residents what they truly wanted themselves and to discover how they can make a contribution themselves. Asking people how they are doing as a way to actually reach them and as a way to be easily accessible in the neighbourhood; to be close to people; building a relationship with people. An opportunity of this strategy is the equal and development-oriented approach, instead of 'seeing the other person as a victim'.

Their approach is not problem-oriented, they are not asking 'which problems do you have?' and offering 'solutions'. Instead, they are questioning 'what do you want, and do you need support with that?' Besides, through the focus on the neighbourhood itself, there is a natural context you involve the residents in. A barrier of this strategy is that ringing door-to-door can be scary, because you can be rejected, and people can get angry; and that it is quite labour-intensive.

Using a **financial incentive** to involve long-term welfare recipients is a strategy which is seen at one social community enterprise. According to the initiator, some participants initially are attracted to the social community enterprise by this financial incentive [I#2].

At four initiatives, long-term welfare recipients flow in **via (welfare)organisations or municipalities**. This can either be via an so-called 'volunteer bank' or 'volunteer support point', where residents announce themselves, or via a purchased learning-work trajectory, in the case of the initiative that offered learning-workplaces for people with a long distance to the labour market. What is also seen, is that participants flow in via neighbourhood teams of the municipality: sometimes, people from the neighbourhood teams inform residents about– and refer them to the initiatives. Inflow can also take place via healthcare institutions who visit their clients, or via social services such as 'UWV'.

Four participants got involved by reading a call for volunteers in the **newspaper** or on a **flyer**.

4.4.3 Effectiveness of strategies

Generally, the strategies used by the social community enterprises to involve long-term welfare recipients were perceived to be effective. Once residents got involved, they remained involved in the initiative. Reasons for drop out of participants were finding regular work, migration, sickness, or death (in the case of elderly people).

Four initiators questioned the effectivity of placing advertisements or spreading flyers to involve long-term welfare recipients. According to them, a personal approach would work much more effectively for this target group.

Another aspect that turned out not to work at one social community enterprise, was an approach from the municipality with the intention to "tell how to do it" [I#2]. It is essential that the wishes and needs arise from the residents themselves. Thereby it is important to note that the wishes and needs are very neighbourhood dependent, and that a community enterprise can only exist, and can exist well, if it is established *from* the neighbourhood and *for* the neighbourhood – really from a **bottom-up approach**. At least, this is what worked for one social community enterprise: being a local resident for years [the initiator]. "*People also know that you do not do this for yourself, but really for the neighbourhood. I think that is the most effective thing you can do. People know that it is not self-enrichment for us. We are not here because we ourselves are getting much better"* [I#2].

As already noted in the introduction, this bottom-up approach is a phenomenon which is more and more seen in today's society. This goes along with the positive approach of the interviewed initiatives that are based on the power of people, the emancipation and

empowerment of people, instead of focusing on their problems and solving them. This different process requires something completely different from the people who do it. The civil servant gave the example of being too fat: "*You cannot really impose top-down and say 'you are too fat'. No, they have to experience it for themselves. But you can help them to come up with the solution themselves"* [I#1].

4.5 Perceived impact on health

In the following paragraph, participants' and initiators perceived impact on health as a result of participation in social community enterprises is described. Generally, the most frequently mentioned perceived health impacts were related to building social contacts, feelings of belongingness to a group and to society, an increase of mental health and an increase of competences. What stands out is that many of the health outcomes are interrelated. As one initiator put it nicely: "*if you are closer to yourself, then you feel better, then you are healthier, then you take care of yourself better, then you cook more often, then you may move more, then you have more contacts where you get energy from again"* [I#3]. Therefore, these structure of results should not be seen as 'black and white': there are many interrelationships. The results below are structured based on the six health outcomes of positive health, corresponding to the conceptual framework.

4.5.1 Bodily functions

In different respects, participants experienced an perceived impact on bodily functions. One participant was still suffering from fatigue after a chemotherapy of five years ago. She still did not feel well, but was hoping that physical work would help. Another participant suffered from panic attacks for muscles. By working in the community garden, she became a bit quiet. Four participants referred to building physical condition. For one participant suffering from burnout symptoms, participation had a big impact: after 'sitting 1,5 years on the chair', his muscle building deteriorated, he got sores all over his body, he was not walking and he was not in the open air. Now, his muscles started to build things up again. Another participant spoke about building energy that was loosened by participating in the initiative.

For initiators, it is sometimes more difficult to see if there is an health impact on participants, because health often improves gradually from the moment participants start at the initiative. However, one initiator mentioned an impact on participants' lifestyle: since the participants know they have to work the next day, they do not drink the day before. Another participant only starts blowing after 1.00 PM, after work [I#2]. Another initiator referred to a group of people who have lost weight enormously as a result of participation in a social community enterprise [I#1].

4.5.2 Social and societal participation

Eleven participants mentioned building social contacts as an health impact factor. Meeting new people, working with people of different backgrounds and learning and experiencing that they are different. Also, feelings of belongingness to a group and to society play an important role: *"I feel a bit responsible to go back to the community garden, even when it rains. Because I notice that others are also there when it rains. That stimulates me to go as well"* [I#6].

One initiator notices that sometimes real friendships are developing, and that people even meet each other in private situations. She said: "*You should not go to the supermarket here at 5:00 PM. Then the whole neighbourhood goes, and then you are three hours away to pick up something"* [because of all acquaintances you meet in the supermarket; I#2].

4.5.3 Mental functions and perception

Ten participants mentioned positive feelings, distraction from problems of daily life and job satisfaction as mental health impact factors. If they would stay at home, they would worry all day long. Two participants referred to job satisfaction as a result of their efforts: a good end result leads to feelings of pride and happiness that it succeeded. Three participants indicated they calm down in the group of people at the initiatives. For one participant with a stress disorder, the group of elderly people at the initiative was important for his mental wellbeing. In this group of people, he experienced less stimuli and no irritation. According to him, these elderly people have a serious worldview and cannot make him angry. Another participant said*: "You can be yourself here. For example, I used to have a number of jobs, and then you have to apply. Then I put a mask on. But you do not have to do that here, here you can just be completely yourself. That gives a great feeling"* [I#2].

