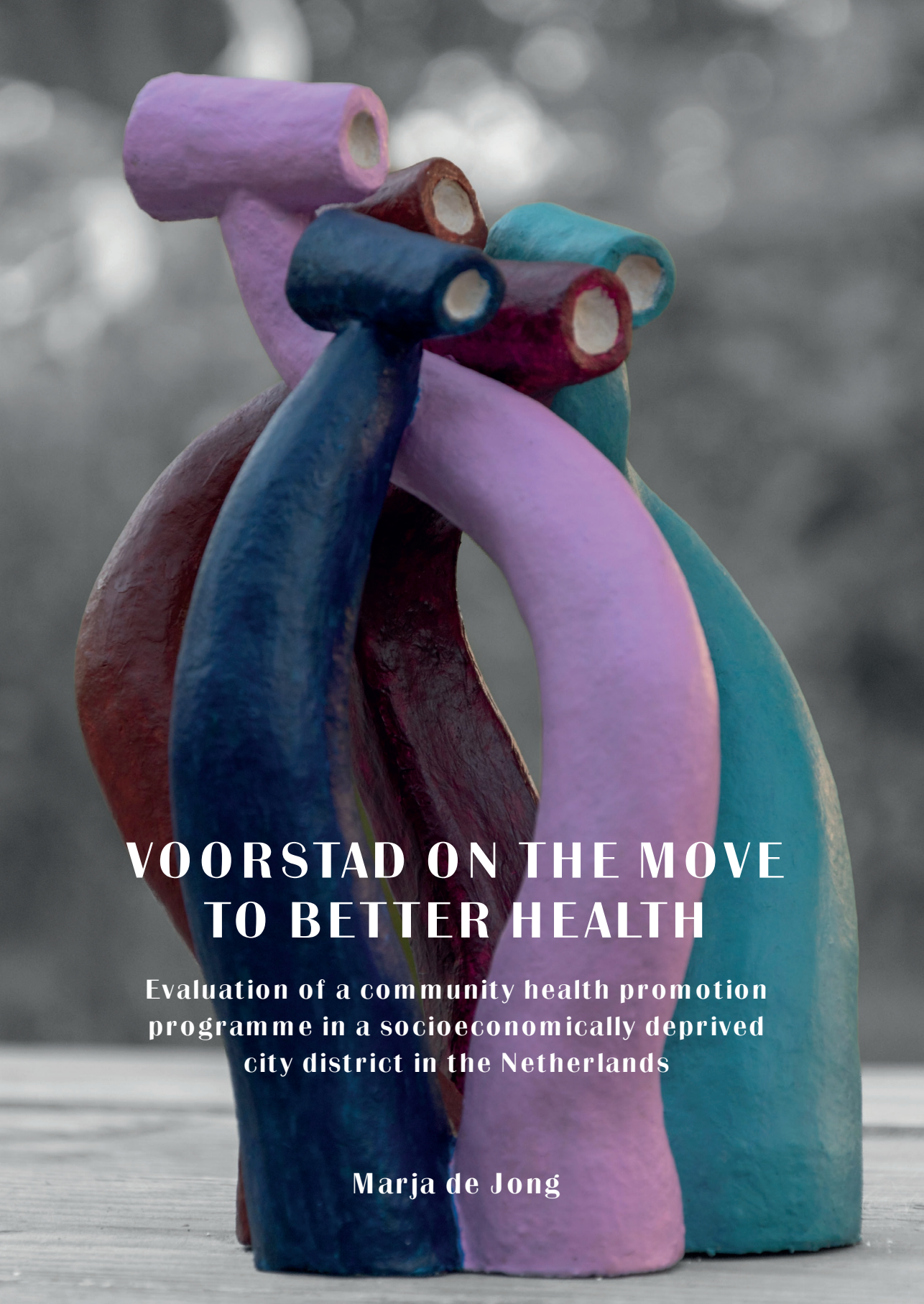

VOORSTAD ON THE MOVE TO BETTER HEALTH

Evaluation of a community health promotion programme in a socioeconomically deprived city district in the Netherlands

Marja de Jong

PROPOSITIONS

1. Co-creating supportive environments is decisive to promote health and well-being.
   (this thesis)
2. Visible programme outputs are prerequisite to realise long-term health outcomes.
   (this thesis)
3. Participatory action research is key to realise societal change.
4. The time you lose in exchanging perspectives at the beginning of research projects, you earn back double and straight at the finish line.
5. Successful collaboration depends on carefully choosing and using our words.
6. Lifelong learning requires taking on new challenges again and again.

Propositions belonging to the thesis, entitled

Voorstad on the move to better health. Evaluation of a community health promotion programme in a socioeconomically deprived city district in the Netherlands

Marja de Jong

Wageningen, 6 December 2022

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VOORSTAD ON THE MOVE TO BETTER HEALTH

Evaluation of a community health promotion programme in a socioeconomically deprived city district in the Netherlands

Marja de Jong

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Chapter 1

General introduction

1.1 Introduction

Health inequality, a persistent health gap between groups with a higher and a lower socioeconomic status (SES), is a wicked problem caused by multiple factors in the social, physical, and economic environment and the interplay between individuals, groups, and communities. The recent health crisis arising from the Covid pandemic may have made the health gap even larger [1, 2]. Although the unequal distribution of health among different SES communities and neighbourhoods was recognised long ago, to date, health policies and health promotion programmes have not been successful in substantially reducing the gap [3–5]. It is broadly acknowledged that more effective strategies should be based on an ecological perspective, addressing factors at multiple levels and looking at the interaction between factors [6–8]. A principle-based, community health promotion approach is recommended, but its implementation and evaluation have proved challenging.

This thesis aims to study and understand the impact of a community health promotion programme on health and health-supportive environments on the one hand and the working of the action principles in that programme on the other hand, thereby contributing to finding ways to reduce health inequalities.

This chapter starts with a short background on health promotion approaches with special emphasis on the citizen participation and intersectoral collaboration action principles. Participatory action research (PAR) is introduced, because it both facilitates and evaluates community health promotion programmes. Next, a brief overview is provided about policy developments and strategies employed to address health inequalities in the Netherlands. Finally, the study setting, the main aim and the research questions of the study, and a general outline of this thesis are described.

1.2 Socioeconomic health inequalities in the Netherlands

Despite growing attention and policy commitments to tackle inequalities, including in the Netherlands, differences in health between social groups still exist [9, 10]. In the Netherlands, people with a low SES live on average 6 years shorter (life expectancy) and even 15 years less in good perceived health (health expectancy) than people with a high SES [11]. This link between SES and (healthy) life expectancy shows a strong gradient: with each step up the social ladder, the chance of good health increases. Furthermore, there is a strong interaction between SES and health: people with good health are better able to obtain and maintain more favourable positions on the social ladder; and vice versa, people who are in a favourable position are also more likely to stay healthy. The persisting health gap is a wicked problem and, because of its complexity, single health promotion

interventions, i.e., behaviour change or lifestyle approaches, are not sufficient to reduce health inequalities [12, 13]. The (wicked) problem of health inequalities should be addressed from an ecological perspective [14] with a focus on creating community capacity and health-supportive environments [15]. In a recent essay, the Council for Public Health and Society (RVS) [16, p.9] conclude that: '*Disadvantages in health for a substantial group are the result of a reality in which different factors accumulate and are intertwined*' and follow this with the recommendation that it is necessary to look at the causes behind the causes, because '*by focusing mainly on individual lifestyle and behaviour, in fact it is the symptom that is mainly combated and not the disease*.' The question then arises as to how health promotion can help in closing the health gap.

1.3 (How) can health promotion help in closing the health gap?

An obvious answer is provided in the Ottawa Charter for Health Promotion that resulted from the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986 [17]. The aim of that conference was to identify actions to achieve health for all by the year 2000 and beyond. The Ottawa Charter formulated the following definition of health promotion: '*Health promotion is the process of enabling people to increase control over and improve their health. Health is seen as a resource for everyday life, not the objective of living. Health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing'* [18, p1]. The Ottawa Charter is often presented as health promotion's founding document as it has endorsed the positive definition of health that orients public health actions towards people's living conditions and towards health equity [18].

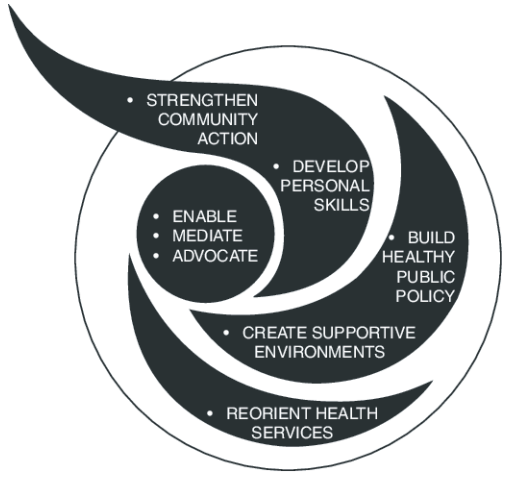

Fig. 1.1 Three strategies and five action areas proposed in the Ottawa Charter.

The Ottawa Charter proposes three strategies and five action areas that extend well beyond the health care sector. The strategies are: advocate, mediate, and enable; and the action areas are: 'build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, and reorient health services' (Fig. 1.1) [17].

The Ottawa Charter continues to be relevant for health promotion, because it has provided a framework for practitioners, researchers, and decision makers to explore alternative practices that promote the engagement of citizens and communities and alliances with other sectors, with an emphasis on the process and the action-oriented strategies by which health is produced [18].

As health is created largely outside the health sector, engagement in health governance, policy, and intervention development and implementation by sectors other than health is important [19]. Dahlgren and Whitehead's model, also called the social determinants of health model or the rainbow model, is frequently used to show how individual health is affected by various determinants [20].

The main influences or determinants of health can be seen as a series of layers: individual lifestyle factors, social and community networks, material and social conditions in which people live, and, overall, the general socioeconomic, cultural, and environmental conditions (Fig. 1.2) [21]. The individual is placed in the centre, characterised by factors that mostly cannot be controlled, like age, sex, and genetic factors. Importantly, this model focuses on health, rather than on the causes of diseases. The determinants can be health-promoting, protective, or health-damaging risks [21]. The layers of influence interact with one another and can be translated into levels for (policy) interventions.
This explicitly emphasises that the promotion of health is a joint responsibility of all relevant sectors and that intersectoral collaboration is essential [22, 23].

Nonetheless, up till now, behaviour change approaches have been dominant in health promotion programmes, despite limited effectiveness, particularly in reducing health inequalities [13]. Behavioural approaches to health promotion are based on theories of behavioural change and health behaviour stemming from social psychology, such as social cognitive theory [24] or the theory of reasoned action and planned behaviour [25]. Although some of these theories do take the potential influence of wider social factors into account, the main focus is on individual action and choice as the key mechanisms for improving health behaviour [26]. The idea that providing people with knowledge of health risks and benefits will lead them to change their unhealthy behaviour sounds logical, and certainly in some circumstances behavioural strategies can influence individual health behaviour. In fact, the modest successes of behaviour change in health promotion programmes have been achieved by people who have access to a range of social and

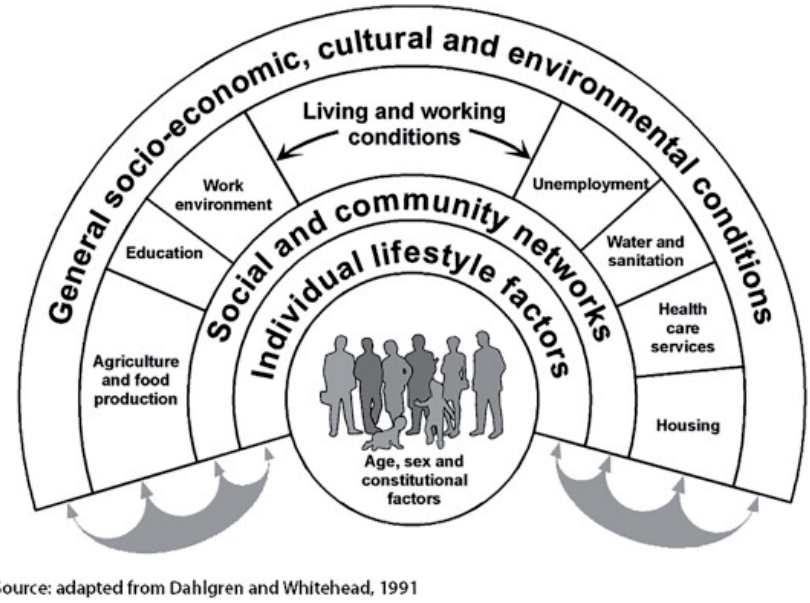

Fig. 1.2 The social determinants of health proposed in Dahlgren and Whitehead's model.

economic resources (high SES), and indeed the successes may possibly have led to an increase in health differences [27, 28]. Baum and Fisher asked: 'Why does behavioural health promotion endure despite its failure to reduce health inequalities?' and found a variety of reasons [29, p.1]. Historically, health education focuses largely on chronic diseases or conditions that result from poor individual lifestyle choices, e.g., smoking behaviour or unhealthy diets. From the disease perspective, it is an easy step to see chronic conditions as preventable through lifestyle changes encouraged by behavioural messages. Moreover, the neoliberal movement in politics and policy in several Western countries, including the Netherlands, is accompanied by individualism, privatisation of public organisations, and reduced welfare programmes. The dominant biomedical model of disease and treatment on which most health policy is based also reinforces individualism and directs most resources to medical services and research. Thus, health promotion programmes that directly target behaviour linked to chronic conditions have been normalised and have easily gained public acceptance. In addition, time-limited interventions with short-term measurable outputs aiming at behaviour change fit more easily with demands for evidence-based policy.

Addressing the social determinants of health requires policies that change the conditions in which people make their unhealthy choices. This is very complicated for politicians and other stakeholders because it requires policy domains and sectors other than health to be influenced, involves legislation and regulation, and needs a long-term vision and action programme, see also Table 1.1. Furthermore, the impacts of the use of legislation and

long-term community health promotion are harder to measure [30]. In the 2012 strategic review of health inequalities in England post-2010 'Fair society, healthy lives', Marmot underlines the importance of addressing the social determinants of health. He states that 'the link between social and environmental conditions and health have been convincingly demonstrated and should therefore become the main focus of public health policy and health promotion action, not health care and unhealthy behaviours' [31, p3].

Changing the broader determinants of health fits with social practice theory. In this theory, health and wellbeing are considered to be outcomes of participation in a set of social practices, commonly created by the reality of everyday life [32]. A social practice is defined as constituted by meanings about how and why to do things (cultural conventions, expectations, and socially shared meanings), materials (objects, tools, and infrastructures), and competences (both knowledge and embodied skills) [33]. In the attempt to understand why people living in low SES neighbourhoods are less likely to engage in healthy behaviours, it is suggested that the focus should be on the social factors that lead people to behave in different ways and how these social factors interact with the (un)healthy behaviours. In other words, this means broadening the established concept of individual health behaviour to a contextualised understanding of health practices and a switch from focusing

Table 1.1 Overview of the main characteristics of behaviour change approaches and social determinants of health approaches. Based on [13, 24, 26, 27, 29–31]

BEHAVIOUR CHANGE APPROACHES	SOCIAL DETERMINANTS OF HEALTH APPROACH
Biomedical model of disease, or disease perspective	Socioecological model, or health perspective
Focus on prevention of chronic diseases that result from poor individual lifestyle choices, e.g., smoking behaviour or unhealthy diets	Focus on promotion of health, influenced by individual lifestyle factors, social and community networks, material and social conditions in which people live, and overall socioeconomic, cultural, and environmental conditions
Theories of behavioural change stemming from social psychology, such as social cognitive theory or the theory of reasoned action and planned behaviour	Theories, for example, social practice theory, ecological model, theory of change, systems thinking
Individual action and choice as the key mechanisms for improving health behaviour	Policy interventions as well as health-promoting actions at different levels, from local to national
Providing knowledge of health risks and benefits to influence behaviour	Supportive environments, citizen participation, and intersectoral collaboration as mechanisms or action principles to promote individual and community health
Predominantly in health care and public health sector	Joint responsibility of all relevant sectors inside and outside healthcare
Evaluation methods: RCT, large-scale surveys	Mixed methods, including participatory action research (PAR)

on health inequalities in outcomes to health inequalities in conditions [34]. Regarding health behaviours as social practices rather than just individual behaviour fits well with the community approach focusing on social change, instead of attempting to change what is referred to as individuals' ABC (attitudes, behaviours, choices) [35].

1.4 Principle-based community health promotion

Community health promotion programmes (CHPPs), based on a socioecological perspective, are promising for increasing health and the equity of its distribution [36, 37]. The health promotion approach applied in such programmes should be based on action principles that align with the Ottawa Charter, such as citizen participation and intersectoral collaboration. Action principles can be defined as actions, processes, or mechanisms that help establish the effect or impacts of a health promotion programme. They moderate the relation between the social environment and health-predicting mediators and are used as entry points to make the social environment of health researchable and manageable by communities [38].

Citizen participation

Citizen participation, described as the active involvement of citizens, or members of the priority population, in the articulation of the problem and in the development, implementation, and evaluation of health-promoting interventions, is regarded as central in an effective multilevel-strategies approach [30, 39, 40]. The reasons for the importance of citizen participation are numerous and include democratic, instrumental, and educational arguments [41]. Democratically, citizen participation is advocated as a tool for providing a voice to the voiceless [42]. The instrumental argument is that active citizen involvement increases the effectiveness of health promotion programmes by connecting with the existing local situation, informal networks, and cultural aspects [43, 44]. Educationally, citizen participation enables people to contribute to solving a personal or a societal problem, it can increase meaning and awareness of, and responsibility for, health behaviour, and it can also increase feelings of self-esteem and competence [45]. Finally, the involvement of a group or community in health promotion initiatives may result in their having greater control in making decisions and performing actions regarding their own health and in achieving healthier, sustainable lifestyles [46, 47]. The arguments described here show that citizen participation is inextricably linked with empowerment, which is defined as the process by which people acquire influence on their personal life [48]. Empowerment is one of the main elements in the definition of health promotion [17].

Intersectoral collaboration

Another core element of implementing a CHPP is intersectoral collaboration: building and strengthening networks within healthcare sectors and between health and other societal sectors [22, 23, 38]. Policy changes in public health, care, and social support in recent years have led to intersectoral partnerships and to local-level community engagement becoming even more important [49]. Intersectoral collaboration requires the engagement of partners from different sectors, identification of opportunities for collaboration, negotiation of agendas, mediating different interests, and promoting synergy [50]. However, collaboration in coalitions and networks can be challenging and does not develop just because it is needed. A broker role can be helpful in facilitating the building and maintenance of collaboration, for example by exchanging knowledge between stakeholders [51–53]. Brokers can add considerable value to a coalition or network by crossing gaps or boundaries, making advice and knowledge more accessible, and producing environments in which collaboration can flourish [54]. The benefits of a broker role, especially in health promotion, lie in connecting stakeholders from health and non-health sectors with citizens, and subsequently stimulating an integrated community approach to address health inequalities [55, 56].

1.5 Evaluation of a CHPP: participatory action research

CHPPs pose challenges for evaluation, as it is necessary to consider the complexity of the approach. The research has to demonstrate that taking into account processes, values, and action principles in CHPPs does result in better health and/or more equitable health distribution [57, 58]. PAR is recommended, as it reflects the values of health promotion, such as participation and empowerment, and it facilitates the development of capacities and learning, thus contributing to health [59–62]. PAR is process oriented and aims to involve all stakeholders, including citizens with a low SES, thereby capturing the different perspectives of citizens and professionals [63–65]. The combination of applying research methods for evaluation and facilitating action enables those involved to continually optimise their strategies and working practice. It contributes to developing both theories and research methods to understand and explain what works and why it works.

1.6 Health promotion strategies in the Netherlands

In the mid-1990s, systematic research into the problem of socioeconomic inequalities in health in the Netherlands was commissioned by the Dutch Ministry of Health. The focus of policies and research was on measures and interventions targeting socioeconomic disadvantages on the one hand and on interventions targeting accessibility and healthcare

services on the other hand [66]. In the early 2000s, researchers and policy advisors advocated a Health in All Policies (HiAP) strategy, in which policies from ministries inside and outside the public health domain became involved in public health problems, because this was assumed to be more effective for addressing socioeconomic inequalities in health [6, 67]. However, before 2011, socioeconomic health inequalities and addressing the social determinants of health received only limited attention in the national public health policy documents that are published every four years. Consecutive national policy documents, such as 'Live longer and healthier. Also a matter of healthy behaviour' [68] and 'A choice for healthy living' [69], focused on reducing chronic diseases, with prevention and promotion of healthy lifestyle interventions as main themes and areas of action. With the national health policy 'Health close to people (2011-2015)' [70] published in 2011, a change was made to local policy, emphasising intersectoral collaboration and community interventions. The current policy document, entitled 'Health broad on the agenda. National health policy 2020-2024' [71], addresses health inequalities explicitly as a complex problem to which a HiAP approach should be adopted. The municipalities are regarded key in the implementation of the policy intentions. Since 2014, the Ministry of Health has facilitated Dutch municipalities to reduce health inequalities locally with specific subsidies and a national support programme called 'Within health' [72].

Another important aspect of current national and local health policies in the Netherlands is the use of a broad view on health, in which health is defined as the ability to adapt and self-manage in the face of social, physical, and emotional challenges [73]. This positive health concept is dynamic and is not about a person's disabilities, but rather about what that person can do, finds important, and possibly wants to change. Moreover, it is not only about the physical aspects of health, but also about wellbeing, self-direction, resilience, participation, and meaning. Using this concept in their working practice stimulates professionals and policy officers to look beyond the boundaries of their own organisation or domain. It facilitates collaboration between different local and regional stakeholders, e.g., care, welfare, and sports organisations, health insurance companies, and municipalities.

In line with these developments, community health promotion and local health programmes have attracted growing interest in the Netherlands. During the 1990s, accompanying the Healthy Cities movement [74], community health promotion programmes were executed in several Dutch cities, e.g., the SUPER project [75], but not much research was published [76, 77]. Recently, the WRR calls for a new perspective in policies that aim to reduce health inequalities by shifting focus from differences in health to health potential [9]. In the past years, evaluation studies of community health promotion programmes aimed at reducing health inequalities have been boosted – among other things – by several subsidies from ZonMW [78] and FNO Healthy Future Nearby, a programme with over 40 local programmes to reduce socioeconomic health inequalities [79].

1.7 Setting: a case study in a socioeconomically deprived city district in the Netherlands

From July 2016 to December 2019, a community health promotion programme called Voorstad on the Move (VoM) was implemented in a socioeconomically deprived city district of 10,750 inhabitants in a city in the east of the Netherlands. In this city district, both the SES and the health status of inhabitants are relatively low compared with other parts of city [80]. In line with national and local policy objectives, the aim of the programme was to contribute to the improvement of health on the one hand and to find ways to reduce health inequalities on the other hand.

A preparatory study was conducted from October 2015 to February 2016 to get an impression of the health situation in Voorstad in order to decide on programme goals and methods. The preparatory study consisted of focus groups with citizens and interviews with professionals from various disciplines about health and health behaviours. These qualitative data were supplemented with quantitative data from health monitors [81] and the local citizens' survey [82]. An important finding of the preparatory study was the presence of a comprehensive infrastructure of public, welfare, and social support, sports and care organisations, community centres, and (informal) networks in which both professionals and inhabitants collaborated [83]. Moreover, a discrepancy was found in perceptions on health and wellbeing between inhabitants – who barely mentioned unhealthy lifestyles, e.g., obesity and smoking, in relation to health – and professionals who focused on lifestyle and healthy behaviours when talking about health. This highlighted the need to include citizens' perceptions in health promotion activities [84–86]. The Voorstad inhabitants' viewpoints were the starting point for VoM, thereby giving the inhabitants ownership to address health in a positive way, focusing on assets and resources [87]. This means that the programme activities were not chosen or planned beforehand, but rather developed and implemented as a result of questions and needs expressed by Voorstad inhabitants. The preparatory study confirmed the choice to take citizen participation and intersectoral collaboration as action principles in the community health promotion programme. The VoM programme was financed by FNO, a Dutch wealth fund for health, quality of life, and future perspective [79].

1.8 Purpose of this thesis

The overall research aim was to study and understand the impact of a community health promotion programme on health and health-supportive environments and the working of the action principles in that programme. Therefore, four interrelated research questions (RQs) were formulated:

1. How do Voorstad inhabitants perceive health and health-supportive environments?
2. What benefits do citizens who participate in the Voorstad on the Move programme observe in terms of perceived health, lifestyle, and empowerment?
3. What factors and mechanisms contribute to citizen participation and intersectoral collaboration?
4. What is the overall impact of the Voorstad on the Move programme in terms of health promotion activities, social and physical environment, and inhabitants' perceived health?

Outline of the thesis

This thesis contains six chapters based on the studies executed to find answers to the research questions. Table 1.2 presents an overview of the research questions and the corresponding chapters. Research questions 2 and 3 have been swapped to match the order of chapters in this thesis more logically.

In **Chapter 2** the study protocol is presented with a description of the study setting, the VoM community health promotion programme, and the theoretical framework. The logic model for the impact evaluation, as well as the design of, and methods used in, this thesis are described here.

Table 1.2 Overview of research questions and chapters

RESEARCH QUESTION	CHAPTER
RQ 1. *How do Voorstad inhabitants perceive health and health-supportive environments?*	***Chapter 3.*** *'We don't assume that everyone has the same idea about health, do we?'* Explorative study of citizens' perceptions of health and participation to improve their health in a low SES city district
RQ 2. *What factors and mechanisms contribute to citizen participation and intersectoral collaboration?*	***Chapter 4.*** Intersectoral collaboration in a community health promotion programme; building a coalition and networks ***Chapter 5.*** Unravelling mechanisms underlying the action principles of a community-based health promotion programme: a realist evaluation in a low SES city district in the Netherlands
RQ 3. *What benefits do citizens who participate in the Voorstad on the Move programme observe in terms of perceived health, lifestyle, and empowerment?*	***Chapter 6***. Perceived benefits of active participation in a community health promotion programme
RQ 4. *What is the overall impact of the Voorstad on the Move programme in terms of health promotion activities, social and physical environment, and inhabitants' perceived health?*	***Chapter 4.*** Intersectoral collaboration in a community health promotion programme; building a coalition and networks ***Chapter 5.*** Unravelling mechanisms underlying the action principles of a community-based health promotion programme: a realist evaluation in a low SES city district in the Netherlands ***Chapter 6.*** Perceived benefits of active participation in a community health promotion programme ***Chapter 7.*** Overall impact of the Voorstad on the Move programme in terms of programme outputs

RQ 1 is addressed in **Chapter 3**, which describes an explorative study of citizens' perceptions of health and participation to improve their health using a concept mapping method.

The answers to RQ 2 about the citizen participation and intersectoral collaboration action principles are presented in Chapters 4 and 5. Intersectoral collaboration within the VoM coalition and with a communitywide network was studied using PAR. The findings of this study are presented in **Chapter 4,** followed by **Chapter 5**, in which a realist evaluation approach, used to unravel mechanisms underlying the action principles of the community health promotion programme, is described.

RQ 3 is discussed in **Chapter 6** describing the findings of a mixed-methods study using a small-scale survey and in-depth interviews to gain insights into the perceived benefits of active participation in the community health promotion programme.

In **Chapter 7**, an overview of the outputs generated by the VoM programme as part of the programme's overall impact is presented.

Finally, **Chapter 8** summarises and integrates the findings from the previous chapters. Subsequently, the key insights are reflected upon, and implications for health promotion practice and policy in reducing health inequalities and suggestions for future research are presented.

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Chapter 2

Study protocol: evaluation of a community health promotion program in a socioeconomically deprived city district in the Netherlands using mixed methods and guided by action research

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Abstract

Background: Voorstad on the Move (VoM) is a community health promotion program implemented in a socioeconomically deprived city district in the Netherlands. Based on exploration of the health situation, concurrent views on health promotion, and insights from literature, VoM is grounded in a social-ecological perspective and puts three action principles center core: citizens' participation, intersectoral collaboration, and a health supportive environment. VoM aims to improve the health of inhabitants, mostly low socioeconomic status (SES) families, and to realize changes in the social and physical environment. This current research, as part of the wider VoM project, aims to study the impacts and action principles of VoM. The main research questions concern the inhabitants' perceptions on health and health supportive environments, the perceived benefits of citizen participation in terms of health literacy and empowerment, and the factors and mechanisms that contribute to citizen participation and intersectoral collaboration.

Methods: The study has a mixed methods design, including process evaluation and monitoring, and combines qualitative and quantitative data. Research activities include literature study, in-depth interviews, focus group discussions, concept and capacity mapping, document analysis, and health survey data. A prominent strategy is action research, which aims to involve all stakeholders, capturing the different perspectives of citizens and professionals, and engaging low SES groups. The principle of triangulation is continuously applied to optimize the reliability of this study, using multiple methods and multiple sources. Internal validity is enhanced by triangulation of methods and resources. Other verification techniques will also be used, such as expert consultation.

Discussion: The design of the study, with a strong focus on action research, facilitates the involvement of all stakeholders and contributes to the development of capacities, learning, and empowerment, and thus contributes to health. The VoM program is innovative because it adopts an open approach in which activities evolve from citizens' needs, with a focus on action elements. This study will unravel the mechanisms of the action elements at community level, thereby helping to find ways to reduce health inequities. The findings will further elucidate what works and why it works for low SES groups.

2.1 Background

In the Netherlands, less educated inhabitants live – on average – six years less than most educated people, and the difference in healthy life expectancy between these groups is almost 19 years [1]. Although the healthy life expectancy of less educated people has increased considerably in the last decade, the difference in life expectancy between the two groups has remained the same [1].

Health inequities are a complex problem caused by the interplay between individuals, groups, communities, and multiple factors in the social, physical, and economic environment [2–5]. To date, health promotion programs have not been successful in substantially reducing the health gap between the higher and the lower socioeconomic groups. It is therefore a challenge to develop more effective strategies [6–10]. These strategies should be based on an ecological perspective, addressing factors at multiple levels and looking at the interaction between factors [11–13].

Such strategies are being developed in the community health promotion program called Voorstad on the Move (VoM). In line with national and local policy objectives, the aim of the program is to contribute to the improvement of health and to find ways to reduce health inequities [14, 15]. The program is being implemented in four socioeconomically deprived neighborhoods in a city district of 10,750 inhabitants in a city in the east of the Netherlands between July 2016 and January 2020. In Voorstad, both the socioeconomic status (SES) and the health status of inhabitants are relatively low compared with other parts of city [16].

Casus: Community health promotion program 'Voorstad on the Move' (VoM)

VoM is grounded in a social-ecological perspective, based on the exploration of the health situation in Voorstad, concurrent with views on health promotion and insights from the literature [17–21]. VoM puts three action principles at its center: citizen participation, intersectoral collaboration, and a health supportive environment, that that were emanated from the results of an preparatory study (Oct–Dec 2015) [22].

The aim of the preparatory study was to get an impression of the health situation in Voorstad in order to decide on the program goals and methods. This preparatory study consisted of seven focus groups with citizens (n=40) and 30 interviews with professionals from different disciplines about health and health behaviors. Overall, the top three most mentioned aspects of health were: feeling at ease (no stress), being in control, and being together with friends, family, and neighbors (joint activities). There was a clear focus on health as an asset or resource for meaningful living [23, 24]. The inhabitants barely mentioned unhealthy lifestyles, e.g. obesity and smoking, which are the focus of professionals and of the data in

monitor and health surveys. These qualitative data were supplemented with quantitative data from health monitors [25] and the local citizens' survey [26]. The discrepancy in perceptions on health and wellbeing between inhabitants and professionals emphasizes the need to include citizens' perceptions in health promotion activities [19, 20, 27].

The Voorstad inhabitants' viewpoints are the starting point for VoM, thereby giving the inhabitants ownership to address health in a positive way, focusing on assets and resources [24]. This means that activities in the program are not chosen or planned beforehand, but rather developed and implemented as a result of questions and needs expressed by Voorstad inhabitants. Citizens' active involvement and responsibility for activities strengthen their health literacy and empowerment [28–30]. Citizen participation, including defining 'health', developing, implementing, and evaluating activities with and by the citizens [31, 32], is one of the action principles in VoM.

Another important finding of the preparatory study was the presence of a comprehensive infrastructure of public, welfare, social support, sports and care organizations, community centers, and (informal) networks and alliances in which both professionals and inhabitants collaborate [22]. Intersectoral collaboration [33–36] between primary care, social services, and environmental, policy, and public health workers is therefore a second action principle of the program. VoM joins and uses the existing social infrastructure to add the broader view on health and bring in knowledge to make health promotion activities possible.

Both inhabitants and professionals mentioned barriers that hinder healthy living and keep them from changing behavior, such as accessibility of sports facilities and prices of healthy foods, as well as social norms, attitudes, and habits. This indicates the third action principle of VoM: creating a supportive social and physical environment for health [37–39].

These action principles can be defined as actions, processes, or mechanisms that help establish the effect or impacts of a health promotion program [40–42]. The premise of principles for action is that they contribute to health through multiple pathways and serve multiple purposes, such as program effectiveness, the creation of supportive environments for health, and empowerment of all stakeholders, both professionals and citizens [32, 43].

In July 2016, two health brokers started to support these action principles by facilitating citizens' participation in developing and implementing activities that fit citizens' needs and build healthy alliances. Recent studies show that the broker role is essential in facilitating intersectoral collaboration and exchanging knowledge between stakeholders [44–46].

The aim of the VoM program is to improve the perceived health of the Voorstad inhabitants, mostly low SES families, and achieve changes in the social and physical environment that

support health and healthy behavior. The overall research aim is to study the impacts and action principles of VoM comprehensively on different levels. This will contribute to finding ways to reduce existing health inequities. Therefore, four interrelated research questions (RQs) have been formulated:

1. How do Voorstad inhabitants perceive health and health supportive environments?
2. What benefits do citizens who participate in the Voorstad on the Move program observe in terms of perceived health, health literacy, and empowerment?
3. What factors and mechanisms contribute to citizen participation and intersectoral collaboration?
4. What is the overall impact of the Voorstad on the Move program in terms of health promotion activities, social and physical environment, and inhabitants' perceived health?

Theoretical framework

Because the VoM program is based on a social-ecological perspective on health, the theoretical framework consists of different theories and models that recognize the link between practice and context within social situations.

To study and understand impact on health and the environment on the one hand and the working of the action principles on the other hand, a framework to facilitate and evaluate a community health promotion program will be used [32, 47, 48]. This framework (Fig. 2.1) visualizes the relation between the social environment, health predicting mediators (e.g. lifestyle), and population health status (e.g. perceived health).

It provides operationalizable variables that moderate the relation between the social environment and health predicting mediators. The moderating variables are the action principles in the VoM program. Citizen participation, intersectoral collaboration, and a health supportive environment are used as entry points to make the social environment of health researchable and manageable by communities.

Social practice theory (SPT) [49], the reasonable person model (RPM) [50], and the Healthy Alliances (HALL) framework [33] are used to understand the working of the action principles comprehensively and on different levels.

