Healthy Inclusion

Providers' perspectives on participation of migrants in health promotion in The Netherlands

Empirical analysis I: Interviews with providers

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1. Introduction

This chapter introduces the Healthy Inclusion project and gives a short presentation of health promotion in The Netherlands. The providers who are interviewed with regard to this project are presented here, as well as the methods used.

1.1. General introduction of the project

Background information

Migrants belong to the most vulnerable and exposed social strata in society and require special consideration in public health strategies. The overall health status of migrants is remarkably poorer than that of the general population. This is related to the fact that migrants are more exposed to risks that have an impact on health, such as poverty, bad living conditions, restricted access to the labour market and health services, etcetera.
Additionally, a lack of information and, last but not least, communication problems create barriers for getting access to health promoting interventions. Thus, an equal accessibility and quality of the general health services are essential for enhancing the health level of migrants. This does not only apply to health care services, but also to prevention strategies and health promotion interventions.
In this project, the following definition of migrants is used: “Persons who have been born in another country, who have lived in the host country for at least five years and who have the intention of staying permanently, who have a legal (residential) status and who (as a group) have a disadvantaged (socio-economic or social cultural) position in the host country”.

Health promotion represents a comprehensive social and political process; it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. Health promotion is the process of enabling people to increase control over the determinants of health, thereby improving their health.

Participation is essential to sustain health promotion action. The Ottawa Charter identifies three basic strategies for health promotion. These are advocacy for health to create the essential conditions for health indicated above; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health.

These strategies are supported by five areas of action: build healthy/public policy, create supportive environments, strengthen community action, develop personal skills, and re-orient health services[1].

About Healthy Inclusion

Healthy Inclusion is an international project carried out within the Public Health Programme 2003-2008 and co-funded by the European Commission, DG Health and Consumers, and Public Health (EAHC). The general objective of the project is to contribute to the increase of the participation of migrants in health promotion interventions. “Healthy Inclusion” aims at being instrumental in reducing health inequalities for migrants and in developing policies and innovative approaches to addressing migrant health issues. Thus, the project tends to provide knowledge about barriers to the access of migrants to health promotion interventions as well as strategies to amend this circumstance. The results contribute to the development of innovative concepts for the planning of health promotion interventions that touch the needs of migrants and will be compiled as recommendations for integrating socio-cultural standards in municipal health promotion interventions.

The project is concerned with improving the access of migrants to health promotion interventions. The project will:

- provide information about migrants’ perceived barriers for participating in health promotion interventions as well as about facilitating factors;
- provide examples of good practice and suggested means of enhancing migrants' participation in health promotion interventions;
- develop specific recommendations on how health promotion interventions at the community level can be adapted to better meet the needs of migrants.

The results will be disseminated to the health promotion community and to policy makers in each partner country.

[1] WHO. (1986). Ottawa Charter for Health Promotion. Geneva; WHO. (1998). Health Promotion Glossary. Geneva. WHO/HPR/HEP/98.1. (pp 1-2); http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf .

The aims of the project are achieved through:

- a literature review of national literature concerning the particular situations regarding migration and health promotion in each country involved in the project;
- interviews with representatives of organisations providing health promotion interventions;
- interviews with migrants who do and who do not have access to these interventions, in their native language;
- the support of an Advisory Board consisting of various experts on migration, health promotion etcetera;
- Delphi rounds including the participation of various experts on migration, health promotion, etcetera.

This national report describes the results of the literature analysis and the analysis of the interviews with representatives of organisations providing health promotion interventions.

The performed interviews focused thematically on the barriers for the inclusion of migrants in health promotion initiatives through the following guiding **research questions**:

1. Do migrants participate in health promotion activities?
2. What are hindering and conducive factors for participation of migrants in health promotion initiatives? What is the influence of images of health/disease on the use of health promotion initiatives?
3. Which strategies and solutions are used to improve access of migrants?

