Healthy Inclusion

Migrants' perspectives on participation in health promotion in The Netherlands

Empirical analysis II and III: Interviews with migrants with and without access

National report – The Netherlands

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1. Introduction

Most of world migrants, about 64 million, live in Europe (UN Migration Chart, 2006). Its current migration flows are very heterogeneous and the profiles of migrants are very diverse. While some migrants may not face any special threat or radical change, others encounter many and can put people in a more vulnerable situation. Frequently similar to those of the disadvantaged groups, migrants are overexposed to several risks which have an impact on health: dangerous and low-paid jobs, poor nutrition, deprived housing, missing social insurance, lack of access to information and (health) treatment. This further may have repercussions on education, possibilities of active participation in (municipal) living, and feeling welcome and respected as determinant for wellbeing in general (Caritas Europa 2006). Consequently, the health dimension of migration is a critical issue for the EU and for the member states. The EU, as agreed by all member states, shall respect fundamental rights as guaranteed in the European Convention for the Protection of Human Rights and Fundamental Freedoms. Addressing the health of migrants is seen not only as a humanitarian cause, but moreover as a need for attainment of the best level of health and well-being (Padilla & Miguel 2007). Realizing these rights and bettering the health status of all people living in the EU, the access to the health care system and all related issues that support equity has to be fostered.

“Healthy Inclusion. Development of Recommendations for Integrating Socio-Cultural Standards in Health Promoting Interventions and Services” is an international project carried out within the Public Health Programme 2003-2008, co-funded by the European Commission, DG Health and Consumers, Public Health. Nationally it is co-funded by ZonMw The Netherlands organisation for health research and development. It is taking the special impact of health promotion in mind:
Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices (c. p. Ottawa Charter, WHO 1986).

The project’s overall aim is to contribute to the increase of participation of migrants in health promotion interventions. Specifically, “Healthy Inclusion” is aiming at gaining

knowledge about barriers and supporting factors for migrants in using health promotion interventions by exploring the providers' as well as the migrants' perspectives. Based on this gained knowledge and with support of external experts, recommendations for health promotion providers on how to integrate migrants in health activities will be developed. The chosen setting is a municipal one as interventions especially provided within local communities have an important function in reducing the barriers; they are relevant for building networks which are central for social inclusion (Portugal, R., et al. (Eds.), 2007: 21).

The project's duration lasts from July 2008 to July 2010. Eight EU-members states are part of the consortium of "Healthy Inclusion": Austria, Czech Republic, Denmark, Estonia, Germany, Italy, The Netherlands and Slovakia. In each country (except Germany, which is evaluating the project) national explorations are carried out. All national results are merged and will finally lead to the recommendations. As it is important to consider local needs and possibilities of individual countries when developing health promotion strategies and programmes, the recommendations will have a "general suitable part" for all countries but will also include national recommendations specifically related to each country.

A first exploration phase had taken place between September 2008 and March 2009. It focussed on the providers' perspectives on barriers and their concretely experiences with migrants as participants of interventions as well as their suggestions for enhancing the participation of migrants. The report "Providers' perspectives on participation of migrants in health promotion in The Netherlands" reflects the results; it is available under www.verwey-jonker.nl.

A second and third exploration phase had taken place between June and October 2009. The explorations centred the perspectives of two migrant groups: One group which already has had access to health promotion interventions and one group who did not have access yet. The present report "Perspectives of migrants on participation in health promotion in The Netherlands" describes the results of a background literature review as well as of these interviews. First it gives an overview on national migrants' data in The Netherlands and views their actual (living) situation by focussing especially "migration and health" issues. Second, selection criteria of interviewees and methods used are delivered. The third and main part concentrates on the empirical results; besides hard facts like origin,

legal status, religion, marital status, etc, soft facts like ability to speak language of the host country, habits or (cultural) orientation - based mainly on self-estimation of the interviewees - are described. Furthermore interviewees' perceptions of health, their information level and awareness about health rights and opportunities are spotlighted. Finally, the report demonstrates the interviewees' experiences respective suggestions for fostering participation and compares the migrant users' suggestions with those of the providers.

2. Background

2.1. Migrants in the Netherlands

The Dutch population is approximately 16 million. The non-indigenous population numbered just over 1.7 million at the start of 2007 (CBS StatLine). Statistics Netherlands considers anyone with at least one parent born abroad as a member of an ethnic minority. The country of origin for those not born in the Netherlands (the first generation) is their own country of birth. For the second generation (born in the Netherlands) the country of birth of the mother is used (unless she was born in the Netherlands, in which case the country of birth of the father is used). The 'non-Western' category comprises ethnic minorities from Turkey, Africa, Central and South America, and Asia (excluding Indonesia and Japan). In 2007, the proportion of non-Western migrants in the Dutch population was 10.6%. The proportion of Western migrants in 2007 was 8.8% (SCP 2008).

Around two-thirds of non-Western immigrants originate from Turkey (372,714), Morocco (335,127) and Surinam (335,799). Each of these groups accounts for around 2% of the population. Migrants from the Netherlands Antilles and Aruba account for just under 1% of the population (SCP 2008 ibid).

On average, the non-Western ethnic minority population is younger than the indigenous population and is much less affected by population ageing (SCP/WODC/CBS 2005). The average age of members of non-Western ethnic minorities was 28 years in 2005, against 40 years for the indigenous population, while those aged over 65 accounted for fewer than 3% of the total, against more than 15% in the indigenous population. The youthfulness of the non-indigenous population also applies to groups that have lived in the Netherlands for some time, in particular Surinamese, Turks and Moroccans. However, these groups will be subject to population ageing in the coming decades, due in part to falling immigration and growing emigration, especially of young people.

Members of non-Western ethnic minorities have traditionally concentrated in the west of the Netherlands, and particularly in the four major cities of Amsterdam, Rotterdam, The Hague, and Utrecht. Although this is true of all ethnic minority groups, Surinamese and Moroccans are particularly overrepresented in the west of the country (and in the four major cities), while Turks tend to live in the former industrial regions in the east of the

country. The other non-Western ethnic minorities – especially refugee groups – are also overrepresented in the west of the Netherlands, but live mainly in the medium-sized towns and cities. However, despite a policy of deliberate dispersal throughout the country on arrival, these groups eventually also tend to gravitate to the cities (Latten et al. 2005), (SCP 2008 ibid).

Ethnic minorities in the major cities are highly concentrated in specific neighbourhoods. If the district and neighbourhood division used by Statistics Netherlands (CBS) is applied, there were 83 districts in 2004 in which more than 25% of the residents were of non-Western origin (SCP/WODC/CBS 2005). In 13 of these districts, the non-Western population made up the majority. Furthermore, there were 456 neighbourhoods in which ethnic minorities made up more than 25% of the population, and in 92 neighbourhoods they accounted for more than half the population. Almost half these 'concentration neighbourhoods', as they are called, are situated in the four major cities, where they account for more than 10% of all neighbourhoods (SCP 2008 ibid).]

2.2. Migrants and health

Non-Western migrants generally have poorer health (RVZ 2000, VTV 1997). Their *perceived* health is also poorer than that of the native Dutch population. Furthermore, non-Western migrants are more likely to suffer from chronic diseases (Nivel 2004). Socio-economic factors can explain only some of the differences in health between the native Dutch and the non-Western migrants in the Netherlands (Pacemaker, 2007). In some ethnic groups, health problems and diseases occur more often, or take a specific form. Some examples are infectious diseases (e.g. Helicobacter Pylori infection), blood diseases (e.g. sickle cell anaemia and G6PD deficiency), heart diseases, diabetes and asthma.

Health behaviour also differs between non-western migrants and the native Dutch population (Kunst e.a. 2008). In concordance with the higher mortality and prevalence of diabetes the four main migrant groups in the Netherlands have a higher prevalence of overweight and obesities and are less physically active compared to the native Dutch population. In concordance with the low mortality of lung cancer, the prevalence of smoking is lower among migrant groups, especially women. However, the prevalence of

smoking is higher among Turkish and Surinamese men compared to the native Dutch population.
Alcohol consumption is considerably lower among migrant groups, especially for those with a Muslim background. Many uncertainties still remain, however, and more research is needed to explain matters such as differences in life expectancy and the relationship with ethnicity (Pacemaker ibid).

The use of health care facilities by non-Western migrants also differs from that of the native Dutch. Turks and Moroccans in particular use the health care system and facilities differently. Their use of some facilities, such as paediatricians and prescribed medication, is relatively high and of specialized medical care relatively low (Pacemaker ibid). Again, more research is needed to gain an insight into the factors underlying these discrepancies. The Dutch Ministry of Health, Welfare and Sport has primary responsibility for the development and execution of policies in the field of prevention. Apart from classical prevention, government policy also aims for the improvement of public health. Among the health promotion methods used are the provision of general information and tailored advice, and the creation of social and physical environments that stimulate healthy behaviour. In 2006, the government published its policy document ‘Opting for a Healthy Life’ (VWS, 2006). The following preventive policy priorities were identified: smoking, problematic drinking, overweight, diabetes, and depression. In 2007, the government published its vision document ‘Being Healthy and Staying Healthy’ (VWS, 2007), which projects long-term policy lines and defines conceptual frameworks within which both the ministry and its partners can develop strategies and action plans for a healthy nation.

In its vision document, the government refers to considerable health inequalities between different groups in Dutch society in terms of both socio-economic status and ethnic background: ‘On almost all indexes, the health of people of low socio-economic status is not as good as that of people of high socio-economic status. The less well-off perceive themselves to be in poorer health, and are more likely to suffer chronic conditions or disabilities. The ethnic minorities are also disadvantaged in terms of health risks. People from minority backgrounds are more likely to be overweight, and mortality rates are higher among children in these groups.’ (VWS, 2007).

Another joint policy of the national government and the municipalities is to improve communities that face serious problems in housing, employment, education, integration, and safety. The forty districts that are facing the most difficult problems have been identified. These districts must now work to achieve drastic reductions in school drop-out rates and unemployment. The quality of housing must also be substantially improved. Improving health is also an issue, as most residents of these districts have low socio-economic status and many are members of ethnic minorities.

Recently, the government published the 'Policy plan for tackling health disparities based on socio-economic backgrounds' (VWS, 2008): 'In the field of public health, there are specific measures aimed at providing more effective care for low-wage earners and for ethnic minorities. Preparations to extend the basic health insurance package are in full swing. The aim is to include measures such as helping people to give up smoking, providing physical exercise courses, etc.. Structured approaches are also being developed for people with chronic illnesses.'

Local authorities carry out much of the actual work on public health. In the Netherlands, the development and implementation of prevention policy is a cyclic process in which the National Public Health Status and Forecast Reports (VTV) of the National Institute for Public Health and the Environment (RIVM), the national public health policy documents, and the local authority public health policy documents all build on each other.

Until now, prevention and health promotion have been financed mainly by local governments under the Public Health Act. Recent changes in the legislation and financial system of health care and social support may have an impact on future financing of health promotion activities. Under the new Health Insurance Act, all residents of the Netherlands are obliged to take out health insurance. Furthermore, the new Social Support Act[1] gives municipalities the opportunity to develop a cohesive policy on social support, living and welfare, along with other, related matters.

The main providers of health promotion are the local and regional public health services. However, providers of general health care, mental health care, youth care, elderly care,

[1] The Wmo puts an end to various rules and regulations for handicapped people and the elderly. It encompasses the Services for the Disabled Act (WVG), the Social Welfare Act and parts of the Exceptional Medical Expenses Act (AWBZ).

and a growing number of others, such as schools, welfare, sports, and business organizations, are also becoming involved in health promotion. Most public health services offer specific health promotion activities for non-Western migrants, and other organizations, such as those in youth care and mental health care, are increasingly doing so as well, particularly in areas with large migrant groups. Among non-Western migrants, an accumulation of factors is contributing to a decline in health and decreased use of preventive health measures. These factors include a low educational level and income, a deteriorating position on the labour market, and deprived neighbourhoods. Furthermore, prevention aims at maintaining healthy behaviour, such as low alcohol consumption and sensible eating habits.

Health-promoting activities are provided by municipal and regional health services and, increasingly, other health care organizations (van Vliet, de Gruijter & Bulsink, 2009). These organizations normally offer health-promoting activities to all residents of a region or to all their clients. However, most organizations, especially those in the major cities, or regions with many migrant groups, focus on specific groups (i.e. people with a low socio-economic status, ethnic minorities, and vulnerable older people) in disadvantaged neighbourhoods. Furthermore, the health care and other organizations that provide health promotion focus on people with specific issues, such as physical, mental, or psychosocial problems, and problems with addiction, relationships, development, or education.

Most organizations work in several settings, depending on the focus and type of intervention, the target group, and so on. The most common settings of health promotion interventions are the neighbourhood, the community centre, the health care centre and school. Other settings are the sports club or accommodation, the home, and the media.
All organizations have migrants as participants. Most organizations (10 out of 15) also provide interventions especially for migrants. Most organizations (11 out of 15) have policies for improving the participation of migrants in health promotion.

Most of the organizations provide several types of health promotion interventions. The public health services in particular provide a variety of health promotion programmes to increase the attention people give to their health, and to encourage them to make healthy choices. These interventions focus on a healthier lifestyle and the prevention of diseases. Common themes are alcohol, drugs and tobacco use; obesity/overweight, exercising and

healthy food; and psychosocial problems (depression, loneliness). Examples are an anti-smoking competition for secondary school students, a project to combat obesity for Turkish and Moroccan women, and a programme to encourage children to exercise and practise sports.

The most common forms of health promotion interventions are information, advice, and support in sessions or courses. Some organizations provide information, advice, and support in individual contacts. Beside sessions and courses, other methods used include leaflets and media campaigns.

3. Empirical analysis

3.1 The interviewers

For the selection of the interviewers the following criteria were formulated:

1. A maximum of three interviewers because of the limited number of interviews
2. The interviewers have the same native background as the respondents in order to perform the interviews in the native language of the respondents;
3. The interviewers are female because of expected problems for female respondents to be interviewed by a man;
4. The interviewers have some interview experience.

Three interviewers were recruited by a specialised agency: one of Moroccan, one of Turkish and one of Surinamese origin. The interviewers received instruction and training.

3.2 Interview respondents

3.2.1 Selection criteria and sampling of migrants

Two research groups were defined for this research component:

- present or past participants in health-promoting activities;
- non-participants in health-promoting activities.

Respondents for both research groups were recruited among first-generation migrants of Turkish, Moroccan and Surinamese origin, which are the three largest non-Western ethnic minority groups in the Netherlands.

There were ten interviews for each research group. The numbers of respondents chosen reflect the fact that the Turkish group is the largest in the Netherlands. There were eight Turkish, six Moroccan and six Surinamese respondents, who were divided equally between the two research groups.