SPT integrates the individual with his or her social environment and will be used to study the mechanisms of citizen participation and health behaviors. In contemporary theories of social practice, health and wellbeing are considered to be outcomes of participation in

Fig. 2.1 Framework to facilitate and evaluate community health promotion [48]

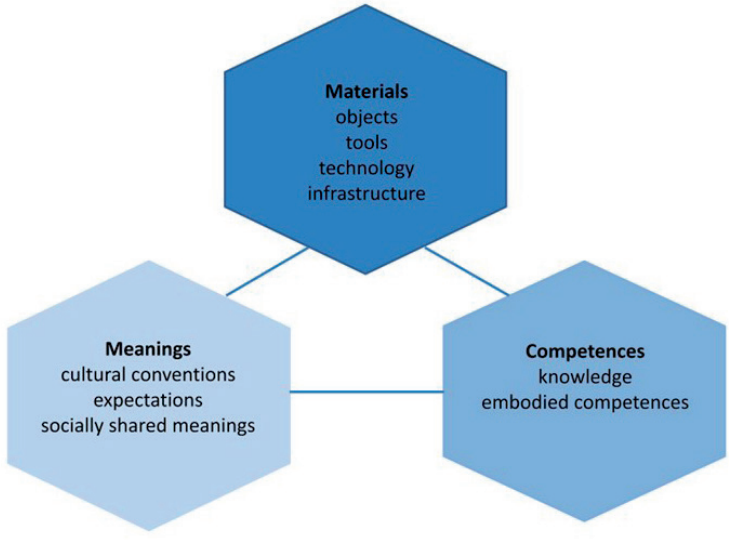

Fig. 2.2 The elements of a social practice. Adapted based on Shove et al. [51]

a set of social practices, commonly created by the reality of everyday life [49]. Following Shove et al [51], a practice is defined as being constituted by meanings about how and why to do things (cultural conventions, expectations, and socially shared meanings), materials (objects, tools, and infrastructures), and competences both tacit and explicit (knowledge and embodied skills) (Fig. 2.2). In this study, participation and health behaviors will be regarded as social practices rather than only individual behavior, because they fit with the community approach focusing on social change, instead of attempting to change what Shove et al [51] refer to as individuals' ABC (attitudes, behaviors, choices).

The RPM is a conceptual framework that links environmental factors with human behavior [50].
People are more reasonable, cooperative, helpful, and satisfied when the environment supports their basic informational needs. The same environmental supports are important factors in enhancing human health. Reasonableness is used, rather than well-being, because it focuses on bringing out the best in people. Central in the RPM is the management of information, either visual or written, indicating that people are more reasonable when their informational needs are met [52].

The RPM consists of three domains: building mental models, meaningful action, and being effective (Fig. 2.3). Mental models influence our perception of what is going on and guide our actions. Meaningful action implies that people feel listened to and respected, even if their wishes are not met. The sense that one is making a difference can go a long way towards bringing out the best in one [53]. Being effective concerns effectiveness and reasonableness, because of mental fatigue. It is about a particular aspect of mental functioning described as directed attention, caused by the many complex and competing demands in one's environment. The RPM framework will be used to study the way in which

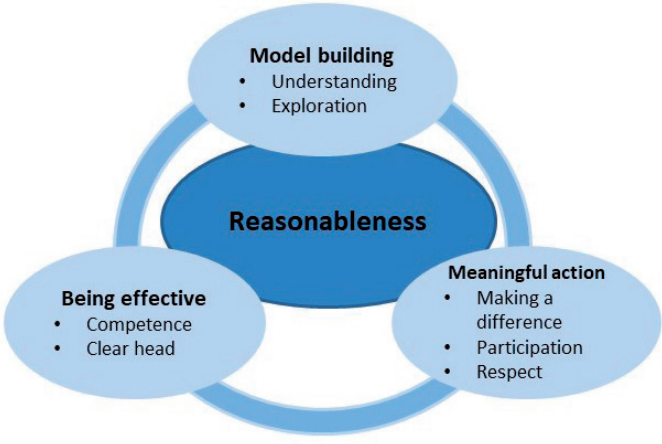

Fig. 2.3 The Reasonable Person Model [52]

the physical environment can be health supportive to the inhabitants. Both SPT and RPM put great importance on the interaction between the environment and the behavior of an individual. They are complementary, as SPT focuses on the social environment and RPM on the natural (physical) environment.

Within the extended network that exists in Voorstad, intersectoral collaboration is facilitated by a small steering group of partners from the healthcare and societal sectors, with health brokers as essential participants. This group can be regarded as the healthy alliance. The updated HALL framework, will be used to study intersectoral collaboration within the healthy alliance in VoM (Fig. 2.4).

This framework recognizes three groups of factors – institutional factors, (inter)personal factors, and the organization of the alliance – that can either facilitate or hamper the collaboration between the partners in the alliance [33]. The updated HALL framework visualizes the importance of context and learning culture in intersectoral collaboration [54].

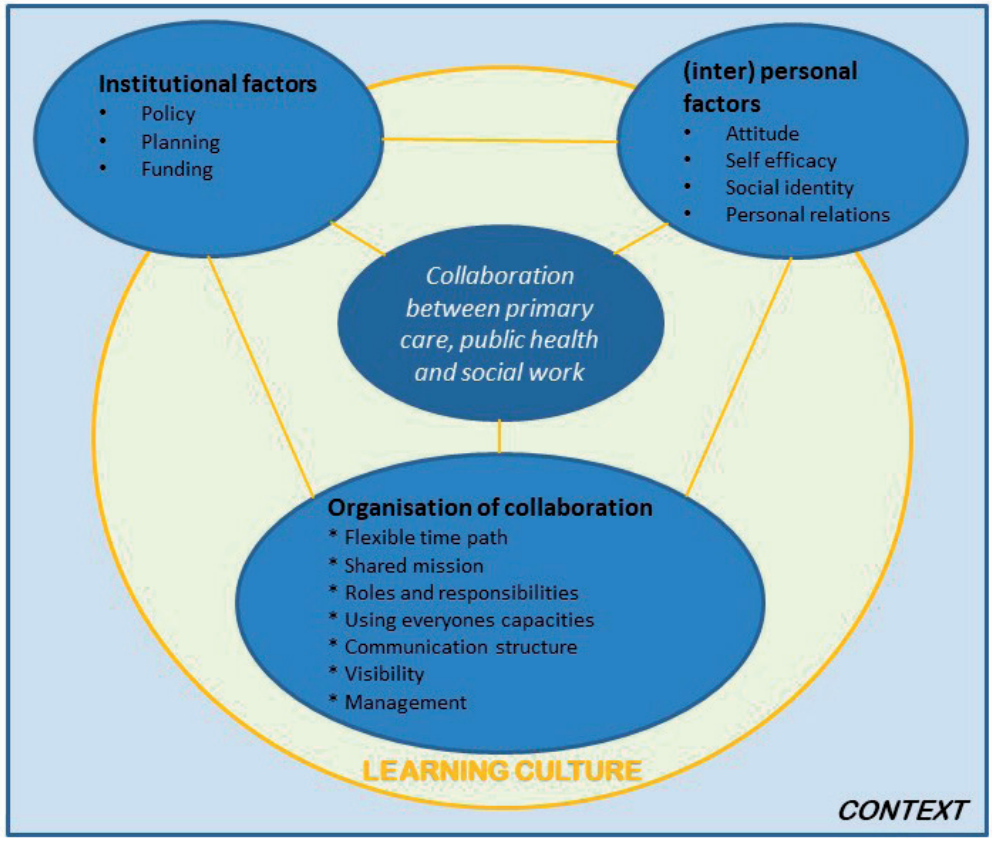

Fig. 2.4 The updated Healthy Alliance framework [54]

2.2 Methods/design

Study design

The study will use a mixed-methods design and will combine qualitative and quantitative data. The research activities will include literature study, in-depth interviews, focus group discussions, concept and capacity mapping, document analysis, and analysis of citizens' survey data (Table 2.1).

The use of multiple strategies and multiple research methods across multiple levels is assumed to be the most effective approach. The combination of information from multiple sources and methods – triangulation –increases data validity [61]. Also, partners and citizens will be involved in the planning of the research as well as in different research activities.

A prominent strategy is action research, which aims to involve all stakeholders, capturing the different perspectives of citizens and professionals and engaging citizens with low SES. The value of action research is that it reflects the values of health promotion, such

Table 2.1 Study overview – frameworks, methods, tools, participants, and repeats

Research question	Framework	Methods	Tools	Participants	Repeats
RQ1. Perceptions	SPT RPM	Interviews Photography	Focus groups Photovoice [55, 56]	100 inhabitants 32–40 inhabitants	1 2
RQ2. Participation	SPT	Literature study Interviews Questionnaire Document analysis	Pretty's participation ladder [34] Empowerment checklist [57] Health literacy questionnaire (HLS-EU-Q) [58]	100 inhabitants	2
RQ3. Mechanisms	HALL Framework	Document analysis Interviews Checklist	Coordinated action checklist [48] Participatory network mapping tool (PNMT) [59] Network analysis tool [59]	12 professionals 6–8 network partners	3 3
RQ4. Overall impact	Logic Model	Literature study Questionnaire Interviews Document analysis	Activities database Photovoice [55, 56] Citizens' survey (2 yearly) [16] Health monitor (4 yearly) [60]	 32–40 inhabitants Representative sample of 600 inhabitants	1 2 3

Abbreviations: HALL: Healthy Alliance; HLQ: Health Literacy Questionnaire; RPM: Reasonable Person Model; PNMT: Participatory network mapping tool; RQ: Research Question; SES: Socioeconomic Status; SPT: Social Practice Theory; VoM: Voorstad on the Move

as participation and empowerment [6, 62–64]. It thereby facilitates the development of capacities, learning, and empowerment [4] and thus contributes to health [65]. It also enables those involved to continually optimize their strategies [59, 66, 67], and it contributes to developing both theories and research methods to understand and explain what works and why it works.

To operationalize, and to provide insights into, factors relevant to addressing the RQs, the logic model, based on the framework for planning, implementation, and evaluation of health promotion programs [68], will be used (Fig. 2.5). This logic model will help to make explicit the hypothesized pathways; to define processes, output, and outcome indicators at different levels (individual, professional, and community); and to unravel action elements [32, 69].

Fig. 2.5 illustrates the logic model for the impact evaluation of VoM, based on literature on community-based approaches [6, 32, 69] and evaluation studies of complex community health promotion programs [69]. The hypothesis is that a community-based participatory approach to developing and implementing health activities at different levels such as individuals, professionals, and community will result in improved perceived health, a health supportive environment, and sustainable local health policy, leading to a reduction in health inequities in the long term. These long-term expected outcomes will be preceded by measurable short-term outcomes like e.g. health literacy, healthy alliances, and changes in the physical environment, moderated by the action principles. In this model, citizen participation, intersectoral collaboration, and a health supportive environment are defined as program outcomes and, at the same time, are action principles in this principle-based health promotion program [32]. The operationalization of each of the four research questions is now set out.

Research question 1. How do Voorstad inhabitants perceive health and a health supportive environment?

Perceptions on health and health supportive environments will be measured using focus groups and photovoice.

a. Collecting and discussing the perceptions and priorities of the inhabitants about health is the starting point for citizen participation in the VoM program. At the start of the program, focus groups will be held with 15 existing groups of inhabitants to explore perceptions and meanings about health [70, 71]. Results of the first focus group session will be fed back to, and discussed, with the same group in a second session. Participants are challenged to think of actions and plans to work on their own health. In total, about 100 inhabitants will participate in this research study.
b. Photovoice will be used to reveal inhabitants' perceptions of their neighborhood as a source of health opportunities or barriers [55, 56, 72]. In total, 32–40 inhabitants (8–10

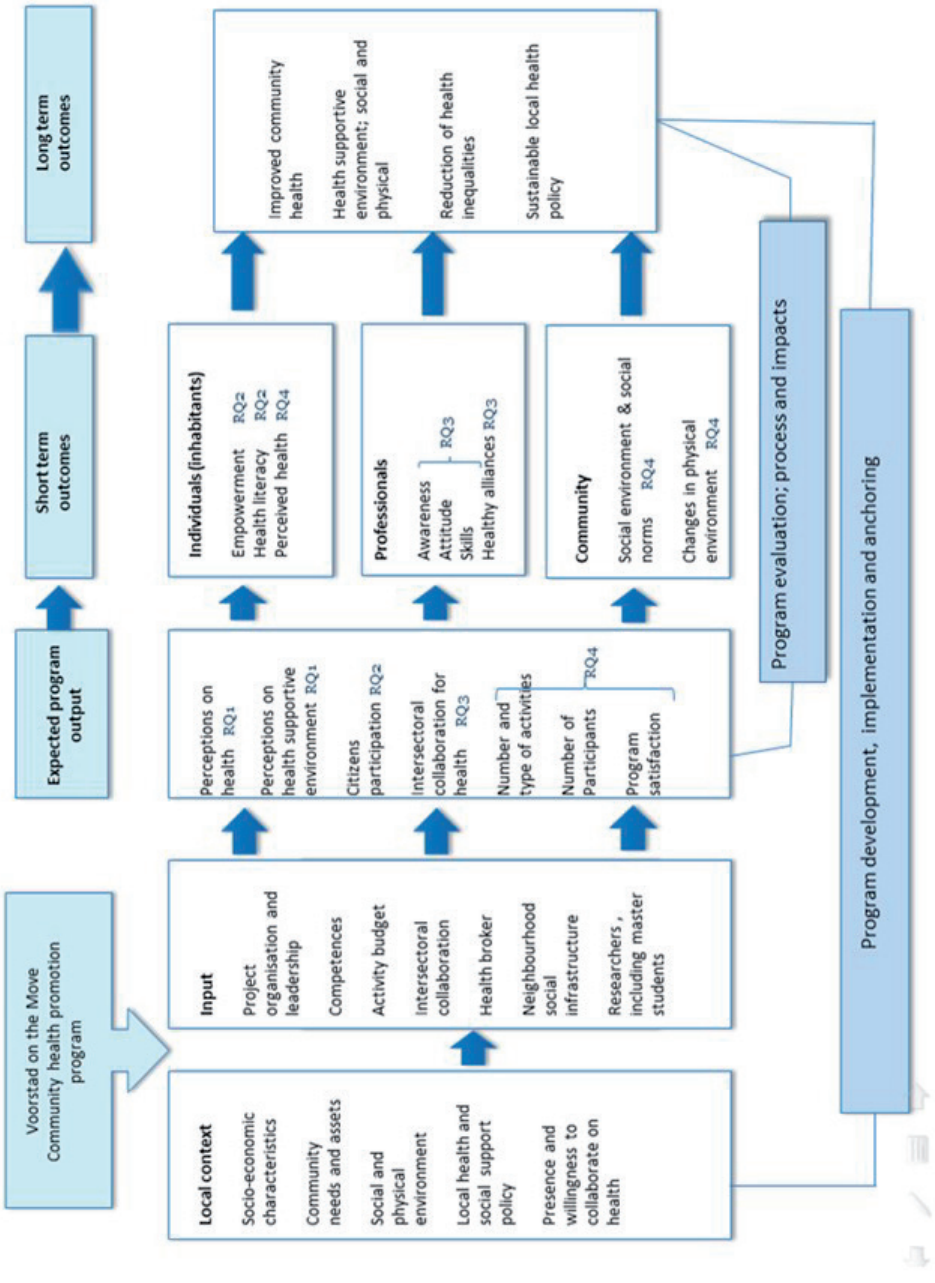

Fig. 2.5 Logic model used for evaluation of Voorstad on the Move. Adapted based on Saan & Haes [68]

from each of the four neighborhoods) will be asked to tell 'the story of the photo or image'.

Research question 2. What benefits do citizens who participate in the Voorstad on the Move program observe in terms of perceived health, health literacy, and empowerment?

Active participation in health promotion activities, varying from consultation and collaboration to partnership or ownership, can either result from the focus groups or otherwise be initiated by the VoM health brokers or collaborating partners. A total of 100 inhabitants who either participate in focus groups (RQ 1) or are involved in community activities will be 'followed' during the program. They will be asked about their way and level of participation using Pretty's participation ladder [34, 73], health literacy using the 9-item Health Literacy Questionnaire (HLQ) [58, 74, 75], and empowerment using the Netherlands Empowerment Checklist [57, 76]. Perceived health is assessed based on the question on self-perceived health: 'How is your health in general', which contains five answering categories; 1) very good, 2) good, 3) fair, 4) bad, and, 5) very bad. This question is part of the citizens' survey which takes place every two years in Deventer [16] and of the Health Monitor conducted by the Municipal Health Services in the Netherlands [77]. Subsequently, in-depth interviews and focus groups will be held to discuss citizens' perceptions on the connection between participation, perceived health, and empowerment.

Research question 3. What factors and mechanisms contribute to citizen participation and intersectoral collaboration?

The HALL framework will be used to study the intersectoral collaboration and active involvement of stakeholders and to identify conditions that contribute to the collaboration and make these alliances successful [33, 54] [Fig. 4]. A special focus will be placed on the role of health brokers, as these seem to be crucial for connecting different sectors [78]. The Coordinated Action Checklist [48] will be used to evaluate and facilitate the collaboration of the core stakeholders, members of the Voorstad social team, the neighborhood manager, health brokers, and the program coordinator. The results of the checklist on various dimensions, such as task, relations, growth, and visibility, will be discussed with this core group. These evaluation sessions will be held once a year, in total three times.

A document analysis of all the reports, plans, and notes produced by the project team will be used to describe the collaboration processes that have taken place. Furthermore, a network analysis [35, 59] will be conducted to map the collaborating organizations – community centers, schools, grassroots organizations, and neighborhood sports club – that take part in the program irregularly and on a less structured basis. Five to 10 organizations will be interviewed twice (2018 and 2020) to get insights into the impact of VoM, the collaboration processes [79], and the health broker role.

Research question 4. What is the overall impact of the Voorstad on the Move program in terms of health promotion activities, social and physical environment, and inhabitants' perceived health?

Results and outcomes of the program will be measured on different levels: individual, professional, and community [Fig. 5]. At the individual level, perceived health, lifestyle, and health behaviors have been or will be measured in the local citizens' survey every two years (2015: T0; 2017: T1; 2019: T2) [16]. Additionally, the health monitors [60] carried out in 2016 and 2020 will provide more detailed information on the health status of the city district, Voorstad. In both surveys, citizens' health and lifestyle data are monitored at neighborhood level.

The program activities are monitored in a so-called activity database. The number and type of health promotion activities developed with citizens' involvement and the number of participants per activity will be registered, thereby monitoring the program output. Citizens who participate in the program activities will be asked about their satisfaction.

In order to map changes in perceptions of the social and physical environment, the photovoice study (RQ1) will be repeated in 2019.

Qualitative research data from interviews and focus group discussions will be audiotaped, transcribed, and analyzed using Atlas-ti to manage the data and guarantee transparency. A coding scheme based on theory and the framework will be developed to analyze the qualitative data stepwise, data driven, and thematically. Top-down as well as bottom-up coding will be used. The top-down coding will use predefined codes based on factors mentioned in the theoretical models: the HALL framework, SPT, and RPM. The bottom-up coding (free coding) will trace general themes that emerge in interviews and focus groups. In this way, relevant topics devised in advance of the study design and relevant topics from practice will be fully mapped. These themes will make it possible to interrelate and interpret the gathered data [80].

Quantitative data will be analyzed by descriptive statistics and regression analysis techniques using the SPSS program. In the analysis, quantitative data obtained to measure changes in perceived health (RQ4) will be combined with qualitative data on participation, empowerment, and health literacy (RQ 2), with data at professional level – short-term outcomes realized by the healthy alliances and health brokers (RQ 3), and with data at community level – the social and the physical environment (RQ1).

The impacts on the different levels will be integrated and related to the action principles using realist synthesis [81] in the data analysis, facilitating the identification of the contextual factors and program mechanisms determining the outcomes (or impacts).

These context–mechanism–outcome (CMO) configurations [18] will provide insights into the overall impacts in relation to the action principles.

Sample size and power

The perceived health of adult inhabitants in the neighborhood will be used as the primary outcome of the VoM program at the individual level. In line with common practice in presenting perceived health prevalence rates, response options for self-perceived health will be dichotomized, with the response categories 'very good' and 'good' into one 'very good or good' category and the other response options in a 'less than good' category [82]. In 2015, the percentage of inhabitants in the city of Deventer scoring (very) good health was on average 79 %, whereas this was 75% for the city district Voorstad [16]. Therefore, the estimate of the effect size of perceived health to be obtained by implementing the VoM program was determined by the difference between Voorstad (0.75) and the city of Deventer (0.79): 0.04. The sample size calculation was conducted with G*Power version 3.1.9.2. with alpha set on 0.05, and a power of 0.80. The used test family was exact and based on the difference from a constant (0.75). The required lower critical number of participants is 542, the required sample size is 697. The response rate of Health Monitors in general is 40 % [83]. As there are differences in response between city districts, we assume a modest response rate of 35%. The required number of participants to obtain reliable estimates of increase in perceived health is therefore 2000. The total adult population in Voorstad is 8,412 inhabitants. 2,200 Inhabitants will be invited to join the online survey, in order to be sure of sufficient power.

2.3 Discussion

Relevance

This study will evaluate the impact of a community-based health program in a socioeconomically deprived city district in order to find keys to reducing health inequities. It is a single case study in which low SES inhabitants – in the view of health professionals usually hard to reach and not very interested in health promotion activities – are actively involved. It will provide insights into perceptions, values, and needs regarding the health of low SES groups.

The VoM program is innovative as it is different from usual health promotion programs in which health subjects and activities are set by professionals. Instead, the VoM program shifts from being a pre-devised health promotion program with a set of interventions to being an open approach with a focus on action elements. Unravelling the mechanisms of these action elements – citizen participation, intersectoral collaboration at community level, and a health supportive environment – will help to find ways to reduce health inequities.

The findings will contribute to a better understanding, and will expand the knowledge, of what works for low SES groups and why it works. Other local health promotion programs can benefit from the knowledge and experiences gathered in this study.

Strengths and limitations

The study design is optimized for internal and external validity because of the combination of action research, process evaluation, and citizens' monitoring and survey data. The principle of triangulation is continuously applied to optimize the reliability of this study, using multiple methods and multiple sources. Internal validity is enhanced by triangulation of methods and resources, whereby results will be checked with other stakeholders. In addition, other verification techniques will be used, such as expert consultation.

In this study, the inhabitants' survey will be used to measure perceived health and health determinants in a pre-test/post-test design. The results obtained from these surveys will be linked with results from the intervention, the environment, and the organizational level in order to be able to explain why changes in perceived health have taken place or not.

The application of SPT, the HALL framework, and RPM provides the researcher with a strong theoretical framework and guarantees validation of the results gathered in this single case study. This study contributes to the knowledge on the benefits of citizen participation, being a necessary aspect of health promotion, and how to realize it. Recent studies [84] recommend evaluation of community participation in creating a 'health in all policies' knowledge base. Hence, the participatory action research in itself contributes to health literacy, is empowering for those who participate, and contributes to community building [27].

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Chapter 3

"We don't assume that everyone has the same idea about health, do we?" Explorative study of citizens' perceptions on health and participation to improve their health in a low socioeconomic city district

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Abstract

In community health promotion programmes that aim to reduce health inequities, citizen participation is recommended, as it strengthens citizens' active involvement and has a positive impact on health. A prerequisite for citizen participation is recognizing and incorporating citizens' perceptions on health. Therefore, this study aimed to explore these perceptions and actions needed to improve the health of citizens living in a low socioeconomic city district. Concept mapping was used to actively engage community members as part of the action research method. Eleven community groups (n=89 citizens) together with community workers participated in the study. Participants in all groups agreed that health entails more than the absence of disease, and therefore it is a multidimensional concept. Social relations, physical activity, positive life attitude, healthy eating, and being in control were important perceptions about health. Although participants were aware of the relation between lifestyle and health, actions to improve health included doing things together, collaboration, self-confidence, focusing on possibilities, and socially shared meanings. Creating a supportive environment to address health behaviour appeared to be the most important action for citizens to facilitate behaviour change. Concept mapping helped to involve citizens and provided community workers with valuable information to shape the programme together with citizens.

3.1 Introduction

In this study, the health perceptions of citizens in a socioeconomically deprived city district in the Netherlands were explored and subsequently used to develop a community health promotion programme that aimed to reduce health disadvantages [1]. Socioeconomic health inequities persist in the Netherlands, with a 7-year difference in life expectancy between people with low and high socioeconomic status (SES), and an approximate 18-year difference in years lived in good perceived health [2]. It is uncertain how these differences will develop in the near future. We know that health inequities are a complex problem caused by the interplay between individuals, groups, communities, and multiple factors in the social, physical, and economic environment [3–6]. Therefore, strategies to reduce health inequities should be based on an ecological perspective, target social determinants of health, and address factors at multiple levels and the interaction between factors [7–9]. Research on health inequities within different lifestyle groups has shown that individual health-related behaviours are bound up in activities that correspond to the person's context (habitus) combined with his/her position in social space and subjective perceptions [10]. Consequently, health promotion ought not to target the individual health-related behaviour or social participation/engagement in the neighbourhood but rather to consider the underlying drivers and their causes [11–13].

To date, health promotion programmes have not been successful in substantially reducing the health gap between citizens with a higher and a lower SES [14]. It is therefore a challenge to develop more effective strategies to reduce this gap [6, 15–18]. Health promotion, focusing primarily on lifestyle and risky behaviours, is an inadequate strategy for addressing social inequities in health [12]. Whereas citizens experience health as an integral part of everyday life, health promotion interventions often address isolated health themes or lifestyle factors, thereby focusing on the individual level [19]. Therefore, multi-level strategies are recommended, in which community participation is made central, because that in itself has a positive impact on health [20, 21]. Community participation – citizens' active involvement and responsibility for activities – strengthens health literacy and empowerment [22–24]. In addition, the inclusion of members of vulnerable populations in the articulation of the problem and the development of the programme is necessary because this takes into account the context of people's lives [25, 26] and empowers citizens to address health in a positive way, focusing on assets and resources [27].

A prerequisite for citizen participation is to recognize how citizens perceive health and the issues that are important for them regarding health and wellbeing. Studies that explored low SES citizens' perceptions on health found that how people experience and define health differs, depending on the context and the situation [28, 29]. In general, citizens with a low SES are less likely to perceive the need for lifestyle advice and participate less

often in lifestyle programmes compared to citizens with a high SES [30–32]. A possible explanation is that these programmes do not take sufficiently into account the low SES groups' perspectives on health, life, and wellbeing. Furthermore, there appears to be a discrepancy in health perceptions between citizens and health professionals [33]. Knowledge about differences in perceptions, often gleaned through questionnaires, is used by health promotion professionals to develop new interventions or to adapt existing interventions [34, 35]. Consequently, programmes are often expert driven and people do not recognize themselves, their concerns, or their problems and therefore do not see any reason to participate. Citizens do not make an active contribution to content and development, nor is their context taken into account. It is therefore recommended to be aware of these differences and to actively include citizens' perceptions and citizen participation in health promotion activities and practice [36, 37].

Therefore, the aim of the study was to explore the health perceptions of citizens in a low socioeconomic city district, together with an assessment of citizens' needs and wishes. It is the first step in the development of a community health promotion programme in the same city district, in which citizens' active involvement in programme activities is put centre core. This means that the programme's activities are not chosen or planned beforehand, but rather developed and implemented jointly by professionals and citizens, in their context, and based on the health perceptions and needs expressed by the citizens themselves. Consequently, the following research questions are formulated: What are the perceptions on health of citizens living in a low socioeconomic city district? What factors, in the perception of citizens with low SES, contribute to their health and what actions do they need to improve health?

3.2 Materials and methods

Study setting

This study is part of a larger study in which a community health promotion programme – called Voorstad on the Move (VoM) – was developed, facilitated, and evaluated [1]. In line with national and local health policy [38], the aim of the programme is to contribute to the improvement of health and to find ways to reduce health inequities [1, 40]. VoM was implemented between July 2016 and January 2020 in a city district of 10,750 inhabitants in a town in the east of the Netherlands. In this city district, both the SES and the health status of inhabitants are relatively low compared with other parts of the city [41]. The VoM programme puts three action principles at its centre: citizen participation, intersectoral collaboration, and a health supportive environment [40]. At the start of the VoM programme in 2016, a local team was formed, consisting of community welfare workers, a neighbourhood sports officer, and a health broker [42, 43]. There appeared to

be a strong and lively social infrastructure in this city district, and that was used by the health broker to join and build a network of existing community groups, healthcare and social workers, and volunteers. This was an essential part of this programme's bottom-up approach, where the community workers act to support the citizens in the identification of issues that are important and relevant to their lives, and this knowledge enables them to develop strategies jointly with citizens to resolve these issues [44]. Action research was integrated in the programme's bottom-up approach as a strategy for both facilitation and evaluation purposes. The value of action research is that it reflects the core principles of health promotion, such as participation and empowerment [15, 45–49].

Study design

To explore health perceptions in this study, the concept mapping (CM) methodology was used. CM refers to any method or structured process used to produce a picture or map of the ideas or concepts of an individual or group about a complex multidimensional problem [50–52]. The CM methodology is well-suited to actively and directly engaging community members, as one of CM's major strengths is the inclusion of participants in the interpretation and analyses of maps constructed by the mapping groups [53]. All steps (1–6) of the CM process developed by Trochim [54] were followed, together with the participants in the groups. Because of the action-oriented character of this study and the importance of citizens' involvement, all steps were conducted with citizens accompanied community workers. This is different from other studies in which steps 5 and 6 are conducted by professionals [55, 56].

Participants: recruitment and response

From April to November 2017, community workers guided the recruitment of existing community groups and accompanied them in the group sessions. The groups, which were active in community centres, elementary schools, and residents' associations, were asked to participate in two group sessions each. Every effort was made to include a wide range of citizens involved in a variety of activities (e.g. physical activity or hobby), age, sex, and ethnic background. Eleven of the 14 groups that were invited agreed to participate. Three groups refused because of a lack of interest. Four groups participated only in the first session. The reasons for not participating in a second session varied from difficulty planning (n=2), a strong variation in group composition per meeting (n=1), and lack of motivation to attend a second session (n=1). In two groups, both sessions were held during one meeting. A total of 89 citizens participated in this study, all inhabitants of Voorstad city district, varying from 4 to 11 participants per group (Table 3.1). Groups 1–5 can be characterized as activity groups, e.g. yoga or walking, 6–8 are residents' groups that gather for social interaction, and groups 9–11 consist of volunteers who work together on a specific mission, e.g. to run a community centre or a play garden.

Table 3.1 Characteristics of the community groups and participants

	Name	Participants *Total session** *1 2*			Sex	Mean age	Ethnic background	Occupational status	Educational status
1	Adolescents' group AG	11	11	-**	Male: 5 Female: 6	17 (*14–30*)	Dutch: 11	Student: 10 Employed: 1	Low: 4 Medium: 5 High: 2
2	Language group LG	10	8	7	Male: 2 Female: 8	40 (*27–66*)	Dutch: 2 Turkish: 4 Syrian: 2 Other: 3	Employed: 1 Unemployed: 8 Retired: 1	Low: 6 Medium: 2 High: 2
3	Yoga group YG	8	7	5	Male: 0 Female: 8	71 (57–79)	Dutch: 8	Employed: 2 Unemployed: 1 Retired: 5	Low: 4 Medium: 1 High: 3
4	Knitting group KG	9	8	9	Male: 0 Female: 9	73 (53–92)	Dutch: 9	Employed: 3 Retired: 6	Low: 6 Medium: 1 High: 2
5	Walking group WG	7	7	4	Male: 4 Female: 3	69 (64–77)	Dutch: 7	Unemployed: 1 Retired: 6	Low: 4 Medium: 1 High: 2
6	Residents' group A RA	7	6	4	Male: 1 Female: 6	61 (22–77)	Dutch: 3 Turkish: 3 Indonesia: 1	Employed: 1 Unemployed: 2 Retired: 4	Low: 6 Medium: 1
7	Residents' group B RB	10	10	- **	Male: 3 Female: 7	72 (57–82)	Dutch: 10	Employed: 1 Unemployed: 1 Retired: 8	Low: 8 High: 2
8	Residents' group M RM	8	4	8	Male: 5 Female: 3	47 (16–69)	Dutch: 8	Employed: 2 Unemployed: 2 Retired: 2 Student: 2	Low: 3 Medium: 3 High: 2
9	Volunteers' community centre VD	4	4	-**	Male: 3 Female: 1	69 (66–71)	Dutch: 4	Retired: 4	Medium: 2 Unknown: 2
10	Volunteers' play garden VS	6	6	6	Female: 6	37 (31–47)	Dutch: 5 East Europe: 1	Unemployed: 6	Low: 6
11	Women's group VC	9	9	- **	Male: 1 Female: 8	67 (44–87)	Dutch: 8 Polish: 1	Employed: 4 Unemployed: 1 Retired: 4	Low: 8 High: 1
	TOTAL	**89**			**Male: 24** **Female: 65**			**Employed: 15** **Unemployed: 22** **Retired: 40** **Student: 10**	**Low: 55** **Medium: 16** **High: 16** **Unknown: 2**

* The numbers of participants differed between the first and second focus group sessions
** Group did not participate in the second focus group session

Ethical approval

The project proposal was reviewed and approved by the Social Sciences Ethics Committee (SEC) of Wageningen University and Research. The Committee concluded that the proposal deals with ethical issues in a satisfactory way and that it complies with the Netherlands Code of Conduct for Research Integrity (*Date 18-10-2018*). Participants were recruited on a voluntary basis, could withdraw at any point, and were fully informed about the research activities. Oral consent was obtained from all participants.

Procedure: concept mapping

The community health promotion programme started by becoming acquainted with the existing community groups by inviting them for group interviews about health. This served two mutually reinforcing goals: 1) to gain insight into citizens' perceptions about health and important health issues and 2) to activate citizens to develop or (continue to) participate in activities that contribute to their health and wellbeing.

The group sessions took place at the meeting points of the community groups (e.g. community centre), because the participants were familiar with these places. The sessions were facilitated by trained and experienced moderators. All moderators received the same instructions and scripts. The research assistant supported, observed, and took notes during the group sessions. In addition, the health broker or another community worker was present, because they were responsible for contact with the community groups. These professionals did not participate in the discussion but did support actions that emerged from the discussions.

The CM process developed by Trochim [54] follows a six-step process of (1) preparation, (2) idea generation, (3) structuring, (4) representation, (5) interpretation, and (6) utilization [54, 57]. Two group sessions were held with each community group (Table 3.2). Steps 2–4 were covered in the first session. The second group session consisted of steps 5 and 6. The second session was planned within two weeks of the first session. Sessions lasted on average 55–60 minutes.

Step 1. Preparation step: identification of the focus for the mapping project, selection of participants, and determination of project schedule and logistics

The first step is described in detail in the recruitment and procedure sections.

Step 2. Generation of ideas through brainstorming by engaged community members

In the first session, the question, What does feeling healthy mean to you? was discussed. The moderator asked the question to the group and provided extra explanation in case needed, thereby stimulating the participants to think about positive words or statements. Participants individually wrote words or statements that they associated with health on

Table 3.2 Short description of concept mapping procedure, based on Trochim [53, 54]

First group session 'What does feeling healthy mean to you?'	1. Preparation	Recruiting participants and defining questions and focus of group sessions
	2. Idea generation	Participants individually wrote words or statements that they associated with health on separate cards.
	3. Structuring the ideas	With all cards collected, the group composed clusters of words/ statements that belonged together and assigned a name to each cluster.
	4. Representation	Participants individually selected the three most important clusters. The rankings resulted in a group rating from 1 (most important) to 10 (least important).
Second group session 'What do you need to retain / improve health?'	5. Interpretation	The results of the first focus group session, clusters as well as ranking, were fed back in a second session. Needs and wishes for improving health were inventoried and discussed.
	6. Utilization	Resources, facilitators, barriers, and ideas about health-improving actions were explored. A visual representation of the results of this session was made by a cartoonist. All results of both sessions were brought together and used as input for the VoM health promotion programme.

separate cards. From all the words gathered, a so-called word cloud was composed using the online tool [58] (*Fig. 3.1*).