1.2. Methods

Literature

In order to provide an overview of health promotion and access to health promotion for migrants in the Netherlands, we carried out a literature review. We conducted a search in the national literature and project databases, and national websites in the field of public health and related fields. Key words were: Migrants[2]/ (ethnic) diversity/ interculturalisation and Prevention/ preventive health care/ health promotion. The purpose of the literature review was to get an overview of policies and practices on health promotion and migrants in the Netherlands.

[2] In Dutch: ‘allochtonen’.

Interviews

Fifteen semi-structured qualitative interviews were conducted with providers of health promotion activities. The fifteen providers were selected based on the results of the review, knowledge gained from earlier projects, by consulting members of the advisory board, and the formulated inclusion criteria. The selected providers offer health promotion interventions for the whole population on the local or regional level. The interventions aim for the promotion of health: improving people's lifestyle, living conditions, the physical and social environment, and quality of life. Furthermore, a number of providers offer general interventions as well as interventions for specific migrant groups. This provides the possibility of exploring good practices and strategies to improve the accessibility of health promotion for migrants. An additional criterion was that interviewees must have (hands-on) experience with health promotion interventions and/or a sufficient overview of activities and policies of their own organisation. Furthermore, in the selection of the providers we took into account variety in type of organisations, settings, target groups, and health promotion activities. An interview guide was developed to structure the interviews. The interviews mainly were qualitatively analysed: Categorisation of the data material takes as its starting point an existing conceptual structure, which signifies that the categorisation starts with already identified concepts, drawn from the previously determined structure of the interviews and the report. These concepts provide the overall structure for the analysis, which contains interpretation at a micro, meso and macro level.

1.3. Health promotion in The Netherlands

The Dutch Ministry of Health, Welfare, and Sports is primarily responsible 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. One of the prevention methods is health promotion by offering general information and tailor-made advises and the creation of social and physical surroundings that stimulate healthy behaviour. In 2006, the government published its policy document 'Opting for a Healthy Life' ('Kiezen voor gezond leven'). The following priorities for preventive policy were identified: smoking, problematic drinking, overweight, diabetes, and depression. In 2007, the government published its vision document 'Being Healthy and Staying Healthy' ('Gezond zijn en gezond blijven').

It 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 within Dutch society with regard to 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. 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 terms of housing, employment, education, integration, and safety. Forty districts were selected, facing the most difficult problems. These districts must work to achieve drastic reductions in school drop-out rates and unemployment. The quality of housing must also be substantially improved. Improving health is an issue as well, as most inhabitants in these districts have a low socio-economic status and/or are from an ethnic minority group.

Recently, the government published the 'Policy plan for tackling health disparities based on socio-economic backgrounds’ (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, etcetera. Structured approaches are also being developed for people suffering from chronic illness.’

Largely the local authorities carry out 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) from 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 mainly been financed by local governments under the Public Health Act. Recent changes in the legislation and financial system of health care and social support may have effects on the financing of health promotion activities in the future. Under the new Health Insurance Act, all residents of the Netherlands are obliged to take out health insurance. Furthermore, the new Social Support Act[3] 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/regional public health services. Yet, general health care, mental health care, youth care, elderly care and, increasingly, other organisations such as schools, welfare-, sports-, and business organisations, are also getting involved in health promotion. Most public health services offer specific health promotion activities for (non-Western) migrants, and increasingly other organisations, such as youth care and mental health care organisations, do so as well, especially those in areas with large migrant groups. Among non-Western migrants, there is an accumulation of factors contributing to a declined health and a decreased use of preventive health measures, such as a low educational level and income, a deteriorated position on the labour market, and living in deprived neighbourhoods. Furthermore, prevention aims for maintaining healthy behaviour like a low alcohol consumption and good eating habits.

Recently, the Dutch Organisation for Health Research and Development (ZonMw) [4] has been developing the 'Ethnic Minorities and Health Care' programme. This programme aims to promote the implementation of the knowledge and skills available in this area. It targets both providers and users of care. The programme focuses on improving somatic curative care, an area in which knowledge and methods are available that could potentially improve care for ethnic minorities in the Netherlands. The aim is to spread this knowledge and these methods, and to ensure that they become part of mainstream care.