3.2.2 Methods used to reach migrants

The interviewers were responsible for recruiting the respondents. The first respondents to be recruited were the health-promoting activity participants. An aim in the recruitment was to achieve a variation in gender, educational level and age in the ethnic groups.

This respondents group was recruited through several providers that had been interviewed in the first research component (van Vliet, de Gruijter & Bulsink, 2009). The non-participant respondents were then recruited among the recruiters' family and acquaintances (6), through an interest group (2), and through migrant social care workers in a care organization (2). The interviewers were instructed to give preference to respondents for the non-participant group who matched the participant group in terms of gender, age and educational level. This aim was not fully achieved. The participant group had a higher average age and slightly lower educational level than the non-participant group, which was attributable to the interviewers' tendency to select from among their own circle. The Moroccan interviewer in particular selected only highly educated women as non-participant interviewees. Tables 1 and 2 list the respondents' characteristics. Both groups had more female than male respondents. The Turkish interviewer reported some difficulty in identifying male respondents in the recruitment process. The interviewers' gender may have been partly responsible, since it can be awkward for a Turkish or Moroccan female interviewer to make contact with a man.

Table 3.1 Characteristics of Group 1: participants

Participants	Gender	Age	Education
Turkish	0 men 4 women	W1: 47 W2: 53 W3: 37 W4: 32	W1: None W2: Higher professional (HBO) W3: Advanced elementary (LO+) W4: Pre-vocational secondary (VMBO)
Moroccan	1 man 2 women	M1: 59 W1: 52 W2: 49	M1: Upper secondary vocational (MBO) W1: None W2: ~Advanced elementary (LO+)
Surinamese	2 men 1 woman	M1: 36 M2: 65 W1: 57	M1: Upper secondary vocational (MBO) M2: Extended upper secondary vocational (MBO+) W1: PE

Table 3.2 Characteristics of Group 2: non-participants

Non-participants	Gender	Age	Education
Turkish	0 men 4 women	W1: 37 W2: 67 W3: 36 W4: 32	W1: Upper secondary vocational (MBO) W2: Elementary (LO) W3: Higher professional (HBO) W4: Elementary (LO)
Moroccan	0 men 3 women	W1: 26 W2: 20 W3: 25	W1: Higher professional (HBO) W2: Higher professional (HBO) W3: University (WO)
Surinamese	1 man 2 women	M1: 56 W1: 36 W2: 48	M1: Higher professional (HBO) W1: Pre-vocational secondary (VMBO) W2: Pre-vocational secondary (VMBO)

3.2.3 Description of methods used in empirical analysis

The interview method involved a questionnaire translated into the respondents' own languages. The interviewers were given training prior to the interviews, and there was consultation with them during and after the interview process, in particular about how the respondents were recruited.

The interviews were recorded on tape and transcribed literally. The raw data were coded with reference to a theme list. The theme list was based on the questionnaire and our prior knowledge of migrants and health promotion (see Chapter 2). The answers were analysed by theme and by seeking to identify patterns in the answers, and then summarizing and analysing them in the context of the research questions and prior knowledge gained in the research among providers.

3.2.4 Characteristics of the interviewed migrants

The appendix includes a table of the respondents' characteristics.

Eight respondents were of Turkish origin, six of Moroccan, and six Surinamese. The participant group comprised seven women and three men, and the non-participant group nine women and one man. A factor in this unbalanced distribution is the difficulty of recruiting male respondents. The average age of the participant group was 49 years, with the youngest 32 and the oldest 65. The average age of the non-participant group was 37

years, with the ages ranging from 20 to 67. The participants' educational level varied from none to upper secondary vocational (MBO). The average educational level of the non-participants was somewhat higher, varying from elementary (LO) to higher professional (HBO) and university. The average period of residence in the Netherlands for the participant group was 32 years, and for the non-participant group 25 years. The reason for coming to the Netherlands for the great majority of participants and non-participants alike was family reunion or family formation. The main differences between the participants and the non-participants are attributable to the recruitment of three young highly educated Moroccan respondents to the non-participant group.

Social situation

The majority lives as part of a family, with a partner (1), partner and children (9), children (single-parent family) (4) or parents (and brothers and sisters, if any) (3). Three of the participants lived alone. There were three single-parent families among the non-participants. A minority of the respondents (6 out of the 20) were in paid work (part time). Furthermore, one of these respondents performed paid work at home as a carer for her disabled child. Almost half had no work: they were looking for a job (2), had a work disability (6) or had taken early retirement (1). The number of disabled workers is greater among the participants (4) than the non-participants (2). Two respondents worked in the family or household, and three were following an educational programme. The greater number of disabled workers in the participant group could have to do with their higher age and poorer health (see 3.2). Half the respondents stated that they found it neither difficult nor easy to make ends meet with their total household income. Four respondents could easily make ends meet, and 5 could do so with difficulty or extreme difficulty. There were no differences in this respect between the participants and the non-participants.

3.2.5 (Self-perceived) integration level

We determined the degree of integration as reported by the respondents from answers to questions about command of the Dutch language, whether they felt accepted in the Netherlands, and whether they considered it important to uphold their own cultural customs and traditions in the Netherlands. Although we asked no direct questions about religion, the answers to the question about upholding cultural customs and traditions did yield information on this subject.

The majority of the respondents in both groups stated that they speak Dutch reasonably well (9) or well (7). Four respondents said they could speak a little Dutch. The participants estimated their command of the Dutch language somewhat lower than the non-participants.

The majority of the respondents, both among the participants (6 out of the 10) and the non-participants (7 out of the 10), felt well accepted in the Netherlands. Some did immediately qualify the comments, observing that attitudes to foreigners and the general atmosphere have deteriorated in recent years, and that they encounter people in their surroundings who tend to generalize.

"The Netherlands has changed. Once we were welcomed here as migrants or Moroccans, because we were needed then for the good of the economy. Now they don't need us any more, so we are no longer wanted. […] Dutch people used to be nicer to us. Now they can't remember your name, even in the factory you've worked in for 33 years." (Moroccan man, participant).

"I always used to think so, but now we can sometimes be treated as if we're all tarred with the same brush. Even if you have lived in this country for 30 years". (Turkish woman, non-participant).

Others feel accepted mainly in their immediate surroundings, and get on well with their Dutch neighbours. Some emphasize the atmosphere of tolerance that they still perceive in the Netherlands.

"In my little micro environment I do feel accepted. My friends no longer notice that I have a different origin. But the situation is different in macro terms. I have black hair. But I am still content in the Netherlands. The Netherlands is a developed country; migrants are given sufficient scope, without assimilation." (Turkish woman, participant).

"I would even go as far as to say that I feel more accepted here in the Netherlands than when I go to Surinam on holiday. [...][2] I think Dutch culture is more a matter of thinking

[2] […] means that the respondent has stated more information, that was not relevant for the subject discussed.

everything is fine as long as you don't disrupt their culture and don't make a nuisance of yourselves. I think the Netherlands is one of the most tolerant countries in the world." (Surinamese man, participant).

Most participants (8 out of the 10) and all non-participants considered it important to uphold their own cultural customs and traditions, and to pass them on to their children. They see it as part of their identity and are unwilling to renounce their own background. At the same time they sense a change in attitude towards ethnic minorities in the Netherlands.

"I am of the first generation, and in the early days no one thought it strange if I wanted to stick to my own standards and values. Indeed, people expressed understanding. I can't understand why our customs are suddenly under the microscope. I don't think there is anything wrong in people having different expectations of the second and third generations. But for us, the first generation, it is difficult to learn the language." (Moroccan woman, participant).

"I am fairly true to my customs and traditions in how I live. I have four children. My children speak Dutch well, and I have also taught them Turkish and sent them for religious instruction. They know the difference between right and wrong. I have yet to have anyone at the door complaining about my children." (Turkish woman, participant).

For some, upholding their own cultural and religious traditions and customs is also related to not being recognized as Dutch, or fear of losing identity.

"You are never recognized as Dutch, however hard you try to integrate. This is why I think you have to know your culture and traditions well, so that you can identify with your Moroccan background. Otherwise you risk an identity crisis: you don't feel like a Dutch person, and are not treated as one, but you can't call yourself Moroccan either, because you don't know your background." (Moroccan woman, non-participant).

"Otherwise you have nothing at all. Because if Dutch society doesn't accept you, and you were to discard your own cultural traditions, you would have nothing left. [...] You need

something to hold on to: firm ground, which you can call your own." (Surinamese man, non-participant).

Some participants feel Dutch, and want to take the best from both cultures. Some examples of customs from their own culture that respondents speak of frequently are respect for older people and hospitality.

"You shouldn't renounce your own background […] You are a foreigner; you are not a national. You can feel Dutch. You can feel Hindu. But actually, you are both. And you should just combine the two. And it is very important to retain cultures. And passing on cultures is even more important for the new generations […] I try as hard as I can to do this. I am also a member of a musical group, and this is how I try to do something cultural for young people." (Surinamese man, participant).

"'Interviewer: Is it just that you happen to live in the Netherlands that makes you feel more at home here, or is there something else?"
"Respondent: we have learned to speak and to listen in the Netherlands. The person is the important thing in the Netherlands. […] I think it is important to adopt the good parts of both cultures. Respect is very important in Turkish culture." (Turkish woman, participant).

In brief, most respondents speak Dutch reasonably well or well, and they feel reasonably accepted in the Netherlands, and definitely so in their immediate surroundings. However, they note deteriorating attitudes towards foreigners and an unpleasant atmosphere in recent years. The respondents generally do adhere to their own cultural customs and traditions, and pass them on to their children. Some also feel Dutch, and want to take the best from both cultures. There were no clear differences between the two research groups. The participants estimated their command of the Dutch language somewhat lower than the non-participants, which could be attributable to the higher average age and the somewhat lower educational level of the participant group.

3.3 Migrants' perceptions of health

3.3.1 Perception of health and health promotion

What do the respondents think about health and its importance? What does the concept mean to them? To answer these questions we asked the respondents to say in their own words why it is important for people to be healthy. All respondents answered that they think being healthy is extremely important. Most respondents describe health as a *condition* for living well.

"Health is in first place. Without health you can't achieve anything" (Turkish woman, participant).

"People have to be healthy to live well. Health is one of the highest - what's the word - priorities. If you are not healthy, you just can't do anything. And then you can't enjoy anything, and all you are is ill. And if you are healthy, you can do most of the things you want to do". (Surinamese woman, non-participant).

The above quote shows how health can be linked with the ability to *do* things. Health is also important in being able to *enjoy* life. Most respondents mentioned one or both of these elements. We address the two aspects separately below.

Several respondents described the opportunity to *do* things in general terms, such as "activities" or "performance".

"*It is very important for people to be healthy, because then they can perform socially, and because they then have an active stance in life*. (Turkish woman, participant).

Other respondents identified an activity that is possible for someone in good health. The activities mentioned most often were work, looking after the children, caring for the household, *"going out"* and recreational activities (with the children, or a sport).

"If people are healthy, they can do their work properly. They can perform their duties and feel happy." (Moroccan woman, non-participant).

The second element that respondents linked with health is being able to *enjoy* life. Many respondents, including the one quoted above, linked health with happiness, or contentment.

"Being healthy is a fine thing. If you are healthy, you also see others clearly." (Turkish woman, participant).

"*People who are healthy are happy."* (Moroccan woman, non-participant).

Furthermore, several respondents said that taking steps to be and to stay healthy was a responsibility both to themselves, and, more in particular, to their children and other family members.

"And then I stopped smoking immediately. Because your health is more important. And that is not all: I am not getting any younger, either. I also want a family, and that means you have to be healthy yourself. You can hardly be sick every day and bring up a child at the same time." (Surinamese man, participant).

"If you are not in good health, neither can you make anyone around you happy. When I am unhappy, my children notice straight away". (Turkish woman, participant).

Two respondents remarked that health is a gift that you have to treat with care:

*"I think health is important. In a nutshell, people's health is part of the creation of life, a gift from God. God did that." (*Surinamese man, participant).

"Health is the most important thing you have. You only become aware of just how important health is when you get sick. It is like a pearl, so you should treat it with care." (Moroccan woman, non-participant).

The respondent in the quote above says that people only become aware of how important health is when they fall ill. Several respondents mentioned the consequences of a *lack* of health. The respondents consider that poor health or illness leads to undesirable dependence on others (such as their own children), uncertainty, and, in a more general

sense, loss of control over their own lives. In other words, a lack of health is a limitation, or impairment, in everyday life, and the impact of ill health often extends beyond the individual concerned.

"If you lose your health, then you are impaired. If you have impairment you soon notice that you are less happy. (Turkish, woman non-participant).

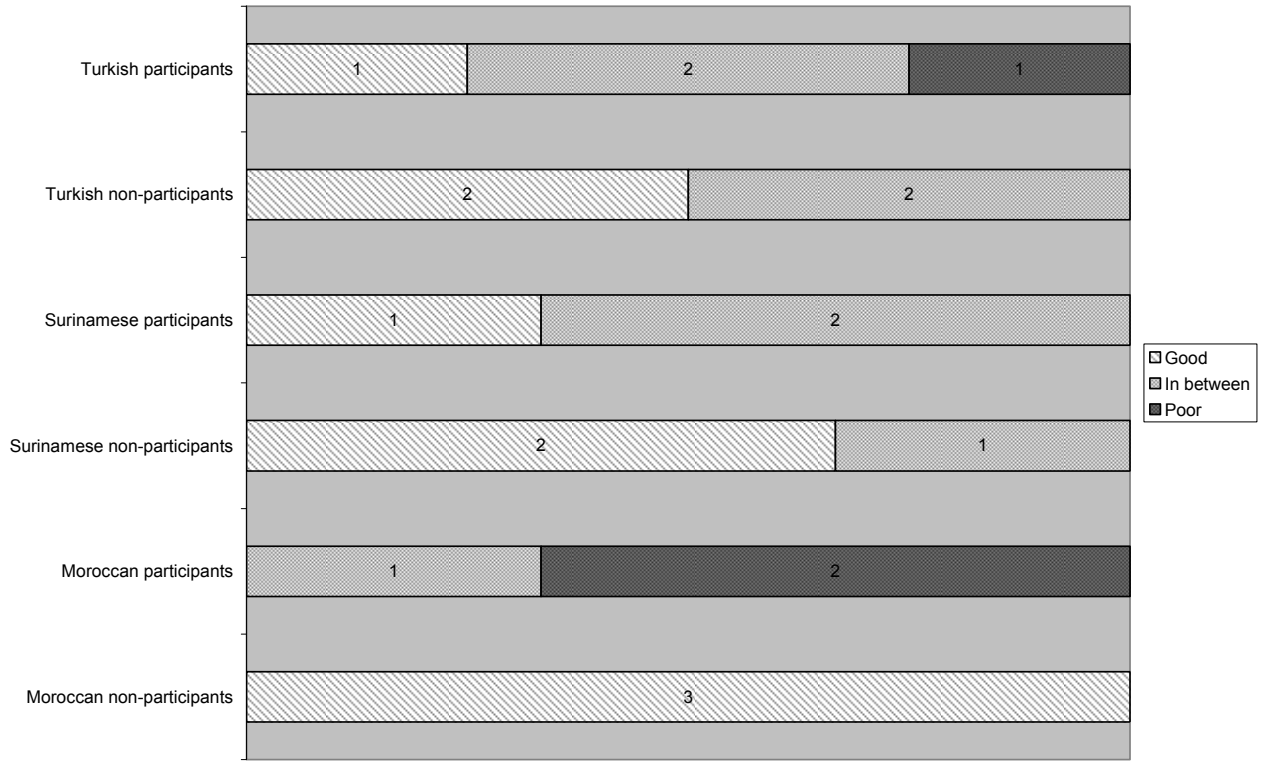
"If someone at home is sick, everyone in the same house is sick. It is very hard to live with a situation like that". (Turkish woman, participant).