4.5.4 Spiritual/existential dimension

Nine participants mentioned recognition and gratitude as most important spiritual health impact factors. As one participant literally said: *"First I was a pariah of society. Now I am a full fellow man of society again"* [I#5]. Participants feel important and feel appreciated by the gratitude they receive from the people who need their help: *"Someone who is truly not able to pour the coffee himself, but really wants that cup of coffee. Those are very small things, but it is important"* [I#3]. Another participant said that it is always said to her 'you are needed', and if you have not been here for a moment, 'gosh, we've missed you'. For her, that is very warm to hear, and it gives her feelings of belongingness [I#3].

Besides, participation gives meaning to the existence of participants: *"You also have something to tell at the end of your day. If you're sitting on the couch with the two of you here, you only look at the walls. Then you think: 'let it be"* [I#3].

One initiator explicitly mentioned the goal of his initiative to offer a place for people to make them feel socially valued again [I#1], and another initiator argued that having respect for each other was an important part of the culture on the initiative [I#6].

4.5.5 Daily functioning

Seven participants mentioned increase of competences as a perceived health impact. Two participants of the community garden enjoyed the fact that they have learned things about gardening and about nature. One participant with an ethnical background and with language problems enjoyed the fact that she learned new Dutch words and phrases, it makes her more independent. For one participant who could not handle too much environmental stimuli, participation has led to an ability to go to the supermarket again, making a walk around the house, and learning him again to talk to people. Now, he is even thinking about caring for his children for a whole week. Three participants and one initiator related these increase of competences to an improved self-confidence.

One participant also explained the link between participation in a group and daily functioning: *"You can also help each other. Sometimes people can do almost nothing, but they can do that one thing. And someone else can do what the other person is not able to. So there could be one who has good hands, and another has bad eyes. You can do things together"* [I#3].

Initiators and the civil servant also notice an impact on daily functioning. The civil servant took an example of a woman who used to be very bullied as a child, was too fat and was unable to work as a result of psychological problems. Being active as an initiator resulted in an incredible personal growth: she has held a plea in the district commission, she approaches tax authorities independently, she arranges the so-called ANBI status, an accounting for the annual accounts... Like her co-initiators, she is very much emancipated and proud of what she has achieved. Hereby it is important to note that this long-term welfare recipient was quite involved, as an initiator of the enterprise, compared to other long-term welfare recipients. A stronger involvement may lead to a bigger health impact. Another initiator referred to the ability of participants to bring structure in their daily life: after being active in the initiative for a while, they have learned to be on time every day.

4.5.6 Quality of life

Quality of life is a subjective judgment of a person about his/her own life on physical, mental and social level (Theofilou, 2013). Taking this definition into consideration, that includes more or less all of the health outcomes of the theoretical framework, quality of life is seen more as an overarching outcome. Generally, participants' quality of life has been improved as a result of participation in a social community enterprise: they feel better physically and mentally, they have gained more social contacts and they have undergone self-development in different respects.

5. Discussion and conclusion

In this chapter, the main findings are discussed and compared with the literature and the theoretical framework. In addition, the strengths and weaknesses of this study are described and suggestions for further research are given.

5.1 Main findings

The objectives of this study were two-fold: 1) to get insight in motivations of long-term welfare recipients to participate in social community enterprises, and to connect these motivations to its perceived impact on individual health outcomes; and 2) to get insight in effective strategies to involve long-term welfare recipients in social community enterprises. This is important since it is often difficult to involve long-term welfare recipients in such social community enterprises, while they can have a large benefit from it.

5.1.1 Difficulties and strategies to involve long-term welfare recipients in social community enterprises

A number of explanations have emerged from the interviews with the initiators on difficulties to involve long-term welfare recipients in social community enterprises. The first explanation lies in the group of people who are ‘used to’ receiving a welfare, that they are familiar with it. This group is also referred to as ‘generational welfare recipients’, whereby a form of lethargy is seen. This phenomenon is also described by Lammerts (2000), who does not consider it inconceivable that generational welfare recipients are pressed by their network to consider their (own) joblessness as normal and to accept it. However, the network can also provide incentives to change the situation, for example in supporting each other in tackling a particular problem (Lammerts, 2000). It is known that many people find a job via their own network.
Besides, people seem to have the idea of 'I cannot do volunteer work' [for bureaucratic reasons, next to their welfare]. Other reasons are feelings of pride, the perception of receiving a welfare as a form of ‘right’, feelings of shame, and the multiple problems that long-term welfare recipients already face.

According to this study, using a **personal approach** and listening to the wishes and needs of residents is the strategy that comes back in the method of all social community enterprises. Besides, some long-term welfare recipients flow in via (welfare)organisations or municipalities, or by reading a call for participants in the newspaper or on a flyer. Moreover, two social community enterprises used innovative strategies to involve long-term welfare recipients, such as a financial incentive or applying the concept of a ‘social mortgage’. The use of innovative strategies is supported by earlier mentioned research of Graaf, Van Hulst & Michels (2015), who argue that these innovative, non-standard activities are needed to get citizens in disadvantaged neighbourhoods to participate, which should have a positive influence on the conditions under which participation flourishes.

An important boundary condition for the effectiveness of these strategies turned out to be a **bottom-up approach**. A community enterprise can only exist, and exist well, if it is established *from* the neighbourhood and *for* the neighbourhood. It is essential that the wishes and needs arise from the residents themselves, and that the wishes and needs are

very neighbourhood dependent. The latter ties to the concept of what Donaldson (2001) calls *contingency theory*: the idea that there is not one proper organizational model, but that it depends on the local situation. What is the population composition, what other parties are already active, what is the political landscape, what is going on locally, and who are willing to take the lead?
Although most of the initiatives are based on the vision that takes the power of people and emancipation into consideration, sometimes elements of a top-down culture are still seen. For example, this is illustrated by the fact that at one initiative the initiators could not be interviewed, since the civil servant decided for the initiators that they would lack the time to be interviewed - instead of asking the initiators themselves.
Another boundary condition is **trust** in organisations and their employees: unemployed who have little or no trust in organisations and their employees will be little inclined to let them advise in what they can do to improve their situation (Lammerts, 2000).