[3] 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).

[4] ZonMw is a national organisation that promotes quality and innovation in the field of health research and health care, and initiates and fosters new developments. ZonMw also actively promotes knowledge transfer and implementation, ensuring knowledge is exchanged between all relevant stakeholders (health researchers, health professionals, patients/consumers and the general public). This in turn facilitates the structured implementation of newly developed knowledge in the health care system and guarantees emerging health care issues a place on the research agenda.

1.4. Migrants in the Netherlands

The Dutch population counts approximately 16 million people. The non-indigenous population numbered just over 1.7 million people at the start of 2007 (cbs-Statline). Statistics Netherlands counts as ethnic minorities the people of whom are least one parent was born abroad. The country of origin for those not born in the Netherlands (the first generation) is determined on the basis of their own country of birth. For the second generation (born in the Netherlands) the country of birth of the mother is decisive (unless she was born in the Netherlands, in which case the country of birth of the father is used). The category 'non-Western' 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 is 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 Suriname (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 for groups which 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, partly due to a falling immigration and growing emigration, especially by young people.
Members of non-Western ethnic minorities have traditionally been concentrated in the west of the Netherlands, and particularly in the four major cities of Amsterdam, Rotterdam, The Hague, and Utrecht. Although this applies for all ethnic minority groups, Surinamese and Moroccans are particularly overrepresented in the west of the country (and in the four major cities), while Turks relatively often 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 mainly live in the medium-sized towns and cities. However, after initially being deliberately dispersed throughout the coun-

try, ultimately these groups also tend to move to the cities (Latten et al 2005), (SCP 2008 ibid).

Within the major cities, ethnic minorities are highly concentrated within specific neighbourhoods. If the district and neighbourhood division used by Statistics Netherlands (cbs) is applied, in 2004, there were 83 districts 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. At neighbourhood level, 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 of these 'concentration neighbourhoods' are situated in the four major cities, where they account for more than 10% of all neighbourhoods (SCP 2008 ibid).

Non-Western migrants generally have poorer health (RVZ 2000, VTV 1997). Their *experienced* health is also poorer that that of the native Dutch population. Furthermore, non-Western migrants suffer relatively more often from chronic diseases (Nationale Studie 2, Nivel 2004). Socio-economic factors can explain only part 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 in a specific way. Examples of this are infectious diseases (e.g. Helicobacter Pylori infection), blood diseases (e.g. sickle cell anaemia and G6PD deficiency), heart diseases, diabetes and asthma. There are still a lot of uncertainties though: more research is needed to explain e.g. differences in life expectancy and the relation with ethnicity (Pacemaker ibid).
The use of health care (facilities) of non-Western migrants is also different compared to that of the native Dutch. Especially the Turks and Moroccans use health care (facilities) in a different way. Their use is characterised by overconsumption of some facilities, like the paediatrician and prescribed medication, and under-consumption of specialised medical care (Pacemaker ibid). Again, more research is needed to gain insight into the factors causing these discrepancies.

1.5. Health promotion providers and interventions

For an overview of the organisations, see table 1 in the Annex.

The interviewed providers work in various types of organisations: public health services (4), mental health care organisations (4), general health care centres (2), a (home) care organisation, a youth care organisation, an academic medical research centre, a local organisation for support of health care and social services, and a national organisation for smoking prevention. Public health services are the main providers of prevention and health promotion activities. Other organisations offer prevention and health promotion activities in addition to (health) care.

The main funding of almost all organisations comes from various national governmental and local governmental sources (see also 1.4). On the national level, these sources are The Health Insurance Act, the Exceptional Medical Expenses Act, and the funding of projects, in particular by the Dutch Organisation of Health Research and Development. On the local level, these are the Public Health Act and (increasingly) the new Social Support Act, as well as the policy regarding the improvement of disadvantaged districts.