In other words, all respondents attach great importance to being healthy. Being healthy enables you to be a person, or to be *"able to live well"* as one respondent put it. Diminished health or illness restricts a person's freedom to live life as they see fit. It constitutes an impairment that often has repercussions on the family and others close to the person in poor health. Most respondents therefore considered it their own responsibility to care for their health as well as possible.

3.3.2 Self-perception of health status

The main question in this respect is how respondents estimate and perceive their own health. We asked the respondents to describe their own health and then to interpret it: do they consider their own health to be good, bad, or somewhere in between. To start with this last point, nine out of the twenty respondents, or almost half, described their own health as good. Eight of the twenty said their health was neither good nor bad, but "somewhere in between". Three respondents said their own health was poor. The table gives the results for the participants and the non-participants.

Figure 3.1 Self-perception of health status, participants and non-participants



The respondents who considered themselves to be healthy tended to describe their health in terms of the absence of symptoms, feeling "fit" or "good", and "feeling good about themselves".

The explanations of the self-assessments of health reveal that the respondents had different ideas about the classifications: what one called good health, another might call moderate, or even poor.

"Respondent: "First I had diabetes, now I have been told that my kidneys have also been affected. And I might have a constriction in my heart, so I'm being sent for tests. […]. My health is reasonable, I think that would be the right word. I say that because I have something wrong: the diabetes, which is quite nasty and insidious. It won't go away. You can stabilize it, and watch out for sugar, and poor kidney function. But it won't get better". Interviewer: so you just feel reasonable?" Respondent: "Yes, and that is how I conduct myself. I won't let it get on top of me. I am still mobile, and so on. People wouldn't believe me if I said I was ill." (Surinamese man, participant).

This respondent, and others, point out that how they perceive their own health also has to do with their own attitude, or mind-set. When it comes to health, the glass can be either half empty or half full.

Respondent: "There have also been times when I didn't feel well. But now I know why I don't feel well, and I have a totally different outlook and I feel much better about myself too."
Interviewer: could you tell me what brought about this change?
Respondent: "Because I am at home during the day, I felt very lonely, and that made me unhappy. When I had thoughts like that, I became very unhappy and started to cry. One day I said to myself "Why am I doing this: I still have so many happy days to look forward to. I am healthy and I have all I need." Now I feel much better. […]. I have started to look upon everything differently. I am now trying to be optimistic. I used to be very negative. Now I take a positive view, and what I see is positive." (Turkish, woman, non-participant).

"I am a healthy, strong woman. For example, when I wake up, I look in the mirror and say: 'I am not fat', although I put on weight after my youngest child was born. What you see of yourself in the mirror can be beautiful, or utterly dismal. But I see myself as a beautiful woman. I see my health as very good". (Turkish woman, participant).

What health problems did the respondents identify? Five of the twenty (who all classified their own health as "good") mentioned no symptoms at all. None of these respondents is a participant in health-promoting interventions. The other five non-participants reported physical symptoms (kidney problems, a stroke, overweight, migraine and diabetes), psychiatric symptoms, or both.

The respondents who are present or past participants in health-promoting interventions mentioned – as is to be expected given the more negative assessment of their own health – more symptoms. All ten respondents mentioned physical symptoms, such as diabetes, overweight, back problems, kidney problems, high blood pressure and headache. Seven of the ten respondents also alluded to psychiatric symptoms, ranging from often feeling "gloomy" or "melancholic", to diagnosed depressions.

Without specific prompting from the interviewers, the majority of the respondents drew a distinction between physical and mental health. The descriptions of many of the respondents suggest that they view both aspects as intrinsic components of their own health.

"I really don't feel healthy. I went to the doctor today. He told me my health had deteriorated. I have to go on a diet. I am also on medication for psychiatric illnesses. Mainly because I am alone now. I don't feel healthy mentally, either. I hardly have any enthusiasm for anything. Not for talking, and not for doing anything. This is mainly because of the pressure and the stress. It is hard. I have been here for twenty-five years, but I have no family here. Everyone is in Morocco. That is hard. […]. If I feel listless, or stressed, I notice the effect on my body." (Moroccan woman, participant).

"But otherwise I feel fine, just a bit off now and again. But that's in the mind, isn't it: sometimes it can be hard mentally. It is – yes, your own kidney has gone – you don't know what's happening. I have worked hard all my life, and so on, and I have had many jobs. So I take early retirement or a pension. Then I can't do this any more, and I can't do that any more: you are just so restricted in your freedom. And it all leaves you a bit depressed: I can't think of a better word." (Surinamese man, participant).

Most respondents who reported both physical and psychiatric symptoms link the two, as did the respondent quoted above. Physical symptoms lead to psychiatric symptoms, or vice versa. Three – Turkish – women (two non-participants and one participant) emphasized the relational aspect of psychiatric symptoms. The symptoms come from having insufficient support from your own social environment. In other words, other people (family, friends and close acquaintances) have a considerable influence on your mental wellbeing.

Respondent: "I sometimes get depressed and all I want to do is sleep, and I can't get up. I got depressed again two weeks ago, and all I could do was sleep for about a week and a half. I put on four kilos then. I thought it was awful when I went for a blood sugar test."
Interviewer: what made you depressed?

Respondent: "I had some problems with my friends. They gossiped about me and that hurt me very badly. I have lost confidence in people and in family. I just don't want to talk about it any more."
Interviewer: are you often depressed?
Respondent: "Not very. About once every three months, perhaps." (Turkish, woman, non-participant).

The respondents had no difficulty describing their own health. Most drew a clear distinction between common-or-garden fleeting symptoms (*"I get the odd cold in the winter")* and more serious or chronic disorders. Most respondents also distinguished between physical and psychiatric symptoms, usually attributing a mutual influence.

3.3.3 Care consumption and health behaviours

We set out in this section the respondents' care consumption and health behaviours.

Medication and general practitioner visits

We asked the respondents whether they used any care facilities or medicines. Eight of the ten participants, and four of the ten non-participants, used medicines, which is to say physician-prescribed pharmaceuticals. Over-the-counter medication, such as paracetamol and hay fever nasal sprays, are not included.

We mapped out the use of care by asking about the frequency of *general practitioner* visits. We also asked whether the participants were satisfied with their general practitioner. There was a large variation in frequency of general practitioner visits, from "less than once a year" to as high as once a fortnight. The frequency was related to the seriousness and the nature of chronic disorders. For example, the diabetes patients were regular visitors to the GP surgery for blood tests. On the other hand, the kidney and heart patients among the respondents said they almost never went to a general practitioner because they received treatment directly from a hospital specialist. Of the twenty respondents, fifteen expressed an opinion about their general practitioner: nine were satisfied or very satisfied, and six were not entirely satisfied, but not dissatisfied. None of the respondents said they were dissatisfied with their current general practitioner. One or two said they had been dissatisfied in the past, which prompted them to find a new one. The general practitioner assessments in the respondents' answers appear to have been influenced by two main

factors: social or relational qualities of the general practitioner and the willingness of the general practitioner to refer the patient to a specialist or to prescribe medicines.

The first aspect – the relational or social qualities of the general practitioner – was related mainly to the interest of the general practitioner in the patient's questions and needs, and the willingness to listen attentively and ask persistent questions about problems.

"He has been my GP for more than thirty-six years. He knows me inside out and doesn't ask too many questions. And he knows exactly what is wrong with me. And he is also a very good listener. He is an understanding person, and is also sympathetic to Hindu culture. He knows what he is talking about, because his wife is Hindu." (Surinamese man, participant).

"I have an excellent GP. She is always late and behind schedule, but that's only because she spends half an hour with every patient, not just ten minutes. She shows great interest, not only in patients, but also in the person behind the patient. She always treats me well, and I am very happy with her. I appreciated that very much with my husband [who was taken ill and died]. She felt very involved. She always phoned or came to visit. She tried to help us in a certain way in dealing with doctors, papers, and with information about patient care and home care. These aspects may be part of her job, but I hear from other people that GPs are not always so helpful. I used to have a different GP, but she was extremely formal. With my current GP it is as if she shares our grief." (Turkish, woman, non-participant).

The second aspect of satisfaction with the general practitioner is willingness to prescribe medicine and to refer the patient to a specialist. The majority of respondents said that the general practitioner was sometimes too reluctant, and that they had to insist in order to be given medicines or a referral to a specialist.

"I changed GP six years ago. I had an argument with my old GP. I had severe back pain. I had to support myself on my hands. He just sat there and prescribed aspirin! I said "Am I not your patient? Why are you prescribing aspirin, without even examining me?" He answered "I'm very busy and there are many patients in the waiting room." I retorted "Am I not your patient? I am not leaving this chair until you examine me." He then examined me

and prescribed some ointment. You really have to fight for what you get. A baby that doesn't cry gets no dummy. You have to explain your problem clearly. If you can't do that yourself, you have to take someone along with you." (Turkish, woman, participant).

Several respondents added that general practitioners tend to attribute physical symptoms to psychiatric problems.

"For instance, I had something wrong with my insides, and I couldn't go to the toilet for two or three days. The GP said it was because I was depressed. Afterwards I got piles. She said that was because of stress, too. She seems to think everything is caused by stress…" (Turkish woman, participant).

Two respondents – both non-participants – said that an ethnic health care adviser helped them communicate their story and needs more clearly in the surgery. Both were very satisfied with the adviser's assistance.

"The general practitioner already knew that I had a weight problem. I had told her earlier that I couldn't afford to go to a gym and I asked her to refer me somewhere. However, I got nothing. Only when I went along with Fadime [the ethnic health care adviser] did she refer me to a physiotherapy exercise programme". (Turkish, woman, non-participant).

Although we did not ask the respondents explicitly about any other carers they used, the following professionals were mentioned in the interviews: physiotherapists, a psychologist, a psychotherapist, hospital specialists, dieticians, district nurses and a social worker. One of the respondents was offered an annual "health check" by her employer.

Health behaviours

We asked specific questions to map out the respondents' *health behaviours*. We first asked the respondents what they did when they felt unwell. The respondents would frequently have more than one answer. The ones given most often were "resting", "staying in bed" or "taking it easy" (mentioned thirteen times).

"I stay in bed, or at least stay home," (Turkish, woman, participant).

Only one respondent (a participant) referred emphatically to his own cultural customs surrounding illness and health. The respondent implied that there was nothing he could do himself if he was ill.

"*What do I do if I don't feel well? What a stupid question. What can you do? You are just sick. If you go for a walk, or go to sleep, does that make the pain any less? No, the only thing you can do is to rest. […]. We [Moroccans] accept what God has preordained for us. If I don't feel well, do I take my dog for a walk, or go for a stroll, like Dutch people do?*" (Moroccan man, participant).

Respondents mentioned taking part in social activities, seeking distraction, or talking with friends, twelve times. Conspicuously often, this was broached *in combination* with resting, or doing nothing.

"I lie down on the sofa and watch TV. My hobby is watching TV. And listening to music. And I occupy myself with the grandchildren, which I really enjoy, and then I forget all about it. If I am ill and I see my grandchildren, then I forget that I am ill. They are a form of distraction for me." (Surinamese woman, participant).

When I don't feel well, I don't do any chores in the house. Even if everything is a mess, I do nothing at all, and I visit a friend I can talk to." (Turkish, woman, participant).

"Then I go for a stroll, get out of the house, and get some fresh air. Or chat to someone. Or we walk along the beach. And then rest for a couple of days and things start to improve." (Surinamese woman, non-participant).

The above quotes also show how broadly the respondents define "not feeling well"; many respondents even start by thinking of their mental wellbeing, and only then about their physical state.

When feeling unwell strategies that were each mentioned twice were meditating, taking over-the-counter medicines and going to the doctor. One respondent said that he took prescribed medicines, and there were two respondents, one who reported "crying" and the

other “screaming”, when they felt unwell. Both of them said the strategy helped by providing a degree of relief.

We later asked the respondents whether they were physically active, whether they were careful about nutrition in connection with their health, and whether they did anything else to maintain or improve their health.
Half the respondents (approximately equal numbers of participants and non-participants) took part in sport. Exercising on fitness machines was the most common, but aerobics, yoga, gymnastics, group exercise classes and swimming were also mentioned. The other half of the respondents did not take part in any organized sporting activity. Nevertheless “walking” (eight times) and “cycling” (four times) were named as physical activities that respondents might engage in, alongside an organized sporting activity.

“*I don’t do any sport, but I am fairly active. I am out of the house five or six days every week. I like cycling. I give cycling lessons on Wednesdays to Turkish and Moroccan women. And I walk.”* (Turkish woman, participant).

“I don’t do any sport. But I still consider myself extremely active. I can never sit still. I do something around the house every day. Sometimes I will visit my mother-in-law and help her with her chores. I either walk or cycle to her house. I visit my mother and the shopping centre. As supervisor of a cleaning firm, I have to walk a great deal.” (Turkish woman, non-participant).

All things considered, only a few respondents admitted to no physical activity at all. All respondents – even those temporarily not engaging in physical activities – said that sport and exercise were extremely important. Over half the respondents said that sport or exercise were necessary to make oneself feel better, fitter, more relaxed, or more satisfied.

“Sport perks you up. It gives you a boost. It is a pick-me-up. It makes you feel good.” (Surinamese man, participant).

Almost half the respondents added that sport and exercise were beneficial to physical condition. A quarter of the respondents said they thought sport was important in losing or

maintaining weight. Several other points were raised at least once: taking part in a sport is a good example to the children, any disorder will get worse without exercise, and the general practitioner recommends sport.