5.1.2 Motivations of long-term welfare recipients to participate in social community enterprises

What is striking about motivations of long-term welfare recipients to participate in social community enterprises, is that all interviewees mentioned aspects related to the atmosphere of the group, gaining social contacts, distraction from problems of daily life and meaning something for others and for society. This also corresponds to the earlier mentioned study of Bierbaum and Gassmann (2016). Other motivations were meaning something for the neighbourhood, learning things, and having pleasure. Motivations on organizational level were management of work, kind of work, and structure; and on economic level ‘a stepping stone towards work’, ‘income’ and ‘social service’.

For the participants who are asked to do the exercise with the interview cards (n=6), it was difficult to assign importance to the specific cards. Generally, they ranked the cards on an equal level and believed that everything related to the whole picture. Because of this result, the question is whether the interview cards were a good method to examine the value that the participants attached to the various motivational factors for participation. The interview questions showed namely that participants often mentioned socio-cultural motivational factors as first, from which it may appear that participants do indeed attach different values to the various factors. A reason that participants ranked the cards on an equal level, may be that they are shown all the cards at once. However, the interview cards were a good method to probe the interviewee to generate further explanation, certainly because some people sometimes found it hard to find the right words.

5.1.3 Participants’ and initiators’ perceived impact on health

Despite the fact that several initiatives with various unique elements have been visited, such as a green initiative, non-green initiatives, initiatives that offer learning workplaces or initiatives that merely had an 'open entry' (*in Dutch: open inloop)*, generally the same health outcomes are seen by participating in these initiatives. Health impact outcomes are often related to gaining social contacts, distraction from problems of daily life, and meaningfulness.

Looking at the social health impact dimension, eleven participants mentioned building social contacts as an health impact factor. Meeting new people, working with people of different

backgrounds and learning and experiencing that they are different. Also, feelings of belongingness to a group and to society played an important role.

Ten participants mentioned positive feelings, distraction from problems of daily life and job satisfaction as mental health impact factors, and nine participants mentioned recognition and gratitude as most important spiritual health impact factors. Seven participants mentioned increase of competences as a perceived health impact, and three participants and one initiator related these increase of competences to an improved self-confidence. Regarding physical health impact, an improved condition and improved lifestyle were the most important factors.

5.2 Reflection on theoretical framework

Looking back on the theoretical framework, it stands out that many of the motivational factors for participation correspond with the health outcomes resulting from participation. For example, gaining social contacts and expanding one's network can be both a socio-cultural motivational factor for participation and a social health outcome; as well as that distraction from problems of daily life can be both an individual motivational factor for participation and a mental health outcome as a result of participation.

Likewise, it is seen that many of the health outcomes are interrelated. Hereby a positive circle is seen whereby health outcomes influence each other. For example, if one feels better [mental functions], one may move more [bodily functions], one may cook more often [daily functioning] and one may have more contacts [social functions] where you get energy from again [positive influence on mental and bodily functions] (figure 4).

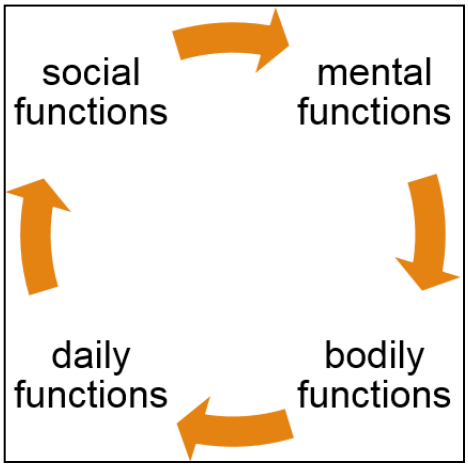

Figure 4: Positive circle of health outcomes

As already touched upon in the introduction, these health outcomes can strengthen one's motivation to participate. According to this research, the strongest relationship is seen between the health outcomes daily- and mental functions and the individual motivational factor perceived behavioural control. That is, three participants and one initiator related an increase of competences [daily functioning] as a result of participation with an improved self-confidence [perceived behavioural control].

The adapted theoretical framework, with the interrelationships of the health outcomes, the revised position of the health outcome quality of life, and the link between the health outcomes and the motivational factors is shown below (figure 5).