Step 3. Structuring the ideas through clustering

The groups composed clusters by putting together the words or statements mentioned by the individual participants. To compose the clusters, the meaning of the words was extensively discussed, facilitated by the moderator. Each cluster was assigned a label that the group agreed upon. This resulted in a minimum of 6 clusters in one group to a maximum of 14 clusters in other groups.

Step 4. Representation: individual priorities

The participants were asked to prioritize the clusters in an individual top 3. The priorities taken together resulted in a ranking of the clusters from 1 (most important) to 10 (least important) for each group.

Step 5 and 6. Interpretation and utilization

In steps 5 and 6, participants were actively involved and took the lead in the interpretation and utilization of the results of steps 2 to 4. The word cloud from the first session was presented as a reminder. Needs and wishes for retaining and improving health were addressed by asking the following questions: *What is going well*?, *What changes concerning your health would you make?*, and *What do you need to retain or improve your health?*".

Participants were challenged to explore specific actions and ideas. Resources, facilitators, and barriers relating to health-improving actions were explored. The results were again represented visually by a cartoonist and served as an action plan for each group (*Fig. 2)*. The cartoonist attended five groups to make the live report and used audio recordings from the other groups to visualize the results. All participants received a hard copy of the picture. The results of all sessions were brought together and used as input for the health promotion programme.

Overall data analysis

The CM steps 1 to 6 were analysed within the community groups, as described in the CM steps. In addition, the researcher made an overall ranking of the perceptions on health and analysed comprehensively all the data gathered in the 11 groups to identify needs, barriers, and facilitators. The sessions were audiotape recorded and transcribed verbatim. The data from the sessions (e.g. cards, titles of clusters, and scoring) were collected, and field notes were compiled. A thematic content analysis approach was applied to the data (transcripts, results, and field notes), supported by Atlas-ti 8.4. Two researchers performed this analysis, which involved open, axial, and selective coding. Firstly, the data from the first three focus groups were individually read, marked, and coded (open coding). The researchers discussed and compared the codes and reached consensus on the use of codes. Next, the codes were individually categorized and clustered into themes (axial coding). Once the themes and interpretations had been discussed, a thematic map was developed. Constant comparison was made across and within cases. An overall ranking of the clusters was composed by counting the number of groups that mentioned the cluster together with the group ranking. The results of the overall analysis were reported and discussed in a special meeting with community workers and in regular meetings with the project team.

3.1 Results

Perceptions on health

A wide range of statements emerged from the first group sessions, varying from 22 to 162 statements per group. These included more general aspects about the meaning of health (e.g. cheerfulness, relaxation, social network, self-dependence) as well as aspects that were either facilitators or barriers (e.g. physical activity, fresh air).

Overall, seven clusters or perceptions of health were ranked highest (Table 3.3). The social relations cluster, including friends and family was ranked on top together with the physical activity cluster. Physical activity was perceived to be good for your health, but also a way to do something together with others (a social activity), to relax, to spend time outdoors, and to de-stress. A positive life attitude or mindset – also called cheerfulness or happiness

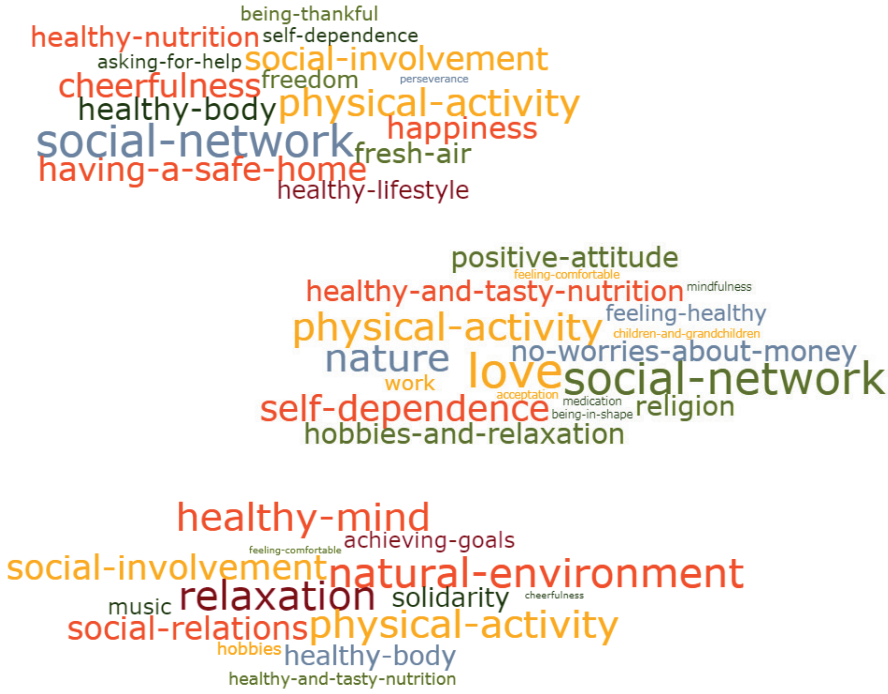

Fig. 3.1 Word clouds of three different groups

– was the third most important cluster of perceptions. In eight groups, the healthy eating cluster was discussed extensively. Participants perceived healthy eating as an important health-related behaviour, similar to physical activity. The fifth cluster – being in control and empowered – was listed in seven groups and related to being able to decide and react by oneself. The relaxation and mental rest cluster was indicated as the positive opposite of stress and having troubles, e.g. having a mind that was too occupied. In six groups, the natural environment was prioritized as an important cluster for health.

Needs and barriers to improving health

In the second group sessions, a large variety of needs, barriers, and specific actions were discussed (Table 3.4). Doing things together with others, having colleagues, friends, or family members around to support you were mentioned frequently as prerequisites to retain or improve health. Self-confidence or self-reliance, thinking in possibilities instead of barriers, acceptance, and talking about the situation or problem and subsequently asking for help were also often identified as assets that are supportive of good health. On the other hand, physical restrictions and disabilities and chronic diseases were viewed as barriers to good health. In the groups (groups, 3, 4, 5, 6, 11) with elderly citizens in particular, chronic disease and physical impediments were topics of discussion, but were not written on the

Table 3.3 Clusters of statements/perceptions of health in order of importance

Perceptions	# groups mentioned	Quotes	Actions to improve health
Social relations	10	"Relations, I think, are very important, with other people. Has to do with health as well." (WG) "Look, as soon as one doesn't have social relations, you are getting lonely and loneliness is bad for your health." (VD)	Participate in one of the community or activity groups Activities in neighbourhood centres
Physical activity	10	"If you keep on moving, you experience; I feel healthy." (YG) "When I've been swimming; I feel relaxed and then afterwards I can pay attention to my child and be fully present." (VS)	Swimming lessons Biking buddy Walking, yoga, Zumba
Positive life attitude	9	"Just always putting the focus on positive things." (AG) 'Seize the day, that's what I always say." (YG) "To stay healthy, you need to think positively about all problems." (LG)	No specific actions
Healthy eating	8	"Food and eating have different aspects, like enjoying it, but also you simply need it." (RB) "Healthy eating, making tasty soup and … don't eat too much." (LG)	Cooking workshops (adolescents, Turkish women)
Being in control / empowered	7	"That I can decide about what to do and what not." (YG) "Being able to do everything by yourself; self-dependence." (RA)	Course 'Looking for sense'
Relaxation / mental rest	7	"It's a way of relaxing and taking time for myself." (RM) "No duties, everything is allowed, well... everything …. Ha ha." (LG)	No specific actions
Natural environment	6	"Spending time outside is relaxing, a kind of rest." (YG) "Being outdoors is a piece of happiness." (YG) "Fresh air also has something to do with it, with health." (RB)	No specific actions

cards. In the majority of the groups, financial barriers were a main topic, as this highly affects citizens' resources, e.g. to buy healthy food for their children. In the multicultural groups, participants mentioned language and cultural habits as barriers to communicating and interacting with others in the neighbourhood. The participants exchanged their experiences and provided suggestions on how to deal with the limitations resulting from diseases and impediments and other barriers that they met.

Table 3.4 Needs and barriers to improving health

Supportive of health	Barriers to improving health
Social environment, friends	Cultural aspects
"….. because you are in contact, you matter again." (YG)	"It depends on, I think, the family and culture you grow up with. What the habits are." (KG)
Doing things together, collaboration, giving and asking for help	Beliefs, convictions
"… but there are people surrounding you, that care and want to give help." (RB)	"Your own thoughts can hinder you, you know." (RB)
"If you get started together, I mean having social interactions with other people, then it becomes easier to accept yourself as well." (RM)	Physical impediments
Acceptance, openness about the situation	"I have a lot of physical impediments. Still, I would feel like being the same as before; a very competitive person I am. And because of that, I've lost my quality of life." (RM)
"It does not work, or it works with some extra effort. That doesn't matter. It's all part of getting older, I always say." (RB)	"I really find it difficult not to be able to open a jar of marmalade for example." (RB)
Self-confidence, focus on possibilities	(Chronic) Diseases and illness
"It is just that you should better not complain but just hop on your bike and go." (KG)	"I only have 50% lung capacity, so I am permanently, when doing something, I am always out of breath." (RM)
Character traits like perseverance, courage, being strong, and taking the initiative	Financial aspects, money
"With a strong character, one does everything with perseverance and confidence. A strong character is what you need." (VS)	"A lot of things just cost a lot, for me too. I have four children and I am getting older and it all becomes very expensive." (VS)
A dog (pat)	Language
"With a dog, you get enough physical activity." (KG)	"Often, things go wrong because of the talking and the language barrier that one has." (RA)
Bike, e-bike	
"A special low step through bike; very nice and now I can use it more." (KG)	

Actions to improve health

In five groups, participants were convinced that they were doing well and they did not feel the need to improve their health or engage in actions other than they already did. They did not suggest actions to improve health for themselves and the group. They pointed out that the group served as a meeting place, where they spent meaningful time together, could talk about happy and sad things, and ask one another for help. Therefore, no suggestions for other activities came up. Rather, the focus was on the group activity. For example, the

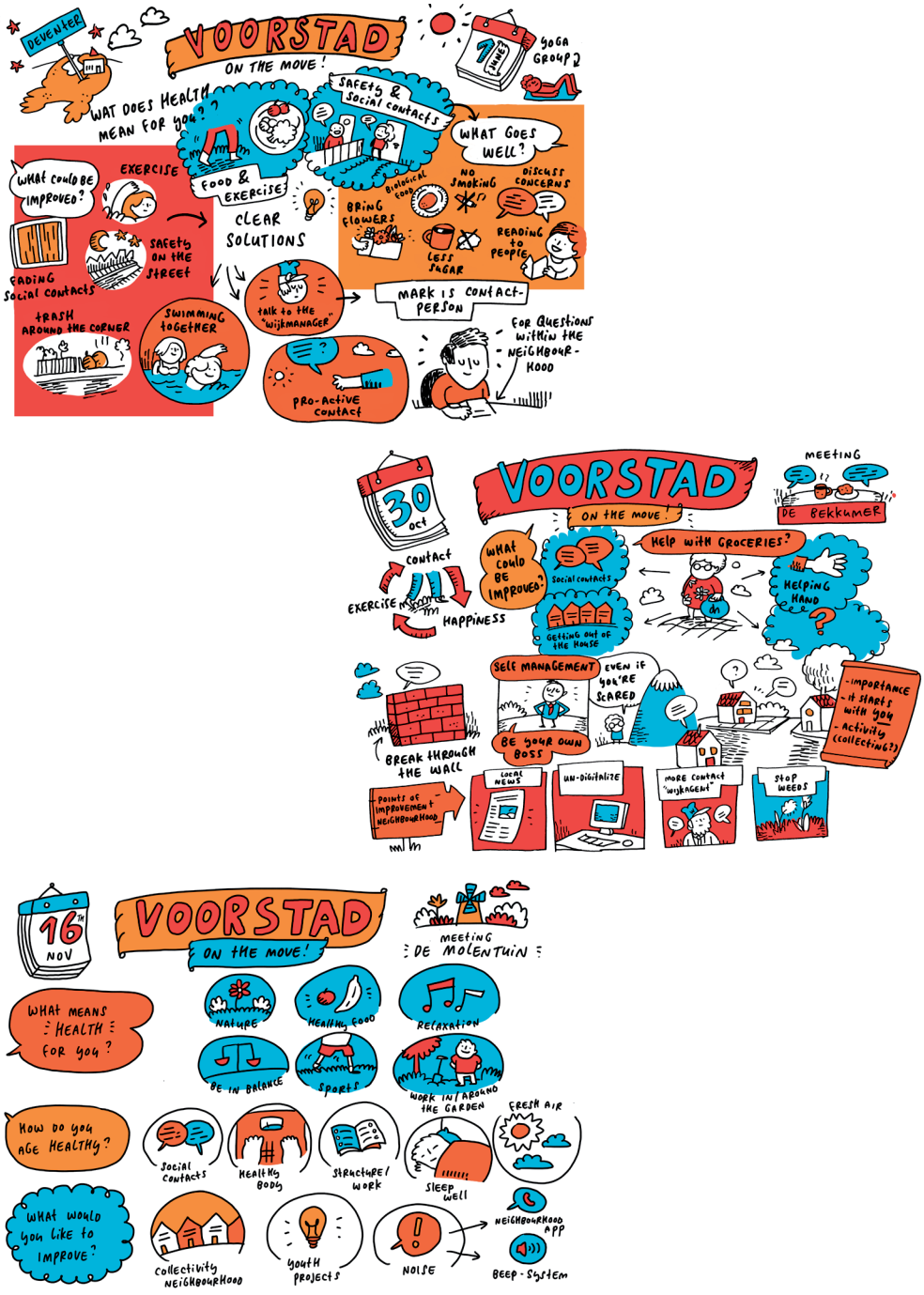

Fig. 3.2 Visualization of the action plans of three different groups[1]

1 Illustrations by: Studio Rood Gras Live beeldverslag & visuele communicatie – Studio Rood Gras

walking group talked only about walking, and there was a strong consensus on the opinion that walking is the solution for everything and walking was what they were already doing!

In the other groups, only a few new actions were suggested, but there were individuals who had ideas and wishes about health-promoting activities (Fig. 3.2): for example, go swimming together, start a conversation with and visit new neighbours, and keep the street clean.

The community workers who attended the group sessions acquired a broader view of the citizens' health perceptions and their needs and facilitators. Moreover, by attending the group sessions, they were motivated immediately to initiate and support the participants' proposed actions, by removing practical barriers or taking the first step towards action together. The following actions resulted right away from the CM sessions:

- The language group and the yoga group participants went swimming
- Two people got a biking buddy
- Some language group participants took guitar lessons
- The resident group participants made appointments to meet more regular;
- One group organized a high tea to meet (new) neighbours.

3.4 Discussion

As part of a community health promotion programme, this study aimed to explore the health perceptions of citizens living in a low socioeconomic city district. In addition, citizens were asked what factors, in their perception, contribute to their health and what actions could improve their health. Exploring these questions, using CM in two group sessions, stakeholders (professionals as well as citizens) were involved and provided the information to engage the community and to further develop the health promotion programme jointly.

Health is a multidimensional concept

The citizens with low SES in this study were well aware of the relation between health and behaviour and they were also very clear about what was important for them. In all groups, health is considered a multidimensional concept. Participants agreed that health entails more than the absence of disease. Although several citizens had a (chronic) disease, they viewed themselves as healthy, as long as they were not limited in their daily functioning, as also found in the study of Lopez et al. [59]. Throughout the groups, which differed in age, cultural background, and activities undertaken together, there appeared to be broad agreement on the clusters of statements, regarded as perceptions on health, and the priorities given to these perceptions. In the different groups, a consistent pattern emerged between perceptions, needs, and actions. Our study revealed seven perceptions that were

perceived to be most important; 1) social relations and interactions, 2) physical activity, 3) positive life attitude, 4) feeling in control, 5) healthy nutrition, 6) mental rest, and 7) the natural environment. This is in accordance with the findings in recent research on perceptions of health and lifestyle in other SES groups [33, 60–63].

Perceptions on health and the social and natural environment as important assets

Participants ranked the social relations perception as the most important one for health and indicated that what they needed to improve their health was doing things together, collaboration, giving and asking for help. The groups in which they participate, the volunteers' work, and social gatherings already provided considerably for their needs. The group meetings can – in themselves – be regarded as health promoting.

A positive life attitude, feeling in control, and mental rest – perceptions with high rankings in all groups – can be considered as aspects of mental health and citizens' attitude towards life. Accordingly, a focus on possibilities, self-confidence, and acceptance were mentioned as supportive of good health. This indicates the importance of paying attention to the subjective dimensions that determine health judgements and the way in which citizens cope with circumstances [28]. Participants asked for different social activities in the community centres, e.g. a 'Looking for sense' course, nearby, in their own neighbourhood, and free of charge.

These findings show that it is necessary to create a supportive, social environment to facilitate behaviour change and improve health [64, 65]. This corresponds with the view on social determinants of health, which recognizes that health behaviour is greatly influenced by people's environmental, socioeconomic, and cultural settings [12].

According to the participants, a supportive environment also refers to the physical (natural) environment. In the majority of the groups, the natural environment was extensively discussed as an important perception, in relation to good perceived health. It was expressed by phrases such as fresh air, lots of green in the living environment, and spending time outdoors. The natural environment was connected to an active lifestyle, performing physical activities, but even more to social activities and mental relaxation. Citizens considered the natural environment a notable health asset and therefore a resource to maintain and sustain health and wellbeing [27].

Citizens and professionals working together to build a health promotion programme

The co-production by citizens and community workers in this study, with the citizens taking the lead, resulted in changes in professionals' views on health promotion. In general, a

professional's view on health promotion focuses on health behaviour or lifestyle, referred to as determinants of health [19, 66]. In our study, two lifestyle aspects – physical activity and healthy nutrition – had high rankings in health perceptions, but citizens hardly mentioned health-related behaviours needed to improve their health. Although they were aware of the importance of lifestyle and behaviour in relation to health, this was not prioritized in the actions mentioned, nor was it sufficient to build the health promotion programme on it. This corresponds to contemporary theories of social practice that suggest that: "interventions to improve the health of populations and create positive social change will be better served by targeting social practices rather than the attitudes, behaviour and choices of individuals" [67]. In these theories, health and wellbeing are considered outcomes of a set of social practices, part of everyday life, and not only the result of a healthy lifestyle [10].

Witnessing the process and outcomes of the group discussions, the community workers adopted the citizens' perceptions, priorities, and needs. Moreover, these views and needs increased professionals' awareness of citizens' health perceptions and helped them to develop actions and engage other professionals working in other disciplines, e.g. social workers, the district manager, neighbourhood sport connectors, general practitioners, and physiotherapists. The multidimensionality of health, as expressed by the participants, should be reflected in the development and implementation of health promotion programmes. These findings support the idea that interventions should always take into account the target group's social environment and perceptions and should involve the target group in their development [68–70]. Altogether, the changes in professionals' knowledge and attitude, together with knowledge and understanding of the social determinants of health in a community, can affect practical action to improve health equitably [71].

Methodological considerations

The CM method contributed to a great extent to the outcomes of this study by providing insights into low SES citizens' health perceptions and at the same time fostering stakeholder participation in the VoM programme. This study laid the basis for the VoM programme. As described, the programme started with the formation of a local team consisting of community workers, that already worked for several years in the city district. Furthermore, the health broker was an inhabitant of Voorstad; she knew many people in person. The local team proved to be a good starting point for the programme, because the team members were able to reach the different community groups and keep them involved during the entire programme. The CM process appeared to be a good mechanism to initiate dialogue with the community and a way to stimulate critical thinking across stakeholders in the community, as also stated by Risisky et al. [50]. It created an opportunity for community engagement in the VoM programme. The community groups that took part in the study remained involved over the term of the programme by participating in activities and research interventions. The discussion and reflection helped citizens to

express their view on what they needed to stay healthy and improve health. However, the lack of ethnic variability in most of the groups, is affecting the representativeness. Most existing community groups in this city district have a homogeneous composition regarding ethnicity and the majority of these groups are Dutch. The local team did an effort to recruit groups with Turkish participants, but these groups were reluctant to participate, because of the language barrier.

An important contribution deriving from our way of applying CM is that participants contribute directly to data analysis by taking part in the discussion and in the interpretation of findings. Unlike other qualitative methods, such as in-depth interviews or focus group discussions, in which the data are collected and then analysed later by the researcher, CM ensures that the results directly reflect participants' thoughts and perceptions [53]. The downside is that the participants may have influenced one another, e.g. by calling out loudly the words they wrote on the cards, before everyone had written their own cards. On several occasions, respondents started to confer immediately with one another on their thoughts and perceptions. The moderator of the group sessions had an important role. The VoM moderators were very experienced and made a big effort to give room to all participants, thereby diminishing the potential confirmation bias. As it is challenging to manage the group dynamics, and the focus of the moderator should be on the group discussion between participants, the splitting of the facilitator role and the researcher role is recommended [71], as was the case in our study. The use of visual recordings like the word clouds and the pictures of the action plans strengthened the discussion and reflection and thereby contributed to outcomes such as actions [55]. The word clouds proved to be useful as input for the discussion about needs and barriers in the second group session. The researcher used content analysis, facilitated by Atlas-ti to process all the information gathered in het CM process [72]

In this study, we worked with existing community groups, and this had several advantages, but also limitations. Firstly, the groups are part of the social infrastructure in the neighbourhood and formed a relatively solid base on which to build the community health programme. Secondly, these groups were easy to reach, because they were on the radar of welfare and other community workers and therefore easy to start with. Group sessions could take place during regular meeting times and thus did not put much extra strain on the participants. Thirdly, the participants knew one another and felt secure talking about their own health and health problems [73]. Participants in several groups corrected one another and gave advice to others on how to deal with the barriers raised.

Although several different individual actions resulted right away from the CM sessions, the groups did not suggest new group activities, because these citizens were convinced that they were doing well already. This can be regarded as a limitation of working with

existing community groups in this study. The participants already had their social network and did activities together. Other ways of getting in contact with the harder-to-reach groups or individuals in this city district should be explored, for example through housing associations, youth healthcare, or employment projects. It should be taken into account that this will be time and energy consuming. A cost-benefit assessment is recommended [35].

3.5 Conclusions

The results of the CM sessions showed a wide range of perceptions on health and the requirements and possibilities to improve health. Although most participants in the existing community groups did not take up new health promotion activities, the study helped to involve citizens and community workers. The results were used to develop the VoM programme together. It has become clear that the focus in the health promotion programme should be on the social dimensions of health, offering citizens different possibilities for action, on demand, and adapted to their wishes. Activities should have a positive approach and should take place in the neighbourhood, free of charge, thereby fostering social relations and networks.

CM, as part of action research, proved to be a very useful method for gaining insights into low SES citizens' health perceptions and at the same time fostering stakeholder participation in the programme. The use of visual recordings in the CM procedure strengthened the process and the outcomes.

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Chapter 4

Intersectoral collaboration in a Dutch community health promotion programme: building a coalition and networks

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In health promotion programmes (HPP), it is crucial to have intersectoral collaboration within coalitions and to build networks between health and other societal sectors. A health broker role is recognised as being helpful in connecting the coalition with the broader network, and participatory action research is deemed supportive because it facilitates evaluation, reflection, learning, and action. However, there is a lack of insight into how processes that affect collaboration develop over time. Therefore, this study aimed to provide insights into the coalition's processes that facilitate building and maintaining intersectoral collaboration within a HPP coalition and network and how these processes contribute to the coalition's ambitions. As part of participatory action research, the coalition members used the coordinated action checklist (CAC) and composed network analysis (CNA) in 2018 and 2019. The CAC and CNA results were linked back into the coalition in five group sessions and used for reflection on progress and future planning. Coalition governance, interaction with the context, network building and brokerage, and generating visibility emerged as the most prominent processes. Important insights concerned the health broker's role and positioning, the programme coordinator's leadership, and the importance of visibility and trust leading to investment in continuation. The combined research instruments and group sessions supported discussion and reflection, sharing visions, and adjusting working strategies, thereby strengthening the coalition's capacity. Thus, participatory action research was useful for evaluating and simultaneously facilitating the processes that affect collaboration.

Abstract

4.1 Introduction

In health promotion, intersectoral collaboration -building and strengthening networks within healthcare sectors and between health and other societal sectors- is increasingly recognised as a core element of implementing a health promotion programme (HPP) [1–3]. Policy changes in public health, care, and social support in recent years have led to intersectoral partnerships and to local-level community engagement becoming even more important [4]. Intersectoral collaboration is defined as 'a recognized relationship between (parts of) different sectors of society which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone' [5]. Intersectoral collaboration requires the engagement of partners from different sectors, identification of opportunities for collaboration, negotiation of agendas, mediating different interests, and promoting synergy [6].

The formation of cooperative networks of mostly non-profit and public organisations is a widespread approach to intersectoral collaboration, especially in health and human services. Within the network structure, community coalitions can be formed to act as effective entities for promoting and facilitating HPPs [7]. Thus, by working together, community organisations can draw on the broad range of resources and expertise provided by the other organisations in the network, and, consequently, community members' health and well-being will be improved [8, 9].

However, collaboration in coalitions and networks can be challenging and does not develop just because it is needed. To build and sustain successful collaborations, several factors that affect intersectoral collaboration are identified in the literature [7, 10, 11]. Koelen [12] defined prerequisites for success in coordinated action for health and combined them in the Healthy Alliances (HALL) framework. Three interdependent clusters -institutional factors, (inter) personal factors, and organisation of the coalition- are recognised as affecting collaboration. For example, an institutional factor is that organisations have their own philosophy and culture, a personal factor is that people have different backgrounds, knowledge domains, interests and perspectives and an organisation factor is that collaboration involves working in a new area and that ambitions need to be defined. Collaboration in a coalition is also influenced by the context, e.g. the history of the collaboration, experience of partner organisations in working together, and political climate [13–15].

A broker role can be helpful in facilitating building and maintenance of networks, for example by exchanging knowledge between stakeholders [16–18]. Brokers can add considerable value to a coalition or network by crossing holes or boundaries, making advice and knowledge more accessible, and producing environments in which collaboration can

flourish [19]. The benefits of a broker role, especially in health promotion, lie in connecting stakeholders from health and non-health sectors with citizens, and subsequently stimulating an integrated community approach to address health inequities [20, 21].

Participatory action research (PAR) is a favourable approach to both facilitate and evaluate coalition building, as it integrates learning and offers tools for action, reflection, discussion, and decision making [22–24]. In PAR, researchers and communities work together with the primary aim of developing actions to address the communities' priority issues. PAR strengthens community capacity to make positive changes and improves programme sustainability [25, 26]. Besides capacity building, PAR enables those involved to continually optimise their strategies and contributes to the visibility of achievements [27, 28]. For example, regular evaluation and feedback sessions facilitate community coalition's processes, including collaboration processes, and sustain collective learning and stakeholder enthusiasm [2, 29, 30].

A vast body of knowledge exists about the factors that relate to the building and maintenance of intersectoral collaboration in health promotion. Less is known about how coalition's processes evolve and interact over time, and how they contribute to capacity building in practice. Coalition's processes are -in line with Nutbeam [31] defined as a series of steps taken in order to achieve the coalition's ambitions. In this study, PAR was applied in a community HPP to explore what these processes entail and to gain a more detailed understanding of the complexity of these processes. By following the coalition and its network over time, it was possible to monitor the processes and the multiplicity of influences at work, and thereby contribute to practice-based knowledge [32, 33]. Overall, the aim of this study was to provide insight into the processes that facilitate the building and maintenance of 1) intersectoral collaboration within a coalition and 2) its network in a community HPP and 3) how these processes contribute to the coalition's ambitions. Special attention is paid to the broker role in facilitating the intersectoral collaboration and/or coalition processes.

4.2 Methods

Study setting

This study is part of a broader project, the community HPP 'Voorstad on the Move (VoM)', with the overall aim of contributing to the improvement of health and to find ways to reduce health inequities in a city district of low socioeconomic status in the Netherlands. Intersectoral collaboration between social services, primary care, policy, public health, and community workers is one of the action principles in the HPP approach [34]. In the VoM preparatory phase (Oct–Dec 2015), an explorative study was performed to ascertain the

health situation in the city district and to decide on the programme's goals and methods. One important finding was the presence of a strong and lively social infrastructure of public, welfare, social support, sports and care organisations, community centres, and (informal) networks in which both professionals and inhabitants collaborate [35].

In June 2016, programme VoM started with five organisations, all part of the existing social infrastructure: the municipal health service, the Social Support team Voorstad, the welfare organisation, the neighbourhood viability coalition, and the local Sports Service organisation. The VoM coalition, a group of six persons, was formed, in which the five organisations were represented along with a health broker, who was an inhabitant of VoM, working self-employed. This coalition was the programme's driving and leading force until the end of the funding term, December 2019. The coalition members built a communitywide network of organisations, workers, and inhabitants based on the existing social infrastructure and the contacts that each of them brought in. At the start of the VoM programme, coalition members formulated three ambitions (a, b, d), in relation to the overall aim of the HPP. In March 2018, three more ambitions (c, e, f) were added, resulting from a mid-term programme evaluation. Together with the researchers, of whom one was part of the coalition, the main indicators (measured concepts) and the related research methods and instruments were formulated (Table 4.1). Ambitions a and b provide insight into the processes that facilitate intersectoral collaboration within the coalition, ambition c into the coalition's network, and d, e, and f into the processes that contribute to the ambitions. In addition, ambitions b and c also provide insight into the broker role.

Study design

Intersectoral collaboration in the VoM programme was studied from the perspective of the HALL framework (Fig. 4.1). From this perspective, building and maintenance of intersectoral collaboration in a HPP is viewed as a dynamic process. The framework shows that collaboration within the coalition and its network was mutually affected by institutional factors, (inter)personal factors, and the organisation of the collaboration, together with the interaction of the context.

The programme was implemented using PAR with the aim of both facilitating and evaluating the HPP [36]. Discussion and reflection on the ongoing programme processes, in particular the collaboration within the coalition, building and sustaining the broader network, and the health broker role occurred in five separate group sessions with the coalition members at their regular project meetings (Fig.4.2).

At three junctures, November 2017, March–April 2018, and November 2019, specific research instruments -the coordinated action checklist (CAC) and the composed network analysis tool (CNA)- were applied to measure collaboration within the coalition and to map

Table 4.1 Coalition's ambitions, indicators, research methods and instruments

Coalition's ambitions	Achievements
a. To strengthen intersectoral collaboration in the coalition	Perceived suitability of coalition members Clear and shared mission, ambitions and planning Personal commitment to the coalition's ambitions Improved relationships between coalition members Leadership programme coordinator
b. To clarify roles and tasks of coalition members, specifically the broker role	Agreement on division of roles and tasks Recommendation to position the health broker in one of the collaborating organisations Different coalition members performed the broker role, not only the appointed health broker
c. To expand the coalition's network	New and strengthened connections with: Inhabitant groups Community centres Educated volunteers Municipality, policy officials, and alderman Therapist 'solid movement' Trainer mental health courses General practitioners and their supporters
d. To realise health promoting activities, initiated by and/or involving inhabitants	Chair gymnastics 'Looking for sense' courses 'Mothers on the move' group Training/education 'Leader Sports and recreation' Kids' activity groups Play-o-theek 'Drinking water tap': contribution to reconstruction of a central square in the neighbourhood
e. To enlarge visibility	Coalition members and network connections reported a broader view on health Visible commitment in local health policy documents External orientation of coalition members
f. To make the programme sustainable	Involvement of municipality in the network Continuation of coalition membership after end of programme Institutionalisation of the broker role Funding: 'bridging budget' (€20,000)

the network of coalition members, respectively. The results of these measurements, were input for four of the five group sessions. The fourth group session, in June 2019, was an evaluation session, part of the overall FNO evaluation study with the action points of the preceding sessions as input [37]. Conclusions and recommendations resulting from the sessions were used to adjust the participants' working methods and activities. The duration of the group sessions varied from 48 minutes to 98 minutes.

Coordinated action checklist (CAC)

The coordinated action checklist (CAC) -based on the HALL framework [12]–was used twice to discuss and evaluate the collaboration and to make results visible [2]. The main CAC topics are partners' suitability, task dimension, relationship dimension, growth dimension,

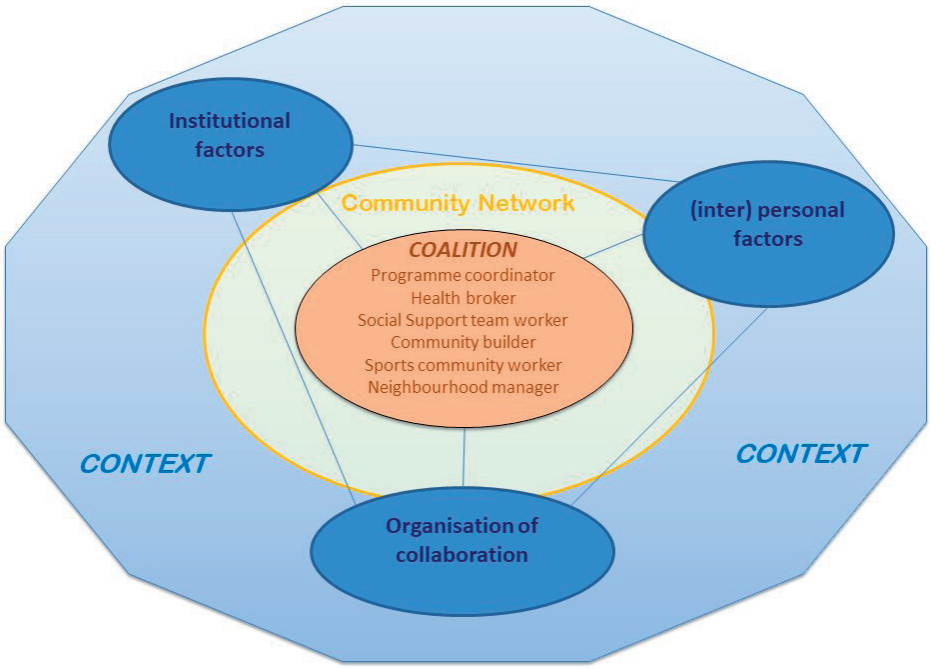

Fig. 4.1 The Healthy Alliances framework**.** Adapted based on [12].

and profiling, consisting of 25 items, presented as statements. Respondents were asked to rate their degree of consent/agreement regarding each statement on a 5-point scale. For this study, two items were added relating to the health broker role, namely, '*the health broker functions to full satisfaction*' and '*the positioning of the health broker within the collaboration works well*'. In addition, one item evaluating the preconditions of the collaboration was added. Two items were removed from the original checklist, as these items were covered by the CNA.

The final checklist included 26 items. In November 2017, a group of 11 respondents (nine VoM partners, a health broker, and the project coordinator) completed the CAC on paper. The CAC checklist scores were calculated per item and per topic. The scores per item were calculated by adding the scores of all partners together and dividing the total score by the number of partners. The topic score was calculated by adding the average of the total item scores, then dividing that by the number of items in that topic. Item and topic scores ranged from 0 to 100.