The main reasons put forward by respondents for *not* taking part in sport or exercising had to do with lack of time *"I have small children and I am just too busy for sport"*, or with motivation "*I can't get going. I am lazy and unmotivated."*

All except two respondents answered that they are careful about nutrition in connection with their health. The respondents most commonly reported aiming to have a moderate and varied diet in accordance with the *"schijf van vijf"* nutritional golden rules that are popular in the Netherlands. Some explicitly referred to reducing the amount of fat in their diets.

Several respondents blamed their own culture for difficulties in maintaining a healthy diet.

"If my kids want something to eat after seven o'clock in the evening, they choose fruit. The pity about our culture is that when we have visitors we feel obliged to eat with them, because it would be impolite not to." (Turkish woman, participant).

"I watch what I eat. But sometimes I give in. You know what it's like: in our culture there is always something tasty on the table, and I sometimes I tell myself 'Today I will just eat whatever I feel like'." (Turkish woman, non-participant).

Furthermore, one third of the respondents said they kept an eye on the number of snacks and the amount of junk food they ate. A number of respondents claimed to eat nothing after the evening meal, and others professed to drinking a large quantity of water every day for the good of their health. Two of the respondents had a vegetarian diet.

Finally, we asked the respondents whether they did anything else to stay healthy besides exercise and watching their diet. Most respondents said they did other things in the interests of health. Many of the things the respondents referred to were concerned with relaxation *"a walk along the beach, getting some fresh air, reading, going to bed on time"*, or amusement *"chatting with friends, going to the cinema, going out".* One respondent said

she forced herself to be optimistic, and claimed that it helped. Another respondent meditated and one respondent contended that prayer improved her health.

"I pray. Praying also seems to be a very good sport. Those movements you have to do, like bending and kneeling, are good for the circulation and for your body." (Moroccan woman, participant).

Several respondents asserted that doing voluntary work was a good way to stay healthy.

"I belong to four or five associations".
Interviewer: and that helps your health?
"Yes, you get to meet people: it's more about broader social contact, if I might put it that way. I think that companionship is a relevant aspect. You are not alone in the world." (Surinamese man, participant).

"I think that my being on the women's committee of the mosque is also good for me. Perhaps I would get depressed if I didn't have distractions like that. A good Muslim shouldn't suffer from depression. I go to the mosque often. I am active there. If I were to stay home, everything would be the same. I am also very frightened about being lonely." (Turkish woman, participant).

In other words, all respondents, in varying degrees, think they put some effort into their health and that this is expressed in their behaviour. Most respondents concede nonetheless that their *health behaviours* leave room for improvement.

3.3.4 Differences and similarities between the two migrant groups interviewed

We looked first at how the respondents define health. Since the entire research population largely agrees about what health means, and that it is important, we discovered no surprising differences between the respondents who were participants and non-participants in health-promoting interventions.

However, there were differences between the two groups in their answers to the question about how they assess their own health. The non-participants were appreciably more optimistic about their own health, with none of them considering it poor, and as many as

seven out of the ten describing it as good. Conversely, only three of the ten respondents in the participants group thought their health was good. This difference might be explained by the relatively lower age of the non-participants, their better health status, or the fact that the participants had enrolled in health-promoting activities in response to symptoms, and as such cannot be viewed as a random sample of the population. Symptoms that the respondents did report tended to be fairly serious. Several respondents had diabetes mellitus or kidney problems, or were overweight, and some used antidepressants. The modest size of the research population and the diversity of symptoms rule out making a distinction according to group (participants versus non-participants) or ethnicity. However, some Turkish women conspicuously interpreted symptoms of depression as a relational problem: psychiatric problems arise from problems in interaction, or rather a lack of interaction, with other people.

As observed above, there was great variation in the frequency of general practitioner visits. This variation does not necessarily depend on the seriousness and nature of symptoms, and there were no obvious differences between participants and non-participants. The same is true of medicine use: although the rate for participants was twice as high, we established above that these respondents tended to consider themselves to be less healthy.

Both participants and non-participants said they took steps to improve or maintain their health. We asked explicitly about sport and exercise and about nutritional patterns. According to their own account almost all respondents do some kind of exercise, although many admitted they could do more. The same is true of nutritional patterns: the respondents said they know what they should do, but that they do not always manage to do it. We observed no obvious differences in health behaviours between participants and non-participants in health-promoting activities.

3.4 Migrants who participate in health promotion interventions

3.4.1 Health-promoting activities

This section discusses the health-promoting activities engaged in by the past and present participants.

Half the participants were currently enrolled in a health-promoting activity. The other half were past participants (i.e. in the past five years) in a health-promoting activity. One of the past participants did not complete the activity.

"I went along six or seven times. I could have gone ten times. However, I was unable to finish. I stumbled and after that I had a pain in my chest and ribs." (Turkish woman, participant).

The past and present participants engaged in a wide variety of health-promoting activities. The range included using ethnic health care advisers and client advocates, information meetings about health or healthy behaviour, group exercise, physio-fitness or support in healthy behaviour.

The health-promoting activity in over half the cases targeted ethnic minorities and in one case specifically people of Turkish origin. Some health-promoting activities were intended for ethnic minority elderly people. Other health-promoting activities were for women or residents of a particular neighbourhood.

Finally, it is conspicuous that almost half the participants started the activity concerned together with several other people.

The table below lists the participants, the health-promoting activities, the target group and the time of participation.

Table 3.3 Type of heath promotion activity the respondents have attended and target group of these activities

Participants	Type of health-promoting activity	Target group
Moroccan		
1	Exercising or aerobics in a group.	Residents of a neighbourhood
2	Information sessions for elderly people about health and growing old in good health.	Ethnic minority elderly people
3[3]	Dietary information sessions and aerobics with a group of women in a community centre. Running and fitness training with a group of women in a community centre.	Women
Surinamese		
1	Ethnic health care advisers and client advocates.	Members of ethnic minorities
2	Ethnic health care advisers and client advocates.	Members of ethnic minorities
3	Ethnic health care advisers and client advocates.	Members of ethnic minorities
Turkish		
1	Information sessions about health for elderly people.	Ethnic minority elderly people
2	Support in stopping smoking by e-mail and text messages.	Turkish people
3	Exercising in groups (aerobics, steps).	Residents of a neighbourhood
4	Physio-fitness.	Unknown

3.4.2 Access to health-promoting activities

This section explores how the participants came into contact with the health-promoting activity and why they participated. We also examine whether any account of diversity was taken in the activities, and how beneficial or detrimental this was to participation.

The participants were asked how they heard about the activity.

The primary health care and the community centre appeared to be important in bringing participants into contact with the health-promoting activities.
"My GP referred me. I was always tired, so my GP referred me. (Turkish woman, participant).

"Through the community centre: the mother-and-child centre had a folder, and some of the women were talking about it, and then we enrolled." (Moroccan woman, participant).

[3] This respondent has participated in two health promotion activities.

Informal networks would also appear to be extremely important. For instance, two participants heard of the activity from family members, and one participant heard good reports passed on by word of mouth. One of the participants claimed to have been one of a group of elderly people who themselves requested the activity in the community centre.

"We, a group of elderly people, asked to have the activity in this community centre. We were then passed on to someone who works for Aveant, who ran these sessions for us." (Moroccan man, participant).

In other words, primary health care and the community centre were most important for the participants' access to health-promoting activities. Personal contact also plays an important part.

Reasons for participating in the health-promoting activity

We asked the participants why they decided to participate in the activity. In most cases the participants joined because they expected benefits for their illness or to improve their health. Three respondents gave a reason connected with illness or health. The reason for two of them was to gain information about health, and the other was seeking an active approach to symptoms.

"When you are ill, you should attend as many sessions as possible about your illness, to get to know all you can and discover what you can do about it. If you don't, you'll never find out." (Moroccan man, participant).

For other participants the health-promoting activity fitted in with something they already wanted or were planning for themselves. One participant was looking for a sporting activity for women, and another wanted to stop smoking.

"I had wanted to stop smoking for a long time. Then I heard about the initiative and decided to join in." (Turkish woman, participant).

Two respondents did not come up with a compelling reason for participation, but said they enrolled or decided to join after first going along to take a look at the activity a couple of times. One participant's reason was that he thought some of the taboos in his culture

needed to be broken. He thought this was possible only if people came together and told their stories. Moreover, one participant decided to join an activity on the advice of her general practitioner. Her own contribution was apparently fairly passive.

"To see whether the activity had anything to offer me. What kind of project is it? Is it any good? I have to start somewhere. And it was very good." (Turkish woman, participant).

"Because that woman at the check up recommended it. You should listen to the doctor. Social Services also kept telling me I should be more active, take up a sport, or do voluntary work." (Moroccan woman, participant).

Participants' reasons for participating in a health-promoting activity were therefore fairly diverse, but most were motivated by the expectation of a favourable effect on their illness or an improvement in their health.

Scope for diversity

The participants were asked whether any account was taken of their ethnic background in the activity. Participants confirmed this to be the case for all but one of the health-promoting activities. For instance, many activities are organized for people of the same origin, and there are often separate male and female groups for Turkish and Moroccan people. Account is usually taken of religious or cultural customs. Respondents occasionally noted that the person supervising an activity was of the same origin. Furthermore, various activity themes or subjects that were taboo for the group were handled in the sessions.

"Yes, account was taken of everything and for everyone, with food and drink as well. And it's a Surinamese group, with women too, and single people. So we all join in together. You might not be so keen on going along alone, but I enjoy it because we are together. And it's more fun with Surinamese people: so free and easy." (Surinamese woman, participant).

"Yes, these gatherings were especially for Moroccan men. Because they are the most ignorant. There was plenty of consideration for our Moroccan background. The activity supervisor was Moroccan, and explained everything in Arabic and Berber. He also talked

about illnesses that mainly affect ethnic minorities or Moroccans. For example, he talked about illnesses that Moroccan men are embarrassed to tell their GP about, such as prostate problems. Chronic diseases were also discussed. The information officer explained how important it is to discuss all diseases with the GP. (Moroccan man, participant).

Language was taken into account in some cases, as the quote above illustrates. The health-promoting activity leader speaks the same language. Material may also be translated into the participants' language, whereas in other cases the activity was in Dutch only. Some Turkish and Moroccan participants said they spoke Dutch well enough for an activity in Dutch to be no problem for them, but commented that other participants might have difficulties. They would sometimes act as interpreters for other participants with less of a command of the language.

"It makes no difference to me, but it is important for anyone who doesn't understand. For example, I interpreted in the lessons for a Turkish woman who didn't speak Dutch." (Turkish woman, participant).

One participant also said that as far as he was concerned there was no need to adapt the activity to his own language and culture. Another participant conceded that the activity might not be entirely compatible with her own culture, but that this was no obstacle to participation.

"For instance, the original idea was for us to go swimming. Then they asked me if I had any objection to swimming in a mixed pool. I said it would be all right as long as it was in the quiet morning period. We do not live in a Muslim country. We can't expect luxuries. It's okay as long as there are no Turkish people there who might recognize me." (Turkish woman, participant).

It would therefore appear in general that cultural and religious differences are no obstacle to participation in health-promoting activities, either because the interventions have been adapted, or the participants demand no adjustment. In only one case insufficient consideration of religious background was an obstacle to participation.

"I think it is important to make allowances for your religious background. We once received a proposal for group lessons, but that would have to be without a headscarf, and it was mixed (male-female). I didn't do it." (Moroccan woman, participant).

3.4.3 Opinions about health-promoting activities and effects on health.

This section presents participants' opinions about the activities and their effects on health. Which aspects did participants approve of? What were they less satisfied with? What kinds of favourable health effects did the activities have? And finally, would the participants be willing to join in future health-promoting activities if invited?

All participants were positive about the health-promoting activity they took part in. One of the participants wanted to take the opportunity at the end of the interview to thank the organization behind the health-promoting activity.

"So I went to take a look, and joined straight away. I have been every week since, without missing a single one. That's how good I think it is." (Surinamese woman, participant).

Participants' reasons for favourable assessment

Participants have widely varying reasons for approving of a health-promoting activity. Three participants commented that they found the sessions informative, which ultimately had a favourable effect on their health.

"I thought it was excellent. The sessions made people aware of their health and the preventive measures that could improve their health, or stop their illness getting any worse, in the course of their daily routine. It was very useful and informative. People didn't know those things, but they found out." (Moroccan man, participant).

It is striking that aspects not directly related to health are also often mentioned as a reason for being satisfied with an activity. For instance, three participants praised the social contact with other people during the activity. The activity brought them outside the house, and enabled them to put any problems at home out of their minds for a while.

"For me it means a great deal to be together with other people, because then you feel completely different. Then you forget everything, if you happen to have problems. You

have none here, you leave everything outside. You talk, laugh, and play cards. It is a good feeling being among people like this." (Surinamese woman, participant).

Besides aspects related with health effects and contact with other people in the activity, several other reasons were mentioned for enthusiasm about an activity. Two participants were impressed with the person leading the health-promoting activity. One participant appreciated consideration being given to the speed at which she could perform the exercises. Another participant said that he now had somewhere to go with his problems. There is an obstacle for many older members of ethnic minorities in approaching Dutch people with their problems, whereas they find it easier to approach people from the same country of origin and who speak the same language.

"I really enjoy it; I hope it is allowed to continue. The teacher is a nice woman, she encourages you and makes sure you have enough energy to keep going." (Moroccan woman, participant).

"I remember that it used to be unclear where you should go with your problems. It is particularly good because people from your own culture tend not to venture into the Dutch culture because they are afraid: there is a threshold. And this applies all the more to elderly people, but now they come here. And they can deal with each situation in their own language and with their own people in their own way." (Surinamese man, participant).

Aspects that participants were less satisfied with

A few participants raised an aspect that they were less than completely satisfied with. For instance, two participants thought the health-promoting activity was too short, and there were too few lessons. Both cases were concerned with a health-promoting activity involving a sport. One participant also complained about the costs of the health-promoting activity, and regretted that no gym equipment could be used.

"Big!move is the best I have done. It was a good initiative, but too short. Sometimes I recall the kind of exercises we did there. I would like to try the exercises I learned there at home, but I have forgotten some of the details." (Turkish woman, participant)

Health effects

We asked the participants whether the health-promoting activities contributed to improving their health. The participants were enthusiastic about this aspect, and all of them were able to identify positive effects of the health-promoting activity on their health. A little over half the participants said they felt healthier or fitter because of the health-promoting activity, and some participants also had fewer symptoms.

"Yes definitely, my body always shows the signs. I feel it clearly in my body if I have or have not done any sport. If I skip sport for a day, I fell less well. But if I do the sport I feel healthier and more active, and I am also able to play with my grandchildren. Physical symptoms start to appear as soon as I spend a couple of days at home doing nothing. For example, my joints suddenly start to ache. I think the main reason is sitting around doing nothing." (Moroccan woman, participant).