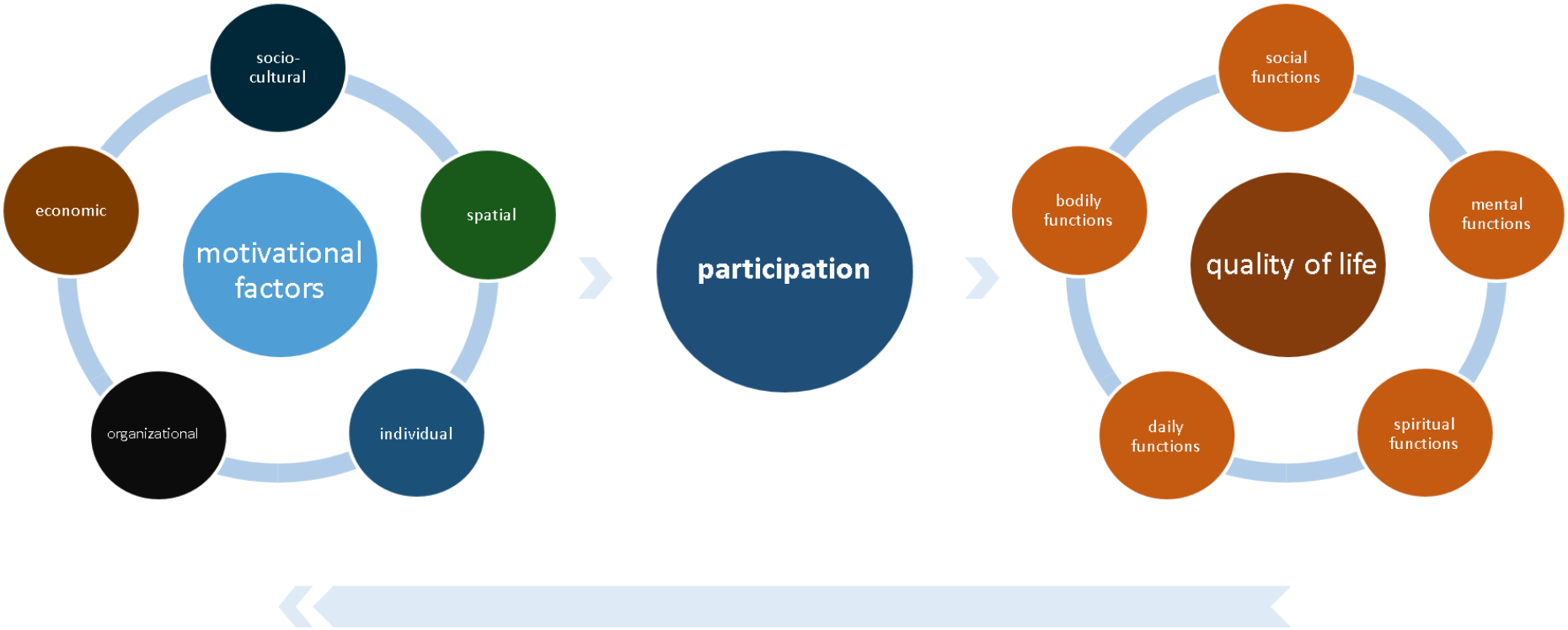

Figure 5: Adapted theoretical framework

5.2.1 Link motivational factors and initiators' strategies

In this research, it was assumed that knowledge on motivational factors of long-term welfare recipients for participation was needed for initiators in order to develop strategies to involve long-term welfare recipients in their initiative. Initially, it seems that initiators base their strategies on experiential knowledge ("professional intuition"), rather than that they base their strategies on the motivational factors as they are shown in the theoretical framework. For example, initiators know from experience that the personal approach is more successful in involving long-term welfare recipients than distributing flyers.
However, it seems that initiators indeed base their strategies on the motivational factors of the theoretical framework, but more implicitly. For example, all initiatives connect to spatial motivational factors, by offering a place close to people's homes, where they can participate and meet people. One initiative that is committed to the reduction of loneliness, connects with this to the socio-cultural and mental motivational factors [I#3]; and another initiative that offers a financial compensation, connects to the economic motivational factor [I#2]. Another initiative connects to individual motivational factors [attitude, pride], by stimulating residents to do things themselves and not to find it 'normal' to receive social assistance benefits [I#4].

5.3 Strengths and weaknesses

A strength of this study is the development and use of the theoretical framework, which brings participants' motivation to participate in social community enterprises and its related perceived health impact together into one framework.

One of the weaknesses of this study was that in the sample selection, the inclusion criteria have not always been fully met. Firstly, two initiatives were not situated (anymore) in a disadvantaged neighbourhood. One of these initiatives was surrounded by vacant lot. The other has been situated in a disadvantaged neighbourhood in the past, but due to housing policy of the municipality, more wealthy families came to live there - such as young two-income households. As a result, the social community enterprise could no longer connect with local residents, since the residents of the young two-income households had other priorities than participating in a local social community enterprise. However, this initiative was valuable for this study, as it has shown the importance of a neighbourhood-oriented approach.

Secondly, one of the interviewed participants of the first initiative was in a short-term- instead of a long-term welfare situation; and another interviewed participant has only been in a long-term welfare situation in the *past*. However, it was valuable to conduct these interviews: participants who were in a learning-work process mentioned other motivations and health impacts than participants of the other initiatives, which were merely focused on participation in itself. The different nature of this initiative was therefore of value as comparison.

Thirdly, one initiative cannot be considered as a 'social community enterprise' as was defined earlier in this study. This initiative depended on annual subsidies from the municipality.

One last point that was unfortunate, was that the initiators of one initiative could not be interviewed. According to the involved civil servant of this initiative, these three initiators were all in a long-term welfare situation: an aspect that is not seen in the other initiatives. In the

other initiatives, the long-term welfare recipients were ‘only’ participants of the initiative instead of the initiators. It would have been interesting to have interviewed the initiators who were in a long-term welfare situation, since this stronger level of involvement may result in other motivations and another health impact.

5.4 Suggestions for further research

In England and the Netherlands, the emphasis is mainly on social community enterprises in urban areas, especially in those neighbourhoods that were previously classified as disadvantaged neighbourhoods. However, it would be interesting to research the potential of social community enterprises in reducing health inequalities in rural areas as well. Through urban eyes, a village can seem to be a close-knit community, where everyone cares for everyone. But behind that facade of almost old-fashioned social connections, people in rural areas also live in completely social isolation (Van Houten, 2011). And in some ways they are even worse off than their counterparts in the city. Villagers have on average a larger and closer social network than city dwellers, more contact with each other and do more things for and with each other. Expressed in figures, ten percent of urban residents can be described as socially isolated and three percent of rural residents. However, embarrassment about the social isolation is incredibly high in rural areas.
Besides, social poverty often goes along with financial poverty – which is less visible in rural areas. However, this cannot be seen in poverty statistics of rural areas, since villages are popular with wealthy city dwellers in search of peace and space.
The problem is also denied: 'they live so idyllic, they have a beautiful view'. Compared to their wealthy neighbours, the vulnerable in the villages feel powerless and marginalized: they are not part of it.
According to Thissen, in the same article of Van Houten (2011), villagers have more trouble surviving than the poor in the city. They can meet each other more easily because they are with more, and they are recognized by policy makers as a category that needs help.

Besides, this research has only focused on the social community enterprises that were *successful* in involving long-term welfare recipients. However, it would also be interesting to research those enterprises that were *not successful* in involving long-term welfare recipients.

In this research, subjective measures are used to research health impact and effectiveness of strategies (‘perceived’ health impact and ‘perceived’ effectiveness). A methodological suggestion for further research would be to use objective measures as well. An example of an objective tool to measure health impact would be a questionnaire that is administered among individuals multiple times during a certain period of time. For example, before they start participating in a social community enterprise, at the start of their participation and after one and two years.