Most of these organisations are large organisations providing their prevention or (health) care activities to all inhabitants in one or more cities and/or a region in the Netherlands. However, most organisations, especially those in the large cities or regions with many migrant groups, focus on specific groups (people with a low socio-economic status, ethnic minorities, vulnerable older people) in disadvantaged neighbourhoods. Furthermore, the (health) care organisations providing health promotion focus on people with specific problems, such as physical, mental, or psychosocial problems, and problems in the field of addiction, relations, development, or education.

Most organisations work in several settings, depending on the focus and type of intervention, the target group, etcetera. The most common settings of health promotion interventions are the neighbourhood (10), the community centre (10), the health care centre (7) and school (8). Other settings are the sports club/accommodation (2), at home (1), and the media (1).

All organisations have migrants as participants. Most organisations (10 out of 15) also offer interventions especially for migrants. Most organisations (11 out of 15) have policies to improve the participation of migrants in health promotion.

Most of the organisations offer several types of health promotion interventions.
Especially the public health services offer a variety of health promotion programmes to increase the attention people pay to their health, and to stimulate 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 education pupils, a project to combat obesity in Turkish and Moroccan women, and a programme to encourage children to move and practise sports.

The most common forms of health promotion interventions are information, advice, and support in meetings or courses. Some organisations provide information, advice, and support in individual contacts. Beside meetings and courses, other methods are used, too, such as leaflets and media campaigns.

2. The participation of migrants in the health promotion interventions (provider/intervention level)

In this chapter, we will describe the participation of migrants in sixteen health promotion interventions in the Netherlands. First, we will briefly describe some characteristics of the interventions. Then, we will draw on the background and living conditions of the migrants who participate in the interventions and of those who do not. In paragraph 2.2, we will discuss both hindering and conducive factors for the participation of migrants *on the intervention level*.

2.1. The actual participation of migrants in the interventions

Interventions

In total, sixteen interventions were discussed in the interviews with providers[5]. Five interventions focus mainly on promoting healthy living habits, both physical and mental, in a group setting in which health education is actively combined with sports, or other activities (e.g. informal meetings). An example of this is a community-based intervention that aims at stimulating people (with a low socioeconomic status) to gain (more) control over their own health by offering them a programme to exercise in a group and to attend meetings.

In five interventions, health education is the most important feature. Examples of this kind of interventions are health education for migrants with a high risk of hypertension (e.g. people from sub-Sahara Africa), health education in the migrants' own languages for migrants who are not (fully) integrated in Dutch society and a (multi-media) campaign to tempt Turkish people to quit smoking.

Two interventions focus on supporting obese children and their parents. These interventions consist of meetings for children and parents, exercise activities, diet advice, etcetera.

In three interventions, which are community-based, intermediaries are used to reach migrant groups. One focuses on subsidising and supporting migrant groups with regard to their role in the prevention of HIV; another focuses on migrants' 'confidential advisors' who play an intermediary role between migrants and health professionals. In a third interven-

[5] In one interview, two interventions were discussed. For an overview of the interventions, see table 2 in the Appendix.

tion, professional youth nurses pay house visits to migrant families (pregnant women and young families) in order to incite them to start using the regular available facilities for mother and child.

Who are the target groups of the interventions? Six interventions are not aimed at a specific ethnic group. They are aimed at children and parents (2), youth (1), women (1), people with a low socioeconomic status (1) and the elderly (1). Ten interventions are aimed specifically at migrant groups. There are interventions for Turkish and Moroccan women (2), Turkish migrants (1), Moroccan migrants (1), migrants from sub-Sahara Africa, Suriname and the Dutch Antilles (1), migrant women (1) and migrant (young) families and pregnant women (1). Two interventions target migrants in general (including refugees) and one intervention specifically targets migrant *organisations*.