Furthermore, half the participants acknowledged that the health-promoting activity had contributed to healthier behaviour. The contribution in most cases came from the participants having more information about what constitutes health, and being made aware of their own behaviour, such as their eating patterns. One participant disclosed that the health-promoting activity increased the level of action among the participants, with many more people taking up a sport.

"Yes, really, the diet information meetings are an example. I have to tell you that we eat bread with many Moroccan meals, like lentils and beans, but then you learn that beans and lentils are actually alternatives for bread, so we Moroccans eat double bread. I have now stopped doing that." (Moroccan woman, participant).

"For example, I used to spend a lot of time just zapping from one TV channel to another. But a leader once commented "You always keep doing the same things, but you fail to notice that they don't make you feel any better. Try not doing the same thing for once. Find something else to do, perhaps which might work." When I remember that, I turn the TV off immediately. Those words have been burned in so thoroughly that they will never be erased." (Turkish woman, participant).

Several participants claimed that the health-promoting activity helped them cope better with their illness and with pain. One participant declared that the health-promoting activity had helped her relax.

"For me too, this activity really helped me improve my health. I learned how to recognize my illness, and how I can live with it. You also learn about the consequences of your illness." (Moroccan man, participant)

Many participants felt fitter or had fewer symptoms. The activity often contributed to healthy behaviours, and some participants learned to deal with their illness better. In other words, all reported favourable effects of the activity on their health.

Participation in future health-promoting activities

As noted above, the participants were enthusiastic about the activities they took part in. They also all reported favourable effects of the activity on their own health. It is therefore hardly surprising that all participants expressed willingness to take part in a future health-promoting activity, whether the same or different, albeit that some participants attached conditions, such as not being too expensive, or being exclusively for women.

"Certainly, if it is affordable, I would definitely be willing to take part. As long as it was a sporting activity." (Moroccan woman, participant).

3.4.4 Summary

In this paragraph, we saw that half of the "participant" respondents had participated in an health promotion activity in the past. The other half is currently involved in a health promotion activity.

The past and present participants engaged in a wide variety of health-promoting activities. The range included using ethnic health care advisers and client advocates, information meetings about health or healthy behaviour, group exercise, physio-fitness or support in healthy behaviour.

The health-promoting activity in over half the cases targeted ethnic minorities, and in one case specifically people of Turkish origin. Some health-promoting activities were intended for ethnic minority elderly people. Other health-promoting activities were for women or residents of a particular neighbourhood.

We then went on to explore how the participants came into contact with the health-promoting activity and why they participated. We found that primary health care and the community centre were most important for the participants' access to health-promoting activities. Personal contact also plays an important part.

The participants stated a variety of reasons for participating in the health promotion activity. Most of them were motivated by the expectation of a favourable effect on their illness or an improvement in their health.

We also examined whether any account of diversity was taken in the activities, and how beneficial or detrimental this was to participation. All participants but one found that diversity was taken into account in the activities. Language, single sex groups, religious customs were most often mentioned as subjects were diversity of the participants was taken into account. It would therefore appear in general that cultural and religious differences are no obstacle to participation in health-promoting activities, either because the interventions have been adapted, or the participants demand no adjustment. In only one case insufficient consideration of religious background was an obstacle to participation.

Lastly, we discussed the opinions of the participants: how do they evaluate the health promotion activity that they participated in and how do they estimate the effect of the activity on their health? Overall, the participants were very satisfied with the activities. They found that the activity contributed to improving their health (behaviour), but sometimes also to enlarging their social contacts. Any dissatisfaction was related to the organization of the activity, of the intensity of the activity: the activity was finished too soon.

All of the participants were able to identify positive effects of the health-promoting activity on their health. A little over half of the participants said they felt healthier or fitter because of the health-promoting activity, and some participants also had fewer symptoms. Furthermore, half the participants acknowledged that the health-promoting activity had contributed to healthier behaviour. Several participants claimed that the health-promoting activity helped them cope better with their illness and with pain.

All participants expressed willingness to take part in a future health-promoting activity.

3.5 Migrants who do not participate in health promotion interventions

3.5.1 Reasons for non-participation in health-promoting activities

We explore in this section the reasons non-participants gave for not taking part in a health-promoting activity. Were they unaware of the activities? Do they acknowledge the importance of health-promoting activities, or do they expect them to have no effect?

Access of non-participants to health-promoting activities

All non-participants appeared to be aware of the existence of activities, such as courses and information meetings, which are intended to help people to be healthier. Two people said they knew little about health-promoting activities. A condition for future participation given later in this chapter by two non-participants was that they would have to be made aware of the currently ongoing health-promoting activities. This is evidently not the case now.

Without prompting almost all non-participants gave several examples of health-promoting activities, such as courses given by the Municipal Health Care Services (GGD), courses for “stopping smoking”, training at Lady Fit, swimming lessons or separate times for women’s swimming or sports, *fitkids* (for children, given by the Municipal Health Care Services (GGD), information about nutrition, and sport.

There are many and varied channels though which non-participants got to hear about the health-promoting activities. Several non-participants also became aware of the activities in different ways, as the quote below demonstrates.

“Well, this could be through the local newspaper, internet, or the community centre. And from other people, by word of mouth. Whenever I go to the community centre there are always all sorts of activities on the notice board.” (Surinamese man, non-participant).

The channel most often referred to was the community centre, which was mentioned by three non-participants. Primary health care also plays a part.

One non-participant read a folder in the general practitioner's waiting room, and another person received information through the Municipal Health Care Services (GGD). Finally, several people received information through personal contacts, usually people who themselves had taken part in health-promoting activities.

"I read a folder about "stopping smoking" in the doctor's waiting room. I am also aware that the GGD runs some courses. However, I have never looked into it."
(Moroccan woman, non-participant).

"I have heard from my children at school that some women do things together, like swimming." (Surinamese woman, non-participant).

Seven out of the ten non-participants know someone in their family, friends, or circle of acquaintances who has participated in a health-promoting activity.

*"I know someone, an older person who lives nearby, an old acquaintance. She does Lady Sport, which is exercising in a group. She enjoys it, and is still in very good condition at nearly 70, and she looks very cheerful and fit. And she can do everything and is still involved in all sorts of things." (*Surinamese woman, non-participant).

In other words, the non-participants were aware of the existence of health-promoting activities, and almost all of them could give examples spontaneously. However, not all of them knew exactly what these health-promoting activities involved, or what specific activities were available in their neighbourhood.

The non-participants heard of the health-promoting activities through various channels: the community centre, primary health care or personal contacts. In most cases they knew someone who had taken part in a health-promoting activity.

The importance of health-promoting activities and the expected effects

We asked non-participants whether they thought it important to have activities aimed at helping people to be or to stay healthy. They usually answered this question in general rather than personal terms.

All non-participants attached importance to the existence of health-promoting activities. Many of them pointed to a lack of knowledge about health and health-promoting behaviours in the target group, including them.

"Many people who are unhealthy really want to do something about it, but don't know what. You often think you know how to live healthily, but when you take one of these courses it can be something of a revelation. You find things out about your health and your body that you would not normally think about." (Moroccan woman, non-participant).

The social aspect, meeting other people, was the reason why many non-participants thought it important to have health-promoting activities. One participant also spoke of the obstacle for some people to taking part in activities. The threshold is lower in a group, especially with your own people.

"Yes definitely, also for people who are alone, it is important that they are not alone. For them to meet people in these activities and have an opportunity to get involved. They have to be available, so that people can use them. (Surinamese woman, non-participant).

Finally, several non-participants touched on the effects of health-promoting activities on health and personal happiness, and the importance of exercise.

"Yes, so that it is easier for everyone to live in peace and happiness, without stress or worries about health. People are more cheerful and happier if they are healthy, and obviously that's a good thing." (Moroccan woman, non-participant).

The non-participants did recognize the importance of health-promoting activities. It can therefore be assumed that a lack of knowledge is not the reason for not participating.

When we examine non-participants' reasons for finding the existence of health-promoting activities important, they align fairly well with the participants' reasons. They also singled out the acquisition of information, the social aspect and the effects on health.

Reasons for non-participation in health-promoting activities

Although non-participants appear generally well informed about the activities to help them improve their health, and also acknowledge the importance, they still do not participate in these activities. A little over half of them gave reasons, which vary considerably however. For instance, two participants said they had no time to spare for the activities, or the times were inconvenient.

*"I know that there are information sessions about nutrition, and sporting activities, but I never get round to them." (*Surinamese man, non-participant).

One respondent professed not to know where to go with a health problem. Another respondent explained that she did not attend the activities because she would be likely to find only Dutch people there. One respondent also maintained that she once saw no need to participate, but had now changed her mind. She now considers it important for people to develop themselves constantly.

"Yes, I am interested, and some things look interesting, but as a rule I don't go. It is usually only Dutch people who turn up. But if more people went, I might join them." (Surinamese woman, non-participant).

3.5.2 Participation in future health-promoting activities, with conditions and preferences

Do the non-participants have a need for support in improving their health? Would the non-participants be willing to take part in future health-promoting activities? If so, what conditions and preferences would be attached? And finally, how would they like to be informed about nearby health-promoting activities? The answers to these questions are handled below.

Support needs in improving personal health

When asked, half the non-participants expressed a need for support in improving their own health. However, their underlying reasons differed substantially. One respondent expressed a need for support in changing her diet. One respondent was looking for support in maintaining motivation for sport, possibly in a group or with supervision. One respondent admitted that taking part in group activities could help her persevere. She also

thought it would be more enjoyable to do things with other people than alone. One respondent had questions about health that she was keen to find a personal answer to.

Respondent: "Look, if you join a club, you have to follow the lead, but if you do something alone, you eventually get de-motivated. So some support would be a good thing, and this includes some sort of motivation boost from the support."
Interviewer: and what form of support would you prefer?
Respondent: "Coaching, or a sports club. Or going on courses and information sessions, and so on." (Surinamese man, non-participant).

Two non-participants clearly rejected any support. The two concerned were young highly qualified Moroccan women who had sufficient access to the resources they needed to improve their health.

"No, I know myself how to improve my health. If I need to know anything I look on internet. I can find out a great deal there about how to improve my health. Therefore I wouldn't need a course of this kind. (Moroccan woman, non-participant).

Participation in future health-promoting activities

With one exception, all non-participants said they thought they would take part in a future activity aimed at improving health. The respondent who claimed to know enough herself about how to improve her health was still undecided about future participation.

The activities that were broached were: sports, the provision of information and courses about sport and other subjects, exercising or walking with a group, something about nutrition, spinning, swimming, and information sessions on medical topics. In other words, information sessions about health and sports, which almost all non-participants said was a health-promoting activity they would take part in in future. One participant announced he was on the point of joining an exercise programme.

"Yes, I would definitely want to participate, my health permitting. I would do more sport and attend sports activities. I would also go along to information sessions and courses about sport and other subjects too." (Surinamese man, non-participant).

Conditions for participation in future health-promoting activities

On the other hand, the non-participants often attached conditions to participation in a health-promoting activity. They might only be interested in a sport they like and enjoy, their state of health must permit it, the activity must be nearby, there must be a child minding service, or the timing should fit in with their children's school hours.

"Yes, I think so. As long as there is someone to look after my children.
Interviewer: and what sort of activity would you consider?
"Respondent: something like exercise, a sport, or walking with a group." (Surinamese woman, non-participant).

Two respondents also said that they were currently unaware of any health-promoting activities. If they had been, they would take part.

"Yes, I would be willing to take part. But I don't really know what sort of activities are available right now. I would like to take part in a health-promoting sport activity. I am someone who is willing, but takes no action." (Turkish woman, non-participant).

Personal preferences for participation in health-promoting activities

Several non-participants ventured that they would personally find participation in a health-promoting activity more pleasant if their own cultural and religious background was taken into account. Some of the aspects mentioned were separate activities for men and women, sessions conducted in their own language, or with an expert from the same origin.

"I would be very pleased if the activities could be in Turkish. I don't speak Dutch very well, so that would mean I would understand everything and get more out of it." (Turkish woman, non-participant).

Need for information about health-promoting activities nearby and the preferred way of being informed.

Almost all non-participants were interested in information about the health-promoting activities in their neighbourhood. One non-participant said her friend would tell her.

"Yes, I believe I would benefit a lot. New information is always a good thing. Maybe they could send an information pack by post. Actually, I don't really know what I want, or who I should approach." (Turkish woman, non-participant)

The non-participants were then asked how they would prefer to receive the information. The answers to this question were diverse. The suggestions included by post, through a friend, the community centre, the children's school, a newsletter, folders, a newspaper, by e-mail, on Internet, an information evening and through a sports club in the community centre. A preference for being informed through the community centre was expressed a little more often than any of the other channels. Furthermore, most respondents identified multiple ways in which they would like to be informed. One respondent volunteered that he had no preference for how he should be informed, whether by e-mail, telephone or face-to-face.

There is therefore no unequivocal way in which non-participants wished to be informed, and there was often no preference for any specific method. Rather, non-participants saw multiple options for how they could be informed.

3.5.3 Summary

In this paragraph, we explore the reasons non-participants gave for not taking part in a health-promoting activity. First, we examined whether the non-participants are aware of the existence of health promotion activities. We found that all of them were, but not all to the same extent. Many had no knowledge of the *current* offers regarding health promotion activities in their neighbourhoods.

We then asked non-participants whether they thought it important to have activities aimed at helping people to be or to stay healthy. All non-participants attached importance to the existence of health-promoting activities. Many of them pointed to a lack knowledge about health and health-promoting behaviour in the target group, including themselves.

It can be assumed that a lack of general knowledge is not the reason for not participating. Non-participation also cannot be attributed to indifference regarding the beneficial effects of health promotion activities on health (behaviour). We found that is it quite difficult to establish the reasons for non-participation. Almost half of the non-participants did not give a clear reason. Reasons that were mentioned were: lack of time and the fact that the

health promotion activities are available at times which do not ‘fit’ the respondent (e.g. during the day, when the respondent is working). Other reasons were the expectation that one would find only Dutch people in health promotion activities and the fact that the respondents thought that they did not need health promotion activities for themselves.

Half of the non-participants however also expressed a need for support in improving their own health and with one exception all non-participants said they thought they would take part in a future activity aimed at improving health. The activities that were broached were: sports, the provision of information and courses about sport and other subjects, exercising or walking with a group, something about nutrition, spinning, swimming, and information sessions on medical topics. In other words, information sessions about health and sports, which almost all non-participants said was a health-promoting activity they would take part in future.