Another methodological suggestion for further research would be to add a question in the interview protocol for initiators that questions why it is so difficult to involve long-term welfare recipients, before asking which strategies are used to involve long-term welfare recipients in social community enterprises.

5.5 Conclusion

This study has provided insight in long-term welfare recipients' motivations for participation in social community enterprises, in their perceived health impact as a result of this participation; and in initiators' strategies to involve long-term welfare recipients in their initiative. The most often mentioned motivational factors for participation were related to the atmosphere of the group, gaining social contacts, distraction from problems of daily life and meaning something for others and for society. Interestingly, these motivational factors mainly correspond with long-term welfare recipients' perceived health impact of participation. Using a personal approach and listening to the wishes and needs of residents is the most often used strategy to involve long-term welfare recipients, in the light of a bottom-up approach which is more and more seen in today's society.

This study can be of value as a first step in the four-year research programme 'Addressing health inequalities in vulnerable urban neighbourhoods by social community enterprises', subsidized by ZonMW, providing input for which objective health outcome measures can be used.

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Appendix I: Categorization of social community enterprises

As mentioned earlier, a large diversity of organizations on different scale levels is indicated with the term community enterprise. In order to give more insight into the different types of social community enterprises and the practical issues they entail, some fictional examples of these different types are given in the following appendix. They are ordered based on the most important activities they offer: catering, care, and (urban) agriculture respectively.

Social community enterprises in the horeca sector

The horeca sector has different target groups: individual visitors, groups of people, two-income households, pensioners, families and the business market. A fictional example of a social community enterprise in the horeca sector is given below.

Hüseyin Kaya and his wife Eline both have a background in the catering industry. They see the vacant community center as the possibility for them to combine knowledge, passion, and experience with their desire to mean something for the neighbourhood. After a thorough investigation of the needs in the neighbourhood and various discussions with the municipality, who owns the community center, the couple decides to get serious about this.

They set up a foundation. The foundation aims to bring local residents together for an affordable and healthy meal, thereby increasing mutual involvement in the neighbourhood and promoting a healthy lifestyle. The municipality provides a start-up subsidy for this district enterprise. A large fund finances part of the inventory because it supports the objectives of the foundation. Through the deployment of volunteers from the neighbourhood, donations from retailers for preparation of meals and income from meals, the foundation will no longer be dependent on external financing. Hüseyin and Eline want to be recognized as a training company, making it possible for pupils and students to offer an internship. This contributes to the future perspective of young people from the neighbourhood (Rijksoverheid, 2014).

Social community enterprises in the care sector

Through decentralization, municipalities are given a lot more caring tasks. To execute these tasks, municipalities sign contracts with different providers. This is potentially a big market. Often, community enterprises lack the expertise to support their clients. Therefore, they need to collaborate with care institutions and/or welfare organisations. A fictional example of a social community enterprise in the care sector is given below.

In a disadvantaged neighbourhood in The Hague, a group of Moroccan women meets weekly in a participation center. They talk with each other about their lives, their health and their problems while they are working on their handicrafts. Part of the group has the need to
work more active on their health and to exercise more. From that need, women ask support of the welfare- and care organizations which are also located in the center. Collectively they look what the needs and possibilities are. From existing structures, a volunteer is sought who can provide exercise lessons once a week. The location is found in the
gymnasium of a school building, which can be used free of charge. Because the women want more than just exercise, they decide to establish an association. As a member they all pay a small contribution (most women are dependent on a benefit), and have influence what happens within the association. The women would like to swim, but there are costs connected with it. They also want to cycle, but they do not have a bicycle. From regular means there is no money for that: that is why alternative sources of financing are searched for. As an association, the women ask for a large subsidy to promote health and well-being. Also, they are in conversation with a health insurer, who, from a preventive point of view, wants to contribute to this initiative. Since the activities are combined with information about health, medicine use and responsible nutrition, this can save care costs. The

women are already being asked by other parties outside The Hague to talk about their successful approach. This
is done with the guidance of a welfare worker. The money that is earned with this, flows back to the association and is used to finance new activities (Rijksoverheid, 2014).

Social community enterprises in the green sector

A substantial part of social community enterprises takes place in the green sector. Examples of these 'green social community enterprises' are urban agriculture initiatives or other food garden projects.

Involving lower socioeconomic groups in green social community enterprises is interesting, since research from Maas et al. (2009) has shown that groups with a lower socioeconomic status seem to benefit more from a green environment in experiencing their own health than groups with a high socioeconomic status: lower SES people's activities and social contacts are generally located close to their homes (Maas et al., 2009). Although the latter argument is often used in green environments, it might also go for social community enterprises in non-green environments.

Community and neighbourhood settings such as urban agricultural initiatives are excellent opportunities for long-lasting health promotion (Biddle & Seymour, 2012). Several researchers have proven the beneficial health effects of working and participating in the green environment of such urban agriculture initiatives. It is found to stimulate movement, to connect people, and it offers meaningful activities in which the diversity of people who can participate is large (Bronsveld, 2014; Dijkshoorn-Dekker & de Blaeij, 2015). Other researchers have shown that gardening reduces pain, increases fitness, reduces stress and depression, and assists with coping with illness such as cancer (Alaimo, Beavers, Crawford, Snyder & Litt, 2016). Moreover, gardens influence key intermediate health behavior changes, such as physical activity and diet, which influence mental health and chronic diseases. Next to the health benefits, urban agriculture initiatives provide local food, green space for recreation, and they offer employment (Veen, Breman, & Jansma, 2012). This demonstrates that the main goal of urban agriculture initiatives is not only to promote health, but could also cause side-effects such as improving the environment in the neighbourhood (Dijkshoorn-Dekker & de Blaeij, 2015).