The CAC results were presented and used as input for the discussion in group sessions 1, 2, and 5. In the first group session, respondents were asked to explain their personal scores and what they considered collaboration success factors. The second group session

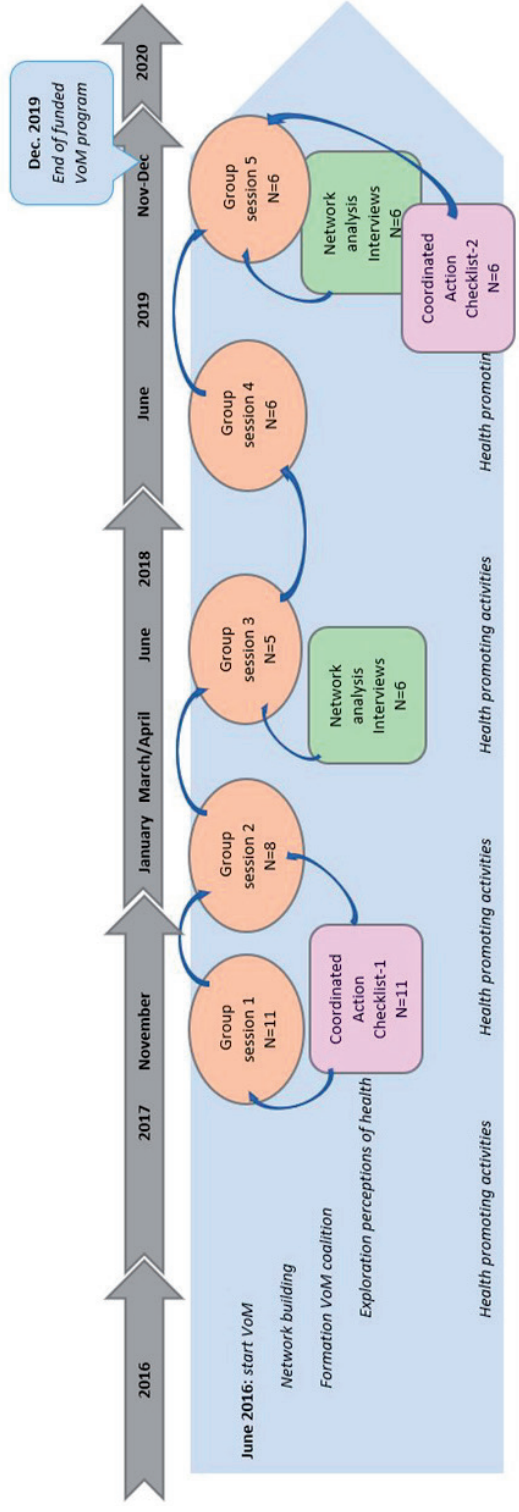

Fig. 4. 2 Timeline with research activities embedded in the VoM programme

with eight participants, which took place in January 2018, was a continuation of the first session. Again, the CAC results were discussed; in particular, the high scores (above 80) and the low scores (below 60) were highlighted. The discussion focused on a shared vision and working strategy, specific actions needed to improve the collaboration, and the VoM activities plan 2018.

Two years later, in November 2019, the checklist was administered again, expanded with four items about 'continuation', ending up with a list of 30 items. The members of the coalition (n=6) completed the CAC online. In Group session 5 (November 2019), the coalition members discussed the results of the second CAC measurement, together with the composed network results. The focus of that session was on the continuation of the HPP and the coalition after the programme term had ended.

Composed network analysis (CNA)

In March/April 2018, an extended network analysis was conducted. The CNA method, developed for this study from a literature review [38], uses a combination of different methods, like network drawing, interview, questionnaire, and group sessions [8, 29, 39–42]. This CNA method was derived from the social network analysis (SNA) approach, which describes and analyses interactions among a defined set of actors. It regards social relations as more powerful than individual attributes in explaining social phenomena [43]. One of the CNA outputs is a network map, in which actors or units are called nodes, and the connections are the ties between nodes. The relationship or tie is a flow of resources that can include social support, time, information, money, and shared activity [43].

The first step of the CNA method is to draw the network with the coalition members (P1–P6). The drawing was conducted with each participant individually, as individual visualisations and evaluations of the network were expected to be more effective. Schiffer and Hauck's [39, 44, 45] drawing method, which utilises 'influence towers', was used. During and after the drawing of the network, a semi-structured interview was conducted by a researcher (YT), reflecting on the results. First, the respondent listed all actors in his/her network on post-its and stuck them on a map with the respondent in the centre. Subsequently, relations between the actors were drawn, and respondents were asked to define their influence by putting influence towers beside the actors, literally a tower of fiches. The question was: 'How strongly can these actors influence the coalition's ambitions?' Thus, the respondents evaluated their networks and the quality of the collaboration with each actor. The interviews, with the drawing process included, took between 85 and 120 minutes, with an average of 92 minutes. NetDraw, part of the UCINET program, was used to visualise the results of the network mapping by drawing a complete network map [46]. A network map of the VoM coalition was composed by putting all actors mentioned together. Coloured nodes were used to distinguish different actor-groups, namely, local government (orange),

organisations (blue), inhabitant (groups) (rose), research (yellow), trained volunteers (purple), and the VoM coalition (green). The lines in the network map represent a direct relation from a coalition member to an actor. The important actors in the network are highlighted by an increased node size.

Group session 3 was held with five coalition members in June 2018 to discuss the results of the network drawings and the questionnaires. The composed network map of all coalition members together was input for the discussion and conclusions, and points for improvement and action were determined.

In November 2019, another network analysis was conducted with the then coalition members. Using the 2018 network maps, the respondents were asked to draw their network by going through all the actors that they had mentioned in 2018 and indicating any changes. As building the influence towers was very time-consuming, this time, each respondent was asked to indicate his/her five most influential actors by circling their names, resulting in 21 important actors in the 2019 composed network map.

The network drawing was part of a semi-structured interview with each coalition member individually, in combination with questions about the sustainability of the collaboration. The CNA results were evaluated and discussed in Group session 5, together with the results of the second CAC measurement. The focus of that session was on the achievement of the coalition's ambitions and the continuation of the coalition and health promoting activities after the end of the programme.

Overall data analysis

The overall analysis consisted of an integration of the data generated by the research tools (CAC and CNA) and qualitative information from the interviews, group sessions, minutes of the coalition meetings, and reports of activities. The integration was focused on the processes that facilitated the building and maintenance of intersectoral collaboration, using the results of the measurement instruments at two junctures and the transcripts from the interviews and the group sessions. Reports of meetings, activities, and interviews were consulted to determine the achievements resulting from the collaboration.

A thematic content analysis approach was applied to the transcripts of the individual interviews and the group sessions, guided by the CAC topics and supported by Atlas-ti 8.4. Two researchers (MdJ, YT) performed this analysis, which involved open, axial, and selective coding. Each researcher read, marked, and coded (open coding) a number of interviews and group sessions. Researcher YT did the first coding of the 2017 and 2018 measurements and MdJ the 2019 interviews and group session. Then, all the researchers compared the

codes, discussed the differences, and reached consensus on the codes used. The coding of the 2019 transcripts was held to be decisive, and consensus was reached readily.

4.3 Results

Achievements resulting from the collaboration in the VoM coalition

The coalition's ambition was to realise a coherent set of health promoting activities that fit in or connect to already existing social programmes and running activities in the community. Also, ambitions on collaboration and network development, organisation of the collaboration, including visibility and sustainability were defined and pursued. Table 4.2 presents the achievements for each of the six ambitions (a-f).

a. Strengthen the collaboration within the coalition

All scores on the dimensions measured with the CAC improved over time, with especially high scores on partners' suitability, the task dimension, and the relation dimension (Table with CAC scores 2017 and 2019 measurement in appendix).

Coalition members agreed that, from the start, the right partners were represented in the coalition. In both measurements, the 'partners' suitability' score was good and increased (respectively, from 78 to 93). The statement 'the contribution of the different partners is to everyone's full satisfaction' (item 4) received a low score (43) initially and improved strongly to a score of 100 two years later. Also, the statement 'I feel strongly involved in this coalition' (item 7) ended up with a maximum score of 100. The coalition members explained that the low score in 2017 resulted from the absence of a clear mission and vision for VoM and uncertainty about the division of roles and tasks. Lots of discussions arose about the mission, ambitions, and planning of the VoM programme, and disagreement on a workable division of roles and tasks was noticed.

> *"…. I am missing, and that is what I already indicated in November (2017), I am missing a little bit, a mission and a vision about where are we working towards in 2018, and that is what I need to stay committed to the programme."* (P5, session 2)

The programme coordinator took the lead in clarifying roles and tasks, confirming decisions, and composing a working plan for the years 2018 and 2019 together with the members, and this proved to be very helpful. In 2019, in the fifth group session, discussing the second measurement, coalition members reported that they had reached clarity and agreement on roles and tasks.

Table 4.2 Achievements resulting from collaboration within the coalition and with its network

Coalition's ambitions	Achievements
a. To strengthen intersectoral collaboration in the coalition	Perceived suitability of coalition members Clear and shared mission, ambitions and planning Personal commitment to the coalition's ambitions Improved relationships between coalition members Leadership programme coordinator
b. To clarify roles and tasks of coalition members, specifically the broker role	Agreement on division of roles and tasks Recommendation to position the health broker in one of the collaborating organisations Different coalition members performed the broker role, not only the appointed health broker
c. To expand the coalition's network	New and strengthened connections with: Inhabitant groups Community centres Educated volunteers Municipality, policy officials, and alderman Therapist 'solid movement' Trainer mental health courses General practitioners and their supporters
d. To realise health promoting activities, initiated by and/or involving inhabitants	Chair gymnastics 'Looking for sense' courses 'Mothers on the move' group Training/education 'Leader Sports and recreation' Kids' activity groups Play-o-theek 'Drinking water tap': contribution to reconstruction of a central square in the neighbourhood
e. To enlarge visibility	Coalition members and network connections reported a broader view on health Visible commitment in local health policy documents External orientation of coalition members
f. To make the programme sustainable	Involvement of municipality in the network Continuation of coalition membership after end of programme Institutionalisation of the broker role Funding: 'bridging budget' (€20,000)

From the beginning, the conditions for the existence of the collaboration were not satisfying (item 13) and did not improve over time (scores 50 in 2017 and 54 in 2019); this is attributable to organisational and policy choices, like management of the social support team, limited time and budgets available. Although coalition members struggled to get permission from their organisations to spend time at project meetings, tasks, and consequent actions in working time, the coalition members are personally dedicated to the collaboration.

> *"For me, the programme got a fixed number of hours a week, as part of my total working hours. (…..) So, the collaboration is not my main task, like it is for the other*

> *coalition members or the welfare workers, they are really neighbourhood based."* (P4, session 5)

In 2018, one of the core organisations decided to convert from its membership by rotation, into two members being permanent part of the VoM coalition. From then on, a solid group formed the coalition and had regular meetings facilitated by the coordinator, and initiated and facilitated activities together. This scenario created togetherness and personal commitment to the coalition's ambitions on which they were working, as reflected in the scores on the relation dimension (from 59 to 93). Three items, open communication, willingness to make compromises, and loyalty to implement decisions and actions (items 14, 16, 18), even got a maximum score of 100.

> *"I can look back on the team with warm feelings now. We had such struggles in the beginning, like: who are you, as a public health advisor to tell us what should be done in this neighbourhood, you know, that attitude. Why is the health broker role not part of the social support team? Well, we have had a lot of fights, conflict, and confrontations about this in our meetings, it chafed every now and then. And now, I realise, hey, it does not chafe anymore, we complement one another, we make beautiful one-two punches."* (P5, session 5)

The importance of knowing one another personally, and having shared ambitions and joint activities, became visible when members of the group left or were absent for a long time, because of illness or changing jobs. The new members fitted in easily and took up their roles without much discussion.

b. Clarify roles, tasks and the broker role

The respondents were moderately positive about the health broker in 2017, with an average score of 60 on the CAC. As an explanation of the low scores, coalition members mentioned the uncertainty about this newly created function and the fact that the health broker, specially appointed within the VoM programme, was not employed by an organisation. This caused confusion and a lot of discussion about division of tasks and responsibilities in relation to the other coalition members, which have broker roles as well, arising from their core functions.

> *"I do not consider my contribution (to the VoM coalition) as my core task, let's say. But, making connections, yes for me it is very clear, that is what I do, so I euh, I find it difficult to say if that is part of my core task, my responsibility, or the project its responsibility, or the health broker's who has fixed hours for it."* (P6, session 1)

To create clarity about roles, tasks, and responsibilities, in the second group session -spring 2018- decisions were made regarding the health broker role. The broker role was no longer reserved for the person appointed as health broker. Other coalition members also took up broker tasks, for example connecting inhabitant groups with (health) professionals and supporting groups in organising activities, facilitated by the programme's budget. This change in who should fulfil the broker role is reflected in the network maps, showing a shift in contacts from the health broker to other coalition members (social support team worker, community builder and neighbourhood manager). The coalition members were convinced that a health broker role was crucial to enable the continuation of the VoM programme after the funding had ended.

Both the positioning and the functioning of the health broker had improved during the programme, ending up with a mean score of 75 (items 19, 20) in 2019. In order to assure sustainability, the health broker role had to be transferred from being a 'free player's' task to being a task for a collaborating organisation.

> *"At a certain moment, it will fade out. So, the contacts that have arisen between workers, but also between workers and inhabitants, that well, that will still need something like a booster, a connector, for example such as a broker, who could do that."* (P1, session 5)

c. Expand the coalition's network

The network analysis, conducted twice at 1.5-year intervals, resulted in two composed network maps of the VoM coalition (Fig. 4.3).

The composed network maps revealed useful information about the extent and diversity of the actors in the network, central (important) actors, and missing actors. The coalition consisted of 6 members (green nodes), from whom the health broker and the community builder had the highest number of contacts. Central actors mentioned by all the respondents were inhabitant groups (rose nodes), welfare workers/child workers (blue nodes), and the community centres (also blue), referred to as important meeting points and facilitators of social and health promoting activities.

> *"What strikes me is that, when you look at the community centre nodes, we put much of our effort into them to strengthen these powerful places."* (P6, session 3)

Overall comparison of the 2018 and 2019 network maps shows that the total number of actors did not change much. The neighbourhood manager was no longer an official member of the coalition, but still closely connected (from green to orange). The importance of the sports community worker diminished and some other representatives had disappeared. Also, new and important partners joined the network, e.g. trained volunteers (purple nodes).

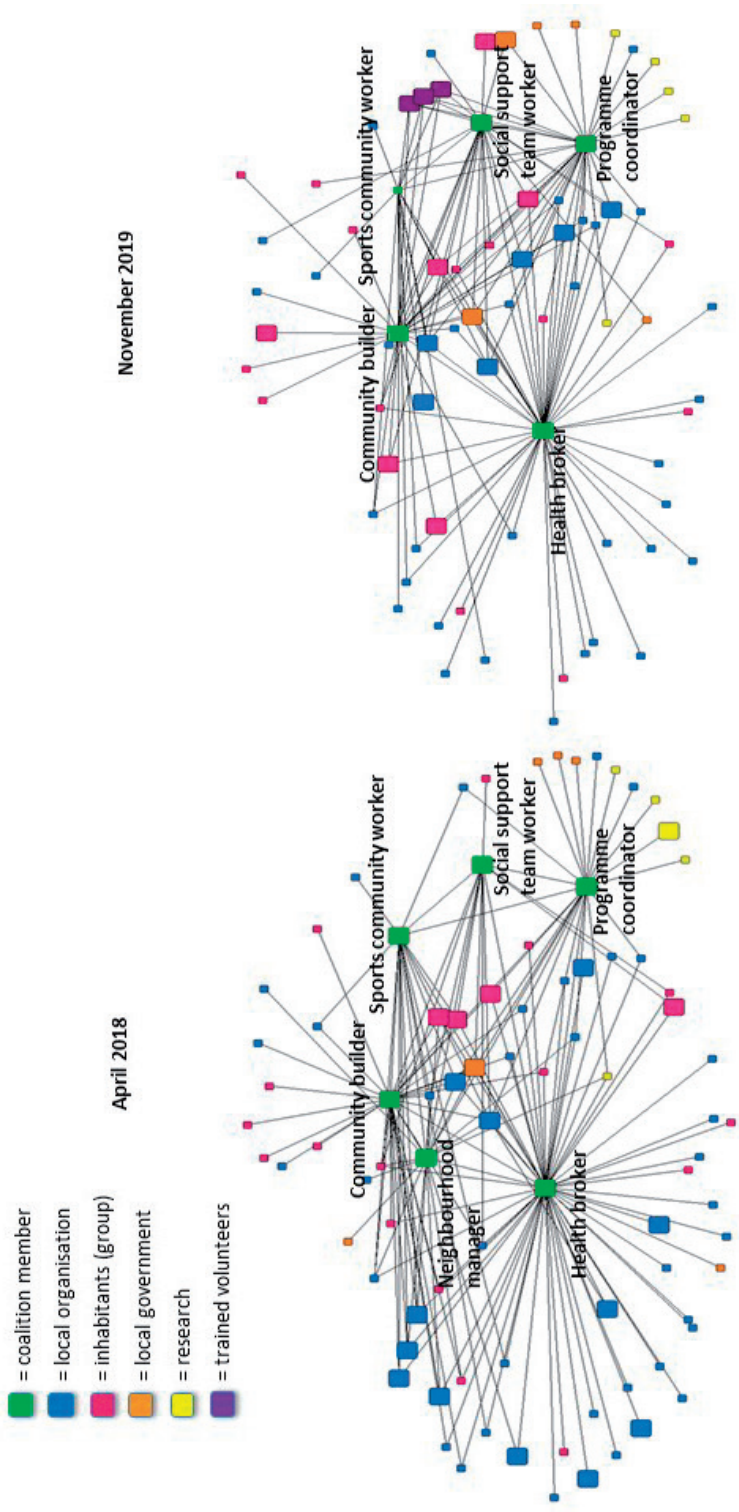

Fig. 4.3 Network maps of the VoM coalition, April 2018 and November 2019 here]

Overall, coalition members indicated that the number of relations had not increased over time, which might be due to the coalition's agreement in 2019 to focus on consolidation and continuation of the programme after the funding period and on supporting inhabitants and workers in sustaining successful activities. This change in focus is also illustrated by the differences in the importance rating of actors, from mostly organisations, welfare workers, and community centres to community groups, volunteers/inhabitants, a general practitioner, and municipal policy officers by the end of 2019.

In 2018, the primary schools in the city district were viewed as missing actors, because they could and should be important partners in the network to contribute to the programme's goals. Only the health broker had mentioned them as contacts, adding, however, that meeting frequency was low (small blue nodes). The Turkish inhabitants living in the neighbourhood were another missing actor group. There were no direct relations with Turkish individuals or groups, only indirectly through colleagues.

> *"No, that is what I see as well, but what I also see is the difficulty to sometimes involve these groups of Turkish people, let's say, so that is what we experience as well from our working method in the neighbourhood."* (P8, session 5)

Group session 3 resulted in the following agreements and actions: intensify the relations with the primary schools; find ways to contact the Turkish inhabitants, especially the elderly; involve the aldermen and policy officer in the programme's network; align the relations with the welfare workers and the welfare organisation; and sustain and strengthen the relationship with the neighbourhood manager and the community centres. Despite the intention to intensify the contacts with the neighbourhoods' primary schools and with the Turkish inhabitants, they still did not feature on the 2019 network map.

Up to 2018, the municipality (orange nodes) was not a central actor, although there were some contacts with local government officials. These relations were distant, and there was no relation with the responsible alderman.

> *"Those are striking results from the network analysis, oh yes, we just did not involve the municipality enough. And why not? That is because we just are very modest about Voorstad on the Move."* (P5, session 5)

Because the respondents considered the municipality a very important actor for the continuation of the programme, as it is responsible for local public health and welfare and social support policies, they made extra efforts to get the alderman and the policy officer more involved in the network. By the end of the programme term, the alderman and

the policy officer were indicated as important actors and were involved in the coalition's network.

d. Realise health promoting activities

A wide range of health promoting activities (physical activity groups, mental health courses, supportive peer groups, mothers' meetings, education, and individual coaching) were implemented as part of VoM together with network contacts and coordinated by the coalition. Adding the participation figures of all the activities together reveals that about 350 inhabitants attended one or more of these activities between 2017 and 2019.

All respondents mentioned that organizing these health promoting activities together, strengthened the collaboration between the various organisations in the coalition and with the new and existing connections in the broader network. Together with the (action) research activities, professionals from different sectors outside health learned about the inhabitants' perceptions on health. This contributed to a shift in thinking, and, as a result, community workers and organisations got a broader view on health and embraced the health and behaviour approach (instead of illness and cure).

> *"And now we have health much more in our sights. And I think that is nice, because we did not have it that way in my organisation."* (P8, session 5)

e. Enlarge visibility

Visibility had a low score (55) in 2017 and showed only a small improvement in two years, to a score of 64 in 2019. Reflecting on the last two years of the programme, the coalition explained the low scores by pointing out their modesty, having an internal orientation, and not taking enough advantage of their network contacts.

> *"… and, that we were very modest about what we were working on, and had accomplished. Then some follow-up actions came up, because yes, we had to put our project on the political agenda, and achieve some more visibility."* (P5, session 5)

While considerable time was spent on the collaboration process, hardly any visible results appeared in the first two years of the project. Only in the last year of the VoM programme did the coalition members consider the activities that had resulted from their collaborative efforts as successes, worth being made visible. They started to feel the urge to increase their visibility in order to gain the support of their organisations and the local government for the continuation of the coalition and the VoM programme.

f. To make the programme sustainable

The CAC continuation topic, with four statements that were especially added to the questionnaire for this study, ended up with a mean score of 79 by the end of 2019 and were discussed in group session 5. On the one hand, the respondents were very positive about their personal motivation to stay involved in the VoM coalition (item 30, score 100). On the other hand, they had little confidence in its continuation without extra funding (item 27) and the support of their organisations and the municipality. The coalition members expressed their concern, in particular about the facilitation of collaboration in the coalition and the funding of the health broker role and health promotion activities. For that, besides an external budget and policy support, contacts with the 'right' influential persons within the municipality were needed.

> *"Well, yes, I do miss, especially for continuation, a good connection with the municipality. And that is with the team managers as well as policy-based, the one that has responsibility for the social support teams. So, with the workers it is fine, but these workers themselves are not able to take care of the continuation, of the organisational embedding."* (P1, session 5)

Thus, they agreed on the necessity of having a leading professional or coordinator for a sustainable collaboration (item 29). This coordinator role entails responsibility for the organisation of the coalition, and is needed in addition to the health broker role that is outward oriented in connecting the coalition with its network.

"Well, the vulnerability is in the fact that we have meetings with the coalition every three or four weeks, and even if an agenda is missing, there will be enough points to discuss. But, imagine there will be no scheduled meetings, then you have to arrange moments to meet and to be reminded of the project and to think Oh, yes, this or that needs attention." (P7, session 5)

The involvement of the municipality, resulting in a so-called bridging budget, was credited to the coalition. This financial commitment had to be invested in sustainable health promoting activities, continuation of the coalition, and finding ways to institutionalise the health broker role to support the community health promotion approach.

Identified processes that facilitate intersectoral collaboration

Summarizing, the most prominent processes that facilitate intersectoral collaboration within the coalition, with the coalition's network, and that contribute to the coalition's ambitions are listed in Table 4.3. These processes are further elaborated on in the discussion.

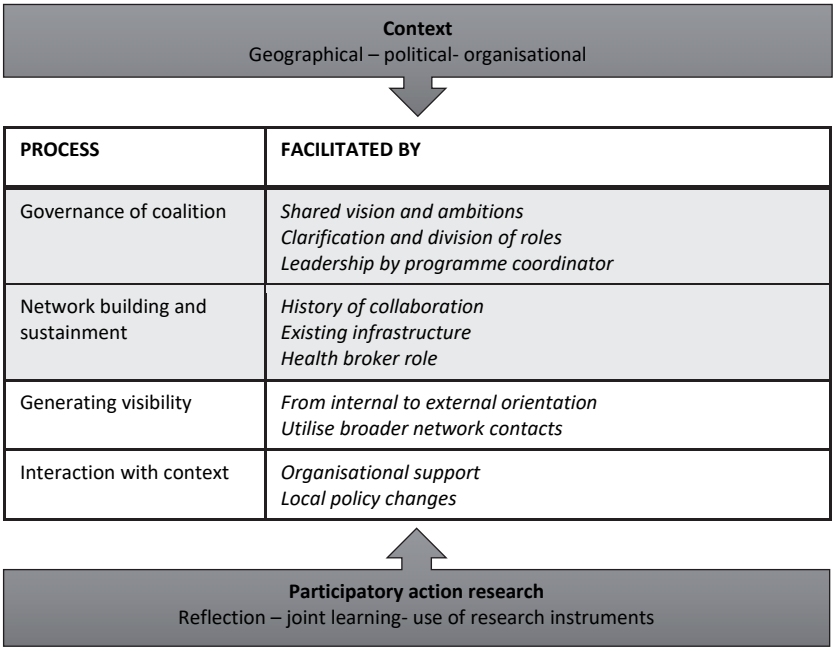

Table 4.3 Summary of processes that facilitate intersectoral collaboration

4.4 Discussion

This study has revealed more detailed insights into the processes that facilitate building and maintaining intersectoral collaboration within a coalition and its network in a community HPP over two years. Those insights concern the most prominent coalition's processes: 'governance of the coalition', 'network building and the health broker role', 'generating visibility', and 'interaction with the context'. The research instruments integrated in PAR and adapted to the coalition's context, proved useful for evaluating the collaboration and helped coalition members and researchers to recognise the processes and act upon them. Moreover, this study focused on the processes, thereby making visible the coalitions' ambitions and achievements.

Governance of the coalition

The programme coordinator was essential to govern the internal organisation of the coalition and to enhance coalition capacity. A clear governance of the coalition, by defining a shared vision and clarifying the division of roles, convinced the collaborating organisations to commit to the coalition and to facilitate their employees with time to attend meetings and for programme activities. The programme coordinator's leadership -which stimulated personal involvement- and togetherness in the coalition was decisive

in holding the coalition together, which was also found in other studies [1, 7, 47]. The group sessions that were part of practice and research helped the members to reflect and take time to discuss the results, share visions, and adjust their working strategy, thereby strengthening the capacities of individual members and the coalition as a whole.

Network building and health broker role

The coalition's network evolved relatively easily, because it could be built on the existing infrastructure in the city district and each individual member of the coalition brought in his/her contacts. Brokerage, in this study not performed exclusively by the appointed health broker, was essential in connecting the coalition with the broader network. The network analysis helped the coalition members to clarify the health broker role and other roles and tasks, and to make decisions about the division of responsibilities. In line with other studies, it was concluded that embedding the health broker(s) in a professional organisation was the preferred way to foster the acceptance of the health broker role in the coalition as well as in the broader network [19, 20].

Generating visibility

Through the network of new and existing contacts a range of health promoting activities were implemented, arising from citizens' ideas and wishes. Only in the third year of the HPP did awareness of the coalition's achievements grow, thanks to the PAR activities, especially the CAC and the reflection meetings. Subsequently, the coalition members paid more attention to the visibility of the achievements, resulting in a growing appreciation of their own efforts and the feeling of involvement of the members in the coalition. This strengthened the capacity within the coalition and encouraged investment in the continuation of the HPP by gaining local government support and the commitment of the organisations involved. The value of the coalition and its activities was acknowledged, indicating that coalition capacity, like other researchers found, can induce changes in local policy decisions, commitment, and readiness to invest in health promotion [25, 48–50].

Interaction with the context

This study elucidated the interaction between the collaboration and the context, showing not only the importance of taking into account the changing context in studying intersectoral collaboration, but also the power of the coalition to influence the context [13, 15].

The context of the VoM coalition had important advantages, such as the history of collaboration in the city district and community engagement that helped the coalition members to build the network in a relatively short time. However, the (policy) context in which the VoM programme was implemented was unstable because of transitions of policy responsibilities from the national to the local government [4]. Coalition members were

confronted with cutbacks, uncertainty, and tasks in their own organisation that diverted attention from collaboration in the beginning. Later on, the action research clarified the contextual influences, making it possible to discuss, reflect, and subsequently (re)act and learn from it.

Achievements

In practice, the particular processes described evolved simultaneously and interacted mutually, concurrently resulting in observed and visible achievements. Besides achievements that were expected beforehand, such as health promoting activities and a strengthened community network, unexpected achievements resulted from the collaboration, e.g., the professionals' broader view on health and local government involvement. Observation and discussion about the achievements have contributed to commitment to, and continuation of, the coalition, as is required to realise community change and the desired health outcomes in the long term. We agree with Butterfoss and Francisco [30], that to evaluate coalitions, it is recommended to focus on the achievements and short-term successes, as well as on processes affecting the collaboration

Reflection and recommendations for using PAR in practice

As has become clear, PAR facilitated reflection and learning through a continuous process of dialogue. It was convincingly demonstrated in this study that PAR proved useful for evaluating the collaboration and helped coalition members and researchers to recognise the processes and act upon them. At the same time, while focusing on the processes, the research helped to make achievements visible.

Both research instruments, the CAC and the CNA, provided different information and complemented each other. The application of the CAC offered good opportunities for evaluating and discussing upcoming issues, thereby improving the collaboration [51]. The (extended) network analysis (CNA), which was especially composed for this study based on a literature review [38], was a very complete method, but appeared to be time-consuming and difficult to use in practice. Therefore, it was simplified in the second measurement, which might have resulted in a too low number of identified actors in the network. In addition, the identified actors were not asked for their input, a missed opportunity to engage these actors and the organisations they represent. Still, the network analysis has proven its worth by visualising the variety and the influence of actors according to the coalition members and by comparing the actual situation with the map of the situation 1,5 years ago. Altogether, the combination of instruments, with in-depth evaluation sessions of the collaboration can be seen as capacity-building method, facilitating coordinated action.

Using PAR has added value, because it adapts to the particular situation in practice and always takes into account the perspectives of the persons involved. In this study, the insights

into the processes concern just one case -the VoM programme- which is a strength and a limitation [52]. On the one hand, it created a thorough understanding of the processes that evolved simultaneously and interacted mutually in a real-life situation. On the other hand, it may be hard to generalise the findings, because every HPP has its own characteristics and is implemented in a different context. In order to gain broader insights into the processes that are generalisable and those that are context-specific, more practice-based studies are needed.

Notwithstanding, some interesting recommendations for research and practice emerged from this study. The research activities were time consuming for coalition members and programme coordinator. Along the term of the VoM programme, the focus was mostly at the internal processes of the coalition. This may have hindered a more outside oriented view of the coalition, resulting in less attention for the visibility of programme activities and achievements in the broader network of the coalition, one of the coalition's ambitions. At the same time, coalition members appreciated participating in the research activities, because it gave them more insight into the emerging processes and they got to know each other better. Eventually, this resulted in a strengthened collaboration and ample attention paid to the visibility of the programme's activities and achievements outside the coalition in the last year of the programme.

The role of the action researcher is challenging, because it requires flexibility and a broad range of competences. In our study, the action researcher coordinated the programme and was a member of the coalition. The researcher took part in the coalition meetings and managed to gain the trust of the coalition members, which made them willing to participate in the research activities. At the same time, the researcher had to monitor the processes and to report on the programme. Next to flexibility, communication and social skills and competences that relate to self-reflection, conflict management and perseverance are required [51].

In PAR, practice and research are closely related, which results in a dual role of researcher and health promotion professional [53]. The action researcher/programme coordinator must be clear about these different roles and have the flexibility to change roles when needed. It is recommended that in HPP's accompanied by PAR, both research and practice need to justify the dual role, health promotion professionals need additional research competences and researchers should become more familiar with challenges of health promotion practice.

4.5 Conclusion

The added value of this study is that it revealed more detailed insights into the processes that facilitate the building and maintenance of intersectoral collaboration in the setting of a community health promotion programme. By following the coalition, including the health broker, during a two year period, we gathered insights on the coalition's processes, that evolved over time. Above, we convincingly demonstrated that PAR proved useful for evaluating the collaboration and helped coalition members and researchers to recognise the processes and act upon them. At the same time, while focusing on the processes, the research helped to make achievements visible.

In-depth insights into the processes and the interdependence between them helped the community workers and researchers to optimise their working strategies and strengthened the coalition's capacity. The particular processes described evolved simultaneously and interacted mutually, concurrently resulting in visible outputs. Making the achievements, some unexpected, visible contributed to the commitment and continuation of the coalition, as is required to realise community change and desired health outcomes in the long term. Accordingly, PAR and the integrated research instruments–adapted to the coalition's context–were useful for evaluating and simultaneously facilitating the processes that affected the collaboration and for determining the short-term achievements. Additional practice-based studies are required to gain broader insights, especially to distinguish between generalisable and context-specific processes.

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Chapter 5

Unravelling mechanisms underlying the action principles of a community-based health promotion programme: a realist evaluation

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This chapter is submitted as: Unravelling mechanisms underlying the action principles of a community health promotion programme: a realist evaluation.

Background. Since 1986, WHO has advised that applying action principles such as citizen participation and intersectoral collaboration leads to better health. However, less is known about the workability of these principles and how they trigger specific outcomes in interaction with the context. A realist evaluation was conducted to get a better understanding of what worked, and why it worked, in the context of a Dutch community-based health promotion programme (CBHPP). The aim of the study was to unravel the mechanisms underlying the action principles and find combinations of contextual factors and mechanisms that trigger outcomes in a CBHPP.

Methods. In this single case study, a realist evaluation methodology was followed. Qualitative data used in this study originated from multiple sources and methods to ensure validity. They include evaluation sessions with coalition members (n=6) and individual interviews (n=6); group sessions with community workers (n=1), a health broker (n=1), and citizens (n=12); and seven semi-annual progress reports and minutes of the coalition meetings. The collected data were then compared with the programme theory through a heuristic process of constructing, exploring, and refining context-mechanism-outcome configurations.

Results. The programme initiated a variety of new activities that differed in content, intensity, duration, and number of participants, organised and implemented together with citizens. The most prominent mechanism underlying both action principles were programme-related, namely, patience, personal contact, contribution of budget, and the programme coordinator's leadership. Another important mechanism was creating visibility, which resulted in the involvement of the municipality and a budget to sustain the programme.

Conclusion. In this case study, personal contact, patience, perseverance, participatory action research activities, and visibility were found to be the most notable mechanisms underlying the citizen participation and intersectoral collaboration action principles. As the principle-based approach added value to the existing context and introduced most of the mechanisms that triggered the outcomes, it is recommended to include citizen participation and intersectoral collaboration not only as action principles but explicitly as targets in a CBHPP.

Abstract

5.1 Background

People with a low socioeconomic status (SES) live – on average – six years less compared to those with a high SES, and the difference in healthy life expectancy between these groups is huge, e.g., almost 19 years in the Netherlands [1, 2]. Although the healthy life expectancy of people with a low SES has increased considerably in the last decade, the difference in life expectancy between the two groups has remained the same, or even become worse as a result of the Covid pandemic [3–5]. Health inequities are a complex problem caused by the interplay between individuals, groups, communities, and multiple factors in the social, physical, and economic environment [6, 7]. There have been many studies on the causes of health inequalities [8–10]. The persistence of health inequalities within societies indicates the importance of research on the social determinants of health [11] and on policies and interventions that aim to reduce inequalities [8, 12].

Community-based health promotion programmes (CBHPPs), based on an ecological perspective, are seen as a promising approach to diminish health inequities, as they address the social determinants of health at multiple levels as well as the interaction between these determinants and factors that impact the determinants [13–16]. In CBHPPs, citizen participation and intersectoral collaboration are essential elements, also called action principles [17–19]. These action principles contribute to health through multiple pathways and serve multiple purposes, such as programme effectiveness, the creation of supportive environments for health, and the empowerment of all stakeholders, both professionals and citizens [20]. Action principles can be defined as actions, processes, or mechanisms that help establish the impacts of a health promotion programme [21, 22]. Through citizen participation, the context of people's lives can be taken into account, thereby offering opportunities to address the social determinants of health, for example by addressing informal networks and cultural aspects. Because of their connection with the existing local situation, health promotion programmes can be more effective [23, 24]. In addition, intersectoral collaboration between professionals in health, care, and other societal sectors is regarded as crucial for working on diminishing the health gap [25, 26]. Professionals from different sectors that collaborate can achieve more than one sector alone can [27, 28]. By working together, they can draw on the broad range of resources and expertise provided by the other organisations in the network to improve community members' health and well-being [19, 29].