The non-participants often attached conditions to participation in a health-promoting activity in the future. They might only be interested in a sport they like and enjoy, their state of health must permit it, the activity must be nearby, there must be a child minding service, or the timing should fit in with their children’s school hours. Several non-participants ventured that they would personally find participation in a health-promoting activity more pleasant if their own cultural and religious background was taken into account. Some of the aspects mentioned were separate activities for men and women, sessions conducted in their own language, or with an expert from the same origin. Almost all non-participants were interested in information about the health-promoting activities in their neighbourhood. There proved to be no unequivocal way in which non-participants wished to be informed, and there was often no preference for any specific method. Rather, non-participants saw multiple options, like by post, through a friend, the community centre, the children’s school, a newsletter, folders, a newspaper, by e-mail, on Internet, an information evening and through a sports club in the community centre.

4. Participants' suggestions for improvement

4.1 Migrants' proposals

In this chapter we first examine the respondents' proposals for improving the accessibility of health-promoting interventions. We start by discussing suggestions for the preferred *form and content* of health-promoting interventions in the view of the respondents. We then list any *conditions* brought up by the respondents.

The respondents had the following suggestions for the *form* of the intervention: easily accessible publicity strategies; separate health-promoting interventions for ethnic minorities as necessary, and more group interventions that pursue multiple objectives. We briefly discuss each of the proposals below.

Easily accessible publicity strategies

Many of the respondents deliberated on how they personally, or others, could best be informed about health-promoting interventions. They generally suggested a mix of publicity strategies, such as information through folders or internet, combined with an information session in the community centre. A common feature of the publicity strategies proposed by the respondents is ease of access.

Respondent: "Information nearby is convenient, because then you can also involve and persuade other people."
Interviewer: how would you like to be informed?
Respondent: "At an information evening, or through a sports club in the community centre. And to find out from folders, the internet and from visits to the community centre". (Surinamese man, non-participant).

"You can reach migrants through the tea circles. Every community centre has them. You could hold an information session there." (Turkish woman, non-participant).

A number of respondents considered it important for friends, acquaintances and others also to take part in the activity, as this would help persuade them to cross the participation

threshold themselves. The respondents therefore proposed that publicity should be both through formal channels such as folders and informally by word of mouth.

Respondent: "I am interested, and now and again there is something [nearby], but I usually don't go. Generally only Dutch people turn up. But if more people went, I might join them."
Interviewer: And how would you like to be informed?
Respondent: "I don't know, maybe in a folder, or in the newspaper. Perhaps through the children's school." (Surinamese woman, non-participant).

"I now receive information about community centre activities by post. I think that is also a good way. Friends also phone me and ask if I would like to join in." (Turkish woman, non-participant).

In other words, the respondents proposed a mix of publicity strategies with the common factor that they address potential participants fairly directly in their own living environment.

Separate health-promoting interventions for ethnic minorities

Several respondents, participants and non-participants alike, and from a variety of ethnic backgrounds, propose to set up more separate health-promoting interventions for specific target groups. These proposals are concerned mainly with *elderly people* and first-generation members of ethnic minorities. The respondents argue that these groups have an information disadvantage, or have specific disorders that call for separate intervention.

"These sessions make you aware of your illness and how best to deal with it. For instance, you can find out more about diabetes, what exactly it is, how to stop it getting worse, that you shouldn't eat too much couscous on holiday in Morocco, and so on. The sessions are intended to break our cycle of ignorance, and give us information about our health. […].
The sessions targeted Moroccan men. Because they are the most ignorant. Incidentally, our women don't know these things either, so I think it is a shame that there are no similar sessions for them." (Moroccan man, participant).

"People must also be more aware of what they eat, and relevant information must be provided, like Hindus shouldn't eat too much carbohydrate." (Surinamese woman, participant).

"Many people have no idea what exactly they eat, how much they should eat, what carbohydrates are, what makes you fat, and which combinations are bad. Information about these things could be provided. It is customary for Turkish people to bake many pastries, cakes and bread for a tea circle. Just think of all those calories! Few will even give it a second thought. […]. This awareness is important." (Turkish woman, non-participant).

Two respondents, one Surinamese and the other one Turkish, point to the importance of setting up separate interventions for first-generation migrants, with a view to breaking the taboo against psychiatric problems in these groups.

"They should also address mental care. You can see that psychologists and psychiatrists are something of a taboo because of the image they have in certain cultures. To break through this attitude you need to give the right information, that there is nothing wrong in going to a psychologist, and that he is not a shrink. Point out that you will not be put on medication straight away, but that many things can be treated in therapy, and there is nothing to be ashamed of." (Turkish woman, non-participant).

"People are afraid to talk about some things. There are certain awkward topics. Women, for example, find it easier than men to talk about sexual matters. It would be good, then, if there were training courses for how to approach subjects of this kind. […]. People also need to be more assertive, and not always deferential. The old-style Hindus are a pack of pit bulls in that respect. Sometimes they adhere too strongly to their culture, and that has to change." (Surinamese man, participant).

Group interventions that pursue multiple objectives

Many respondents proposed the pursuit of multiple objectives in health-promoting interventions. The combinations most commonly put forward were exercise and social contact, and exercise and information provision.

Respondents often hinted they would be interested in interventions incorporating an opportunity for group exercise. Various respondents asserted that exercising with other people has a motivating effect, and is therefore easier to persevere with.

Interviewer: how would you like to be supported?
Respondent: "Through coaching and group exercise. Or going on a course and attending information sessions, and so on." (Surinamese man, non-participant).

"*Some people have to get over a threshold. Then it is a good thing to have [health-promoting] activities. Because you do things more readily in a group, especially with your own people. You do it for the social contact as well. And then you get two things at the same time, exercise and social contact, and both of these are important for people."* (Surinamese woman, non-participant).

In other words, there was considerable interest among the respondents in exercise activities. Some of them also proposed combining these activities with a social contact function or an information session.

The respondents also made proposals about the *conditions* they thought should apply to health-promoting interventions. The following proposals for improvement are discussed below: interventions must be nearby, account must be taken of language and religious or cultural customs, interventions must be easily affordable, and there must be sufficient continuity.

Interventions must take place in the participants' own living environment

Many respondents proposed having health-promoting interventions in their own neighbourhood, to allow people to attend without having to travel far.

"If there was something nearby, I would have done it long ago." (Moroccan woman, non-participant.

Some of them add that besides a location nearby it would also be necessary to make allowances for the time and days on which the potential target group is able to participate. Women's activities should be in school hours, for example. The availability of child day care is important for women with small children. Activities for Muslims should not clash with Muslim festivals.

"I think that many mothers would be keen to join in more daytime activities. This activity is in the evening, and conspicuously few first-generation women come along. It would be more sensible to hold it in the daytime, because there is often no problem leaving the house then, and the children are also at school. I must say that the mother-and-child centre here already tries to do what it can." (Moroccan woman, participant).

Cater for language and religious and cultural customs

Almost all respondents came up with proposals concerned with migrants' command of the language and with religious or cultural customs. Not surprisingly, mainly Moroccan and Turkish respondents stress the importance of having health-promoting interventions in their own language. They suggest the use of an interpreter as an alternative, but only as a second choice.

"I think it is important for it to be in the Turkish language. Or, failing that, that an interpreter should be on hand. I think they listen to us. The subjects are also chosen after consulting us." (Turkish woman, participant).

"I think it is important for it to be given in Turkish. I don't think everyone understands Dutch. It wouldn't work as well if someone had to interpret during this kind of session. It would be more personal if it was in our own language. It wouldn't matter much to me, because I speak Dutch. But it would be important for people whose Dutch is not so good. (Turkish woman, non-participant).

"There is less of a barrier if it is in your own language. Members of ethnic minorities would then be likely to participate. It would make it attractive for this target group." (Moroccan woman, non-participant,).

The Surinamese respondents said no attention to language was needed for their sake, since they all speak good Dutch. However, some of them commented that it could be necessary to take account of language for Turkish and Moroccan people. One or two consider it unacceptable for health-promoting interventions to be given in the participants' own language: one respondent insisted that members of ethnic minorities should integrate, which would mean that their own language would no longer be an issue.

"There is no need to take account of their own language, because there are now civic integration programmes in the Netherlands, and an awful lot of effort is being put into language. So language really doesn't have to be taken into account. There are so many facilities and courses to help improve language proficiency!". (Surinamese man, non-participant).

It is also the Moroccan and Turkish respondents who emphasize that more attention should be given in health-promoting interventions to the need for women to exercise, or to gather, separately.

"Many women don't want to participate because men might be present." (Moroccan woman, non-participant).

"I do think it is important to take account of religious background. We once received a proposal for group lessons, but that would have to be without a headscarf, and it was mixed. I didn't do it". (Moroccan woman, participant).

In other words, mainly Turkish and Moroccan respondents proposed improvements in the form of catering for language deficiency and specific customs.

No financial barriers

Various respondents said that an activity would have to be inexpensive or free if it was to be attractive. Some of them proposed including more health-promoting interventions in the basic health insurance package as a way of making the interventions really easily accessible and open to anyone who needs them.

Interviewer: "So in future you would like to see some change or improvement in the activity?"
"Respondent: "Yes, the price is on the high side. It's only exercising to music, and it's already sixty Euros. I think that's a bit much. It should be cheaper." (Moroccan woman, participant).

"In my opinion there should be general tangible and intangible investment in the health of ethnic minorities. I therefore definitely consider it important to have activities like "stopping

smoking". The health insurance companies should include it in their packages. Members of ethnic minorities often do not know how to approach the organizations involved. If it were to be included in their insurance package it would be easily accessible and they would simply be able to use it." (Turkish woman, participant).

Continuity

A few respondents proposed an improvement in the continuity of health-promoting activities. These respondents concluded that the interventions are too short to produce any real and lasting change in health. The interventions should therefore be for a longer period, or this should at least be an option.

"Although I am aware that they [the organizers of the health-promoting activity] are dependent on financial resources, I would like to see the project and the lessons continue for a longer period. […]. It was a good project, but too short. I don't think that you can recover in such a short time. Six months is too short. They really motivate you, but six months is just too short." (Turkish woman, participant).

It can be concluded that participants and non-participants make largely similar proposals for improvement. In other words, we found no relevant differences between the participants' and non-participants' suggestions for improving health-promoting interventions and their accessibility.

4.2 Migrants' proposals in comparison with providers' proposals

In this section we compare the proposals of the providers of health-promoting interventions with those of the respondents for improving accessibility and quality for ethnic minorities. As the respondents have only offered proposals on subjects that the providers had previously introduced, our approach was as follows. Each of the subheadings below gives a proposal from the providers. We set out under the subheading whether the respondents referred to the subject concerned, and any outcomes that emerged. We do not discuss here *all* the proposals made by the providers. In particular we have omitted proposals concerned with the institutional-level organization of health promotion, for which, as stated in the previous section, the respondents made no proposals for improvement.

Recruitment strategies should be outreaching and "close to home"

The respondents also put forward this proposal. Both providers and respondents propose a mix of publicity strategies and conclude that health-promoting interventions are best performed in the participants' own living environment.

Interventions should contribute to the empowerment of the target group

The respondents did not explicitly refer in their proposals to the empowerment of ethnic minorities. Nonetheless there is in their accounts some hint of this proposal from the providers: health-promoting interventions should also target first-generation older migrants who have an information disadvantage and who are unaccustomed to investigating matters on their own.

Communication and intervention materials should be available in migrants' languages

The respondents also embraced this proposal for improvement. Like the providers, they proposed making information available in their own language if necessary. The respondents added that they would prefer their own language to using an interpreter or translator. This would act as a barrier between the provider and the participant.

The intervention should be free of charge, or inexpensive

This proposal was also made by both respondents and providers. The respondents added that it would be a good thing for health-promoting interventions to be given a more generous place in the health insurance basic package.

Professionals who carry out and organize the intervention should have high professional standards and intercultural competences

The providers are more explicit on this point than the respondents. Nevertheless, the respondents attached importance to having well-trained professionals running the health-promoting activities, and great importance to allowing scope for cultural and religious diversity. Moreover, many of the participants expressed appreciation for the scope already given in existing interventions they have participated in.

Health promoters with the same ethnic background as the target group should be employed

On this point too, the providers were more explicit than the respondents. The respondents considered it important for the intervention to be provided In their own language if necessary, and that it is pleasant to have scope for diversity.

Migrants should be involved in all stages of the intervention

The providers were again more explicit in their proposal than the respondents. Obviously, the respondents formulated their proposals from the perspective of *participants* rather than as co-producer of an intervention. Nevertheless, various respondents stated that an intervention had been provided at their own request, and that they appreciated being involved in determining the subjects.

Health promotion interventions should be part of a chain of support and care

With this proposal the providers envisaged a form of linked care, whereas the participants emphasized the practical aspects: it is useful for an intervention to be provided in a community centre, because people already gather there.

In health promotion interventions physical activities and health education should be combined

This proposal for improvement was made by both the providers and the respondents. The providers mainly emphasized the combination of exercise and information provision, while the respondents also raised the aspect of meeting each other and social contact.

Health promotion interventions should have continuity and remain available for longer

This last proposal for improvement was also shared by respondents and providers. The respondents who raised this point confirm the providers' suspicion: short exercise programmes without clear continuity give an insufficient guarantee that the participant will be able to carry on independently at the end. The respondents have a clear need for long term interventions.

It is clear from the above that the providers' and respondents' proposals share the same aspects. It will come as no surprise that the respondents' and the providers' proposals correspond most closely in terms of *practical* matters, which have a direct influence on

how migrants can participate in health-promoting interventions. The providers' proposals that are concerned with the organization of the intervention "behind the scenes" tend to be more implicit in the respondents' proposals. It may be concluded nonetheless that the respondents' and providers' proposals largely agree. The differences are in emphasis rather than the content or nature of a proposal.

5. Conclusions

We summarize below the respondents' perspectives on health and health promotion. We first zoom in on respondents' favourable experiences with and need for health-promoting interventions, and secondly on suggestions for improvement.

Perspectives on health

A general finding is that there were few clear differences between the participants and non-participants. There were no differences in how participants and non-participants think about health, but there were differences in the assessments of their own health: the non-participants said more often that they feel "healthy" and the participants said more often that their health was "poor". This difference may have something to do with the lower average age of the non-participants. Possibly the selection of participating respondents – who after all had a reason to do something about their health – could also be connected with their relatively poor reported health. It also could mean that non-participants do not participate in health promotion because they feel healthier.

The respondents reported psychiatric problems as well as physical problems. The psychiatric problems varied from occasional low spirits, or feeling melancholic, to diagnosed depressions. Most respondents linked physical and psychiatric symptoms: one was seen to influence the other.

In both medicine use and general practitioner visits, in other words care consumption, there is no link between participation and non-participation in health-promoting activities. Neither is there an unequivocal link with reported state of health: even some seriously ill respondents visit the general practitioner rarely because they go straight to a specialist. An analysis of health behaviours of participants and non-participants also yields no reference points for a link.