Critics of urban agriculture initiatives argue that the physical effort of growing food, is not feasible for everyone (Cockrall-King, 2012). Besides, they question whether such initiatives can help all layers of the population. When urban agriculture initiatives are only accessible for the higher educated people, the gap between lower- and higher educated people might even get larger, causing more health inequalities (Cockrall-King, 2012). Other criticism lies with the argumentation that with such initiatives, it is difficult to break through existing social structures and it is difficult to bring people of different socioeconomic backgrounds in contact with each other (Veen, 2015).

Appendix II: Interview protocol

Initiators social community enterprises

Name enterprise:
Name initiator and impression of this person:

_____

Part I: General questions

1. What is your role in this social community enterprise? *(contact with municipality, finance, working with participants)*

2. Can you tell about the start of this initiative? *(e.g. when did it start, by who, vision and mission)*

3. What are the objectives of this project?

4. What activities take place here?

Part II: Who is involved | Participation

5. Which and how many people are involved in this initiative?
(how many participants, target groups, visitors, management functions; profile of these people; SES, gender, age)

6. What are the activities that different groups do on this initiative?

Part III: Strategies

7. Which strategies are used to involve people in your social community enterprise?

8. To what extent are these strategies effective in involving residents in your social community enterprise? *(barriers, opportunities, dropout participants)*

9. Are there people who quit the project?

   - If yes, which people quit the project?

10. Do you know what they do after they have stopped? *(going to the next step; volunteer work or paid work, moving, illness, work is too heavy)*

11. Regarding involving people in your social community enterprise: are there things you want to do differently than the current situation?

    - If yes, what do you need to do it differently?

12. Is there an official collaboration with the municipality, care institution or other institution?

    - If yes, can you tell something about the collaboration?

Part IV: Health outcomes

13. According to you, is there an impact of participating in this social community enterprise?

- If yes, what is this impact on:

- *Physical health*
- *Mental health*
- *Wellbeing*
- *Social level*

Participants social community enterprises

Part I: Involvement and motivations

1. Since when do you participate in this social community enterprise?

2. How did you get in touch with [name initiative]?

3. What did you do to get involved in this project? Was that easy or difficult?

4a. Which activities do you perform on this [name initiative]? *(also on organizational level/establishment initiative?)*

4b. How often per week, how many hours?

4c. Compared to the start of your involvement, has the kind or amount of activities you perform on the initiative been changed?

5. What do you think of this project?

6. Is there anything you would like to change?

7. What are motivations for you to participate in this social community enterprise?

8. Are there barriers for participation in [name initiative]?

9. Compared to the start of your involvement in [name initiative], have your motivations for participation been changed?

10. The following factors (next page) could be motivations for you to participate in this social community enterprise. Could you arrange the different factors from most important to less important for your situation?
Note: the factors can also be ranged on the same level.

Part II: Impact

11. According to you, do you benefit from participating in this social community enterprise?

- If yes, what is the impact on:

- *Physical health*
- *Mental health*
- *Wellbeing*
- *Social aspects*
- *Quality of life*

12. Compared to the start of your involvement in [name initiative], has the impact of participating in [name initiative] been changed for you?

Part III: General questions

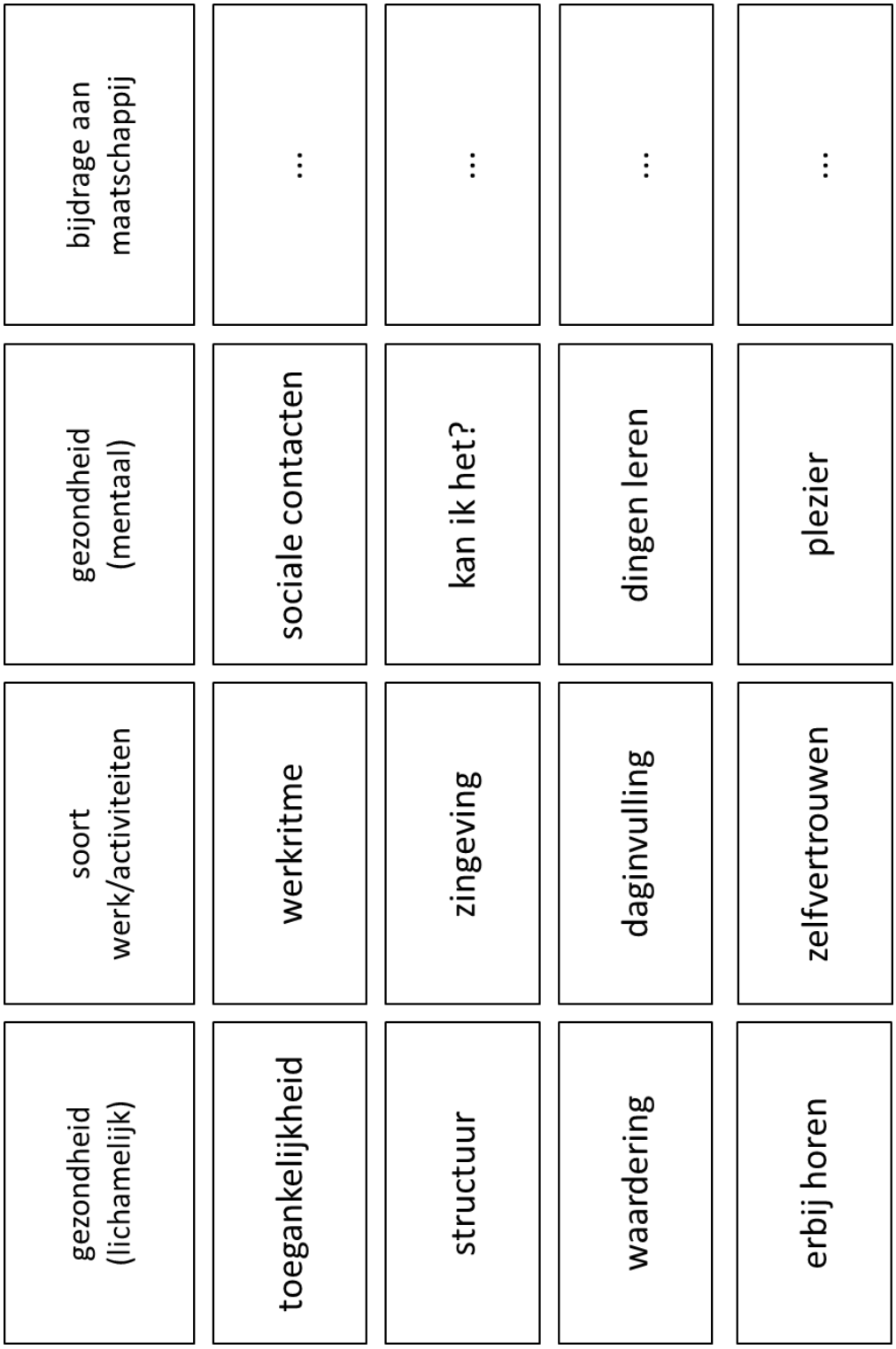
Gender: male / female

13. May I ask for your age?

14. What is the highest level of education you followed?

15. Do you have work experience?

- If yes, what is your work experience?