Since 1986, WHO has advocated the application of these action principles as they lead to better health [30]. Most evaluation studies, however, focus on measuring outcomes, and less is known about how these action principles trigger specific outcomes in interaction with the context [31, 32]. To gain insight into the workability of these principles, an evaluation approach that is sensitive to the operational conditions of the programme as part of a larger

complex system is required. This means that the evaluation should generate knowledge about what works for whom in what circumstances; this is different from the usual evaluation methods that focus on whether or not the programme has succeeded against the criteria set at the start [33, 34]. Unravelling the mechanisms underlying these action principles will expand the knowledge about community-based approaches in practice and thereby contribute to finding ways to reduce health inequities. The aim of this evaluation study is to unravel mechanisms underlying the action principles and find combinations of contextual factors and mechanisms that trigger outcomes of interest in a CBHPP.

5.2 Methods

Study setting

The setting of this study is the community health promotion programme Voorstad on the Move (VoM). This local programme was one of 46 small-scale projects under the umbrella of the Healthy Futures Nearby (HFN) programme funded by the private funding organisation, FNO, with the aim of reducing health inequalities within the Netherlands [35]. From September 2016 to the end of 2019, VoM was developed and implemented in a socioeconomically deprived city district of 10,750 inhabitants in a city in the eastern part of the Netherlands. In this city district, both the SES and the health status of inhabitants are relatively low compared with other parts of the city [36]. The VoM programme pursued multiple goals. On the one hand, it aimed to improve Voorstad inhabitants' perceived health and achieve changes in the social and physical environment in order to support healthy behaviours. At the same time, it focused on finding keys to reducing health inequities [37]. VoM is a local programme developed and implemented with the active involvement of low SES citizens, who – in the view of health professionals – are usually hard to reach and not very interested in health promotion activities. The programme was innovative, as it differed from usual health promotion programmes in which health and lifestyle themes and activities are set by professionals. Instead, this programme shifted from being a predetermined health promotion programme with a set of health behaviour interventions to being an open approach with a focus on the action principles, citizen participation and intersectoral collaboration. The VoM programme was guided by participatory action research (PAR) [13, 37].

In September 2016, the VoM programme started as a collaboration of five organisations, all part of the existing social infrastructure: the municipal health service, the Voorstad social support team (SST), the welfare organisation, the neighbourhood viability coalition, and the local sports service organisation. The programme's driving and leading force was the VoM coalition, with representatives of the five organisations, all community workers, along with a health broker, who was an inhabitant of Voorstad, working in a self-employed capacity.

The coalition members built a communitywide network of organisations, workers, and citizens based on the existing social infrastructure and the contacts that each of them brought in. The health broker role was essential in connecting the VoM coalition with the broader network and in facilitating citizen participation [38]. Citizens' perspectives on health were explored with existing community groups – consisting of Voorstad inhabitants (e.g., a walking, a yoga, and a knitting group) and volunteers at a community centre and a play garden – in two group sessions with each group [39]. These community groups were actively involved in the VoM programme from the start.

Based on the literature on community-based approaches and evaluation studies of complex community health promotion programmes [40–43], a logic model was used for the development, implementation, and evaluation of the VoM programme (Fig. 5.1) [37].

The assumption is that developing and implementing health activities at different levels – i.e., citizens, community workers, and community – will result in the long term in improved perceived health, a health-supportive environment, and sustainable local health policy, and ultimately lead to a reduction in health inequities. These long-term expected outcomes will be preceded by short-term outcomes, defined as outcomes of interest such as health literacy, healthy alliances, and changes in the physical environment. Besides intended short-term and long-term outcomes, there might be unplanned outcomes that sometimes have a greater influence on the health determinants for a community than the more narrowly focused outcome goals of projects [44]. Programme outputs that precede and generate short-term outcomes include, for example, insight into citizens' perception on health, new health-promoting activities, an extended community network, new coalitions of primary

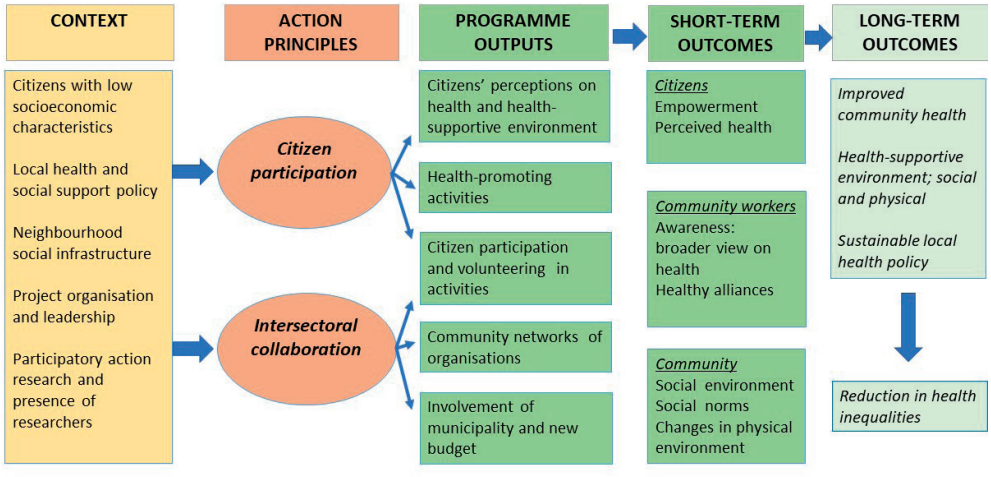

Fig. 5.1 Programme theory Voorstad on the Move

care professionals and social support workers, and municipal involvement. Another assumption is that, by applying the citizen participation and intersectoral collaboration action principles, programme outputs will be generated, leading to short- and long-term outcomes as already explained.

Study design

A realist evaluation methodology was followed to study the citizen participation and intersectoral collaboration action principles in depth, in the single case of VoM. This method is based on the identification of outcome patterns, mechanisms, and contextual conditions that help to assess not only what works, but also for whom and in what circumstances [45–47]. The final research product from the realist methodology is not a statement of effect size, but rather a refinement of the programme theory, based on the gathered insights regarding the mechanisms that have triggered the outcomes in this specific community health promotion programme. A range of qualitative data are collected and then compared with the programme theory through a heuristic process of constructing and refining context-mechanism-outcome (CMO) configurations.

Data collection

As part of the PAR that accompanied the VoM programme, data were collected throughout the programme between 2017 and 2019. In addition, data collected by researchers from the overall evaluation of the FNO HFN programme were analysed [48]. Data used in this study originated from multiple sources and methods to ensure validity. Sources and methods include for example midterm and end evaluation sessions with coalition members; individual interviews and group sessions with community workers, the health broker, and citizens; semi-annual progress reports prepared by the programme coordinator; and minutes of the VoM coalition meetings (Table 5.1). In addition, an activities database, in which characteristics and reports of the activities that were part of the VoM programme were registered and monitored, was consulted.

Data analysis

Interviews and group sessions were anonymised and transcribed ad verbatim. The analysis was stepwise, data driven, and thematic [52], using Atlas-ti 22. Coding was dev eloped based on a realist synthesis protocol with the focus on CMO configurations. The operationalisation of the concepts – context, mechanisms, and outcomes – is illustrated in Table 5.2.

Step 1. Transcripts of the evaluation sessions (Sources I–III, Table 1) were coded in terms of context conditions (C), underlying mechanisms (M) in the actual programme, and outcomes observed by respondents (O) [54].

Table 5.1 Data collection scheme

	Source (material)	Methods	Dates
I	Midterm and end evaluation intersectoral collaboration [38]	6 individual interviews with VoM coalition members 4 group sessions with VoM coalition members (n=6 per session)	Jan.–June 2018 Nov. 2019
II	Midterm evaluation coalition '*Well-being or not to be?*'* [49]	Group session with community workers (n=7) Individual interview with health broker	May 2019
III	Midterm and end evaluation by researchers from the overall evaluation of the FNO HFN programme [48]	2 group sessions with VoM coalition members (n=6 per session)	Feb. 2018 June 2019
IV	Small-scale photovoice study about health-supportive environment [50]	3 group sessions with citizens (n=15 in total), photos taken by citizens	May–June 2018
V	Sub-study 'Benefits of participation' [51]	12 in-depth interviews with actively participating citizens	March–April 2019
VI	Semi-annual progress reports, part of the overall evaluation of the FNO HFN programme	7 reports by the programme coordinator	Feb. 2017–Dec. 2019
VII	Monthly meetings of the VoM coalition	Minutes of the meetings 40 reports	Feb. 2017–Nov. 2019
VIII	Activities database	Project plans, reports	Jan. 2017–Dec. 2019

** A temporary coalition consisting of GPs, practice nurses, social support and welfare workers, facilitated by the health broker, with the aim of strengthening the collaboration between care and welfare, focusing on health and behaviour instead of illness and care.*

Step 2. Quotes coded as context were further thematised into historical-, organisational-, and programme-related codes. Quotes coded as mechanisms were also further thematised into programme- or participant-related. Quotes coded as outcomes were classified as related to citizens, community workers, or community. Each theme was further refined into subthemes and labelled as supportive (+) or restraining (-), thus addressing the aim of differentiating and accumulating evidence on positive and negative CMO configurations [46].

The coding procedures were conducted independently by two researchers (first and second author). Both researchers found that the same phenomenon could be coded as outcome or context, or as context and mechanism, as was also found by Herens et al [33]. Differences in coding were discussed until consensus was reached, thereby making explicit that all coding was based on the perspective of the actual VoM programme activities and processes.

Step 3. Sources IV and V (Table 5.1) were part of sub-studies in which (IV) citizens' perspectives on the living environment were studied [50] and (V) active citizens were asked about the benefits of participation in (health promotion) activities and volunteer work [51].

Table 5.2 Operationalisation of context-mechanism-outcomes concepts in the VoM programme

Concept	Theoretical definitiona	Operational descriptionb	Thematic elaborationc
Context	Refers to the fact that a relationship between causal mechanisms and their effects depends on the specific circumstances	Something (situation or condition) that existed prior to the start of the VoM programme or something happening outside control of the programme	Historical factors Organisational factors Programme-related
Mechanisms	Responsible for the relationship between context and outcome; the cognitive or affective responses of participants to resources offered [53]	Activities and actions taken by actors (citizens, community workers, coalition members) in the VoM programme	*Programme-related*: actions taken by community workers, VoM coalition members *Participant-related*: actions taken by citizens
Outcomes	Results from different layers of reality in social explanation	Results of the VoM programme; programme outputs and short-term outcomes (Fig. 1). Intended short-term and long-term outcomes as defined in the programme theory and unplanned outputs and outcomes as perceived by stakeholders (community workers and citizens)	Results at the level of: - citizens - community workers - community

[a] Based on Pawson et al (2005) [53], Jagosh et al (2015) [31], Herens et al (2017) [21]; [b] Based on Calò et al (2020) [44], Marchal (2012) [54]; [c] Based on Herens et al (2017) [21]

Transcripts of the interviews and group sessions were also coded in terms of contexts (C), mechanisms (M), and outcomes (O). Deductive or top-down analysis was applied by the first author, based on the mechanisms and CMO configurations resulting from Steps 1 and 2.

Step 4. The reports and minutes of the meetings (Sources VI and VII, Table 5.1) were studied to check how often and in what manner the context conditions, mechanisms, and outcomes of interest found in Steps 1 and 2 had been reported.

Step 5. The activities database (Source VIII, Table 5.1) was used to gather more in-depth information about the programme outputs, e.g., the number of participants, the involvement of community workers, duration of the activities, and so forth.

On completion of these steps, two researchers (MdJ, GW) brought together the results in an overview of the most important context conditions, mechanisms, and reported outcomes for each of the action principles. First, the citizen participation action principle was elaborated, followed by intersectoral collaboration, and this made an overlap in CMO configurations visible. The context conditions were divided into supportive and restraining, and programme-related context conditions were marked. The overviews were presented in two figures, one for each action principle (Fig. 5.2 and Fig. 5.3). Subsequently, these figures were discussed with all authors (MdJ, GW, MK, AW) and consensus was reached.

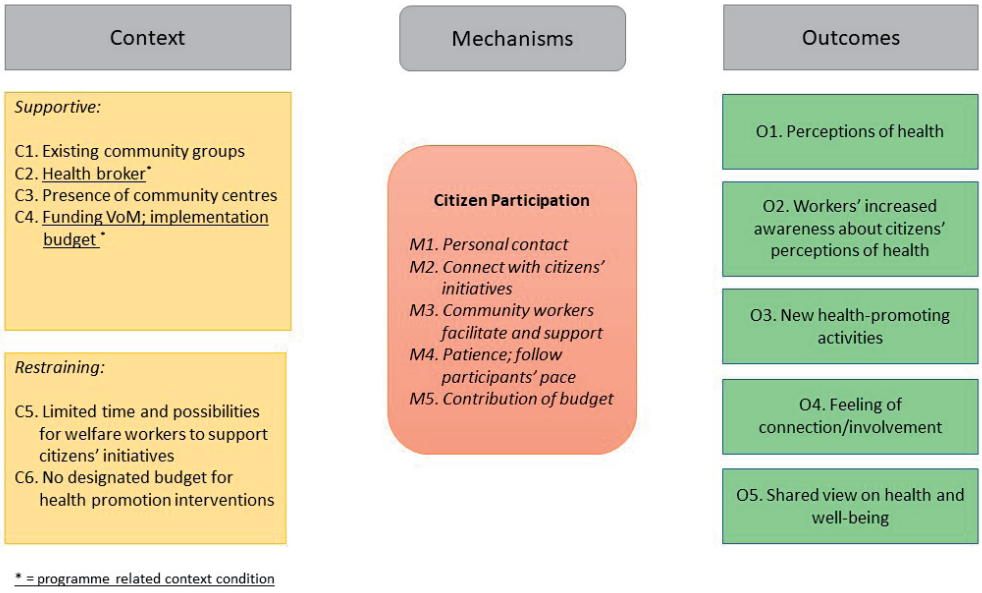

Fig. 5.2 *CMO configurations citizen participation*

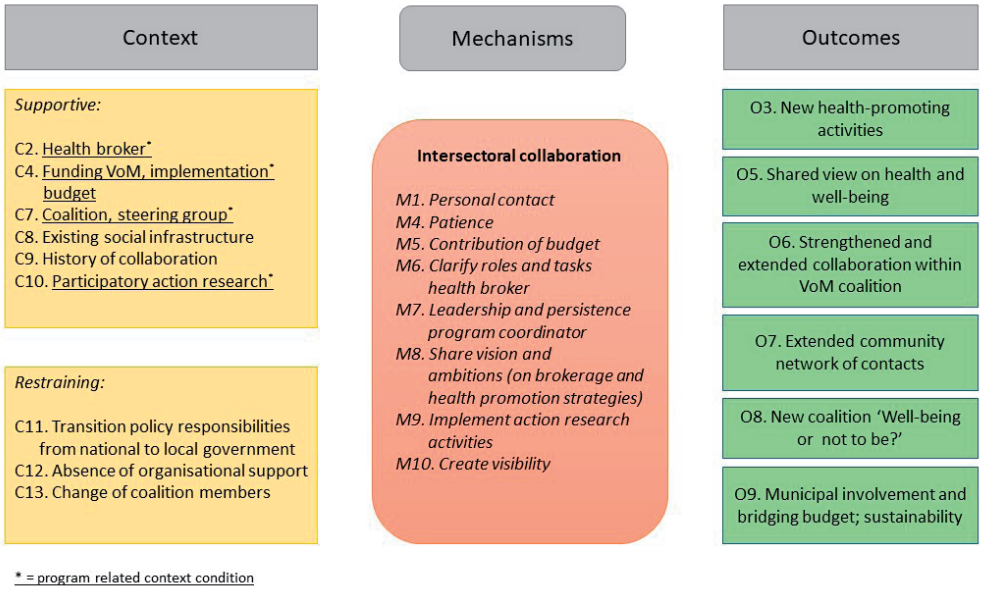

Fig. 5.3 *CMO configurations intersectoral collaboration*

5.3 Results

The VoM programme initiated a variety of new health-promoting activities in the city district that were organised and implemented together with the citizens, e.g., chair gymnastics, a 'Looking for sense' course, a toy lending point, and a reconstruction of a neighbourhood square. The activities were characterised by a great diversity in content, intensity, duration, and the number and kind of participants, e.g., the toy lending point was run by six volunteers for more than two years, five citizens were involved in the reconstruction committee for the neighbourhood square, and 40 older persons participated weekly in chair gymnastics in different groups, which continued after the VoM programme ended.

In 2017, the VoM programme started by exploring perceptions of health with existing community groups (C1), leading to insights into how citizens perceived health (O1) (Fig. 5.2). Social relations and interaction, physical activity, and a positive life attitude were mentioned as the most important perceptions of health.

> *If you keep on moving, you experience: I feel healthy.* (Yoga group participant)

> *To stay healthy, you need to think positively about all problems.* (Language group participant)

The results of these group sessions caused awareness among community workers (O2) about the significance and perceptions of health and resulted in new health-promoting activities (O3). The health broker (C2) managed to involve the community groups by utilising personal contacts (people knew her) (M1) and by taking the presence of community centres as a base (C3). New health-promoting activities (O3) resulted from these contacts and from connecting the ideas of participating citizens with existing citizens' initiatives (M2).

The development and implementation of new health promotion activities (O3) were also facilitated and supported by community workers (M3) and often took place in the community centres located in the city district (C3). These community workers, including the health broker, built the collaboration with citizens on personal contact (M1).

All activities were facilitated by funding from the VoM programme and brokerage and support from the health broker or another VoM coalition member, who regularly kept in touch with individual citizens and community groups by 'showing their face' and following citizens' pace (M4), thus establishing trust.

> *Most important is building trust. Take your time to get to know people and show your face from time to time.* (Health broker)

Citizens who participated or volunteered in activities felt connected and involved as a result (O4).

> *At the course ['Looking for sense'], I am included in the group*. (Participant)

> *Knitting connects us*. (Knitting group participant)

In the first 1.5 years, the health broker was responsible for the achievement of most of the activities, always in cooperation with citizens and other community workers. Because of changes in local health and social support policies and organisational choices resulting from that, community workers found that they had limited possibilities to support citizens' initiatives (C5). Cutbacks on welfare work and policy prioritising individual support measures meant that no designated budget for health promotion activities was available (C6). The activity budget provided by the externally funded VoM programme (M5), together with community workers' motivation to facilitate and support (M3), helped to achieve new health-promoting activities (O3).

> *The organisation of the social support teams is turned upside down, which means that our role is unclear, which makes collaboration difficult.* (Social support team member)

> *Within the existing procedures and regulations, group activities are very difficult to organise.* (Social support team member)

Later, community workers, especially the SST members, became more and more involved in the programme, eventually taking over the health broker role (C2). They anticipated the termination of the contribution of the health broker, who was temporarily subsidised as part of the VoM programme. By taking over this role, the SST members, financed by the local government to execute the social support law, were able to foster the sustainability of the activities. Several years of working together closely with Voorstad citizens, and listening to the citizens' perspectives about health, resulted in a shared view on health and well-being (O5).

> *… that health is so much more than healthy eating and physical activity, or stop smoking, but that it is mainly in the social environment and interactions.* (Health broker)

According to the coalition members, one of the most important outcomes was the strengthened and extended collaboration within the VoM coalition (O6) (Fig. 5.3) and with a variety of stakeholders, citizens as well as workers, in the community. Important outcome-generating mechanisms identified by the coalition members were clarity about

roles and tasks within the VoM coalition (M6), the programme coordinator's leadership and persistence (M7), and sharing vision and ambitions regarding brokerage and health promotion strategies (M8) (Fig. 5.3).

> *I am proud of the obvious collaboration. We contact one another more easily; that's how we do it here. We know how to find one another and that yields a lot for the neighbourhood.* (Social services team worker)

The combination of supportive context conditions like a steering group (the VoM coalition) (C7), the existing social infrastructure (C8), and a history of collaboration (C9) together with personal contact (M1) and patience (M4) resulted in the involvement of new community groups, organisations, and individuals in the coalition's network (O7). In addition, a new coalition, named 'Well-being or not to be?' was formed (O8).

A restraining context condition was the unstable (policy) context in which the VoM programme was implemented because of transitions of policy responsibilities from the national to the local government (C11). Partly because of this, coalition members were confronted with cutbacks and uncertainty at the start of the VoM programme, because of the limited support from their organisations (C12) and changes in their own organisation and coalition members (C13) that diverted attention from collaboration. The implementation of action research activities (M9) helped the coalition members to recognise the processes that evolved within the coalition and made it possible to act upon them.

> *I put lots of time and energy into it and then sometimes you ask yourself: does anything come out of it? The research provides the insight that it really does!* (Coalition member)

In the final year of the VoM programme, no new activities were initiated; instead, the focus of the VoM coalition and community workers was on the continuation of health promotion activities, participation by citizens and community groups, and sustaining the collaboration and the broader network. The PAR (C10) that accompanied the VoM programme increased awareness of the coalition's achievements, like for example the organisation of the training programme 'Leader recreation and physical activities' that eight citizens completed successfully. Subsequently, coalition members paid more attention to creating visibility (M10) for their achievements. Visible achievements, among other things, presented in a 'Keep Voorstad moving' movie, contributed to the involvement of the municipality in the VoM programme and the allocation of a bridging budget (O9) by the end of the programme term, when the funding budget ended (C4). This was promising for sustaining the VoM coalition and communitywide collaboration into 2020 and beyond. With the bridging budget, two successful health promotion activities – the 'Looking for sense' course and chair gymnastics – could be continued in 2020.

5.4 Discussion

In this study, we adopted a realist evaluation approach to unravel mechanisms underlying the citizen participation and intersectoral collaboration action principles applied in the CBHPP, Voorstad on the Move. Because most evaluation studies still focus on measuring outcomes, the added value of this study was to give more tangible substance to these action principles. Using a realist evaluation approach helped to gain insight into what worked under the given circumstances and at the same time to identify a wide range of outcomes, as perceived by the programme's stakeholders. The findings contributed to amplifying and enriching the programme theory with the most important working mechanisms in practice.

In the VoM programme and in this evaluation study, we have made the citizen participation and intersectoral collaboration action principles central. In fact, these action principles became an aim in themselves from the beginning, and therefore we managed to devote time and attention to them in practice and research. Personal contact, knowing one another, and following participants' pace (patience) are important mechanisms underlying citizen participation and are also necessary mechanisms to build relationships and strengthen collaboration within a coalition and a community network. This indicates that these action principles overlap, and both play a pivotal role in realising outcomes of interest. As putting the action principles into practice resulted in a range of interesting outcomes, we argue for the explicit inclusion of citizen participation and intersectoral collaboration as targets in CBHPPs [20].

The outcomes of the principle-based VoM programme triggered by the combination of context and mechanisms did not occur in a linear process. Context conditions changed constantly because of the implementation and development of the VoM programme and the mechanisms at work. Extra manpower brought in by the health broker and the programme coordinator, together with the implementation budget, were added to the existing historical and organisational context. At the same time, the VoM programme put mechanisms to work that generated a continuous interaction with outcomes, such as new health promotion activities, which in turn led to changes in the context.

This made it sometimes difficult to distinguish context conditions from mechanisms, e.g., the presence and efforts of the health broker is a context condition and the characteristics of the broker's methods, such as personal contact and following the participant's pace, are mechanisms. Other studies have also found that supportive contexts set in motion mechanisms that generate programme outcomes and successes, which in turn influence the contextual conditions [33, 45].

Other studies that examined the benefits and outcomes of citizen participation have found that successful and sustainable community involvement does not occur in a linear way and is challenging [55]. Citizen participation consists of complex processes influenced by a range of social and cultural factors, part of the historical and organisational context, thereby confirming once again the importance of patience and perseverance [56–58].

Looking at the mechanisms underlying the action principles reveals that health promotion professionals and other community workers need specific skills and competences to put action principles into practice, especially leadership and brokerage. Other studies on the broker role contend that skills relate to crossing sectoral borders, agenda setting, facilitating citizen participation, and entrepreneurship [59–61]. Showing leadership requires competences such as vision, setting reachable goals, being motivational and inspirational and a team player. In coalitions, the necessary skills and competences can be allocated to the members and do not have to be put on the shoulders of the health broker or the programme coordinator alone.

PAR was one of the context conditions, and implementing the research activities helped those involved in the VoM programme to gain insights into evolving processes and to make the achievements of the programme visible. Thanks to the PAR activities, along the way, awareness of outcomes grew, and subsequently confidence in the programme approach and the collaboration that had been built up increased. It helped stakeholders to recognise the processes that evolved and to act upon them and to pay more attention to the visibility of their achievements, such as the new health promotion activities and the extended and strengthened communitywide collaboration (38). Therefore, it is recommended to apply PAR as an indispensable part of a principle-based CBHPP, because it adapts to the particular situation in practice and always takes into account the perspectives of the persons involved.

Methodological considerations

Our study indicates that using a realist evaluation approach delivers an in-depth analysis of the CMO configurations and contributes to a better understanding of the workability of the citizen participation and intersectoral collaboration action principles. The insights into the mechanisms in this study concern just one case, which is both a strength and a limitation [62]. On the one hand, it has created a thorough understanding of the CMO configurations in a real-life setting. On the other hand, it may be hard to generalise the findings, because every CBHPP has its own characteristics and is implemented in a different context. In order to gain broader insights into the mechanisms that underly these two action principles and to make adjustments to the programme theory, more practice-based studies are needed.

The focus in this study was on two action principles mentioned in the Ottawa Charter of Health Promotion [30]. Our results demonstrate that citizen participation and intersectoral

collaboration are crucial action principles in CBHPPs and reveal outcomes that relate to the other action principles. For example, new health promotion activities and sustainability of the programme through the municipal involvement shape healthy public policy and action. In addition, the skills and competences stakeholders require for collaboration and citizen participation need to be developed, as made explicit in one of the other Ottawa Charter principles.

One of the limitations of this study was the selection of stakeholders represented in the research. Community workers, especially the VoM coalition members, were actively involved in focus group sessions, interviews, and coalition meetings and thereby contributed to a large extent to the research. Recruitment of citizens was challenging, and this may have created bias in the total group of citizens involved in favour of those most involved in, and enthusiastic about, the VoM programme. Compared to the community workers, citizens were less represented in the study. In addition, the analytical processes used to develop the CMO configurations, although gone through with different researchers, were inherently vulnerable to subjectivity. This may have resulted in misattributions about the importance of mechanisms and the CMO configurations applied.

5.5 Conclusions

The most notable mechanisms underlying the citizen participation and intersectoral collaboration action principles found in this study were personal contact, patience, perseverance and visibility. The PAR activities that accompanied the VoM programme were both a mechanism and a context condition and triggered outcomes of interest by helping all those involved to recognise processes, take them further, and make the outcomes visible. The realist evaluation contributed to deepening the understanding of what worked under the given circumstances and helped to identify a wide range of outcomes. Adding the underlying mechanisms to the action principles enriches the programme theory and can be helpful for health promotion professionals working in CBHPPs.

As the principle-based CBHPP added value to the existing context and brought in most of the mechanisms that triggered outcomes of interest, it is recommended to include citizen participation and intersectoral collaboration not only as action principles but explicitly as targets in a CBHPP.

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Chapter 6

Perceived benefits of active participation in a community health promotion programme

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This chapter is submitted as:
Perceived benefits of active participation in a community health promotion programme

Abstract

Citizen participation is regarded as central in health promotion to reduce the health gap between groups with high and low socioeconomic status. To obtain a thorough insight into what citizens actively involved in community activities and volunteers working in their neighborhood perceived as the benefits of participation, this study was executed as part of a community health promotion program in the Netherlands. A mixed-methods approach, consisting of a small-scale survey (n=102) and 12 in-depth interviews with active citizens, i.e., citizens participating in activities and volunteer work, was applied. The survey findings identified the active citizens' characteristics in terms of participation, empowerment, and perceived health. Age, education, and experiencing barriers from physical or mental health problems were associated with empowerment and with perceived health. A (strong) association was found between empowerment and perceived health, meaning that respondents with a high level of empowerment perceived their health as (very) good, and a low level of empowerment was associated with medium to low perceived health. Combined with insights from the in-depth interviews, these findings provided a better understanding of the significance and benefits of active participation and citizens' motivations to become involved in the development and implementation of health promotion activities. Follow-up studies combining large-scale and small-scale surveys are recommended to achieve a deeper understanding of participation, empowerment, and perceived health.

6.1 Introduction

It is widely recognized that citizen participation is a prerequisite for successful health promotion. To reduce the health gap between groups with high and low socioeconomic status (SES), citizen participation is regarded as central in an effective multilevel-strategies approach [1–4]. Citizen participation is described as active involvement of citizens, or members of the priority population, in the articulation of the problem and in the development, implementation, and evaluation of health-promoting interventions [5–7]. Various reasons for the importance of citizen participation can be deduced from the literature and include democratic, instrumental, educational, and communitarian arguments [8].

Democratically, citizen participation is advocated as a tool for providing a 'voice to the voiceless' and therefore valuable for tackling health inequalities [9, 10]. Through citizens participation, the context of people's lives can be taken into account, offering opportunities to address the social determinants of health [11]. Moreover, to understand what concerns people, it is necessary to involve the priority population in health promotion programs [12, 13].

Instrumentally, health promotion programs with active citizen involvement are effective because they connect with the existing local situation, informal networks, and cultural aspects [14, 15]. Including people's perceptions and needs regarding health can help to approach health in a positive way, focusing on assets and resources [16, 17].

Educationally, citizen participation enables people to contribute to solving a personal or a societal problem. Citizen participation can increase meaning and awareness of, and responsibility for, health behavior, and also it can increase feelings of self-esteem and competence [18]. These three elements can contribute to a feeling of empowerment [11].

The communitarian argument relates to the involvement of a group or community in health promotion initiatives, resulting in greater control in making decisions and performing actions regarding their own health and in achieving healthier, sustainable lifestyles [19, 20].

Empowerment, described as the process by which people acquire influence on their personal life, is inextricably linked with citizen participation [21]. Empowerment is stimulated not only for the individual, but also potentially for the community if the health promotion approach facilitates a process of assets and needs assessment, capacity building, and local action. In practice, an empowerment approach involves stimulating citizens to work together to gain more control over their lives and health, such as by organizing exercise classes or self-help groups [22].

Although the importance of citizen participation in health promotion programs is emphasized, there is still very little evidence that directly links citizen participation to improved health outcomes or self-reported perceived health; perhaps because, in research, citizen participation is often defined as an intervention and, consequently, it proves impossible to examine the direct causal link between citizen participation and health outcomes [23]. It would be better to examine citizen participation as a context-specific process and to realize that its benefits can be influenced by shifts in social, economic, and political contexts over time [23, 24]. Nonetheless, citizen participation can be linked to positive gains, e.g., in social capital, social cohesion, capacity building, and participants' empowerment or perceived health [25, 26]. Given the value assigned to citizen participation in health promotion and that the benefits do not appear to lie directly in health outcomes but rather relate to many other gains, it is interesting to ascertain what citizen participation contributes, according to participants themselves. Therefore, this study was conducted to get a thorough insight into what citizens actively involved in community activities and volunteers working in their neighborhood perceive as benefits. A comprehensive understanding of the perceived benefits provides information to plan and implement health promotion programs together with citizens and to support policy choices concerning health and social support services. The research question was: What do citizens perceive as the benefits of their active participation in community health promotion activities and volunteer work?

6.2 Methods

Study setting

This study was part of the community health promotion program Voorstad on the Move (VoM), executed in Voorstad, a low SES city district in the Netherlands. VoM had a twofold purpose: (1) to contribute to the improvement of health and (2) to find ways to reduce health inequities. Citizen participation was one of the action principles, together with intersectoral collaboration and a health-supportive environment [27]. The program was led by a steering group, the VoM coalition, consisting of professionals from organizations in public health, sports, welfare, and social support. In the preparatory phase, an explorative study was performed to obtain a broad picture of the health situation in Voorstad [28]. An important finding was that a variety of community groups, some supported by community workers, were active, and a considerable number of citizens were doing volunteer work, indicated as the presence of 'neighborhood power', as the community workers and citizens called it [28]. So, connecting to, and strengthening, the existing social infrastructure seemed a promising way to build further on citizen participation in VoM. The participants consisted of active citizens living in Voorstad.

Study design

This study used a mixed-methods approach, consisting of a survey and in-depth interviews with active citizens. The survey consisted of a digital or a paper questionnaire. Originally, we aimed for a follow-up measurement after 12–18 months to identify changes. However, the second measurement could not take place, initially because of other research activities and, later, the Covid pandemic. The in-depth interviews were used to elucidate the concepts of citizen participation, empowerment, health, and the benefits of active participation as perceived by active citizens.

Recruitment and response

Survey

Between April and October 2018, active citizens were recruited by community workers, all members of the VoM coalition, to contribute to the study by completing a questionnaire to measure benefits in terms of empowerment and perceived health. Criteria for participating in this study were: being a Voorstad inhabitant and participating either as participant or volunteer in one or more community activities. A purposive sampling strategy was used to recruit respondents. A total of 100 respondents was predetermined as representative of the active citizens. At that time, about 350 citizens had participated in VoM activities or were still active as volunteers. With 100 respondents, a variety of sex, age, education level, and type of community activity could be represented (Table 6.1). The questionnaire was accessible digitally or on paper. Participants could complete the questionnaire at the community center or other location where the activities or volunteer work took place. About 10% of respondents completed the paper version at home and returned it to the researcher. Recruitment stopped when n=102 respondents were reached.

Table 6.1 Respondents' characteristics: questionnaire

Characteristic	Active citizens (n=102) in %
Sex	
Male	24
Female	76
Age (yrs)	
18–34	11
35–64	67
> 65	22
Education	
Low	37
Middle	33
High	30
Volunteer	
Yes	58
No	42

The questionnaire consisted of questions about the frequency and nature of respondents' activities, level of participation, empowerment, and perceived health. Participation level was measured using Pretty's participation ladder, asking which of five statements fitted best for the activity or volunteer work in which the respondent participated [29, 30]. Statements included: "*I receive clear information about the activity of volunteer work*", "*I have co-responsibility for the organization of the activities*."

Empowerment was measured using the Netherlands Empowerment Checklist, consisting of seven statements on a 5-point scale ranging from totally agree to totally disagree [31]. Statements included: "*I often feel helpless in dealing with life's problems*", "*What will happen to me in the future depends largely on myself*."

Perceived health was assessed with one question: "How is your health in general", on a 5-point scale ranging from very good to very bad. The question "How healthy do you think your lifestyle is?" had to be answered on a 3-point scale ranging from very healthy to unhealthy to measure perceived lifestyle. Limitations experienced from physical health problems and mental health problems were educed by the question: "Do you feel hindered by physical health problems in your free time?", to be answered on a 3-point scale ranging from strongly hindered to not hindered.

Parts of the questionnaire, especially the statements about empowerment and participation level, were not fully completed. This may be explained by respondents' limited literacy.

In-depth interviews

At the end of the questionnaire, respondents were asked for their e-mail address if they were willing to participate in an interview. Respondents were also recruited by personal contact with a health broker who introduced the researcher to the respondents. Then, the researcher informed the respondents about the interview and the aim of the study and asked them again to cooperate. After consent, the researcher made an appointment for the interview at the respondents' preferred place. Twelve respondents participated in the interviews in March and April 2019 (Table 6.2).