Regarding health behaviours, the respondents conspicuously focus on both their physical and psychiatric wellbeing. If they don't feel well, they resort to a mix of rest, going to bed and staying at home, and seeking distraction and amusement.

Half the respondents took part in a sport and most of the others said they were active in the form of walking or cycling. Nonetheless, many respondents consider that there is room for improvement. Sport was deemed mainly important as a way of improving physical condition and for relaxing body and mind. Several respondents also reported wanting to lose or maintain weight through sport.

The importance of a good, moderate and balanced diet was endorsed by almost all respondents. Most respondents said they were alert to nutrition, but on this point the respondents also admit that things do not always proceed to their own satisfaction. Several Turkish respondents added that their dietary culture is sometimes at odds with healthy eating. Finally, we asked the respondents whether they engaged in any other activities to stay healthy. Seeking relaxation in the form of hobbies, contact with the family, or voluntary work were mentioned most often in this connection by the respondents.

The analysis of the interviews allows to conclude that the interviewed respondents attach great importance to their physical and mental wellness, and are also willing to do something about it. They are well informed about what they should and should not do for the good of their health. Whether they always act accordingly is another matter. Many respondents accept that they could do better and admit to needing support.

Perspectives on health promotion

All participants had a favourable view of their own current or past health-promoting activity. In more than half the cases the activity was specifically oriented to ethnic minorities. Besides health-related aspects, the reasons given by many participants also included the opportunity for social contact that the activity provided. All participants mentioned the activity's positive effect on their health; they felt healthier or had fewer symptoms, the activity led to healthier behaviour, or the activity helped them cope better with their illness. All participants would be willing to take part in a future health-promoting activity.

All non-participants were aware of the existence of health-promoting activities, and almost all could give examples. However, not all non-participants knew exactly what health-promoting activities involved, or what specific activities were currently available. The non-participants came to hear about the activities in various ways, such as through the

community centre, primary health care and from personal contacts. Most non-participants knew someone who had taken part in a health-promoting activity.

All non-participants considered it important for health-promoting activities to be available. Half the non-participants needed support in improving their own health, such as by exercising together with others, getting answers to questions about their own health, or being helped in developing healthy behaviours. Almost all non-participants said they would take part in a future health-promoting activity. They all mentioned sport, and likewise all mentioned information sessions. Non-participants often stated a condition for participation. Several non-participants had a preference for activities in which account was taken of their own background. Almost all non-participants were interested in information about health-promoting activities in the neighbourhood. The ways in which non-participants would like to be informed were fairly diverse. They often had no particular preference, but gave several options.

It can be assumed that neither general knowledge nor indifference regarding the beneficial effects of health promotion activities on health (behaviour) are reasons for not participating. We found that is it quite difficult to establish the reasons for non-participation. Almost half of the non-participants did not give a clear reason. Reasons that were mentioned were: lack of time, activities at times that do not ‘fit’, the expectation that one would find only Dutch people and the opinion that they did not need health promotion activities for themselves.

We conclude in general that both participants and non-participants assess health-promoting activities favourably, and also need support in living healthily. The health-promoting activities would appear to align with the needs and are sufficiently accessible. Nevertheless, there were some suggestions for improvement.

Suggestions for improvement

The respondents made the following proposals for improvement: easily accessible publicity strategies; separate health-promoting interventions for ethnic minorities where necessary, more group interventions that address multiple objectives, interventions must take place nearby, account must be taken of language and religious or cultural customs, interventions must be affordable, and continuity must be satisfactorily arranged.

No relevant differences emerged between participants' and non-participants' suggestions for improving the content or accessibility of health-promoting interventions. However, there were some differences in emphasis between the Turkish and Moroccan respondents on the one hand and the Surinamese respondents on the other. The Turkish and Moroccan respondents attached greater importance to having interventions in their own language and scope for religious diversity.

Finally, we compared respondents' proposals with those of the providers. The providers' and the respondents' proposals comprised largely the same elements. The respondents' and the providers' proposals correspond most closely on practical matters with a direct influence on how migrants can participate in health-promoting interventions. The providers' proposals that are concerned with the organization of the intervention "behind the scenes" tend to be more implicit in the respondents' proposals. It can nonetheless be concluded that the respondents' and providers' proposals largely agree. The differences are mainly in emphasis rather than the content or nature of a proposal.

6. Summary

This report covers the perspectives of members of ethnic minorities on health promotion. Interviewers from the same ethnic background conducted interviews about health-promoting activities in their own language with ten participants and ten non-participants.

Characteristics of the interviewed migrants

Eight respondents were of Turkish origin, six of Moroccan, and six Surinamese. The participant group comprised seven women and three men, and the non-participant group nine women and one man. A factor in this unbalanced distribution is the difficulty for the female interviewers of recruiting male respondents. The average age of the participant group was 49 years, with the youngest 32 and the oldest 65. The average age in the non-participant group was 37 years, with the ages ranging from 20 to 67. The participants' educational level varied from none to upper secondary vocational (MBO). The average educational level of the non-participants was somewhat higher, varying from elementary (LO) to higher professional (HBO) and university. The average period of residence in the Netherlands for the participant group was 32 years, and for the non-participant group 25 years. The reason for coming to the Netherlands for the great majority of both participants and non-participants was family reunion or family formation. The majority lives as part of a family with a partner (1), partner and children (9), children (single-parent family) (4) or parents and brothers and sisters, if any (3). Three of the participants lived alone. There were three single-parent families among the non-participants. The main differences between the participants and the non-participants are largely attributable to the recruitment of three young highly educated Moroccan respondents for the non-participant group.

The majority lives as part of a family with a partner (1), partner and children (9), children (single-parent family) (4) or parents and brothers and sisters, if any (3). Three of the participants lived alone. There were three single-parent families among the non-participants. A minority of the respondents (6 out of the 20) had paid work (part-time). Almost half had no work because they were looking for a job (2), had a work disability (6) or had taken early retirement (1). The number of disabled workers is larger among the participants (4) than the non-participants (2). Two respondents worked in the family or household, and three were following an educational programme. The greater number of disabled workers in the participant group could have to do with their higher age and poorer

health. Half the respondents stated that they found it neither difficult nor easy to make ends meet with their total household income. Four respondents could easily make ends meet, and 5 could do so with difficulty or extreme difficulty. There were no differences in this respect between the participants and the non-participants.

Self-perceived level of integration

Most respondents speak Dutch reasonably or well, and they feel reasonably accepted in the Netherlands, and definitely so in their immediate surroundings. However, they note deteriorating attitudes towards foreigners and an unpleasant atmosphere in recent years. The respondents generally do adhere to their own cultural customs and traditions, and pass them on to their children. Some also feel Dutch, and want to take the best from both cultures. There were no clear differences between the two research groups. The participants estimated their command of the Dutch language somewhat lower than the non-participants, which could be attributable to the higher average age and the somewhat lower educational level of the participant group.

Perception of health (concept)

All respondents attached considerable importance to health. Most described health as a condition for living well. They view a lack of health as an impairment that has an impact that extends beyond the ill person, to family members in particular. The majority of the respondents therefore asserted that everyone – according to ability – should take as much responsibility as possible for their own health.

Perception of own health

When asked, almost half the respondents said they felt healthy. Almost half felt “somewhere in between”, which is to say neither good nor bad. Three respondents admitted to poor health. More non-participants than participants felt healthy and more participants than non-participants reported poor health. The respondents reported psychiatric problems as well as physical problems. The psychiatric problems varied from occasional low spirits or feeling melancholic, to diagnosed depressions. Most respondents link physical and psychiatric symptoms: one influences the other.

Care consumption and health behaviours

Eight of the twenty respondents used medicines. There was a substantial variation in the frequency of general practitioner visits, ranging from less than once a year to every fortnight.

Most respondents were satisfied with their general practitioner, and those who previously were dissatisfied had changed to a different one. The aspect most appreciated was the general practitioner's personal involvement and interest in the patient's background, questions and needs. Despite the generally reasonable level of satisfaction, there were some complaints, which were mostly about the general practitioner's prescribing policy. A number of respondents thought that the general practitioner should prescribe medicines more readily and more often, rather than trivializing symptoms, or blaming psychiatric problems. Furthermore, some respondents found the general practitioner too strict or too hesitant in referring to a specialist.

The respondents reported using the following care professionals other than the general practitioner: ethnic health care advisers, physiotherapists, a psychologist, a psychotherapist, hospital specialists, dieticians, district nurses and a social worker.

One of the ways we used to map out health behaviours was to ask the respondents what they do when they feel unwell. Almost all respondents understood the question as applicable to both physical and mental wellbeing. Most respondents apply a mix of rest, going to bed and staying at home and seeking distraction and amusement. It was striking that only two said they were unable to do anything when they felt unwell.

Half the respondents took part in sport and most of the others said they were active in the form of walking or cycling. Only few admit to being physically inactive. Nonetheless other respondents think they could do better, particularly in view of how enthusiastically all respondents endorse the importance of sport and exercise for health. Sport was deemed mainly important as a way of improving physical condition and for relaxing body and mind. Several respondents also reported wanting to lose or maintain weight through sport.

The importance of a good, moderate and balanced diet was endorsed by almost all respondents. Most respondents said they were alert to nutrition, but on this point the

respondents also admit that things do not always proceed to their own satisfaction. Several Turkish respondents added that their dietary culture is sometimes at odds with healthy eating. Finally, we asked the respondents whether they engaged in any other activities to stay healthy. Seeking relaxation in the form of hobbies, contact with the family, or voluntary work were mentioned most often in this connection by the respondents.

Differences in perceptions of own health, care consumption and health behaviours

There were no differences in how participants and non-participants think about health, but there were differences in the assessments of their own health: the non-participants said more often that they feel “healthy” and the participants said more often that their health was “poor”. This difference may have something to do with the lower average age of the non-participants. Possibly the selection of participating respondents – who after all had a reason to do something about their health – could also be connected with their relatively poorer reported health.

In both medicine use and general practitioner visits there is no link between participation and non-participation in health-promoting activities. Neither is there an unequivocal link with reported state of health: even some seriously ill respondents visit the general practitioner rarely because they go straight to a specialist. An analysis of health behaviours of participants and non-participants also yields no reference points for a link.

Participation in health-promoting activities

Half the participants are currently enrolled in a health-promoting activity, and the other half were enrolled in one at some time in the past. The means of health promotion included ethnic health care advisers, health promotion behaviour through support, sport, or information sessions aimed at improving health. In more than half the cases the health-promoting activity was targeted specifically at ethnic minorities.

Access to health-promoting activities

The participants came into contact with the health-promoting activity mainly through primary health care, the community centre, or personal contacts. They usually decided to participate because they expected a favourable effect on their illness or an improvement in their health. Almost all the health-promoting activities accommodated the participants’ cultural and religious backgrounds.

Opinions about health-promoting activities and effects on health

All participants viewed the health-promoting activity favourably. Besides health-related aspects, the reasons given by many participants also included the opportunity for social contact that the activity provided. Only two participants raised matters about which they were less satisfied. All participants mentioned the activity's positive effect on their health; they felt healthier or had fewer symptoms, the activity led to healthier behaviour, or the activity helped them cope better with their illness. All participants would be willing to take part in a future health-promoting activity.

Reasons for not taking part in health-promoting activities

All non-participants were aware of the existence of health-promoting activities, and almost all could give examples. However, not all non-participants knew exactly what health-promoting activities involved, or what specific activities were currently available. The non-participants came to hear about the activities in various ways, such as through the community centre, primary health care and from personal contacts. Most non-participants knew someone who had taken part in a health-promoting activity. All non-participants considered it important for health-promoting activities to be available.

It can be assumed that a lack of general knowledge nor indifference regarding the beneficial effects of health promotion activities on health (behaviour) are reasons for not participating. We found that is it quite difficult to establish the reasons for non-participation. Almost half of the non-participants did not give a clear reason. Reasons that were mentioned were: lack of time, activities at times that do not 'fit', the expectation that one would find only Dutch people and the opinion that they did not need health promotion activities for themselves.

Participation in future health-promoting activities, with conditions and preferences

Half the non-participants needed support in improving their own health, such as by exercising together with others, getting answers to questions about their own health, or being helped in developing healthy behaviours. Two non-participants insisted they needed no support. With one exception, all non-participants expressed willingness to take part in a future health-promoting activity. They all mentioned sport, and likewise all mentioned information sessions. Non-participants often stated a condition for participation. Several of them had a preference for activities in which account was taken of their own background. Almost all were interested in information about health-promoting activities in the

neighbourhood. The ways in which non-participants would like to be informed were fairly diverse. They often had no particular preference, but gave several options.

Suggestions for improvement

The respondents made proposals for improvement concerned with the form and content of health-promoting interventions and with the conditions that should apply. The following proposals for improvement were made: easily accessible publicity strategies; separate health-promoting interventions for ethnic minorities where necessary, more group interventions that address multiple objectives, interventions must take place nearby, account must be taken of language and religious or cultural customs, interventions must be easily affordable and continuity must be satisfactorily arranged.

No relevant differences emerged between participants' and non-participants' suggestions for improving the content or accessibility of health-promoting interventions. However, there were some differences in emphasis between the Turkish and Moroccan respondents on the one hand and the Surinamese respondents on the other. The Turkish and Moroccan respondents attached greater importance to having interventions in their own language and scope for religious diversity.

Finally, we compared respondents' proposals with those of the providers. The providers' and the respondents' proposals comprised largely the same elements. The respondents' and the providers' proposals correspond most closely on practical matters with a direct influence on how migrants can participate in health-promoting interventions. The providers' proposals that are concerned with the organization of the intervention "behind the scenes" tend to be more implicit in the respondents' proposals. It may be concluded nonetheless that the respondents' and providers' proposals largely agree. The differences are mainly in emphasis rather than the content or nature of a proposal.

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Annexes

Annex 1: Interview guides

Healthy Inclusion

Interviews with migrants who are current or past participants in health-promoting activities

Introduction to the research and the interview

"Hello, my name is ….. and I am doing interviews for a Verwey-Jonker Institute research project. I would like to start by telling you a little about the project and the interview that will begin shortly, and then we can move on to the actual questions."

"'Healthy Inclusion' is an international project that is part of the 2003-2008 Public Health Programme, and co-financed by the European Commission. The project is concerned with improving migrants' access to activities for improving health, such as courses on health, or organized groups for taking part in a sport with other people. Part of the research therefore involves interviewing migrants who have taken part in a health-promoting activity, as you did in …. (identify the health-promoting intervention). The information we gather will be used for improving the health-promoting activities in the Netherlands and the rest of Europe."

"The interview will take about 45 minutes. You will be anonymous, which means your name will not appear in the report of the interview. For the purposes of the report, I would like interview you. Are you willing to be interviewed?"