Most interventions consist of courses. In some interventions (5), individual counselling plays a central part. One intervention uses the mobile network (telephone text messages) as part of a health education campaign, while in another intervention health professionals visit people at home. The frequency of the activities of the intervention show great variation, from two to three courses a year, to 400 meetings, or 28.000 text messages. The same variety can be seen in the number of participants. In courses, the groups generally are not too big (e.g. ten people), but health education meetings reach relatively large numbers of people.

The underlying approaches used in the interventions by the providers also vary from one intervention to the other. Examples of approaches are: using a bottom-up approach; focusing on empowerment as a way to support people to gain more control over their health; using explanatory models that take into account the way people themselves view their health (problems); using ‘outreaching’ methods; taking into account existing (support) structures within the community; etcetera.

The interventions take place in several settings. Most interventions are based in local areas (communities). In these interventions, a local health centre or school are involved, or occasionally a migrant organisation. One intervention takes place at home.

Almost all providers (except for one) use some sort of evaluation to monitor the process and/or the results of the interventions. Only one of the interventions is studied in a Randomised Controlled Trial (RCT design), the other evaluations are more informal and usually mainly focused on the process and the experiences of the target groups. The target

groups are usually (very) positive about the intervention: they report an increase in knowledge and understanding and sometimes a change in (health) behaviour. Results regarding empowerment (an increased sense of being in control of one's own health) have also been reported. In some evaluations, health professionals are involved. They also are positive about the interventions, but usually mention some points of improvement regarding the organisation of the intervention, e.g. the need to develop a solid 'chain' of health professionals to prevent people from dropping out of the intervention. Usually, the providers do not have a clear idea about the exact number of drop-outs, but they state that the percentages generally are quite low. One intervention does have a clear registration system. This intervention has quite substantial drop-out numbers (from both migrants and non-migrants): one third of the participants has quit the intervention after the first stage. The providers explain, however, that this is not necessarily a bad sign. The goal of the intervention is to get people to exercise more. It may be that the people who have quit the intervention have started to exercise on their own rather than in the programme.

Do the interventions succeed in reaching migrants? Ten interventions are aimed specifically at migrants, and their providers actually do succeed in reaching the target groups. The other six interventions are not specifically aimed at migrants. One intervention does not reach any migrants (that they are aware of). The provider thinks that this is because few migrants are living in that particular area. Two interventions reach a limited number of migrants. One of the providers explains that this is because the intervention uses a particular exclusion criteria, namely that children as well as their parents must be able to speak Dutch very well. If not, they cannot participate in the intervention. The second provider thinks that migrants have not been participating in the intervention very much until now, because the provider has not used any specific methods to reach migrants after seeing that they do not seem to take any initiative to participate in the intervention themselves. In three general interventions a lot of migrants participate. One provider states that no specific methods are used to reach migrants, but that the whole intervention is aimed at people with a low socioeconomic status, and migrants often belong to that group. The two other providers explain that specific methods to use migrants are used, namely the assistance of social workers and that of proto-professional migrant social workers, who function as intermediaries between the intervention, the provider, and the (ethnic) community.

Background and living conditions of migrants

The providers of the interventions that reach a considerable amount of migrants (thirteen interventions) have shared with us some of the characteristics of the migrants and their living conditions. The ethnic background of the participating migrants is diverse, but in nearly all cases, migrants from non-European or non-Western countries are targeted and reached. Turkish and Moroccan migrants are mentioned often. This is no surprise, as they constitute a large percentage of the migrants in the Netherlands, as do the Surinamese and Antillian migrants, who are often targeted as well. As we have mentioned before, specific migrant groups are sometimes targeted because of health problems that are characteristic of or more common to that group, e.g. hypertension and HIV for migrants from sub-Sahara Africa or Suriname, and diabetes for Turkish, Moroccan, and Hindustan migrants (a subgroup from Suriname).

Migrant women are the target group of five interventions. When the target group is not defined by gender, the providers mention that more women than men participate. In general, the providers state that it is easier to reach women, because they seem more open to the idea that they need support or information on the subject of health.

The age of the migrants reached is very diverse and, of course, related to the subject and goal of the intervention. One intervention is aimed specifically at the elderly (45+); the other interventions reach adult migrants of all ages.