Respondents' ages ranged from 40 to 84 years, eight women and four men. Regarding SES, all but one respondent had a low education level and all 12 respondents had no job, of whom 10 because of retirement, at the time of the interview. All 12 participants were Voorstad citizens, actively involved in community activities either as participant (6) or volunteer (5). Respondents participated in one of the health promoting activities: Coffee morning, Chair gymnastics, or the Giving Meaning course once a week, or they volunteered at the community garden, the toy-loan center, or one of the community centers. One respondent was participating concurrently in a community activity group as both volunteer

Table 6.2 Respondents' characteristics: interviews

	Sex[aw]	*Age*	*Education*	*Work status*	*Health status*	*Role[b]*	*Type activity*
R1	M	70	Low	Retired	Visual handicap	P	Coffee morning
R2	F	79	Low	Retired	Reuma	P	Meaning course
R3	F	79	Low	Retired	CVA	P	Meaning course
R4	F	84	Low	Retired	CVA	P	Meaning course
R5	M	69	Low	Retired	None	V	Community center
R6	F	70	Low	Retired	CVA	P	Chair gymnastics
R7	M	68	Low	Retired	Mental	P	Chair gymnastics
R8	F	71	Low	Retired	None	V	Community center
R9	F	66	Low	Retired	None	V	Community garden
R10	F	49	Low	Jobless	Mental	V	Toy-loan center
R11	M	40	High	Houseman	None	V	Community center
R12	F	70	Low	Retired	None	P&V	Knitting group

a M=male F=female b P=participant V=volunteer

and participant. The others volunteered at a community center or a communal garden. No interviewed volunteer reported any physical or mental health problems, whereas all participants in community activities (the respondent that also was a volunteer included) reported that they were hindered by mental health problems, rheumatism, cardiovascular disease, or a visual handicap. The respondents had lived across subareas in Voorstad for a long time, ranging from 12 years to their whole lives. In the interviews, perspectives on, and the meaning of, active participation were explored, including the perceived contribution of their activities to their feeling of empowerment and health.

Participation was defined as either being actively involved in community activities or groups in the neighborhood or volunteering at one of the community centers or in community activities. Inclusion criteria for respondents were: Voorstad inhabitant, participating in at least one community activity, and having a low SES. In this study, low SES was indicated by a low education level and no paid job. A semi-structured interview guide was used with questions regarding the concepts: community participation, empowerment, and perceived health. In the interviews, the principles of appreciative inquiring were applied, with an emphasis on positive change, to ensure that respondents were inspired to elaborate on their thoughts and experiences [32]. The interviews lasted 35 to 62 minutes (average 45 minutes). Nine interviews were conducted at the respondents' homes and three at a community center. One of the interviews was conducted together with a translator, as the respondent, whose native language was Turkish, understood Dutch only partially.

Mixed-methods analysis

Quantitative data were analyzed with SPSS Statistics 24. Data were described using frequency tables and crosstabs. The empowerment score was the sum of the scores on seven statements and ranged from a minimum of 7 (low level of empowerment) to a maximum of 35 (high level of empowerment).

The score on perceived health ranged from 1 (very good) to 5 (very bad). Correlations between the independent variables – age, sex, education, and barriers resulting from health problems – with the variables – perceived health, health behavior, and empowerment – were calculated and tested with Pearson Correlation tests.

The qualitative study results were prepared (e.g., transcribed, coded) independently by the researcher who conducted the original study in consultation with the first author (VL, MdJ). Transcripts were coded according to the thematic analysis approach using three phases: open coding, axial coding, and selective coding, using Atlas-ti 22. Content analysis was performed by putting all coded interviews together, resulting in key themes and subcodes. The analysis process was iterative, with the researcher constantly going back and forth between transcripts and codes [33]. Two authors (MJ, AW) combined the survey data with the interview results to enrich the overall findings. The final results were checked by all the researchers to ensure that no information was missed or misinterpreted.

6.3 Results

Citizen participation

All citizens who completed the questionnaire were active in one or more activities, often organized by one of the neighborhood community centers. Of them, 58% (=59 persons) reported doing volunteer work. Almost 75% of the volunteers mentioned volunteering at least once a week. A large variety of volunteer work was reported, e.g., board member or assistant at one of Voorstad's community centers, assistant at the children's school or toy-loan project, buddy or coach. Participation levels, according to Pretty's participation ladder, varied. One-third of the respondents confirmed that they received sufficient information about the activity; 25% had been asked about their opinion and/or said that their opinion was taken into account; 18% stated that they were included in decision making; and 22% said that they were co-responsible for organizing activities (Table 6.3).

Empowerment, health, and lifestyle

The scores on empowerment, perceived health, and perceived lifestyle are presented in Table 3. There were no differences in the scores on empowerment, perceived health, or health behavior between respondents who were active volunteers and those who only

Table 6.3 Questionnaire results on indicators participation, empowerment, and perceived health

Indicator	Respondents per category in %				
Participation level (n=73)	Receive good information	Receive good information and opinion is asked	Opinion is asked for and taken into account	Included in decision making	Co-responsible for organization of the activities
	34	**16**	**10**	**18**	**22**
Time spent on volunteer work (n=59)	Once a month or less	Several times a month	Once a week	Several times a week	
	10	**17**	**22**	**50**	
	(Very) Good	Medium	(Very) Bad		Mean score (SD)
Empowerment[a] (n=79)	**13**	**77**	**10**		25.58 (5.23) Min=7 max=35
Perceived health (n=100)	**58**	**35**	**7**		2.36 (0.84) Min=1, max=5
Perceived lifestyle (n=100)	**54**	**41**	**5**		1.51 (0.59) Min=1, max=3
	Strongly hindered	Lightly hindered	No limitations		
Hindered by physical health problems (n=98)	15	29	56		
Hindered by mental health problems (n=97)	3	29	68		

[a] Empowerment scores 7 to 19 = bad, 20 to 31 = medium, 32 to 35 = good

participated in community activities. Over 40% of respondents experienced limitations because of physical health problems, and about a third reported limitations because of mental health problems (Table 6.3).

We found that age, education, and experiencing barriers from physical or mental health problems were associated with empowerment and with perceived health in the study population (Table 6.4). A (strong) association was found between empowerment and perceived health. All respondents with a high level of empowerment perceived their health as (very) good. A low level of empowerment was associated with medium to low perceived health.

Perceived benefits of participation

All 12 interview respondents had participated in more than one (volunteer) activity in the past, and most of them still were at the time of the interview. Seven interviewees reported health problems and physical or mental impediments resulting from chronic disease or

Table 6.4 Correlations between respondents' characteristics and empowerment and health

	Hindered by physical health problems	Hindered by mental health problems	Empowerment	Perceived health	Perceived lifestyle
Sex **N**	0.108 97	-0.101 96	- 0.247* 79	0.099 99	-0.75 99
Age **N**	0.263** 98	0.141 97	-0.009 79	-0.224* 100	-0.100 100
Education **N**	-0.152 96	0.177 95	0.260* 78	0.201* 97	0.221* 97
Hindered by physical health problems	—	0.259* 97	-0.404** 79	-0.596** 98	-0.144 98
Hindered by mental health problems	—	—	-0.470** 79	-0.494** 97	-0.227* 97
Empowerment			—	0.501** 79	-0.180 79

* Correlation is significant at the 0.05 level (2-tailed). ** Correlation is significant at the 0.01 level (2-tailed).

handicap. All of them emphasized the importance of independence and having control over their lives.

I still am not demented, I still can walk by myself, not that far, but… and I am able to travel with public transport. So, I deserve an eight for independence, why not. (R4)

Overall, the in-depth interviews revealed four key themes: meaningfulness, social contacts, having good times, and connection and involvement.

Meaningfulness

The respondents reported that their community activities or volunteer work added value to their personal lives. This added value varied from satisfaction after performing the volunteer work, to the ability to be themselves within the community activity group, to being in control and able to choose. In addition, respondents participating in volunteer work experienced that the activities contributed value to societal life, by bringing joy either to other participants or to the whole neighborhood, because it kept the neighborhood clean and cozy or the community center running. One respondent mentioned that doing something in return motivated her to do volunteer work. In return for receiving her pension, she took care of the community garden.

When you see that things are going well. That's where you get your energy from. (R10)

Social contacts

All respondents perceived contact with other community members as a positive aspect of participating in activities and volunteer work and a reason to join community activities. On the one hand, they emphasized interpersonal contact as a necessary condition for individual well-being and feeling part of a group or social network. On the other hand, participating in a community activity or volunteering together was considered as a contribution to living together pleasantly in a neighborhood. Interpersonal contact varied from greeting one another in the street to a more profound, or long-term, contact or friendship. Some respondents met new people thanks to the community activity.

> *At the community center, you always run into different people, so you always have another chat*. (R5)

> *Also, exchanging opinions, thinking together about ways to solve a problem, then I am doing something, then I am in contact with others, just being among others*. (R6)

Having good times

For almost all respondents, participating or volunteering literally meant having something to do that they enjoyed. The activities gave them a reason to get out of their homes and offered distraction. Having something to do helped respondents to clear their minds and as a result feel at ease. Only a few respondents reported that participating or volunteering meant being physically active, e.g., in a chair gymnastics group, or because of manual labor or moving around the neighborhood.

> *The coffee morning fills a gap in the week*. (R1)

> *Change your mind, yes. Your mind stays free, when you are busy doing something. I would not know how to formulate it otherwise*. (R8)

Having good times is often indicated in Dutch by the word *gezelligheid* to describe a social setting that is experienced with joy. Although respondents acknowledged that one can have good times on one's own, the social aspect is important. Having good times in a social setting kept the respondents motivated to continue their volunteer work and to participate in community activities. It is clear that this theme is strongly related to social contacts.

> *Having good times. And also, that, not only when good times, but when you feel a little less, that you accept one another. And when something is going on, that you can speak out and do not think, well I'd better not talk about it*. (R12)

Connection/involvement

A feeling of connection was frequently mentioned as a benefit of participation. Thanks to the community activity, respondents felt connected with other participants or even with their neighborhood. For some respondents, a connection entailed being part of a group of people that meet on a regular base and work together on a specific project or target.

> *At the course [Meaning course], I am included in the group*. (R2)

> *Knitting connects us*. (R12)

Feeling mutually connected cannot be separated from involvement, and together they were seen as important values for community life. For this, the respondents noted, it is important to join hands and to collaborate as citizens. By involvement, respondents meant either accomplishing something together, e.g., running the community center, knitting a three-kilometer-long scarf, or supporting, valuing, and helping one another. The respondents emphasized that, without a connection to other people, there was no involvement and, without involvement, the connection is not as strong.

> *I think, because we know our neighbors, you do not have to talk regularly, not every day, but knowing that if something is up, that you can find one another, that they are there for you*. (R11)

All respondents emphasized the presence of a community center as adding value to the neighborhood as a whole. The community centers were seen meeting points; they facilitate meeting new people and maintaining connections with others in the neighborhood, and help people to pull themselves or other community members out of their homes.

> *I want this [community center] to continue. Suppose it is gone. Then you would have a group of people that would stay at home. Then the isolation becomes bigger again. Now, they have found the way to the community center. It pulls them out of their house, they start making connections with one another. If that is taken away, then clearly, there will be decay*. (R11)

Fig. 6.1 presents the perceived benefits of participation: having good times, social contacts, connection and involvement, and meaningfulness. They are clearly interrelated, as having good times cannot exist without social contacts, and social contacts in turn create meaningfulness and conditions for feeling connected and involved.

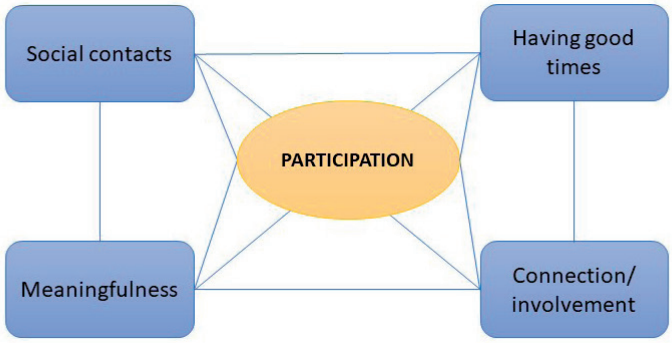

Fig. 6.1 Benefits of participation

6.4 Discussion

In this study, we explored the benefits of citizen participation, as perceived by active citizens in the Voorstad city district. The survey findings provided insight into what characterized the active citizens in terms of participation, empowerment, and perceived health. In the study population, age, education, and experiencing barriers from physical or mental health problems were associated with empowerment and with perceived health. A (strong) association was found between empowerment and perceived health, indicating that a high level of empowerment is associated with a good to very good perceived health and vice versa. Combined with the insights from the in-depth interviews, these findings provided a better understanding of the significance and benefits of active participation as perceived by citizens.

With the small-scale survey, we successfully included citizens with socioeconomic and health disadvantages from whom we wanted to learn more. The survey generated results that could not be found in large-scale surveys. The study population appeared to have relatively low scores on perceived health and empowerment compared to the figures from large-scale surveys, e.g., the municipal health service's health monitor [34] or the Deventer citizen survey [35]. Given the strong correlations between education and reported limitations because of health problems with empowerment and perceived health, our tentative conclusion was that less educated citizens are less represented in these large-scale surveys. This was confirmed by closer examination of the respondent groups in those surveys; and it is precisely these large-scale surveys that are customarily used to determine differences between city districts in health status and to justify choices in local health policy and investment in health promotion.

Active participation in the community seemed to be part of these citizens' lives, and, despite limitations experienced because of physical or mental health problems, considerable time was spent on it and co-responsibility was even taken for the organization of community activities. Perceived benefits related to social participation in general and remaining independent and self-reliant.

Although improving health was barely mentioned as a reason to be active, or as a direct benefit of active participation, the perceived benefits that emerged from this study do have a relation with health. Actually, having good times, social contacts, connection, and meaningfulness correspond with the perceptions of health found in an earlier study [36] and are recognized as dimensions of health in [37] positive health model. These themes are therefore interconnected, and together they contribute to the more comprehensive concept of well-being [38].

The perceived benefits that emerged from this study and are confirmed by other studies [39] can be used to operationalize the multidimensional concept of health or well-being. A shared definition of the benefits and their translation into measurable questions can be used in large-scale surveys, in which perceived health, until now, has been measured with only one question. This one question does not fit with the broad way in which people perceive health in everyday life [40, 41].

The perceived benefits concern not only individual citizens, but also living together and interacting with one another in the neighborhood. Notable here is the role of the community centers, which can be regarded as health assets and facilitators of social networks. This is consistent with other studies that concluded that community involvement in the development of health programs can have positive effects on neighborhoods by increasing social cohesion; and social cohesion and a feeling of empowerment can contribute to people's perception of health [42–44].

From the citizens' perspectives, the educational and communitarian arguments [18, 20] in particular are valuable reasons for citizen participation, and professionals choose it particularly because health promotion programs are more effective when citizens are involved; the instrumental argument [14, 17].

Methodological considerations

The combination of quantitative and qualitative methods provided useful information that helps to elucidate the benefits of participation and can be used for further development and implementation of participatory strategies in the VoM program. We intended to compare our survey results with the Deventer citizens' survey data and had therefore chosen to use the same questions as in that large-scale survey. Although comparison of results by

statistical analysis was not possible, we were able to compare respondents' characteristics and consequently conclude that we succeeded in including citizens with socioeconomic and health disadvantages.

A follow-up measurement of the survey could provide a deeper appreciation of the benefits resulting from participation in health promotion activities. It should be noted that, if the same questionnaire is used, attention must be paid to missing answers, probably resulting from the respondents' lower literacy. The Empowerment Checklist, for example, had relatively many lacunae, making the measurement of this topic less reliable.

6.5 Conclusion

The perceived benefits of participation -meaningfulness, social contacts, having good times, and feeling connected and involved -together contribute to the more comprehensive concept of well-being. On the basis of our findings, we recommend complementing the prevailing large-scale surveys with more targeted small-scale surveys to include citizens with low SES and obtain a better understanding of participation, empowerment, and perceived health. Furthermore, a follow-up large-scale survey – with the benefits found in this and other studies translated into measurable questions – about perceived health and benefits of participation is recommended. It may thus be possible to determine the – hitherto elusive – link between citizen participation and perceived health.

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Chapter 7

Overall impact of the Voorstad on the Move programme in terms of programme outputs

Marja A.J.G de Jong, Maria A. Koelen and Annemarie Wagemakers

7.1 Introduction

For the evaluation of the impact of the community-based health promotion programme called Voorstad on the Move (VoM), a logic model was presented in the study protocol [1] (Chapter 2). The logic model for evaluation was based on literature on community-based approaches and evaluation studies of complex community health promotion programmes [2, 3]. The hypothesis was that – in the long term – the community-based participatory approach implemented in the VoM programme would lead to improved community health, health-supportive environments, sustainable local health policy, and a reduction in health inequities. These long-term expected outcomes would be preceded by measurable short-term outcomes like, e.g., awareness, (feelings of) empowerment, healthy alliances, and changes in the physical environment, moderated by action principles. Short-term outcomes, in turn, would be induced by programme outputs like insights into citizens' perception on health, health promotion activities, as well as citizen participation and intersectoral collaboration.

In this chapter, part of the fourth research question: What is the overall impact of the Voorstad on the Move programme in terms of health promotion activities, social and physical environment, and inhabitants' perceived health? is answered. The focus is on the programme's outputs in terms of programme activities, research activities, and the involvement of stakeholders/professionals, volunteers, and participants as described in the logic model (Fig. 7.1), complementing the data in chapters 5 and 6.

In this model (Fig. 7.1), the realised programme outputs and short-term outcomes are displayed, based on the results of this study. These outputs and short-term outcomes differ at some places from the intended programme outputs and outcomes, defined at the start of the VoM programme and described in fig 2.5 in the study protocol (chapter 2).

7.2 Methods

To determine the outputs of the VoM programme, a combination of methods was used. As part of the participatory action research that accompanied the VoM programme, data were collected throughout the programme between 2017 and 2019.

The activities that originated from the VoM programme were registered and monitored in an activities database, in which project plans, reports, and some characteristics of the participants were kept. Midterm and end evaluation sessions with coalition members; individual interviews with coalition members, including the health broker; semi-annual progress reports prepared by the programme coordinator; and minutes of the VoM coalition

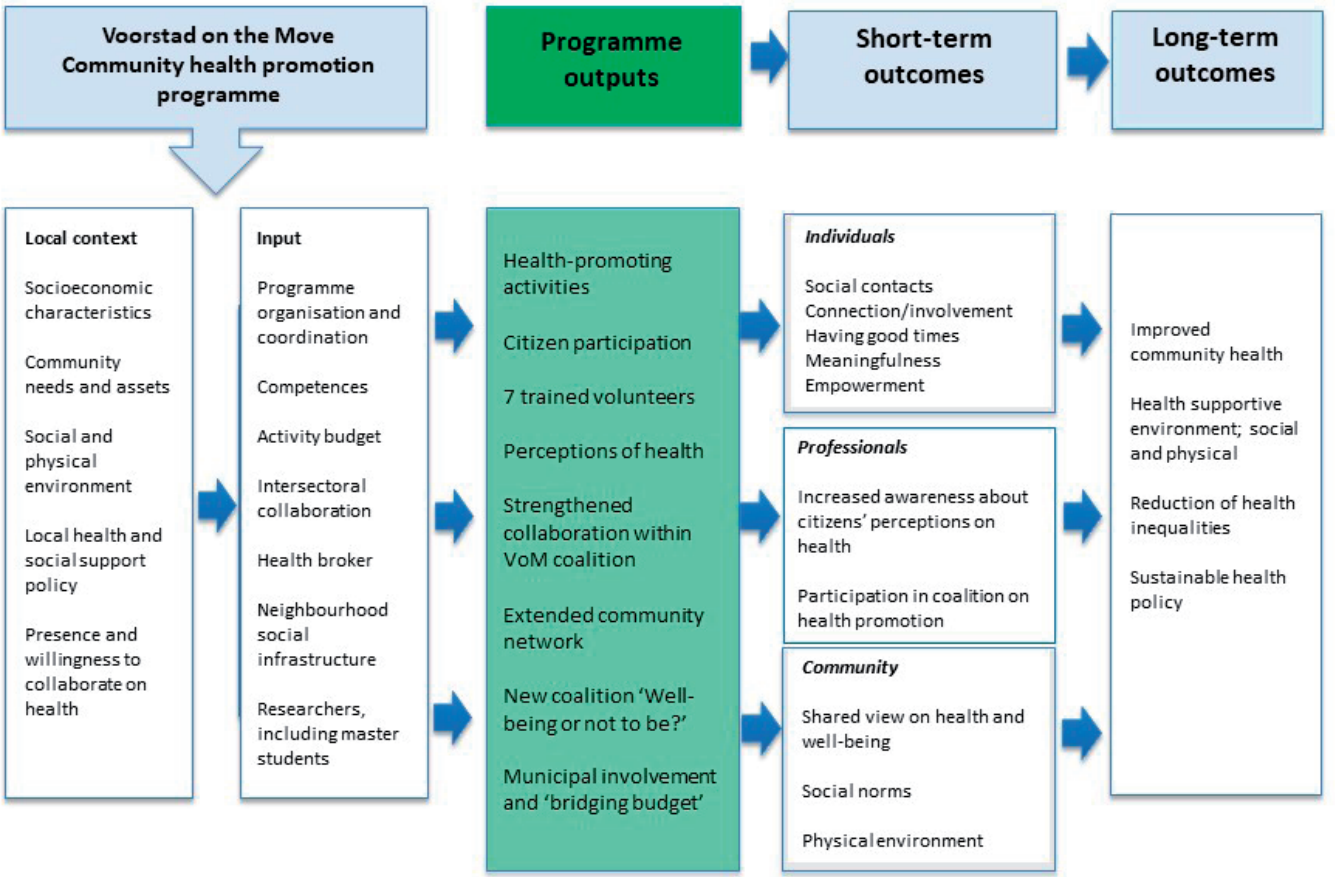

Fig. 7.1 Logic model used for evaluating Voorstad on the Move: programme outputs

meetings were analysed to retrieve data on programme activities, research activities, responsible professionals and involved volunteers, and inhabitants. For visibility, the activities were reported using a timeline. All sources are brought together in Table 7.1.

Table 7.1 Data collection scheme

	Source (material)	Methods	Dates
I	Activities database	Project plans, reports	Jan. 2017–Dec. 2019
II	Midterm and end evaluation intersectoral collaboration[a]	6 individual interviews with VoM coalition members 4 group sessions with VoM coalition members (n=6 per session)	Jan.–June 2018 Nov. 2019
III	Semi-annual progress reports, part of the overall evaluation of the FNO HFN programme[b]	7 reports by the programme coordinator	Feb. 2017–Dec. 2019
IV	Monthly meetings of the VoM coalition	Minutes of the meetings 40 reports	Feb. 2017–Nov. 2019

a See [4]; b see [5]

7.3 Results

All new health-promoting activities – community activities, in which inhabitants participated (in green cells), action research activities (in blue cells), and additional activities for community workers and inhabitants (in brown cells) – are presented in Table 7.2.

During the term of the VoM programme, from July 2016 to December 2019, 15 different activities were organised and implemented, together with the Voorstad inhabitants. A large diversity in content, intensity, duration, as well as in the number and kind of participants, characterised the activities. In the first 1.5 years, the health broker (HB) was responsible for the achievement of eight activities, always in cooperation with (sports) community worker/health broker sports (HB-S) and citizens. Later, starting in the second half of 2017, members of the social support team (SST) became more and more involved in the programme. From the year 2018, two members of the SST took over the health broker role. All activities were made possible with funding from the VoM programme and brokerage and the support of (one of the) members of the VoM coalition. Activities in the VoM programme were dependent on the temporary programme funding. Therefore, activities not being supported in other ways, could not be continued after the VoM programme ended. Nevertheless, the VoM programme had contributed to a solid foundation for sustainability of the community health promotion approach, for collaboration in the VoM coalition had been strengthened, the communitywide network had been extended, citizens were actively engaged and the municipality was involved in the programme. Involvement of the municipality resulted in

Table 7.2 Overview of programme outputs: health promotion activities, research activities, and additional activities

2016 2017 2018 2019	Responsible worker*	Inhabitants involved**
Toy lending point	HB	6 V
Budget cooking workshops	HB	26 P
'Mothers on the move'	SST	35 P
Mancave cooking workshops	HB	23 P
Voorstad kids	HB	65 P
Gardening project	WF	6 P
Outdoor playing 'Molentuin'	HB-S	15 P, 4 V
Physical activity workshops	HB-S	15 P
Group sessions 'Perspectives on health'	HB, HB-S, SST, AR	89 P,
Neighbourhood communication boards	HB, SST	8V
Intersectoral collaboration and network analysis	AR	6 coalition members
Looking for sense course	HB, SST	24 P, 1 V
Beestenmarkt reconstruction, watertap and opening 'party'	ST, WF, HB-S	5 V
First aid 'kids' course	WF	6 V
Chair gymnastics	SST, HB-S	40 P
Healthy eating workshop kids	SST, HB	8 P
Healthy high tea for elderly	SST	8P
Photovoice project: health-supporting environment	HB, AR	16 P
Benefits of participation study	HB, AR	100 + 12 P
Project *Well-being or not to be?* Primary care–welfare coalition	HB, SST, WF	15 CW
Course 'healthy nutrition'	HB-S, WF	10 P
Volunteers' course: 'Leader sporty recreation'	HB-S, SST, WF	7 V

2016	2017	2018	2019	Responsible worker*	Inhabitants involved**
			Group sessions 'How about health?"	SST, AR	29 P
			Film 'Keep Voorstad moving'	PC, HB	
			Municipal involvement and bridging budget 2020	PC, SST	

* HB=Health broker, HB-S=Health broker-sports, SST=Social support team, WF=Welfare worker, AR=Action researcher, PC=Programme coordinator; ** V=Volunteers, P=Participants

health promoting activities research activities additional activities
continuation of activities

a bridging budget (in orange cell). This budget made it possible to continue the 'Mothers on the move' group, the 'Looking for sense' course, and chair gymnastics could in 2020.

The participatory action research activities listed in blue cells in Table 7.2 generated specific programme outputs like insights into perceptions of health, strengthened collaboration within the VoM coalition, and an extended communitywide network. These impacts are described in Chapter 3 and Chapter 4.

Finally, other programme outputs, defined as additional activities (in brown cells), are worth a mention. The *Well-being or not to be?* coalition and the volunteers' course originated from other projects in which VoM coalition members were active, running in the same city district and in the same time period. As we managed to connect both initiatives to the VoM programme, thereby creating a win-win for all stakeholders, we regard them as programme outputs. Moreover, VoM programme funding was invested to make these initiatives possible. In the newly formed *Well-being or not to be?* coalition, SST members and welfare workers collaborated with general practitioners and practice nurses to transform the illness and care vision into a vision of health and behaviour. It started with training and peer/professional consultation together as a group in order to get to know and understand one another better, personally and regarding vision and working strategies. Subsequently, joint activities were undertaken, like visits to the 'Mothers on the move' group and other community groups to talk about health and health behaviour.

The volunteers' course started with 10 Voorstad citizens who aimed to become leaders in sports recreation, qualified to organise and support sports and play activities in their neighbourhoods. Seven citizens completed the course successfully and, by putting their

qualifications as trained volunteers into practice, they were able to contribute to the sustainability of specific health promotion activities.

With the end of the VoM programme approaching, a film entitled 'Keep Voorstad moving' was produced. With this film, which premiered at a closing meeting with the same title, the characteristics and yields of the VoM programme were explained by workers and citizens. Thereafter, the film was used several times in meetings and presentations, presenting the VoM programme as good practice and a plea to implement the community health promotion approach.

Municipal involvement in the VoM programme, with both a policy officer and an alderman, is an important programme output that contributed to the sustainability of the community health promotion approach and intersectoral collaboration on health in the city district. The budget allocation facilitated the continuation of several health promotion activities.

7.4 Conclusion

In this chapter, we have provided an overview of the programme outputs as part of the overall impact of the VoM programme. The programme outputs consist of a large variety of health promotion activities, action research activities that generated impact, and additional activities that contributed to sustaining the community health promotion approach implemented in this programme. This study demonstrated that the impacts of the VoM programme were made possible with external funding and that (extra) budget is indispensable for sustainability.

Methodological considerations regarding research question 4 and research methods used are discussed in the next chapter; 'General discussion'.

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Chapter 8

General discussion

8.1 Introduction

From 2016 to 2019, a community health promotion programme called Voorstad on the Move (VoM) was implemented in a socioeconomically deprived city district in the Netherlands to improve the perceived health of the Voorstad inhabitants, mostly families with a low socioeconomic status (SES), and to achieve changes in the social and the physical environment that support health and healthy behaviour. The programme was grounded in a socioecological perspective, had a principle-based approach with citizen participation and intersectoral collaboration as central elements, and was guided by participatory action research.

The aim of the VoM programme and the accompanying research was to search for keys to diminish the disadvantages in (groups of) inhabitants' health. More specifically, this thesis was designed to study and understand the impact of a community health promotion programme on health and health-supportive environments on the one hand and the working of the action principles to realise output and outcomes on the other hand, thereby contributing to finding ways to reduce health inequalities.

This chapter starts with a summary of the main findings as described in each chapter. Then, the relevance of the findings and key insights resulting from the study are discussed, followed by methodological considerations. In this final chapter, the VoM programme follow-up activities in 2020–2022 are also addressed, as the present author (researcher and project coordinator) was still involved. Finally, overall conclusions and implications for health promotion practice, policy, and research are formulated.

8.2 Summary of main findings

The main findings that resulted from studying the four interrelated research questions are presented in Chapter 3 to Chapter 7. A summary of these findings is given in Table 8.1.

In **Chapter 3**, the research question: How do Voorstad inhabitants perceive health and health supportive environments? is addressed. At the start of the programme, as part of the action research, concept mapping was used to actively engage community members. Eleven existing community groups, together with community workers, participated in the study. Participants in all groups agreed that health entails more than the absence of disease, and therefore it is a multidimensional concept. The study revealed seven perceptions that were most important according to the participants: (1) social relations and interactions, (2) physical activity, (3) positive life attitude, (4) feeling in control, (5) healthy nutrition, (6) mental rest, and (7) the natural environment. The findings show that it is necessary to

create a supportive social environment to facilitate behaviour change and improve health. Citizens considered the natural environment a notable health asset and therefore a resource to maintain and sustain health and well-being.

The concept mapping study helped to involve citizens and community workers, and the results were used to develop the VoM programme together. It became clear that the focus in the health promotion programme should be on the social dimensions of health, offering citizens different possibilities for action on demand and adapted to their wishes. Activities should have a positive approach and should take place in the neighbourhood free of charge, thereby fostering social relations and networks.

Chapter 4 describes the study that revealed insights into research question 2: the processes that facilitated building and maintaining intersectoral collaboration within the VoM coalition and its network and how these processes contributed to the coalition's ambitions.

As part of participatory action research, the coordinated action checklist and composed network analysis were used as research instruments in 2018 and 2019. The results were linked back to the coalition in five group sessions and used for reflection on progress and future planning of the VoM programme. The research instruments integrated in participatory action research proved useful for evaluating the collaboration and revealed in-depth insights into the processes and the interdependences between them. The most prominent processes affecting the collaboration were coalition governance, interaction with the context, network building and the broker role, and generating visibility of the outputs. Moreover, they helped the community workers and researchers to optimise their working strategies and act upon them, and they strengthened the coalition's capacity. The particular processes described evolved simultaneously and interacted mutually, concurrently resulting in visible outputs. Making the outputs – some unexpected – visible contributed to the commitment and continuation of the coalition, as is required to realise community change and desired health outcomes in the long term.

In **Chapter 5**, the findings of a realist evaluation study to unravel the mechanisms underlying the action principles in the VoM programme, part of research question 2, are presented. The qualitative data used in this study originated from multiple sources and methods to ensure validity, including evaluation sessions and individual interviews with coalition members and the health broker, group sessions with community workers and citizens, semi-annual progress reports, and minutes of the coalition meetings. The most notable mechanisms found to underly the citizen participation and intersectoral collaboration action principles were personal contact, patience, perseverance, and visibility. Furthermore, the participatory action research activities that accompanied the VoM programme were both a mechanism and a context condition and triggered outcomes of interest by helping all those involved

to recognise processes, take them further, and make the outcomes visible. The realist evaluation methodology that was followed contributed to further elucidating what worked under the given circumstances and helped to identify a wide range of outcomes.

Research question 3 about the benefits observed by citizens participating in the VoM programme in terms of perceived health, lifestyle, and empowerment is discussed in **Chapter 6.** A mixed-methods approach was applied, consisting of a small-scale survey and 12 in-depth interviews with citizens participating in activities and volunteer work. The survey findings showed that age and experiencing barriers from physical or mental health problems were negatively associated, and education was positively associated, with empowerment. Moreover, a (strong) positive association was found between empowerment and perceived health, meaning that respondents with a high level of empowerment perceived their health as (very) good, and a low level of empowerment was associated with medium to low perceived health. The in-depth interviews revealed the following perceived benefits of participation: meaningfulness, social contacts, having good times, and feeling connected and involved. It appeared that these benefits together contributed to the more comprehensive concept of well-being. Altogether, the findings provided a better understanding of the significance and benefits of active participation of citizens with low SES and their motivations for becoming involved in the development and implementation of health promotion activities.

In **Chapter 7**, part of research question 4: What is the overall impact of the Voorstad on the Move programme in terms of health promotion activities, social and physical environment, and inhabitants' perceived health? is answered. The focus is on the programme outputs in terms of programme activities, research activities, and the involvement of stakeholders/ professionals, volunteers, and participants as described in the logic model presented in **Chapter 2**, the study protocol. During the term of the VoM programme, 15 different activities were organised and implemented, together with the Voorstad inhabitants; these activities were characterised by a large diversity in content, intensity, duration, and the number and kind of participants. The participatory action research activities generated specific programme outputs such as insights into perceptions of health, a strengthened collaboration within the VoM coalition, and an extended communitywide network. Additional activities, which could be regarded as programme outputs, were the W*ell-being or not to be?* coalition and the volunteers' course 'Leader sporty recreation'. Finally, municipal involvement in the VoM programme, together with the allocation of a bridging budget, contributed to the continuation of several health promotion activities and to the sustainability of the community health promotion approach and intersectoral collaboration on health in the city district.

Table 8.1 Research questions and main findings

RESEARCH QUESTION (RQ)	MAIN FINDINGS
RQ 1. *How do Voorstad inhabitants perceive health and health-supportive environments?*	Participants agreed that health entails more than the absence of disease and regarded health as a multidimensional concept. Most important perceptions about health: social relations, physical activity, positive life attitude, healthy eating, feeling in control, and mental rest. Although participants were aware of the relation between lifestyle and health, actions to improve health did not include behaviour change, but rather doing things together, collaboration, self-confidence, focusing on possibilities, and socially shared meanings. Creating a supportive environment to address health behaviour appeared to be the most important action for citizens to facilitate behaviour change. Citizens considered the natural environment a notable health asset and therefore a resource to maintain and sustain health and well-being. This exploration was helpful in involving citizens and provided community workers with valuable information to shape the VoM programme together with citizens.
RQ 2. *What factors and mechanisms contribute to citizen participation and intersectoral collaboration?*	Coalition governance, interaction with the context, network building and brokerage, and generating visibility emerged as the most prominent processes that facilitated building and maintaining intersectoral collaboration within the VoM coalition and its network. Mechanisms that facilitated these processes concerned the health broker's role and positioning, the programme coordinator's leadership, and trust. The most notable mechanisms underlying the citizen participation action principle were personal contact, patience, and perseverance. Another important mechanism for both action principles was creating visibility; that resulted – among others things – in municipal involvement and a budget to sustain the programme. The citizen participation and intersectoral collaboration action principles overlapped, and both played a pivotal role in realising outcomes of interest. The action principles became an aim in themselves from the beginning, and therefore we managed to devote time and attention to them in practice and research. Insights into the processes and mechanisms helped the community workers and the researchers to optimise their working strategies and act upon them, and they strengthened the coalition's capacity. Participatory action research was useful for evaluating and simultaneously facilitating the processes that affect collaboration and for determining the short-term outcomes.
RQ 3. *What benefits do citizens who participate in the Voorstad on the Move programme observe in terms of perceived health, lifestyle, and empowerment?*	Age and experiencing barriers from physical or mental health problems were negatively associated and education was positively associated with empowerment and with perceived health. A (strong) positive association was found between empowerment and perceived health, meaning that respondents with a high level of empowerment perceived their health as (very) good, and a low level of empowerment was associated with medium to low perceived health. In-depth interviews revealed the following perceived benefits of participation: meaningfulness, social contacts, having good times, and feeling connected and involved. It appeared that these benefits together contributed to the more comprehensive concept of well-being.