Participant interview cards (in Dutch).

Appendix III: Interview guide

General information

- Send the informed consent beforehand to the initiators of the social community enterprises in order to prepare them for the interview.
- The bullets and notes under the questions are meant as a kind of checklist for the interviewer. It is not needed to ask the interviewee about all those bullets because in that way his or her answer can be influenced.

Introduction

- Introduce the interview shortly by mentioning the objectives of the study, explaining the topics of the interview and give some general information, such as the duration of the interview and some ethical considerations (anonymity, voluntariness). Make sure the informed consent is signed before starting the interview and start the recording.

Part III, question 11 (participants)

- The idea of the participant interview cards is that the respondent can hold these cards him- or herself and rank them on the table. The interviewer needs to be aware that afterwards you can listen to the things the respondent said because the interview is recorded, but the interviewer does not see or hear which factors someone for instance points out. So the interviewer needs to make notes during this process.
- The interviewer needs to make a picture of the ranking on the table afterwards. Or if a picture is not possible, the interviewer needs to write down the ranking on the cards so the ranking is known when you are back in the office.

End of interview

- Thank the respondent for the interview and taking part in this project. Leave your contact details so the respondent can contact you if necessary.

Appendix IV: Informed consent

Toestemmingsformulier deelname onderzoek 'Sociale wijkondernemingen'

Datum:

Beste heer/mevrouw,

Hierbij nodig ik u uit om deel te nemen aan mijn afstudeeronderzoek over sociale wijkondernemingen. De studie wordt uitgevoerd voor de onderzoeksgroep Gezondheid en Maatschappij van de Wageningen Universiteit. Het doel van de studie is om inzicht te verkrijgen in redenen die mensen met een langdurige bijstandsuitkering hebben om deel te nemen aan sociale wijkondernemingen. Een ander doel is om inzicht te verkrijgen in waargenomen gezondheidseffecten van deelname aan sociale wijkondernemingen.

De interviewer zal vragen stellen over uw redenen om deel te nemen aan een sociale wijkonderneming, en over de waargenomen gezondheidseffecten van deze deelname. Interviews zullen in het Nederlands gehouden worden en zullen maximaal een halfuur duren, hoewel ze ook korter kunnen duren wanneer u dat wilt. De interviews zullen worden opgenomen. Deze opnames worden niet verspreid. De resultaten worden vertrouwelijk behandeld. Alleen de onderzoeker en haar begeleider zullen toegang tot de resultaten hebben. Bovendien kunt u ervoor kiezen om een pseudoniem te gebruiken in plaats van uw echte naam. Uw informatie zal alleen gebruikt worden voor het onderzoeksproject en zal alléén gepubliceerd worden met uw toestemming. Uw naam zal niet verschijnen in een rapport of publicatie van dit onderzoek, echter met uw toestemming kunnen anonieme uitspraken worden gebruikt. Resultaten van dit project worden bewaard op een computer die alleen toegankelijk is voor de onderzoeker.
Als u klachten of vragen heeft over het onderzoeksproject, het interview of uw deelname, dan kunt u mij bereiken per telefoon (06 294 460 77) of per e-mail: julia.hiddink@wur.nl.
Wanneer u besluit om mee te doen aan dit onderzoek, dan wordt u gevraagd om dit formulier te ondertekenen. Door dit formulier te ondertekenen, bevestigt u dat u:

- Begrijpt wat u hebt gelezen;
- Toestemming geeft om deel te nemen aan dit onderzoek;
- Toestemming geeft voor het gebruik van persoonlijke- en gezondheidsinformatie zoals boven beschreven.

Kruist u alstublieft het juiste vakje aan:

☐ Ik wil niet dat uitspraken van het interview worden gebruikt in publicaties die voortkomen uit dit onderzoek.

☐ Ik geef toestemming voor het gebruik van anonieme uitspraken in publicaties die voortkomen uit dit onderzoek.

U zult een kopie van dit toestemmingsformulier ontvangen om te bewaren.

Handtekeningen:

Naam deelnemer:	Datum:	Handtekening:
Naam onderzoeker:	Datum:	Handtekening:

Appendix V: Profile of the researched social community enterprises

For privacy reasons, this information is removed from the report.

Appendix VI: Dutch summary for initiators

ACHTERGROND | In Nederland is er een groep mensen die langdurig in de bijstand zitten, waarbij gecompliceerde gezondheidsproblemen worden gezien. Over het algemeen gaat het om een groep mensen met een leeftijd van 50 jaar of ouder, met weinig werkervaring, een lage opleiding, taalproblemen, fysieke en mentale problemen, schulden, verslaving, isolatie, een laag zelfbeeld – en dit alles in vele combinaties. Het is vaak moeilijk om deze groep te motiveren om te participeren, terwijl ze er wel veel baat bij kunnen hebben. Participatie kan namelijk leiden tot meer sociale contacten, een verhoogd welzijn, meer eigenwaarde en gevoel van autonomie, en meer structuur in het dagelijks leven. Vanwege de voordelen van participatie, kan de setting van een sociale wijkonderneming een zinvolle plaats zijn voor gezondheidsbevordering.