The providers all mention that the socioeconomic status[6] of the migrants they (aim to) reach is low: poverty and unemployment are more common amongst migrant groups. In addition, housing and living conditions in general are below average. Some of the providers argue that it is the socioeconomic status, *not* the ethnic background, that is the most important determinant when it comes to health problems and health needs.

This view is supported by the fact that some of the migrant groups have lived in the Netherlands for a long time (e.g. 30-40 years) and are more or less integrated in Dutch society. The Surinamese and the Antilleans are good examples of this. Yet, not all groups are well-adjusted, or well-integrated into Dutch society: first-generation migrants (migrants who have been born in another country), like e.g. the Turkish and Moroccan groups, often do not speak Dutch well and generally remain quite isolated from Dutch society. These groups consist of people who have migrated to the Netherlands a long time ago (migrant workers) as well as recent migrants (migrant marriages or family (re)unions). Some providers mention that refugees participate in their interventions.

[6] This includes the financial situation of the household as well as the living conditions (housing, neighbourhood, etcetera).

According to the providers, the health status of migrants is generally less favourable. Again, some providers make a connection between the low socioeconomic status of migrants and their health needs. Health problems of migrants that are often mentioned are: obesity, diabetes, depression/stress, cardiovascular diseases, sleeping disorders, addiction to medication, etcetera. Some providers also mention that the knowledge of, and trust in, the Dutch health care system is weak within some migrant groups in particular. In addition, migrants who are not (fully) integrated into Dutch society often have other systems of reference when it comes to the subject of health, healthy living, mental health, and so on.

2.2. Hindering or conducive factors on the intervention level

As ten of the sixteen interventions are aimed specifically at migrants and three more interventions manage to reach considerable numbers of migrants, it will be no surprise that the interviewed providers have mostly mentioned characteristics of the interventions that are conducive for the participation of migrants. However, the following hindering factors for the participation of migrants on the level of the intervention were mentioned as well.

Hindering factors on the intervention level

The lack of specific strategies to recruit migrants was mentioned several times. Some providers have been struggling with this issue. One of the providers reports that in the past, they have tried to co-operate with migrant organisations in order to reach migrants for health promotion interventions, but that this has proven to be difficult, as these organisations have their own priorities and agendas. This makes it difficult to reach a shared understanding of the aim and the quality of the health promotion intervention.

Also mentioned by more than one provider is the fact that **the intervention is very 'verbal'**, e.g. the intervention requires a lot of knowledge and understanding of the Dutch language from migrants, who might have difficulties speaking and understanding the Dutch language. Problems arise when letters are sent to people who cannot read, or when health education consists of a one-way presentation by a Dutch-speaking professional, before an audience of migrants who have just started to comprehend the Dutch language. One professional, however, states that the level of articulation needed to participate successfully in the health promotion intervention is out of reach for some native Dutch speakers as well.

Her intervention is aimed at youngsters with a (beginning) depression. The migrant and non-migrant youngsters are often from lower-class families and go to school in the lower levels of the educational system. Because of this low level of education, the health promotion intervention (which consists of talking and articulating in a group setting) does not 'match' with the target group as well as it should. This, she argues, goes beyond ethnic background. It is a question of (socioeconomic) deprivation.

Other hindering factors at the intervention level that were mentioned are: **the lack of promotion and educational materials** (leaflets, posters, etcetera) in migrants' languages, the fact that the **interpreters' telephone line** (which is widely available) **is not sufficiently made used of** and **the lack of experience and knowledge** of some of the professionals involved in the interventions.

Some providers have mentioned that the **costs** for the migrants of participating in the health promotion activities have proven to be an hindering factor. Lastly, one provider, in whose intervention intermediaries from ethnic communities play an important role as recruiters and co-workers during the execution of the intervention, has mentioned that issues around **privacy** have arisen. The intermediaries might gain information about private issues of individual migrants. A protocol around the issue of privacy / secrecy must be developed to tackle this problem.