RESEARCH QUESTION (RQ)	MAIN FINDINGS
RQ 4. *What is the overall impact of the Voorstad on the Move programme in terms of health promotion activities, social and physical environment, and inhabitants' perceived health?*	Fifteen different health-promoting activities were organised and implemented, together with the Voorstad inhabitants. These activities were characterised by a large diversity in content, intensity, duration, and the number and kind of participants. The research activities generated specific programme outputs, like insights into perceptions of health, a strengthened collaboration within the VoM coalition, and an extended communitywide network. Additional activities were the W*ell-being or not to be?* coalition and the volunteers' course 'Leader sporty recreation'. Municipal involvement in the VoM programme, together with the allocation of a bridging budget, contributed to the continuation of several health promotion activities and to the sustainability of the community health promotion approach and intersectoral collaboration on health in the city district.

8.3 Reflection on the findings

In the VoM programme, a community health promotion approach based on a socioecological perspective was applied because it promised to increase health and the equity of its distribution. Five studies were conducted that helped to further elucidate the working of the citizen participation and intersectoral collaboration action principles and how they relate to the impact on citizens' perceived health and health-supportive environments and consequently contribute to finding ways to reduce health inequalities. This thesis provides several insights on how a principle-based community health promotion programme can contribute to improving health and reducing inequalities. We elaborate on the findings, starting with the first, essential step in the community approach: the exploration of Voorstad inhabitants' perceptions on health and supportive environments. Then, insights into the citizen participation and intersectoral collaboration action principles are presented, thereby addressing the factors, mechanism, benefits, and impacts related to them. Participatory action research is one of the main mechanisms explaining the working of the principles and is reflected upon in a further subsection. Applying the action principles and using participatory action research in practice requires skills, capacities, and a certain attitude on the part of both professionals and researchers; this is discussed in the last subsection.

Perceptions of health and health-supportive environments

The VoM programme started with an exploration of citizens' perspectives on health, thereby taking a bottom-up approach. Participants in this study, mostly citizens with low SES, were aware of the relation between health and behaviour, and about what was important for them. Overall, they agreed that health entailed more than just the absence of disease, and they considered health as a multidimensional concept that includes for example social relations, a positive life attitude, and mental rest. Although several citizens had a (chronic) disease, they viewed themselves as healthy as long as they were not limited in their daily

functioning (see Chapter 3 [1]). This aligns with Huber's dynamic concept of health 'as the ability to adapt and self-manage in the face of social, physical and emotional challenges' [2, p.1]. This relates also to the concept of empowerment, described as the process by which people acquire influence on their personal life [3, 4]. In a small-scale survey, we found a (strong) positive association between empowerment and perceived health, indicating that a high level of empowerment is associated with good to very good perceived health, and vice versa (Chapter 6). Empowerment is inextricably linked with citizen participation [5].

In line with the inhabitants' holistic view on health that emerged, activities organised as part of the VoM programme entailed more than just stimulating healthy behaviours. For example, activities that contributed to health always consisted of multiple components, such as information provided in cooking workshops on healthy nutrition in combination with eating together or fostering physical activity and exchanging experiences during chair gymnastics for older people with health impediments. Other activities focused primarily on the social dimension of health or a health supportive environment, such as the 'Looking for sense' course, the 'Mothers on the move' peer group, and the extension of social activities taking place in the community centres (see Chapter 7 for an overview of all programme activities).

The perceived benefits of participation in (activities of) the VoM programme reflect the holistic view of health. In essence, these benefits do have a relation with health (Chapter 6), even though improving health was barely mentioned as a reason to be active or as a direct benefit of active participation. In fact, participants mentioned having good times, social contacts, connection, and meaningfulness as benefits; these correspond with the multidimensionality of health.

As the perceived benefits concern not only individual benefits, but also living together and interacting with one another in the neighbourhood, the contexts that influence individual and community health are also relevant. Notable here are the community centres, to which citizens attribute an important role. Most of the activities took place in community centres, thereby facilitating meeting new people, maintaining connections with others in the neighbourhood, and doing meaningful volunteer work. In our study, we designated community centres as health assets and facilitators of social networks. In addition, citizens considered the natural environment a notable health asset because it is connected with an active lifestyle, performing physical activities, but even more to social activities and mental relaxation: a resource to maintain and sustain health and well-being, as also recognised by others [6]. Brown et al [7] emphasise that understanding the contexts that influence health is central to identifying points of intervention. Through the collaboration with citizens, community workers recognised these assets and managed to utilise them to support individuals and community groups, as also found by den Broeder et al [8].

As shown by these findings, the exploration of perceptions of health and health-supportive environments at the start of the VoM programme revealed a multidimensional or holistic view on health. This also resonates with the more comprehensive concept of well-being. Several researchers and organisations, including the WHO, argue for putting health under the broader umbrella of well-being [9, 10].

Citizen participation

The study revealed insights into the reasons for successful citizen participation in the VoM programme: a bottom-up approach at the start of the programme, meeting the needs of citizens, and learning together.

At the start of the programme, a bottom-up approach was used to explore citizens' perspectives on health. The programme was 'empty', meaning that programme activities were not chosen or planned beforehand. Instead, VoM started by developing and implementing activities together with Voorstad inhabitants, based on their wishes and needs. With the first study, using concept mapping, we managed to engage low SES citizens and to learn about their needs and assets (Chapter 3 [1]). In some cases, the needs could be met right away, e.g., by offering a biking buddy, arranging guitar lessons, or participants making appointments for follow-up meetings in smaller groups or one-by-one. In all cases, the group sessions had a socialising function: participants benefited immediately by sharing experiences and advice, and this in turn contributed to staying involved. Working with citizens in their social environment had important benefits: people knew one another and felt safe talking about their own health and health problems and gave advice to others on how to deal with the barriers. VoM participants elaborated on the ways in which they coped with circumstances and asked for different social activities in the community centres nearby, in their own neighbourhood, and free of charge.

Witnessing the process and outcomes of the group discussions, the community workers adopted the citizens' perceptions, priorities, and needs as the starting point for an ongoing process of learning together. Furthermore, these views and needs increased the professionals' awareness of citizens' health perceptions and assets and helped them to develop actions and engage other professionals working in other disciplines, e.g., social workers, the district manager, neighbourhood sport connectors, general practitioners, and physiotherapists. The process resulted in a shared view on health and well-being and facilitated co-creation by community workers and citizens. Moreover, it contributed to awareness and support from the municipality and policymakers, leading to the sustainability of the community health promotion programme after the funding ended.

As we started with existing community groups – part of the social infrastructure in the city district and known to the community workers – we could count on participants in those

groups later in the programme. For example, we started asking one or more group members known to us to invite friends or neighbours to study the benefits of active participation and to join the photovoice project. And conversely, citizens could count on support from the VoM coalition members, when needed. Both inhabitants and workers were part of the programme's communitywide network and were collaborative partners, building on mutual trust.

Intersectoral collaboration

Intersectoral collaboration – the second action principle – between primary care, social services, and environmental, policy, and public health workers was crucial for the success in the VoM programme and is also recognised by others as crucial [11–13]. The programme's driving and leading force until the end of the funding term was the VoM coalition, a group of six persons, in which five organisations were represented along with a health broker, who was an inhabitant of Voorstad. The programme was coordinated by a health promotion professional from the municipal public health service, who was also responsible for the research and the author of this PhD thesis.

The VoM programme was built on the existing comprehensive infrastructure of public, welfare, social support, sports, and care organisations, community centres, and (informal) networks and alliances in which both professionals and citizens collaborated [14]. As a result, the coalition's network evolved relatively easily, because it could be built on the existing infrastructure in the city district and each individual member of the coalition brought in their network. However, the cutbacks and uncertainty in their own organisations and in the local government that confronted coalition members created an unstable (policy) context for the VoM programme's implementation. Governance of the coalition, the health broker role, and visibility of the coalition's work appeared to be crucial for the functioning of the coalition and helped the coalition members to optimise their working strategies, thereby strengthening the coalition's capacity.

The programme coordinator's leadership, which stimulated personal involvement and togetherness in the coalition, was decisive in holding the coalition together, as also found in other studies [15, 16]. Whereas formation of the VoM coalition and its network took a relatively short time at the start, sustaining internal collaboration, e.g.., the clarification of roles, tasks, and responsibilities, required the attention and time of all coalition members during the programme. For example, as a result of organisational policy changes, members left the coalition and new ones had to be introduced. Moreover, defining a shared vision for the coalition and clarifying the division of coalition members' roles convinced the collaborating organisations to commit to the coalition and to facilitate their employees with time to attend meetings and for programme activities.

In the VoM programme, brokerage was essential in connecting the VoM coalition with the broader network of organisations, community groups, and individual citizens, as also found in other studies [17, 18]. The broker role was performed by the appointed health broker as well as other coalition members. A recurring point of discussion and confusion was the role and position of the health broker, as the broker fulfilled roles of facilitator, communicator, and community builder, sometimes overlapping with the tasks of the other coalition members. The participatory action research activities helped the coalition members to clarify the health broker role and other roles and tasks, and to make decisions about the division of responsibilities. Although the advantages of an inhabitant taking up the health broker role were endorsed, embedding the health broker(s) in a professional organisation was the preferred way to foster the acceptance of the broker role in the coalition as well as in the broader network (see Chapter 4 [19]). An additional argument was that it fitted in with the existing organisation of the local health and social support system. Other recent studies in the Netherlands about the broker role in intersectoral collaboration on health at local level have confirmed this with similar arguments [18, 20–22].

Over time, the coalition members paid more attention to the visibility of the programme's achievements, thanks to the participatory action research activities and the accompanying reflection meetings (see Chapter 4 [19]). Visibility was enhanced through several products (Box 8.1). This resulted in a growing appreciation among coalition members of their own efforts and a stronger feeling of involvement in the VoM coalition. Consequently, it strengthened the capacity within the coalition and encouraged investment in the continuation of the combined bottom-up and top-down health promotion approach by gaining local government support and the commitment of the organisations involved. The value of the coalition and its activities was acknowledged, indicating that coalition capacity, as other researchers have found, can induce changes in local policy decisions, commitment, and readiness to invest in health promotion [23, 24].

Box 8.1 Products that contributed to visibility and knowledge valorisation in the VoM programme

Visual recordings (see Chapter 3)

Fact sheets

Film: Voorstad on the Move Voorstad Beweegt - een wijkgericht gezondheidsprogramma in Deventer - YouTube

Digital magazine *'Citizens First in Voorstad on the Move'* https://ijssellandscan.nl/rapporten/Verdiepende-onderzoeken/bewoners%20voorop%20in%20Voorstad%20Beweegt

Added value of participatory action research

Throughout the programme, participatory action research was applied to evaluate and simultaneously facilitate the processes and activities in the VoM programme. The previously explained participatory action research values, such as involving all stakeholders, including citizens with low SES, capturing the different perspectives of citizens and professionals, and facilitating the development of capacities, learning, and empowerment, are convincingly demonstrated in the previous sections. A further value of participatory action research is that it contributes to developing both theories and research methods to understand and explain what works and why it works [25, 26], as illustrated hereafter.

Although the added value of participatory action research is evident, it became clear that the action researcher's role in a community health promotion programme is challenging. In this study, the action researcher coordinated the programme and was the chair of the VoM coalition. From this dual role, the researcher took part in the coalition meetings and managed to gain the trust of the coalition members, thereby making them willing to participate in the research activities. Other studies confirm that, in participatory action research, practice and research are closely related, resulting in a dual role of researcher and health promotion professional [26–29]. The action researcher must be clear about these different roles and must have the flexibility to change roles when needed. Besides flexibility, action researchers require communication and social skills and competences that relate to reflection, patience, and keeping balance.

Reflection relates to research activities and also to the role of participatory action researchers. For example, some of the participatory action research activities in the VoM programme were conducted in collaboration with MSc students, who conducted amongst other things focus groups and interviews with stakeholders. Working with these action research assistants, the programme coordinator had the opportunity to reflect upon the research findings, deepen knowledge about the processes and perspectives together with all stakeholders, and at the same time propose adjustments and new activities. Also, discussion with other researchers involved in similar community health promotion programmes and research helped to take some distance when needed and to reflect upon the different roles, tasks, and responsibilities. This peer review or debriefing is also a verification technique, contributing to the validity of the research process [26].

The most challenging aspect of the participatory action researcher's role is to stay patient. This was in particular the case when, according to the insights resulting from research activities, specific actions were needed and agreed upon by coalition members. However, it often took considerable time to realise these activities in practice, as the engagement of citizens was time-consuming. Following the citizens' and community workers' pace

demanded a shift in working method, which meant acting when there was support and willingness to collaborate.

Finding a balance between research and practice is a challenge related to the action researcher's own role(s), working bottom-up and top-down, and taking care that all voices are heard. The combination of the action researcher and programme coordinator roles in VoM required all perspectives to be considered and taken into account, and finding the right balance between taking the initiative (top-down) and facilitating others, thereby following others' pace (bottom-up). In the programme coordinator role, the leader had to take responsibility for leading and realising the programme aims, thereby tending to act in a top-down manner. In the researcher role, it was important for the leader to take into account all perspectives and findings. Thus, in this role, the action researcher was able to hold up a mirror simultaneously, thereby helping to keep balance. Another example of where the role of action researcher/coordinator is to maintain balance is in ensuring that there is room for all participants, thereby diminishing any potential confirmation bias. In participation and collaboration, there is always a risk that the voices of the quiet, modest participants are not heard, silenced by the loud voices of those in front or by well-informed and motivated volunteers, the 'usual suspects'. As it is challenging to manage group dynamics and to focus on the content of the group discussion at the same time, splitting the researcher role and the facilitator role is recommended [30], as was the case in our study. Overall, it was motivating to experience that the participatory action research activities added significant value to the VoM programme and were highly appreciated by coalition members.

The action researcher's position in a community health promotion programme can be regarded as that of an embedded researcher [31, 32]. The embedded researcher concept has gained growing attention in the context of the whole systems approach advocated as a way of responding to the complexity of public health issues such as obesity or socioeconomic health inequalities [33]. Potts and colleagues [31] concluded that it would be challenging to evaluate a complex whole systems approach, and do it well, without an embedded researcher who can help to elucidate changes and unravel how and why they are happening. The embedded researcher role lends itself well to working with key stakeholders to illuminate and understand mechanism of change and develop a culture of continuous improvement and mutual learning processes [31].

Professionals' skills, capacities, and attitudes

In a community health promotion programme, professionals require specific skills and capacities to apply citizen participation, build healthy coalitions, strengthen collaboration in networks, and fulfil a health broker role. From the study about the mechanisms underlying the citizen participation and intersectoral collaboration action principles, it appeared that

personal contact, knowing one another, taking time, following participants' pace, trust, and the programme coordinator's leadership and persistence were most important (see Chapter 5 [19]). With regard to the broker role, performed by several coalition members in this programme, skills relate to crossing sectoral borders, agenda setting, facilitating citizen participation, and entrepreneurship [20, 34]. Leadership requires competences such as vision, setting reachable goals, being motivational and inspirational and a team player. Working in a coalition with professionals from different sectors and with divergent backgrounds, each member has his/her own specific skills and capacities and organisational support. Together, they have access to the range of necessary skills and capacities. It is up to the programme coordinator and the health broker to make the best possible use of all available capacities, because that will also contribute to the sustainability of the coalition.

The bottom-up approach in the VoM programme required a shift in attitudes and approaches on the part of the professionals involved, such as listening and posing questions instead of knowing and handing down solutions; thinking in terms of assets and possibilities instead of problems and limitations; and putting the individual or the community first, rather than the applicable rules and procedures. With the bottom-up approach, low SES citizens, often called hard-to-reach in health promotion interventions or programmes, were involved from the start of the VoM programme. Actually, we prefer not to talk about hard-to-reach, as the fundamental question is not whether professionals think they are engaging citizens or groups but whether people feel engaged [35]. This requires professionals to take into account the perspective of the people with whom they want to work and to make connections with them [36, 37]. This might mean that professionals' values that inform and underly their everyday decisions need to be made explicit [38]. Then a joint ambition can be created, co-creation will take place, and both citizens and professionals can make their contribution.

In the VoM coalition, citizen participation and empowerment were extensively discussed, as coalition members appeared to work with contradictory principles. Some professionals adhered to a top-down approach oriented at behaviour change, whereas others followed a bottom-up approach with empowerment of citizens as the central aim in their support. Along the way, the coalition's focus changed from working towards health-related behaviours to empowerment, meaning helping people to gain more control over their lives [39]. Moreover, professionals needed time and additional free space to match citizens' needs, to innovate, and sometimes 'to colour outside the lines'.

This corresponds to the tension that Laverack [40] describes in combining a bottom-up and a top-down approach in health promotion. Health promotion professionals experience in practice 'how to include the concerns and issues of the community in the top-down programming approach that usually characterises their own job descriptions or funding

mechanisms' [41, p.256]. In the VoM programme, the funding organisation, FNO [41], did not set conditions on the content of the health promotion approach in advance, thereby offering the programme coordinator, together with all stakeholders, the opportunity to implement the bottom-up approach.

8.4 Theoretical and methodological considerations

To study the VoM programme comprehensively, we applied a mixed-methods design, including process evaluation [42]. The theoretical framework was based on a socioecological perspective on health. As no single theory or framework captures all relevant aspects, we proposed using different theories and models to understand the working of the action principles comprehensively and on different levels. We used the framework to facilitate and evaluate community health promotion [43], social practice theory [44], the (updated) Healthy Alliances (HALL) framework [45, 46], and a logic model based on Saan and De Haes [47]. In addition, we proposed in Chapter 2 using the reasonable person model [48] to study the way in which the physical environment can be health-supportive. This model was an inspiration for a study about citizens' perspectives on health-supportive environments, in which we used the photovoice method. Only a small number of inhabitants participated in this study, which was conducted by an MSc student and described in a master's thesis [49]. This study was used as one of the sources in the realist evaluation (Chapter 5), and the photos and the narratives shared with the researchers contained valuable information for the VoM programme.

The framework to facilitate and evaluate community health promotion provided operational variables for both citizen participation and intersectoral collaboration. Thus, the model was helpful in making the social environment of health researchable, while simultaneously showing the interconnectedness between the social environment, health outcomes, and health-predicting mediators [43].

Social practice theory was used at multiple levels and flexibly, incorporating the social environment of health and the whole system. It helped to explain health-related behaviour by including the individual and the environmental level and their interactions [50, 51]. In the explorative study about perspectives on health (Chapter 3), citizens hardly mentioned health-related behaviours as crucial for improving their health. It was striking that, although citizens were aware of the importance of lifestyle and behaviour in relation to health, they did not prioritise changing lifestyle behaviour. Citizens stressed that social interaction, a positive life attitude, and utilising the natural environment were important assets for health. The limited priority that citizens gave to (changes in) lifestyle behaviours indicates that the prevailing focus on individual lifestyle change is not suitable. Health promotion approaches

should not just be centred around individual lifestyle change, but should also incorporate aspects of well-being (at the individual, community, and systems level) in social practices in everyday life, and thus they should be more holistic or systems approaches [33].

The use of the HALL framework and the corresponding coordinated action checklist, together with social network analysis, are comprehensively discussed in the study about intersectoral collaboration (Chapter 4 [19]). The in-depth evaluation using the collaboration's coordinated action checklist can be seen as a capacity-building method facilitating coordinated action. Moreover, using the checklist proved valuable, because it offered good opportunities for evaluating the collaboration and making results visible [52]. Both research instruments, the coordinated action checklist and social network analysis, used flexibly, provided different information and complemented each other [19].

To study the impact of the VoM programme at different levels, a logic model for implementation and evaluation was developed (Chapter 2 [42]). As explained by Hawe [53], a logic model is a pictorial representation of the theory of change underlying the VoM programme. A theory of change is in essence a planned route to outcomes: 'it describes the logic, principles and assumptions that connect what an intervention, service or programme does, and why and how it does it, with its intended results' [53, p.5]. The theory of change and the resulting logic model visualised the intended or assumed programme outputs and short-term outcomes at the start of the programme. Before the VoM programme started, it was assumed that programme outputs such as citizens' perception on health, health promotion activities, active participation and strengthened collaboration, and visualising the mechanisms contributed to involved stakeholders' motivation and to the sustainability of the VoM programme, as appeared indeed to be the case. In Chapter 7, realised programme outputs and outcomes and differences from those initially intended are presented.

A limitation of the logic model is that it gives the impression that processes develop in a linear way, but in practice they do not [54, 55]. Feedback loops created by applying participatory action research and results of the discussion and reflection in the VoM coalition as well as with other stakeholders, including citizens, remained invisible in the model. Furthermore, it can be added that a danger lies in attempting to simplify a complex reality and that an apparently simple model applied to a complex health promotion programme like VoM risks emphasising the idea of causal relations.

A realist evaluation was conducted to unravel the mechanisms underlying the action principles applied in the VoM programme (Chapter 5). The realist evaluation approach was chosen to study what works for whom in what circumstances; this is different from the usual evaluation methods that focus on whether the programme has succeeded against

the criteria set at the start. Realist evaluations are increasingly used in complex health promotion programmes, as they explore the 'black box' of these programmes. Most studies that have used a realist evaluation have focused on impacts, looking at the way in which a combination of contextual factors and mechanisms triggered outcomes of interest [56–58]. Taking the mechanisms as the main focus of our study appeared to be a suitable way to evaluate VoM, as this expanded the knowledge about applying the citizen participation and intersectoral collaboration action principles in practice. The insights about the mechanisms further elucidated the relation among the different levels (individual, community, and social environment) and helped us to understand social practices in everyday life. Moreover, the knowledge cast further light on whether realised changes were similar to assumed changes, and this was used to enrich the theory of change as illustrated in the logic model. Overall, the realist evaluation helped to identify a wide range of outcomes, including programme outputs that would not have been discovered using evaluation methods that focused on measuring health behaviour-related outcomes.

In this study, theories and accompanying methods and tools were deployed flexibly in order to address different levels and cope with the complexity of evaluating a community health promotion programme. Thus, processes, values, and action principles in the VoM programme were taken into account.

Combination of research methods and tools

In this community health promotion programme, we applied a set of different research methods and tools. An overview of the methods and tools used together with stakeholders and their benefits is presented in Table 8.2.

Methods and tools can be used in a flexible way, complementing one another and other research methods depending on what is needed in health promotion practice and research. The most important characteristics of these methods are that they facilitate the engagement of all stakeholders, create insights for researchers and others involved, and are suitable to use with low SES citizens. The application of these methods and instruments contributes to the visibility of findings and achievements, thereby fostering the sustainability of the health promotion programme (Chapter 4 [19]). In combination with the use of visual recordings such as word clouds, network maps, photos, and visual representations by a cartoonist, discussion and reflection are strengthened and the inclusion of low-literate citizens' voices is stimulated.

Table 8.2 Overview of research methods and tools with benefits for practice and research

Tool/Method	Description	Benefits for health promotion practice and research
Concept mapping	Method or structured process used to produce a picture or map of the ideas or concepts of an individual or group about a complex multidimensional problem [59, 60]	* Helps citizens to express their views and needs * Initiates dialogue * Creates an opportunity for community engagement * Stimulates critical thinking and reflection across stakeholders * Participants contribute directly to data analysis by taking part in the discussion and interpretation of findings
Coordinated action checklist	Checklist – with 25 statements based on the HALL framework to evaluate collaboration in a coalition – consisting of five topics: partners' suitability, task dimension, relationship dimension, growth dimension, and profiling [11, 52]	* Facilitates dialogue and sharing experiences * Helps to clarify barriers and see opportunities in collaboration * Enables improvement actions * Makes coalitions' ambitions and achievements visible
Social network analysis	Method to describe, analyse, and understand the structure and interactions among a defined set of actors in an network [61–63]	* Strengthens relationships * Provides insight into missing actors to accomplish goals * Stimulates discussion and fosters action
Photovoice	Method to create and discuss photographs with the aim of facilitating reflection on feelings, ideas, and experiences [64, 65]	* Enables ideas and needs to be addressed * Offers researchers insight into participants' perspectives * Enables the sharing of perspectives and ideas and collaborative action * Is useful with low-literate citizens * Helps to include people in research because it is fun
Timeline method	Tool for (interim) evaluation in a team or coalition to organise the most important events and influences of the project over time and to make them transparent	* Generates positive energy * Provides insight into members' actions and experiences * Stimulates discussion about what is needed * Can be used for reporting

8.5 Implications for practice and policy

This study was conducted to contribute to finding keys to diminish health inequalities. The findings entail implications for health promotion practice and policy, about the citizen participation and intersectoral collaboration action principles as targets of a community health promotion programme, a bottom-up approach, the broader concept of health, and conditions for sustainability.

A first recommendation for implementing community health promotion programmes is to explicitly include citizen participation and intersectoral collaboration as targets in community health promotion programmes that aim to reduce health inequalities. In the VoM programme, the action principles – processes, moderators, or mechanisms that help establish the effect or impacts of a health promotion programme – were considered an aim in themselves from the beginning. Therefore, we devoted considerable time and attention to the action principles in practice and research. The realist evaluation demonstrated that these action principles overlapped and reinforced one another and that putting the action principles into practice resulted in a range of interesting outputs and outcomes.

A second recommendation is to apply a bottom-up approach, as this leads to true and sustainable community engagement. We demonstrated that a bottom-up approach, with citizens' perspectives on health in their social environment as a starting point, was decisive in the involvement of all stakeholders throughout the programme. Consequently, meaningful community engagement was realised, requiring working collaboratively with stakeholders in the community to understand their preferences on how, when, and to what level and degree they wanted to be engaged. This resulted in the VoM programme being driven by community interests, concerns, assets, and needs.

According to Brown et al [7], authentic community and stakeholder engagement is critical to the development, implementation, and sustainability of interventions to tackle health inequalities. Others also emphasise that the participation of all stakeholders and the sharing of knowledge and experiences of people involved at all levels is important, in order for all the different perspectives and specific contexts to be taken into account [26, 66, 67]. Recently, a group of experts in community engagement – community leaders, researchers, and policy advisors – in the US, called the organising committee for meaningful community engagement [68], proposed a conceptual model – assessing community engagement (ACE) – as this illustrates the dynamic relationship between community engagement and improved health and healthcare outcomes. They state that: 'When community engagement takes place with core principles guiding its processes and activities, it propels strengthened partnerships and alliances, expanded knowledge, improved health and health care programs and policies, and healthier communities' [68, p.9]. Although the ACE conceptual model can be viewed as linear and sequential, users also have the flexibility to focus on specific indicators depending on needs and interests; this is important for community health promotion. We recommend that this ACE conceptual model be used in community health promotion practice and research in the Netherlands to assess the quality and the impact of meaningful community engagement across various sectors and partnerships.

A third recommendation for practice and policy is to move from the concept of health to the broader concept of well-being, based both on our findings about the multidimensionality

of health and on the actual developments in views and policies about health and well-being in the Netherlands [69] and abroad [10, 70]. With the exploration of perceptions of health and health-supportive environments at the start of the VoM programme, we revealed a multidimensional or holistic view on health, relating to the concept of empowerment and resonating with the more comprehensive concept of well-being. As a result, activities organised as part of the VoM programme focused primarily on the social determinants of health and health-supportive environments. Moreover, the collaboration of community workers and citizens resulted in a shared view that moved from health to well-being.

Our findings are echoed in the recent World Health Organization (WHO) discussion paper entitled: *Towards developing WHO's agenda on well-being* [70]. In this paper, it is stated that: 'Building societal well-being can help create resilient and sustainable communities that are better able to respond to current and emerging health threats like COVID-19 and ecological disasters. Well-being – as a policy concept – unites the health, economic, social, and environmental aspects of the sustainable development agenda. The application of well-being concepts can bring policy coherence across sectors and galvanize action' [70, p. viii].

In fact, the coherence between the social determinants of health and well-being were already mentioned long ago, in the Declaration of Alma Ata (1978) [71] and the Ottawa Charter for health promotion (1986) [72]. These declarations laid the foundations for health in all policies (HiAP), and, in line with the HiAP approach, the WHO started the Healthy Cities project in 1987, to place health on the agenda of cities around the world and to build support for public health at local level [73, 74]. Since the beginning of the 21st century, in both national and local public health policies, the notion of HiAP and the healthy cities concept have received renewed attention, because – among other things – a HiAP approach is assumed to be more effective in reducing health inequalities [75]. This aligns with growing support in public health, healthcare, welfare, and other sectors for the new dynamic and holistic concept of health introduced by Huber [2], in which empowerment and resilience are central and the focus is on quality of life and well-being and on a shift in thinking from disease and care to health and behaviour, from individual lifestyle changes to social determinants of health, from cure and care to core [76, 77].

Addressing health inequalities with a community health promotion programme requires long-term sustainable investment. A bottom-up approach takes time to involve all relevant stakeholders, build coalitions and networks, and exchange perspectives, needs, wishes, and values. It is recommended, fourthly, to consider the transformation that is taking place in the Netherlands in the domains of healthcare[77], social support, and employment as an opportunity for community health promotion. The VoM programme, funded by FNO Healthy Future Nearby, had a limited term of 3.5 years. We managed to involve the municipality and to acquire a bridging budget that offered the opportunity to explore how

to continue the community health promotion approach into 2020 and beyond. However, only three months after the VoM programme ended, as a result of the Covid pandemic restrictions, all activities were shut down, including the meetings with policymakers and collaborating organisations. As a result, the support and attention gained before the pandemic disappeared from the municipal and organisational policy agendas. This meant that there was no municipal support for acquiring new subsidies needed to sustain the programme. This demonstrates the vulnerability of a temporarily funded programme.

On the basis of our study and endorsed by others, we emphasised earlier some prominent conditions for a sustainable community health promotion approach that aims to reduce health inequalities, such as investing in community engagement, involving sectors other than health in health promotion practice and policy, and taking a holistic view on health and well-being [10, 68, 78, 79]. We recommend exploring the possibilities of connecting with neighbourhood social support teams and the local public health, care, and social support policies that underly these teams.

Since 2015, decentralisation of responsibilities regarding social support, employment, and youth care from national to local governments has been taking place, resulting in new visions on health and well-being, new local structures, and new working disciplines. The multidisciplinary neighbourhood social support teams appointed in most cities aimed to recognise individual health problems at an early stage, offering support nearby, thereby preventing more expensive care. Additionally, these neighbourhood teams became part of the social infrastructure and worked collaboratively with citizens [80, 81]. As they should be focusing more on a community approach, this offers good opportunities to implement a sustainable community health promotion.

8.6 Implications for research

Conducting research in the complex and context-dependent field of community health promotion entails challenges. It was demonstrated in this study that working with a theory of change and logic model increased the evaluability of the VoM programme. A theory of change explicates the pathway along which change is (expected) to be realised [54]. It does not offer any guarantee of effectiveness, but it makes programme outputs and short-term and long-term outcomes explicit and visible.

Furthermore, in our study, the evaluation was conducted with all stakeholders using participatory action research. The benefits and added value of participatory action research have been extensively discussed in previous sections and endorsed by other researchers [82–84], emphasising that stakeholder involvement should be central to the evaluation of

community health promotion programmes, rather than adopting an approach whereby the researcher is completely detached from the programme [85].

Along with the recommendation to apply participatory action research, we recommend having an embedded researcher who is inextricably linked to conducting participatory action research in practice. Besides advantages such as taking into account all perspectives, we have explicated the challenges entailed in the dual role of the embedded researcher, such as (self-)reflection, keeping patient, and finding balance. In order to be able to fulfil the embedded researcher role within a community health promotion programme, being recognised as part of the team is pivotal, as this facilitates a positive working relationship with stakeholders and practitioners so as to be invited into relevant spaces, to receive important information, and to be listened to and trusted [31].

A shift in research paradigm is needed, and it is therefore recommended to use a combination of theories, research instruments, and tools that can be applied flexibly, as demonstrated in this study. A community health promotion programme like VoM consists of complex social processes with activities and interventions that constitute more than the sum of their parts and that involve citizens who act on the basis of their values and perspectives. To develop and evaluate such multilevel, multifaceted programmes, behaviour change theories are of limited use. Other authors stress that researchers should continue to develop and test the tools necessary to implement multilevel interventions, including theories about the role of social networks, institutions, communities, and policies in determining health, and practical mechanisms for measuring the constructs of those theories [86, 87].

This also requires a paradigm shift by funding organisations that support community health promotion programmes and evaluation research. We started VoM with an 'empty' programme, meaning that neither the health themes and activities, nor the expected deliverables, were chosen or fixed beforehand. Having the possibility to be adaptable and flexible resulted in the multiple impacts and interesting insights described in this thesis. We therefore call on funding organisations to encourage and financially support more of these 'open', theoretically well substantiated community health promotion programmes and research proposals.

8.7 Conclusion

This study further elucidated the impact and the working of the action principles of a community health promotion programme on health and health-supportive environments, thereby contributing to finding ways to reduce health inequalities.

Taking citizens' perceptions of health and health-supportive environments as a starting point revealed a multidimensional or holistic view on health that resonates with the more comprehensive concept of well-being. Activities in the programme focused primarily on the social dimension of health and assets in the social environment. This resulted in a shared view on health and well-being and facilitated co-creation by community workers and citizens.

The citizen participation and intersectoral collaboration action principles – processes, moderators, or mechanisms that help establish the impacts of a health promotion programme – were deemed an aim in themselves from the beginning. Therefore, we devoted considerable time and attention to these action principles in practice and research. A bottom-up approach at the start of the programme – meeting the needs of citizens and learning together – was decisive for successful and sustainable citizen participation in the programme. Community engagement was realised, built on mutual trust, strengthening empowerment and intersectoral collaboration within the coalition and in a communitywide network. Governance of the coalition, the health broker role, and interaction with the local context appeared to be crucial for intersectoral collaboration. The broker role was performed by the appointed health broker, an inhabitant, as well as other coalition members and consisted of crossing sectoral borders, agenda setting, facilitating citizen participation, and entrepreneurship.

Throughout the programme, participatory action research was applied to evaluate and simultaneously facilitate the processes and activities in the VoM programme. Participatory action research values, such as involving all stakeholders, including citizens with low SES; capturing the different perspectives of citizens and professionals; and facilitating the development of capacities, learning, and empowerment, are convincingly demonstrated in this study. One of the multiple benefits was that the research activities contributed to the visibility of the programme outputs and outcomes, thereby strengthening the VoM coalition's capacity and encouraging the local government to invest in the continuation of the community health promotion approach after the external funding ended. Furthermore, the participatory action research activities helped the coalition members to clarify roles, tasks, and responsibilities, including those of the health broker.

The professionals and the researchers, who collaboratively and simultaneously implemented and evaluated the VoM programme, required specific skills and capacities such as personal contact, knowing one another, taking time, following participants' pace, trust, and leadership. Moreover, the bottom-up approach in the VoM programme required the professionals involved to shift their attitudes and approaches, such as listening and posing questions, thinking in terms of assets and possibilities, and putting the individual and the community first.