"The interview will start with a few questions about your personal situation, such as which country you come from and what education you have had. Later there will be some questions about your health. Then we will discuss your participation in …. (identify the health-promoting intervention).

"I hope everything is clear. Do you have any questions?"

To be completed by the interviewer in advance

Gender of the respondent
O Male
O Female

Name of the current or past activity the respondent participated in
……
……

The respondent:
O is currently participating in the activity
O participated in the activity in the past,
viz.……
……

(If any current or past participation of the respondent is unknown, solicit the information from the respondent)

A. Migration and background information

1. Which country were you born in?
.....
.....

2. Why did you leave your home country?

O Family reunion or family formation – reasons concerned with family
O Reasons concerned with work
O Reasons concerned with study
O I am a refugee/asylum-seeker
O Other, viz.……

3. When did you arrive in the Netherlands? …….(*enter the year*)

4. Did you live in any other country before arriving in the Netherlands?
O No
O Yes, in……until..... (*enter the name of the country and the year*)

5. What year were you born in? …… (*enter the year)*

6. What is the structure of your household, or, in other words, who do you live with?
O Live alone
O Live with partner
O Live with partner and child(ren)
O Single-parent family: live with child(ren)
O Other (e.g. nursing home or living with others),
viz.……
……

7. What education have you had?
O None
O Elementary school
O Lower secondary vocational (LBO)/domestic science/pre-vocational secondary (VMBO)/junior general secondary (MAVO)
O senior general secondary (HAVO)/pre-university (VWO) or equivalent
O Senior secondary vocational (MBO)
O Higher professional (HBO)
O University
O Other, as follows
……
……

8. Do you currently have paid work
O Yes, as …… (*enter job)*
For (average)…… hours a week *(continue with question 10)*
O No

9. What is the most important reason that you have no paid work
O Work in own home and family (housewife)
O Family care (care for close family because of illness or old age)
O Unemployed/job-seeker
O Incapacitated
O No need/not interested
O Taken early retirement/pension
O Attending school/educational programme/course
O Other, as follows
……
……

10. How easy or difficult would you say it is for your household to make ends meet with the total household income?

O Very easy
O Easy
O Neither easy nor difficult
O Difficult
O Very difficult

11. Do you speak Dutch?

O Not at all
O A little
O Reasonably
O Well

12. As a ……*(give the ethnicity here, e.g. "Moroccan")*, do you feel accepted in the Netherlands? Would you like to add any comments?

……
……

13. Do you think it is important in the Netherlands to uphold your own cultural customs and traditions? Would you like to add any comments?

……
……

B. Health and perceived health

In this part of the interview I would like to ask you about your health.

14. Do you feel healthy or unhealthy, or something in between? Can you tell me anything else about that?

15. Is your health usually the same, or do you sometimes feel better and sometimes worse? Can you tell me anything else about that?

16. I would like to ask you to assess your own health: do you think your health is very good, ordinary, somewhere in the middle, bad, or very bad? Can you tell me why you chose this answer?

17. Please say in your own words why it is important for people to be healthy

18. How often do you visit the general practitioner?

19. Do you think your general practitioner helped you well? Have you anything you would like to add about that?

20. Do you use medicines? Have you anything you would like to add about that?

21. When you feel unwell, what do you do? Would you like to add any comments?

22. Do you take part in a sport and/or are you physically active? Would you like to add any comments?

23. Do you think that sport or being physically active are good for your health? Would you like to add any comments?

24. Do you take care of your diet in order to stay healthy and feel well? Would you like to add any comments?

25. Is there anything else you do to keep healthy? Or to feel well? (*Persist with questions after one answer, possibly giving examples. The point is not just physical health, but also wellness. E.g. do you take care to stay calm, seek distraction, get out of the house, talk about your problems with someone you trust, etc.)*

26. Is there anything else you don't do to keep healthy, but that you would actually like to do? Have you anything you would like to add about that? What stops you doing it?

C. Participation in health-promoting activities

I would now like to ask you about the activity you are taking part in or have taken part in (*preferably identify the activity here)*

27. You take part / have taken part in …… (identify activity here). Could you describe this activity for me in your own words?

28. Could you tell me what you think about the activity?

29. How did you hear about the activity? In other words, how did you find out the activity existed?

30. What made you decide to take part in the activity? Can you tell me anything else about that?

31. Was any consideration given to your ethnic background in the activity? Would you like to add any comments?

32. Would you like to see more consideration given to your wishes or needs in the activity? An example could be being able to speak your mother tongue, or for the activity to be run by people from your own cultural background? Would you like to add any comments?

33. Now you know what the activity entails, would you like to change or improve anything about the activity? Would you like to add any comments?

34. The activity is intended to help you improve your health. Do you think it has been / was successful? Have you anything you would like to add about that?

35. Have you ever taken part in other activities in the past that were intended to help improve your health? Would you like to add any comments?

36. Would you in future be willing to take part in an activity that was intended to help you improve your health? Would you like to add any comments?

We have reached the end of the interview. Do you have any comments or questions?

Healthy Inclusion

Interviews with migrants who are neither current nor past participants in health-promoting activities

Introduction to the research and the interview

"Hello, my name is ….. and I am doing interviews for a Verwey-Jonker Institute research project. I would like to start by telling you a little about the project and the interview that will begin shortly, and then we can move on to the actual questions."

"'Healthy Inclusion' is an international project that is part of the 2003-2008 Public Health Programme, and cofinanced by the European Commission. The project is concerned with improving migrants' access to activities for improving health, such as courses on health, or organized groups for taking part in a sport with other people. Part of the research involves us interviewing migrants who have not participated in a health-promoting activity, in order to find out why not. This is why we would like to have this interview with you. The information we gather will be used for improving the health-promoting activities in the Netherlands and the rest of Europe."

"The interview will take about 45 minutes. You will be anonymous, which means your name will not appear in the report of the interview. For the purposes of the report, I would like interview you. Are you willing to be interviewed?"

"The interview will start with a few questions about your personal situation, such as which country you come from and what education you have had. Later there will be some questions about your health. Then we will discuss health-promoting activities.

"I hope everything is clear. Do you have any questions?"

To be completed by the interviewer in advance

Gender of the respondent
O Male
O Female

How and through whom was the respondent recruited (*concise description)*
.....
.....

A. Migration and background information

1. Which country were you born in?
   .....
   .....

2. Why did you leave your home country?

O Family reunion or family formation – reasons concerned with family
O Reasons concerned with work
O Reasons concerned with study
O I am a refugee/asylum-seeker
O Other, viz
   ……
   ……

3. When did you arrive in the Netherlands? ……(*enter the year*)

4. Did you live in any other country before arriving in the Netherlands?
O No
O Yes, in ……until ……. (*enter the name of the country and the year*)

5. What year were you born in? …… (*enter the year)*

6. What is the structure of your household, or, in other words, who do you live with?
O Live alone
O Live with partner
O Live with partner and child(ren)
O Single-parent family: live with child(ren)
O Other (e.g. nursing home or living with others), viz
……
……

7. What education have you had?
O None
O Elementary school
O Lower secondary vocational (LBO)/domestic science/pre-vocational secondary (VMBO)/junior general secondary (MAVO)
O senior general secondary (HAVO)/pre-university (VWO) or equivalent
O Senior secondary vocational (MBO)
O Higher professional (HBO)
O University
O Other, as follows
……
……

8. Do you currently have paid work
O Yes, as …… (*enter job)*
For (average)…… hours a week *(continue with question 10)*
O No

9. What is the most important reason that you have no paid work
O Work in own home and family (housewife)
O Family care (care for close family because of illness or old age)
O Unemployed/job-seeker
O Incapacitated
O No need/not interested
O Taken early retirement/pension
O Attending school/educational programme/course
O Other, as follows
……
……

10. How easy or difficult would you say it is for your household to make ends meet with the total household income?
O Very easy
O Easy
O Neither easy nor difficult
O Difficult
O Very difficult

11. Do you speak Dutch?
O Not at all
O A little
O Reasonably
O Well

12. As a ……*(give the ethnicity here, e.g. "Moroccan")*, do you feel accepted in the Netherlands? Would you like to add any comments?
    ……
    ……

13. Do you think it is important in the Netherlands to uphold your own cultural customs and traditions? Would you like to add any comments?
    ……
    ……

B. Health and perceived health

In this part of the interview I would like to ask you about your health.

14. Do you feel healthy or unhealthy, or something in between? Can you tell me anything else about that?

15. Is your health usually the same, or do you sometimes feel better and sometimes worse? Can you tell me anything else about that?

16. I would like to ask you to describe your health in your own words: do you think your health is very good, ordinary, somewhere in the middle, bad, or very bad? Can you tell me why you chose this answer?

17. Please say in your own words why it is important for people to be healthy?

18. How often do you visit the general practitioner?

19. Do you think your general practitioner helped you well? Have you anything you would like to add about that?

20. Do you use medicines? Have you anything you would like to add about that?

21. If you feel unwell, what do you do? Would you like to add any comments?

22. Do you take part in a sport and/or are you physically active? Would you like to add any comments?

23. Do you think that sport or being physically active are good for your health? Would you like to add any comments?

24. Do you take care of your diet in order to stay healthy and feel well? Would you like to add any comments?

is there anything else you do to keep healthy? Or to feel well? (*Persist with questions after one answer, possibly giving examples. The point is not just physical health, but also wellness. E.g. do you take care to stay calm, seek distraction, get out of the house, talk about your problems with someone you trust, etc.)*

25. Is there anything else you don't do to keep healthy, but that you would actually like to do? Have you anything you would like to add about that? What stops you doing it?

C. Knowledge of health promotion / conditions

I would now like to talk to about the current options for participating in activities that could improve your health.

Are you aware that there are activities, such as courses and information sessions, which are aimed at helping people become healthier? Would you like to add any comments? (*First allow respondent to answer freely. If the respondent knows nothing at all, carefully provide a few examples, such as: a "stopping smoking" course, or "exercises for migrant women").*

26. How did you get to hear about this activity (these activities)? Would you like to add any comments?

27. Do you know anyone who has taken part in an activity intended to help people stay or become healthy? What kind of activity was that, and do you know what his or her experiences were?

28. Do you think it is important to have activities aimed at helping people to be or stay healthy? Why / why not?

29. Do you think it is important that activities of this kind take account of the cultural background of ethnic minorities, for example by holding them in their own language, or by arranging for the people running the activity to have the same cultural background? Why / why not?

30. Is there anything else that should be taken into account for ethnic minorities? Would you like to add any comments?

31. Would you yourself like to have support in improving your health? If so, would you like to tell us more details – what form should the support take? If not, why not?

32. Would you be interested in information about the health-promoting activities in your neighbourhood? If so, how would you prefer to be informed? If not, why not?

33. Do you think you might take part in a future activity aimed at improving your health? If so: what kind of activity would that be, and why would like to take part? If not, why not?

We have reached the end of the interview. Do you have any comments or questions?

Annex 2: Summary table

Country of Origin / Ethnicity	Religion	Age	Years of permanence	Legal status	Reason for migration	Living situation	Education/ schooling	Work situation	Perception of economic status	Speaking Dutch
Turkish										
Participants										
Woman 1	Muslim	47	34	Citizen	Family	Partner and children	None	Housewife, family care/voluntary work	Medium	A little
Woman 2	Muslim	53	25	Citizen	Work	Alone	MBO	Incapacitated	Medium	Reasonably
Woman 3	Muslim	37	21	Citizen	Family	Partner and children	Elementary+	Employed (24hrs)	Medium	Reasonably
Woman 4	Muslim	32	27	Citizen	Family	Children	VMBO	Unemployed/job-seeker	Difficult	Reasonably
Non-participants										
Woman 1	Muslim	37	37	Citizen	Family	Partner and children	MBO	Employed (12,5 hrs)	Easy	Reasonably
Woman 2	Muslim	67	29	Citizen	Family	Partner and children	None	Incapacitated	-	A little
Woman 3	Muslim	36	30		Family	Children	HBO/University	Employed (24 hrs)	Easy	Well
Woman 4	Muslim	32	27		Family	Children	None	Unemployed/ job-seeker	Medium	A little

Religion: catholic, Muslim, Orthodox, etc.
Age: number
Years of permanence: number
Legal status: citizen, Refugee, Temporary resident , permanent resident
Reason for migration: Family reunion - family reasons, Work/economic reasons, Study reasons, Refugee/asylum seeking, Other
Living situation: lives with partner, partner and children, children (single-parent family), parents (and brothers/sisters)
Education/Schooling: none, elementary level (LO), pre-vocational secondary (VMBO), upper secondary vocational (MBO), higher professional (HBO) and university
Work situation: employed (hours/week), unemployed/job-seeker, housewife, in maternity leave, retired, incapacity for work, in education, family care/voluntary work, other
Perception of economic status (of total household income): Easy to make ends meet, medium (neither easy nor difficult), difficult
Speaking Dutch: well, reasonably, a little.

Country of Origin / Ethnicity	Religion	Age	Years of permanence	Legal Status	Reason for migration	Living situation	Education/ schooling	Work situation	Perception of economic status	Speaking Dutch
Moroccan										
Participants										
Woman 1	Muslim	59	42	Citizen	Other	Partner and children	MBO	Incapacitated	Difficult	Reasonably
Woman 2	Muslim	52	31	Citizen	Family	Alone	None	Unemployed/jb-seeker, incapacitated	Difficult	A little
Man 1	Muslim	49	31	Citizen	Family	Partner and children	VMBO+	Employed (20 hrs)	Medium	Reasonably
Non-participants										
Woman 1	Muslim	26	9	Citizen	Family	Parents (and brothers/sisters)	HBO/University	In education	Medium	Well
Woman 2	Muslim	20	9	Citizen	Family	Parents (and brothers/sisters)	HBO/Univ.	In education	Medium	Well
Woman 3	Muslim	25	19	Citizen	Family	Parents (and brothers/sisters)	HBO/Univ.	In education	Medium	Well

Country of Origin / Ethnicity	Religion	Age	Years of permanence	Legal Status	Reason for migration	Living situation	Education/ schooling	Work situations	Perception of economic status	Speaking Dutch
Surinamese										
Participants										
Woman 1		57	36	Citizen	Family	Partner and children	None	Incapacitated	Easy	Well
Man 1		36	36	Citizen	Family	Alone	MBO	Employed (32 hrs)	Medium	Well
Man 2		65	30	Citizen	Other	Partner	MBO+	Retired	Easy	Well
Non-participants										
Woman 1		36	34	Citizen	Family	Children (single-parent family)	VMBO	Housewife	Difficult	Reasonably
Woman 2		48	30	Citizen	Family	Partner and children	VMBO	Employed (35 hrs)	Difficult	Well
Man 1		56	36	Citizen	Work	Partner and children	HBO/University	Incapacitated	Medium	Well