Conducive factors on the intervention level

As we have said earlier, more conducive factors on the level of the intervention for the participation of migrants have been mentioned than hindering factors. The conducive factors can be roughly divided into two categories: factors related to the *methods* used in the interventions and factors related to the *organisation and recruitment* of the interventions. Firstly, we will discuss the conducive factors within the methods used.

Several providers have mentioned the fact that **using an empowerment approach** has proven to be successful. A lot of migrants, especially women, have a rather marginal place in society. Working on empowering the participants as well as educating them about health and healthy behaviour proves to be a combination that appeals to migrant participants.

The **combination of health education and (physical) activities** often works well, according to the providers. There are several reasons for this success. One reason is that the combination tackles the potentially hindering factor of the intervention being too 'verbal'. Participants do not (only) have to listen to health information, they can actively participate in e.g. relaxation exercises and exercises using sports equipment (fitness machines). These machines have a great appeal for some groups of migrants, as they have not been able to afford the membership of a sports club.

One provider mentions that the intervention is built around the experiences of migrants themselves **(life stories)** and that this works very well, because participants can easily relate to the intervention (it is about them). Another provider states that the shared health issues and health problems give participants the idea that they can relate to each other very well. This generates a lot of **mutual support**. This provider thinks, however, that this constitutes a conducive factor for the participation of non-migrants as well.

Several providers offering interventions for migrant women mention that it is important that the interventions are carried out by women. They argue that it is more important to have **single-gender groups**, than it is to have single-ethnicity groups, especially when physical exercise is involved. In other words, the providers have experienced that (migrant) women prefer to exercise in a group that consists only of women. The (ethnic) background of the women then is of less importance.

Furthermore, the providers have mentioned conducive factors that relate to the organisation and the recruitment of the intervention. Nearly all providers who offer interventions that especially target migrants have developed some kind of **co-operation or co-working with professional or proto-professional intermediaries**. These people can be social workers, or individuals especially trained to bridge the gap between professional care, support organisations, and migrant groups. An examples is the so-called 'parent consultant' at primary schools in Rotterdam. The city of Rotterdam supports around 100 of these consultants, whose main task consists of improving the parents' involvement in the school and in wider society. The consultants have been recruited from the migrant communities and they receive training on the job. One provider, who is offering a training course for migrant women to combat depression and inactivity, has organised to meet with all 100 parents'

consultants. Now, the provider gives 25 courses per year for women who are referred to them by the consultants. This provider describes these proto-professional workers as invaluable to truly reaching the migrant groups in need of support. Some providers mention that the intermediaries also play a role in educating and building trust between the health promotion providers and migrant groups. As many migrants do not have an extensive knowledge of the Dutch health promotion system, this is an important added value.

Some other providers of interventions participate in (elaborate) **networks of migrant organisations**. This offers them the opportunity, not only to recruit migrants for the interventions, but also to use the experiences and knowledge of those organisations for the development and organisation of the interventions. In this respect, some of the providers mention that it is important to invite migrants to participate in all stages of the intervention (from the first development to the evaluation of the intervention).

All providers who reach migrant groups agree that the intervention has got to be **'outreaching**: they have experienced that migrants do not sufficiently ask for support, counselling, or advice themselves. That is why it is important to make sure that the potential participants are targeted as personally and effectively as possible. One way of doing that is to organise an intervention for youngsters at school. When a youngster is invited to join in a programme at school, he or she will almost certainly participate, as the teachers will keep an eye on him/her and because the parents will be supportive, since the programme is related to school. As one provider states:

> *"For migrant families, school is almost a holy place".*

Another provider has organised a **closed reference system**: pregnant women with a migrant background are referred to a professional by their obstetrician, She/he will then visit the future mother at home, to invite her to use the health education facilities.

The providers who reach migrants are also in agreement that the intervention should take place in **a setting that is very close or familiar to the participants** (e.g. their own neighbourhood, community centre, mosque, school, etcetera) and at a suitable hour. Or, as one providers states:

"For women, the intervention should take place during school hours, for men in the evening. For women, the school forms an ideal setting, for the men, the mosque is more suitable".