To study the VoM programme comprehensively, we applied a mixed-methods design, including process evaluation and a theoretical framework based on a socioecological perspective on health. Theories such as social practice theory, the HALL framework, a theory of change, and accompanying methods and tools, e.g., the coordinator action checklist and social network analysis, were deployed flexibly in order to address different levels and cope with the complexity of evaluating a community health promotion programme. An overview of the methods and tools used in collaboration with stakeholders and their benefits is provided. A realist evaluation was conducted to unravel mechanisms underlying the action principles applied in the VoM programme, resulting in an improved understanding of social practices in everyday life. Moreover, the realist evaluation helped to identify a wide range of outcomes at different levels (individual, community, and social environment), including programme outputs.

The findings of this study entail implications for health promotion practice, policy, and research. A first recommendation is to explicitly include citizen participation and intersectoral collaboration as targets in community health promotion programmes that aim to reduce inequalities in health. A second recommendation is to apply a bottom-up approach, as this leads to true community engagement and takes all perspectives and specific contexts into account. A third recommendation is to place health under the broader umbrella of well-being, as the WHO proposes. Next, it is recommended to invest in long-term, sustainable community health promotion programmes to address socioeconomic health inequalities. The current transformation that is taking place in the Netherlands in the domains of healthcare, social support, and employment offers opportunities for community health promotion that should be considered seriously. The final recommendation is to use participatory action research and have an embedded researcher, as this stimulates community engagement and challenges all stakeholders to discuss values, roles, tasks, and responsibilities in citizen participation and intersectoral collaboration.

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Summary
Samenvatting

Summary

Introduction

Health inequality, a persistent health gap between groups with a higher and a lower socioeconomic status (SES), is a wicked problem caused by multiple factors in the social, physical, and economic environment and the interplay between individuals, groups, and communities. It is broadly acknowledged that more effective strategies to reduce health inequalities should be based on an ecological perspective, addressing factors at multiple levels and looking at the interaction between factors. Nonetheless, up till now, behaviour change approaches have been dominant in health promotion programmes, despite limited effectiveness, particularly in reducing health inequalities.

Multilevel strategies, such as a community health promotion approach, based on action principles that align with the Ottawa Charter such as citizen participation and intersectoral collaboration, are promising. As the implementation and evaluation of community health promotion programmes have proved challenging, research is needed that takes into account processes, values, and action principles featuring such programmes. Participatory action research is recommended, as it reflects the values of health promotion, such as participation and empowerment, and it facilitates the development of capacities and learning, thus contributing to health. From July 2016 to December 2019, a community health promotion programme called Voorstad on the Move (VoM) was implemented in a socioeconomically deprived city district in the Netherlands. In line with national and local policy objectives, the programme aimed to contribute to the improvement of health and to find ways to reduce health inequities.

Aim

The aim of this thesis is to study and understand the impact of a community health promotion programme on health and health-supportive environments on the one hand and the working of the action principles in that programme on the other hand, thereby contributing to finding ways to reduce health inequalities. Four interrelated research questions were formulated:

1. How do Voorstad inhabitants perceive health and health-supportive environments?
2. What benefits do citizens who participate in the Voorstad on the Move programme observe in terms of perceived health, health literacy, and empowerment?

3. What factors and mechanisms contribute to citizen participation and intersectoral collaboration?
4. What is the overall impact of the Voorstad on the Move programme in terms of health promotion activities, social and physical environment, and inhabitants' perceived health?

Methods

The study used a mixed-methods design and combined mainly qualitative data from various sources. The research activities included in-depth interviews, focus group discussions, concept mapping, photovoice, social network analysis, document analysis, and analysis of citizens' survey data. The use of multiple strategies and multiple research methods across multiple levels was assumed to be the most effective approach. The combination of information from multiple sources and methods – triangulation – increased data validity. Also, partners and citizens were involved in the planning of the research as well as in different research activities. A prominent strategy was action research, which aims to involve all stakeholders, capturing the different perspectives of citizens and professionals and engaging citizens with low SES. It also enables those involved to continually optimise their strategies, and it contributes to developing both theories and research methods to understand and explain what works and why it works.

Results

Research question 1: *How do Voorstad inhabitants perceive health and health-supportive environments?* was addressed in Chapter 3. At the start of the VoM programme, as part of the action research, a concept mapping methodology was used to actively engage community members. Eleven existing community groups, together with community workers, participated in the study. Participants in all groups agreed that health entails more than the absence of disease, and therefore it is a multidimensional concept. The study revealed seven perceptions that were most important according to the participants: (1) social relations and interactions, (2) physical activity, (3) positive life attitude, (4) feeling in control, (5) healthy nutrition, (6) mental rest, and (7) the natural environment. The findings show that it is necessary to create a supportive social environment to facilitate behaviour change and to improve health. Citizens considered the natural environment a notable health asset and therefore a resource to maintain and sustain health and well-being. It became clear that the focus in the health promotion programme should be on the social dimensions of health, offering citizens a variety of possibilities for action on demand and adapted to their wishes. Activities should have a positive approach and should take place in the neighbourhood free of charge, thereby fostering social relations and networks. This

study helped to engage citizens and community workers and was the starting point for their collaboration and co-creation throughout the VoM programme.

Part of research question 2: *What factors and mechanisms contribute to citizen participation and intersectoral collaboration?* is answered in Chapter 4. Insights into the processes that facilitate building and maintaining intersectoral collaboration within the VoM coalition and its network and how these processes contribute to the coalition's ambitions are presented here. The coordinated action checklist and composed network analysis were used as research instruments, integrated in participatory action research in 2018 and 2019. The results of the Coordinated Action Checklist and the network analysis were linked back into the coalition in five group sessions and used for reflection on progress and future planning of the VoM programme. The most prominent processes affecting the collaboration were coalition governance, interaction with the context, network building and the broker role, and generating visibility of the outputs. The research revealed in-depth insights into the processes and the interdependences between them, it helped the community workers and researchers to optimise their working strategies and act upon them, and it strengthened the coalition's capacity. Making the expected and unexpected outputs and outcomes? visible contributed to the commitment and continuation of the coalition, as is required to realise community change and desired health outcomes in the long term.

In Chapter 5, more insights into research question 2 are provided, resulting from a realist evaluation study to unravel the mechanisms underlying the action principles in the VoM programme. The qualitative data used in this study originated from multiple sources and methods to ensure validity and include evaluation sessions and individual interviews with coalition members and the health broker, group sessions with community workers and citizens, semi-annual progress reports, and minutes of the coalition meetings. The most notable mechanisms underlying citizen participation and intersectoral collaboration were personal contact, patience, perseverance, and visibility. Moreover, the participatory action research activities that accompanied the VoM programme were both a mechanism and a context condition and triggered outcomes of interest by helping all those involved to recognise processes, take them further, and make the outcomes visible. This realist evaluation methodology contributed to deepening the understanding of what worked under the given circumstances and helped to identify a wide range of outcomes.

Research question 3 about the benefits that citizens participating in the VoM programme observed in terms of perceived health, lifestyle, and empowerment is discussed in Chapter 6. A mixed-methods approach was applied, consisting of a small-scale survey and 12 in-depth interviews with citizens participating in activities and volunteer work. The survey findings showed that age and experiencing barriers from physical or mental health problems were negatively associated, and education was positively associated,

with empowerment. Furthermore, a (strong) positive association was found between empowerment and perceived health, meaning that respondents with a high level of empowerment perceived their health as (very) good, and a low level of empowerment was associated with medium to low perceived health. The in-depth interviews revealed the following perceived benefits of participation: meaningfulness, social contacts, having good times, and feeling connected and involved. It appeared that these benefits together contribute to the more comprehensive concept of well-being. Taken together, the findings provide a better understanding of the significance and benefits of active participation of citizens with low SES and their motivations to become involved in the development and implementation of health promotion activities.

Research question 4: *What is the overall impact of the Voorstad on the Move programme in terms of health promotion activities, social and physical environment, and inhabitants' perceived health?* is answered in chapter 4, 5, 6 and 7. Chapter 7 presents the programme's outputs in terms of programme activities, research activities, and involvement of stakeholders/ professionals, volunteers, and participants, as described in the logic model presented in the study protocol. During the term of the VoM programme, 15 different activities were organised and implemented, together with the Voorstad inhabitants, characterised by a large diversity in content, intensity, and duration, as well as the number and kind of participants. The participatory action research activities generated specific programme outputs, such as insights into perceptions of health, a strengthened collaboration within the VoM coalition, and an extended communitywide network. Additional activities that could be regarded as programme outputs were the W*ell-being or not to be?* coalition and the volunteers' course 'Leader sporty recreation'. Finally, the involvement of the municipality in the VoM programme, together with the allocation of a bridging budget, contributed to the continuation of several health promotion activities and to the sustainability of the community health promotion approach and intersectoral collaboration on health in the city district.

Conclusions and recommendations

This thesis provides insights on how a principle-based community health promotion programme in a socioeconomically deprived city district can contribute to improving health and reducing inequalities. Firstly, taking citizens' perceptions of health and health-supportive environments as a starting point revealed a multidimensional or holistic view on health that resonates with the more comprehensive concept of well-being. Activities in the programme focused primarily on the social dimension of health and assets in the social environment.

A bottom-up approach at the start of the programme, meeting the needs of citizens, and learning together were decisive for successful citizen participation in the programme. Community engagement was realised, built on mutual trust, strengthening empowerment and intersectoral collaboration within the coalition and in a communitywide network.

Throughout the programme, participatory action research was applied for evaluating and simultaneously facilitating the processes and activities. The values of participatory action research, like involving all stakeholders, including citizens with low SES, capturing the different perspectives of citizens and professionals, and facilitating the development of capacities, learning, and empowerment are convincingly demonstrated. In participatory action research, practice and research are closely related, resulting in a dual role of researcher and health promotion professional. The role of the embedded researcher is challenging and requires–next to flexibility to change roles–communication and social skills and competences that relate to self-reflection, patience and keeping balance. Next to specific skills and capacities, the bottom-up approach required a shift in attitudes and approaches of the professionals involved, like listening and posing questions, thinking in terms of assets and possibilities and putting the individual and the community first.

Theories, and accompanying methods and tools, were deployed flexibly in order to address different levels and cope with the complexity of evaluating a community health promotion programme. A realist evaluation was conducted to unravel mechanisms underlying the action principles, resulting in an improved understanding of social practices in every day live. Moreover, it helped to identify a wide range of outcomes at different levels (individual, community and social environment), including programme outputs.

This study brings along implications for health promotion practice, policy, and research.

1. Explicitly include citizen participation and intersectoral collaboration as targets in community health promotion programmes that aim to reduce inequalities in health.
2. apply a bottom-up approach as this leads to true community engagement and takes all different perspectives and the specific contexts into account.
3. Place health under the broader umbrella of well-being, as the WHO proposes.
4. Invest in long-term, sustainable community health promotion programmes to address socioeconomic health inequalities.
5. Consider to connect with the current transformation taking place in the Netherlands in the domains of healthcare, social support and employment to invest in community health promotion
6. Use participatory action research and have an embedded researcher, as stimulates community engagement and challenges all stakeholders to discuss values, roles, tasks and responsibilities in citizen participation and intersectoral collaboration.

Samenvatting

Introductie

Sociaaleconomische gezondheidsverschillen, de hardnekkige gezondheidskloof tussen groepen met een hoger en een lagere sociaaleconomische status (SES), is een 'wicked', of moeilijk oplosbaar probleem, dat veroorzaakt wordt door meerdere factoren in de sociale, fysieke en economische omgeving en de interactie tussen individuen, groepen en gemeenschappen. Het is algemeen erkend dat effectieve strategieën om die gezondheidsverschillen te verkleinen gebaseerd moeten zijn op een sociaalecologisch perspectief en zich moeten richten op meerdere factoren op verschillende niveaus en op de wisselwerking tussen die factoren. Echter, tot op heden zijn gedragsverandering benaderingen en bijbehorende interventies dominant in gezondheidsbevorderingsprogramma's, ondanks hun beperkte effectiviteit, vooral als het gaat om het verkleinen van gezondheidsverschillen.

Veelbelovend zijn multilevel strategieën, zoals een wijkgerichte aanpak van gezondheidsbevordering–overeenkomstig de Ottawa charter uit 1986- gebaseerd op actieprincipes als bewonersparticipatie en intersectorale samenwerking. Omdat gebleken is dat zowel de implementatie als de evaluatie van wijkgerichte gezondheidsprogramma's een uitdaging is, is onderzoek nodig dat rekening houdt met de processen, waarden en actieprincipes die onderdeel uitmaken van zulke programma's. Hiervoor wordt participatief actieonderzoek aanbevolen, omdat het de waarden van gezondheidsbevordering, zoals participatie en empowerment in zich heeft. Tegelijkertijd faciliteert het de ontwikkeling van vaardigheden en van elkaar leren, wat ook weer bijdraagt aan gezondheid van de betrokkenen.

Van juli 2016 tot en met december 2019 is er een wijkgezondheidsprogramma genaamd Voorstad Beweegt (VB) geïmplementeerd in een stadswijk met een lage sociaaleconomische status in Nederland. In aansluiting op landelijke en lokale beleidsdoelstellingen had het programma tot doel bij te dragen aan de verbetering van de gezondheid en manieren te vinden om gezondheidsverschillen te verminderen. In de aanpak stonden de actieprincipes bewonersparticipatie en intersectorale samenwerking centraal. De implementatie van het VB-programma werd vormgegeven en ondersteund door de VB-coalitie, een projectgroep bestaande uit leden van het sociaal wijkteam, de wijkmanager, een opbouwwerker, buurtsportfunctionaris en een gezondheidsmakelaar. De projectleider vanuit de GGD, was tevens actieonderzoeker en schrijver van dit proefschrift.

Doel

Het doel van de studie die in dit proefschrift is beschreven, is enerzijds de impact van een wijkgezondheidsprogramma op de gezondheid van bewoners en hun omgeving te onderzoeken. Anderzijds was de studie gericht op het bestuderen en begrijpen van de werking van de actieprincipes in dat programma en hiermee bij te dragen aan het vinden van manieren om gezondheidsverschillen te verminderen. Hiertoe zijn vier onderling samenhangende onderzoeksvragen geformuleerd:

1. Wat zijn de percepties van inwoners van Voorstad van gezondheid en van een gezondheidsbevorderende omgeving?
2. Welke factoren en mechanismen dragen bij aan bewonersparticipatie en intersectorale samenwerking?
3. Wat levert deelnemen aan het Voorstad Beweegt-programma bewoners op, in termen van ervaren gezondheid, gezondheidsvaardigheden en empowerment?
4. Wat is de overall impact van het programma Voorstad Beweegt in termen van gezondheidsbevorderende activiteiten, sociale en fysieke omgeving en de ervaren gezondheid van inwoners?

Methoden

In deze studie is gebruik gemaakt van een mixed-methods-ontwerp en een combinatie van voornamelijk kwalitatieve gegevens uit verschillende bronnen. De onderzoeksactiviteiten bestonden uit diepte-interviews, focusgroepdiscussies, concept mapping, fotovoice, sociale netwerkanalyse, documentanalyse en bewonerssurveys. De combinatie van informatie uit diverse bronnen en methoden – triangulatie – verhoogde de validiteit van gegevens. Samenwerkingspartners en bewoners werden betrokken bij de planning van het onderzoek en bij verschillende onderzoeksactiviteiten. Een prominente strategie was participatief actieonderzoek, dat tot doel heeft alle belanghebbenden te betrekken, de verschillende perspectieven van bewoners en professionals vast te leggen en vooral ook bewoners met een lage SES te laten participaren. Het helpt de betrokkenen -professionals, bewoners en onderzoekers- ook om hun werkwijzen voortdurend te optimaliseren. Ook draagt het bij aan het ontwikkelen van zowel theorieën als onderzoeksmethoden, die inzicht geven in wat werkt en waarom het werkt.

Resultaten

Onderzoeksvraag 1: *Wat zijn de percepties van inwoners van Voorstad van gezondheid en van een gezondheidsbevorderende omgeving?* Komt aan bod in hoofdstuk 3. Bij de start van het VB-programma werd een concept mapping-methodologie gebruikt, om bewoners van de wijk actief te betrekken. Elf bestaande groepen in de wijk namen, samen met wijkwerkers, deel aan het onderzoek. De deelnemers in alle groepen waren het erover eens dat gezondheid meer inhoudt dan de afwezigheid van ziekte; gezondheid is een multidimensionaal concept. De studie bracht zeven percepties van gezondheid in beeld, die volgens de deelnemers het belangrijkst waren: (1) sociale relaties en interacties, (2) fysieke activiteit, (3) positieve levenshouding, (4) gevoel van controle, (5) gezonde voeding, (6) mentale rust en (7) de natuurlijke omgeving. De bevindingen tonen aan dat het noodzakelijk is om een ondersteunende sociale omgeving te creëren om gedragsverandering te vergemakkelijken en gezondheid te verbeteren. Bewoners beschouwden de natuurlijke omgeving als een belangrijke bron om gezondheid en welzijn te bevorderen en te behouden. Het werd duidelijk dat de nadruk in het gezondheidsprogramma moet liggen op de sociale dimensies van gezondheid, waarbij bewoners een verscheidenheid aan activiteiten wordt geboden, die passen bij hun wensen. Activiteiten moeten een positieve benadering hebben, gratis zijn en dichtbij in de buurt plaatsvinden, waardoor sociale contacten ontstaan en netwerken worden opgebouwd en versterkt. Deze studie hielp om bewoners en wijkwerkers te betrekken en was het startpunt voor de samenwerking en co-creatie gedurende het VB-programma.

In de hoofdstukken 4 en 5 wordt onderzoeksvraag 2: *Welke factoren en mechanismen dragen bij aan bewonersparticipatie en intersectorale samenwerking?* beantwoord. Eerst worden de inzichten in de processen gepresenteerd die het opbouwen en onderhouden van intersectorale samenwerking binnen de VB-coalitie en in het brede netwerk mogelijk maken. Ook wordt duidelijk hoe deze processen bijdragen aan de ambities van de VB-coalitie hoe de onderlinge wisselwerking tussen de processen was. De Coordinated Action Checklist (CAC) en de samengestelde netwerkanalyse (SNA) zijn gebruikt als onderzoeksinstrumenten, geïntegreerd in participatief actieonderzoek in 2018 en 2019. De resultaten van de CAC en de SNA werden in vijf groepssessies teruggekoppeld naar de VB-coalitie en gebruikt voor reflectie over de voortgang en planning van het VB-programma. De meest prominente processen die van invloed waren op de samenwerking waren de organisatie en werkwijze van de coalitie, interactie met de context, netwerkopbouw en de rol van de gezondheidsmakelaar en het genereren van zichtbaarheid van de outputs. Dit hielp de wijkwerkers en onderzoekers om hun werkwijzen te optimaliseren, er naar te handelen en de daadkracht van de coalitie te versterken. Het zichtbaar maken van de verwachte en onverwachte opbrengsten en uitkomsten heeft bijgedragen aan de inzet en

voortzetting van de VB-coalitie. Die inzet is nodig om op de lange termijn veranderingen in de wijk en gewenste verbeteringen in gezondheid te realiseren.

In hoofdstuk 5 wordt een 'realist evaluation' studie beschreven, gericht op het ontrafelen van de mechanismen die ten grondslag liggen aan de actieprincipes in het VB-programma. De kwalitatieve gegevens die in deze studie zijn gebruikt, zijn afkomstig van meerdere bronnen en methoden om de validiteit te waarborgen en omvatten evaluatiesessies en individuele interviews met leden van de VB-coalitie en de gezondheidsmakelaar, groepssessies met wijkwerkers en bewoners, halfjaarlijkse voortgangsrapportages en notulen van de coalitievergaderingen. De meest opvallende mechanismen die ten grondslag liggen aan bewonersparticipatie en intersectorale samenwerking waren persoonlijk contact, geduld, doorzettingsvermogen en zichtbaarheid. Bovendien waren de participatieve actieonderzoeksactiviteiten die het VB-programma begeleidden zowel een mechanisme als een onderdeel van de context. Die onderzoeksactiviteiten triggerden interessante resultaten door alle betrokkenen te helpen processen te herkennen, verder te brengen en de resultaten zichtbaar te maken. Deze 'realist evaluation' methodologie droeg bij aan het begrijpen van wat werkte onder de gegeven omstandigheden en hielp bij het zichtbaar maken van een breed scala aan uitkomsten.

Onderzoeksvraag 3: *Wat levert deelnemen aan het Voorstad Beweegt-programma bewoners op, in termen van ervaren gezondheid, gezondheidsvaardigheden en empowerment?* wordt besproken in hoofdstuk 6. Er werd een mixed-methods aanpak toegepast, bestaande uit een kleinschalige enquête en 12 diepte-interviews met bewoners die deelnemen aan activiteiten en/of vrijwilligerswerk in de buurt doen. De uitkomsten van de enquête lieten zien dat leeftijd en het gevolgen van fysieke of mentale gezondheidsproblemen negatief geassocieerd waren met empowerment. Opleidingsniveau was positief geassocieerd met empowerment. Bovendien werd een (sterke) positieve associatie gevonden tussen empowerment en ervaren gezondheid, wat betekent dat respondenten met een hoog niveau van empowerment hun gezondheid als (zeer) goed ervoeren, en respondenten met een laag niveau van empowerment gemiddeld tot laag scoorden op ervaren gezondheid. Uit de diepte-interviews kwamen een aantal ervaren voordelen van actieve participatie naar voren, te weten: zingeving, sociale contacten, gezelligheid en plezier en verbondenheid/ betrokkenheid. Al deze voordelen samen dragen bij aan het meer omvattende concept van welzijn. Alles bij elkaar geven de bevindingen een beter inzicht in het belang en de voordelen van actieve participatie van wijkbewoners, overwegend met een lage SES en hun motivaties om bij te dragen aan de ontwikkeling en uitvoering van gezondheidsbevorderende activiteiten.

Onderzoeksvraag 4: *Wat is de overall impact van het Voorstad Beweegt-programma in termen van gezondheidsbevorderende activiteiten, sociale en fysieke omgeving en de ervaren*

gezondheid van inwoners? wordt beantwoord in hoofdstukken 4, 5, 6 en 7. Hoofdstuk 7 presenteert de output van het programma in termen van programma-activiteiten, onderzoeksactiviteiten en betrokkenheid van belanghebbenden -professionals, vrijwilligers en deelnemers- zoals beschreven in het logische model dat in het onderzoeksprotocol (hoofdstuk 2) is gepresenteerd. Tijdens de looptijd van het VB-programma zijn samen met de bewoners van Voorstad 15 verschillende activiteiten georganiseerd en uitgevoerd, die zich kenmerkten door een grote diversiteit in inhoud, intensiteit, duur en deelnemers. De participatieve actieonderzoeksactiviteiten maakten specifieke output van het programma zichtbaar, zoals inzichten in de percepties van gezondheid, een versterkte samenwerking binnen de VB-coalitie en een uitgebreid, wijkbreed netwerk van contacten. Bijkomende activiteiten die als programma-outputs konden worden beschouwd, waren de 'Welzijn of niet zijn'-coalitie en de cursus 'Leider sportieve recreatie'. Tot slot heeft de betrokkenheid van de gemeente bij het VB-programma, samen met de toekenning van een overbruggingsbudget, bijgedragen aan een vervolg van verschillende gezondheidsbevorderderende activiteiten. Daarmee kon bovendien de wijkgerichte gezondheidsaanpak en de intersectorale samenwerking op het gebied van gezondheid in deze wijk worden voortgezet.

Conclusies en aanbevelingen

Dit proefschrift geeft inzicht in hoe een op actieprincipes gebaseerd wijkgezondheids-programma in een sociaaleconomisch achtergestelde wijk kan bijdragen aan het verbeteren van gezondheid en het verminderen van gezondheidsverschillen. Starten met de percepties van bewoners op gezondheid en een gezondheidsbevorderende omgeving leverde een holistische kijk op gezondheid op, die past binnen het uitgebreide concept van welzijn. Dit had tot gevolg dat de activiteiten in het programma voornamelijk gericht waren op de sociale dimensie van gezondheid en het benutten van hulpbronnen in de sociale omgeving.

Een bottom-up benadering aan het begin van het programma, aansluiten bij de behoeften van bewoners en samen leren en ontwikkelen waren bepalend voor succesvolle bewonersparticipatie in het programma. Betrokkenheid van de gemeenschap is gerealiseerd, door wederzijds vertrouwen, versterking van empowerment en intersectorale samenwerking binnen de coalitie en in het wijkbrede netwerk.

Gedurende het hele programma is participatief actieonderzoek toegepast om de processen en activiteiten te evalueren en tegelijkertijd te vergemakkelijken. De waarden van participatief actieonderzoek, zoals het betrekken van alle belanghebbenden, inclusief burgers met een lage SES, het vastleggen van de verschillende perspectieven van burgers en professionals en het faciliteren van de ontwikkeling van capaciteiten, leren en empowerment, zijn in deze studie overtuigend aangetoond. Onderzoek en praktijk

zijn nauw met elkaar verbonden, wat resulteert in een dubbelrol van onderzoeker en gezondheidsbevorderings-professional. De rol van de ingebedde onderzoeker is uitdagend en vraagt–naast flexibiliteit om van rol te veranderen–communicatieve en sociale vaardigheden en competenties die betrekking hebben op zelfreflectie, geduld en balans houden. Naast specifieke vaardigheden en capaciteiten, vereist de bottom-up benadering een verschuiving in houding en werkwijzen van de betrokken professionals, zoals luisteren en vragen stellen, denken in termen van kansen en mogelijkheden en het individu en de gemeenschap op de eerste plaats zetten.

De methoden en instrumenten zijn flexibel ingezet om onderzoek op verschillende niveaus aan te pakken en het hoofd te bieden aan de complexiteit van de evaluatie van een wijkgericht gezondheidsprogramma. Er werd een 'realist evaluation' uitgevoerd om beter inzicht te krijgen in de mechanismen die ten grondslag liggen aan de actieprincipes. Bovendien hielp participatief actieonderzoek bij het zichtbaar maken van een breed scala aan resultaten en programma output op verschillende niveaus (individueel, gemeenschap en sociale omgeving).

Deze studie levert een aantal aanbevelingen op voor de praktijk, het beleid en het onderzoek op het gebied van gezondheidsbevordering.

1. Neem bewonersparticipatie en intersectorale samenwerking expliciet op als doelen in wijkgezondheidsprogramma's die gericht zijn op het verminderen van gezondheidsverschillen.
2. Pas een bottom-up benadering toe, omdat dit leidt tot echte betrokkenheid van de gemeenschap en rekening houdt met alle verschillende perspectieven en de specifieke contexten.
3. Plaats gezondheid onder de bredere paraplu van welzijn, zoals de WHO voorstelt.
4. Zet in op langdurige, duurzame wijkgezondheidsprogramma's om sociaaleconomische gezondheidsongelijkheid aan te pakken.
5. Overweeg om aan te sluiten bij de huidige transformatie die in Nederland plaatsvindt op het gebied van zorg, WMO en werk om te investeren in gezondheidsbevordering in de wijk.
6. Gebruik participatief actieonderzoek en heb een ingebedde onderzoeker, die de betrokkenheid van de gemeenschap stimuleert en alle belanghebbenden uitdaagt om waarden, rollen, taken en verantwoordelijkheden in bewonersparticipatie en intersectorale samenwerking te bespreken en bevorderen.

Dankwoord

Dankwoord

'Dat is dapper' en: *'Stoer dat je dit doet'. 'Hoe lang gaat dat duren?* Dat waren veel voorkomende reacties als ik vertelde dat ik met promotieonderzoek bezig was.

De wens om promotie onderzoek te doen was er al langer, maar eigenlijk had ik de mogelijkheid ook al verworpen. Met verschillende argumenten: mijn leeftijd '*dan had ik het voor mijn 50ste moeten doen*', de tijd die het me zou gaan kosten, jarenlang, en dat ik naast mijn werk ook nog met werk bezig zou zijn. En natuurlijk moest er een onderwerp zijn dat ik interessant en relevant genoeg vond voor een uitgebreid onderzoek als een PhD.

Dat onderwerp kwam op mijn pad met de toekenning van de subsidie voor het project Voorstad Beweegt en het voorstel van Annemarie om van de evaluatie van dat project een promotieonderzoek te maken, dat ik zelf zou kunnen gaan doen. Daar moest ik over nadenken, maar niet eens erg lang. Eigenlijk wist ik meteen dat ik deze kans niet wilde laten lopen. Het ging over het terugdringen van gezondheidsverschillen (actueel en relevant), een community project waar ik zelf projectleider van werd, zoeken naar een passende manier om aan gezondheid te werken met mensen in een aandachtswijk. Dat past bij mij. Dit zou de vierde keer zijn, sinds 1989 dat ik een wijkgerichte aanpak ging vormgeven en die eerdere ervaringen zouden ook goed van pas kunnen komen voor het onderzoek.

De eerste jaren tijdens de uitvoering van Voorstad Beweegt kon ik het onderzoek grotendeels in werktijd doen. Met de inzet van Lotte, Yvon, Veerle, Anne, Christine, toen masterstudenten die als echte actieonderzoekers meedraaiden in het programma. Dank voor jullie inzet en alle data die zijn verzameld. Gelukkig hebben jullie er allemaal ook een MSc-titel mee verdiend.

De combinatie van projectleider en onderzoeker was uitdagend, soms lastig en zwaar, maar wat heb ik vooral genoten en veel plezier gehad met alle mensen in Voorstad die samen Voorstad Beweegt hebben gemaakt. De leden van de projectgroep, Valentijn, Merel, Muriel, Mark, Irene, Fernand, Barbara en Mariëlle. Het was samen zoeken naar een goede manier om mijn visie op wijkgericht werken om te zetten naar de praktijk. Jullie hebben dat gedaan en Voorstad Beweegt tot een succes gemaakt. Zonder jullie had ik dit onderzoek niet kunnen doen. Heel veel dank!

De bewoners van Voorstad, niet allemaal met naam te noemen. Dank voor het meepraten en meedenken en het delen van jullie ervaringen, zorgen en ideeën. Verschillende mooie uitspraken die gedaan zijn tijdens de groeps- en individuele interviews zijn in dit

proefschrift terecht gekomen als illustratie. Over illustratie gesproken; dank Rob voor de mooie tekeningen. We hebben ze goed kunnen gebruiken. Mariëlle en Leontien bedankt voor het deskundig en vooral positief leiden van de groepsgesprekken met bewoners, die de basis vormden van het programma.

Terwijl het programma in volle gang was, is het eerste artikel, het study protocol, gepubliceerd. Een opsteker voor mij als onderzoeker. Een tweede artikel stond in de steigers toen eind 2019 de subsidie voor Voorstad Beweegt ten einde liep en mijn rol als projectleider stopte. De aanpak van Voorstad Beweegt was geslaagd en het programma had mooie resultaten opgeleverd die zijn vastgelegd in een aansprekende film. De gemeente zegde een overbruggingsbudget toe, zodat de opgebouwde activiteiten niet verloren zouden gaan en er tijd was om naar structurele financiering van activiteiten én werkwijze te zoeken. Vanaf dat moment bleef voor mij de rol van onderzoeker over en was de opgave schrijven, schrijven, schrijven.

De combinatie van mijn GGD werk met het afronden van een PhD bleek ook een uitdaging. Vooral omdat vanaf begin 2020 de corona pandemie iedereen, zeker de GGD en haar medewerkers, in de greep hield. Ik voelde me gesteund door mijn (oud) GGD collega's, die me met rust lieten tijdens mijn schrijfweken en -maanden en altijd geïnteresseerd waren naar de voortgang. In het bijzonder Marita, Manon, Ina, Tessa, Judith, Sandra, Mette: dank voor jullie hulp bij het onderzoek en alle gesprekken, telefoontjes, appjes en (lunch) wandelingen.

Als onderzoeker kreeg ik er nog een groep collega's bij, die van de leerstoelgroep HSO. Hoewel ik -al die tijd- maar heel weinig in Wageningen ben geweest, heb ik me welkom gevoeld bij HSO en voelde het goed om aan de teamuitjes en de HSO social app mee te doen. Dank Gerda dat je mijn sparringpartner was tijdens dit PhD traject. We zaten in hetzelfde schuitje en het uitwisselen van ervaringen als externe PhD en jouw hulp bij een van mijn artikelen was zeer welkom.

Zonder mijn promotoren was dit proefschrift er niet gekomen. Maria: jij was ooit de begeleider van mijn afstudeervak GVO bij Voorlichtingskunde. Daar is bij mij het vuurtje gaan branden voor 'luisteren naar de doelgroep'. Heel veel dank dat je me hebt begeleid in dit promotietraject; ik heb -weer- veel van je geleerd. En Annemarie: jij hebt het balletje aan het rollen gebracht en daar ben ik je nog steeds dankbaar voor. Met jouw deskundigheid, altijd kritische blik en vragen, zeer nauwkeurig lezen en gedegen feedback op teksten heb je me ontzettend geholpen. Ik heb genoten van de reisjes naar Alicante en Marseille en van onze wandelingen. Ik hoop dat we elkaar ook na het afronden van dit proefschrift blijven zien en spreken.

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In alle jaren dat ik werkzaam ben in de publieke gezondheid zijn er veel verschillende mensen een tijdje 'met me opgelopen', waarvan ik heb geleerd en die me hebben geïnspireerd. Een daarvan, mijn eerste collega, die me heeft ingewijd en begeleid in de gezondheidsbevordering (toen nog GVO), wil ik in het bijzonder bedanken. Lieve Nicolette: wat hebben we veel samen gedaan, hard gewerkt en veel gelachen! Naast collega ben je ook een vriendin geworden. Wie anders zou er naast me kunnen staan als paranimf?

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dat ik erg trots ben op jullie allebei, Koen en Luuk. Terwijl ik al die jaren aan mijn PhD heb gewerkt, zijn jullie uitgegroeid tot mooie volwassen mannen met fijne partners, een frisse blik en brede maatschappelijke interesse. Altijd bereid om te luisteren en mee te denken over mijn onderzoek. En Hans, mijn maatje al 40 jaar. Ik meen het als ik zeg dat ik dit hele avontuur niet had kunnen doen zonder jouw altijd aanwezige steun. Je laat me, luistert naar me, zorgt voor me en laat op jouw manier merken dat je trots op me bent. Je bent er gewoon altijd voor me en lieve schat, ik hoop dat we nog heel lang zo samen verder mogen gaan. Ik hou van jullie.

About the author

About the author

Marja de Jong (1963) grew up in Standdaarbuiten, a small village in West-Brabant, the Netherlands. She graduated from the Thomas More College in Oudenbosch in 1981 and started the study Human Nutrition at Wageningen University. She obtained her master degree with specialization health promotion in 1988. Her first job was at the municipal public health service (GGD) of Utrecht where she developed and implemented a community project aimed at healthy eating in Zuilen, a socioeconomically deprived city district. She combined this with working at the national organization of municipal health services, coordinating and supporting local health promotion professionals. She left the public health field to work as a city district coordinator at the municipality of Zutphen, where she learned to bring citizen participation into practice. Subsequently, as a self-employed person, she coordinated various projects in the field of physical activity and health, social support, and welfare usually commissioned by municipalities or civil society organizations.

Since 2006 Marja works as a policy advisor and programme coordinator at the municipal public health service IJsselland. She was one of the founders of 'Zwolle Gezonde Stad', a community approach of overweight prevention among the youth in two city districts. Zwolle became the first so-called JOGG municipality in the Netherlands. She then initiated and supported local networks and health promotion programmes, and did monitoring and evaluation of these programmes in other cities in the IJsselland region. At the same time, she developed into an all-round public health advisor and in 2014 she obtained her Master of Public Health degree.

Over the past decades she gained extensive practical knowledge and research experience in the local and regional field of public health and health promotion. Her motivation to do a PhD study after so many years of practice stems from the community health promotion practices she knows so well and which deserve much more attention and funding than they have received so far.

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