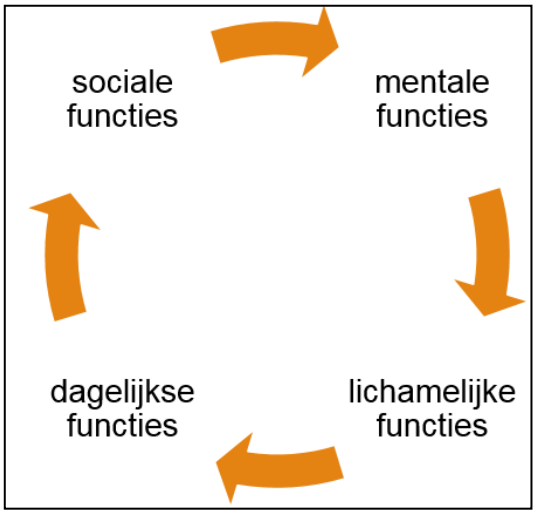
DOEL | 1) Inzicht verkrijgen in motivaties van mensen met een langdurige bijstandsuitkering om te participeren in sociale wijkondernemingen; 2) deze motivaties verbinden met waargenomen impact op individuele gezondheidsuitkomsten en 3) inzicht verkrijgen in effectieve strategieën om mensen met een langdurige bijstandsuitkering te betrekken bij sociale wijkondernemingen.

METHODE | Semigestructureerde interviews met zes initiatiefnemers of coördinatoren van sociale wijkondernemingen in Nederland en met dertien deelnemers van sociale wijkondernemingen. Deelnemers werden vragen gesteld over hun motivaties voor participatie en hun waargenomen impact op gezondheid, en initiatiefnemers werden vragen gesteld over strategieën om mensen met een langdurige bijstandsuitkering te betrekken bij sociale wijkondernemingen.

RESULTATEN | Er lijken een aantal verklaringen te zijn waarom het moeilijk is om mensen met een langdurige bijstandsuitkering te motiveren om te participeren. Ten eerste is er een groep mensen in de bijstand die er als het ware aan ‘gewend’ is geraakt om een bijstandsuitkering te ontvangen en waarvan de familie al meerdere generaties in de bijstand zit. Doordat er zich bij deze groep een bepaalde vorm van lethargie ontwikkelt, is het voor deze groep lastig om uit de bijstand te komen. Het kan ook te maken hebben met gevoelens van trots, met name bij groepen met een niet-Westerse achtergrond: zij willen laten zien dat ze zichzelf kunnen redden met wat ze hebben. Een andere verklaring ligt in een gevoel van schaamte en een minderwaardigheidscomplex dat zich ontwikkelt bij mensen die langdurig in een bijstandssituatie verkeren. Ten slotte spelen er vaak al zoveel problemen bij deze groep mensen, dat er vaak geen prioriteit wordt gegeven om te participeren bij initiatieven als sociale wijkondernemingen.
De belangrijkste motivaties van bewoners voor participatie waren gerelateerd aan de sfeer in de groep, het opdoen van sociale contacten, afleiding van problemen uit het dagelijks leven, en iets betekenen voor iemand anders en voor de maatschappij. De belangrijkste impact van participatie was gerelateerd aan een toegenomen fysieke en mentale gezondheid, meer sociale contacten, structuur in het dagelijks leven, erkenning en dankbaarheid voor het werk en een toename van competenties.
Een persoonlijke benadering en luisteren naar de wensen en behoeften van bewoners is een strategie die terugkomt bij alle zes sociale wijkondernemingen. Deze persoonlijke benadering hield bijvoorbeeld in: huis-aan-huis bezoeken bij bewoners, of simpelweg een ‘praatje aan

het hek'. Andere strategieën om bewoners te betrekken waren met een financiële prikkel, via (welzijns)organisaties of gemeente, of via een oproepje in de krant of op een flyer. Een belangrijke randvoorwaarde is dat een sociale wijkonderneming alleen kan bestaan, en goed kan bestaan, wanneer het opgezet is *vanuit* de wijk en *voor* de wijk.

DISCUSSIE | Het valt op dat veel van de motivaties van deelnemers voor participatie overeenkomen met de gezondheidsuitkomsten als gevolg van participatie bij een sociale wijkonderneming. Het opdoen van sociale contacten kan bijvoorbeeld een motivatie van een deelnemer zijn voor participatie, maar kan ook een gezondheidsuitkomst zijn. Daarnaast hebben veel gezondheidsuitkomsten verband met elkaar. Hierbij wordt een positieve cirkel gezien waarbij gezondheidsuitkomsten elkaar beïnvloeden. Wanneer iemand zich bijvoorbeeld beter voelt [mentaal], beweegt diegene misschien meer [fysiek], kookt misschien meer [dagelijks functioneren], heeft meer sociale contacten [sociaal], waar diegene weer meer energie van krijgt [positieve invloed op mentale en fysieke functies] (figuur 1). Deze gezondheidsuitkomsten kunnen iemands motivatie om te participeren vergroten.



Figuur 1: Positieve cirkel gezondheidsuitkomsten

In eerste instantie lijkt het erop dat initiatiefnemers hun strategieën om mensen die langdurig in de bijstand zitten te betrekken bij hun initiatief, baseren op ervaringskennis. Initiatiefnemers weten bijvoorbeeld uit ervaring dat een persoonlijke benadering beter werkt dan het verspreiden van flyers. Toch baseren initiatiefnemers hun strategieën wel degelijk op motivaties van mensen in een bijstandssituatie om te participeren, maar meer op impliciete wijze. Zo is er één initiatief die aanhaakt op de motivatie van mensen om meer sociale contacten op te doen, door in te zetten op het verminderen van eenzaamheid.

CONCLUSIE | De inzichten van deze studie kunnen van waarde zijn voor het onderzoeksprogramma *'Addressing health inequalities in vulnerable urban neighbourhoods by social community enterprises'*, gesubsidieerd door ZonMW, door het leveren van input in welke objectieve gezondheidsuitkomsten gebruikt kunnen worden.

Kernwoorden: gezondheidsverschillen, sociaal-economische status, participatie, positieve gezondheid, sociale wijkondernemingen.