The possibility to offer the intervention (or parts of it) in the native **language of the migrant groups** is also mentioned as a conducive factor. It is a way to reach migrants who do not speak Dutch, but also to increase the understanding of those participants who do speak Dutch, although this is not enough to truly grasp the health promotion ideas or concepts.

Lastly, some providers have stated that they have noticed that it is very important that the intervention is **free**, or offered for a very small charge, as many migrants belong to the low-income groups.

Hindering factors on the level of the providers

The providers have mainly mentioned one hindering factor: their (own) **lack of specific knowledge of the background and health situation of migrants**.

Most providers have a substantial body of knowledge on the subject, and some are very active in keeping this knowledge up-to-date. This type of provider comes to the conclusion that there is always more to learn and more to know. They argue that if they were more knowledgeable or more experienced, they would be able to reach migrants even better.

Conducive factors on the level of the providers

The conducive factors that the providers have mentioned are in part the opposite of the hindering factors. Some **providers** report that they **have an ethnic background themselves** and that they (thus) have more knowledge and understanding of the migrant groups and existing (health) problems.

Nearly all providers, even those that do not (to a great extent) reach migrants in their interventions, have had some form of **training or education in intercultural competences**. For some providers, the knowledge is refreshed on a regular basis in (in-company) courses, while others report that they read the (academic) literature and visit symposia or study meetings.

Many providers agree that working with a diversity of target groups demands from the staff that they are **flexible, open-minded and respectful**. One providers argues for this reason that:

> *"[training in] social competences is more important than training in intercultural competences."*

Most providers acknowledge when asked that bias or discrimination could potentially be a problem, but they state that being aware of that possibility is the best (and only?) antidote to this risk. As one provider states:

> *"The best remedy is to approach participants as if they are the experts and to present yourself as a layman, this is the best way to prevent discrimination*".

All in all, discrimination and bias are subjects that are not considered to be very relevant or applicable by the providers themselves.

Hindering factors on the level of migrants

The providers have mentioned a lot of factors within the (living conditions of) migrant groups that are impeding their participation in health promotion activities. As we have shown before, these hindering factors have led to the development of interventions that are (specifically) aimed at migrant groups. Therefore, in this subparagraph, we emphasise these hindering factors quite heavily. All providers have argued, however, that there are migrants for whom these hindering factors do not apply, or apply to a lesser extent. For instance, there are many migrants who have language problems, but there are many who do not experience this problem at all as well.

The single most important hindering factor that has been mentioned in the interviews is the **low socioeconomic background of many migrant groups**. This factor was named by almost all providers. They characterise the living conditions of migrants as one of relative deprivation. This deprivation hinders the participation in health promotion interventions in several ways, according to the providers. Firstly, these migrants mostly have a low educational background. General health promotion programmes often prove to be too complicated or too abstract for this group. Besides, people who live in poor circumstances have a

lot of problems to worry about. Health is only one of them and for most people it is not at the top of their priority list. Participating in health care promotion usually costs (some) money. Not all migrants can afford this. Lastly, migrants who live in deprived circumstances also run a higher risk for some health problems, like smoking, obesity, etcetera.
These higher risks are – according to the providers – paired with a **lower sense of self-efficacy**: some migrants are less aware or confident than others that they can take charge of their own lives and carry responsibility for their own (health) behaviour.

Some providers have also mentioned the lack of knowledge of the functioning of the human body.

> "*Some Turkish and Moroccan women have no idea of how the human body 'works'. We have to spend a lot of time to explain basic facts. This takes up a lot of time*".

Sometimes, it is not the lack of knowledge as such, but the fact that in other cultures different concepts of health and healthy behaviour are used.

> *"They [Turkish and Moroccan migrants] might view being chubby in a positive light, whereas we will just think: he or she is overweight".*

Migrants might also have different (cultural) ideas about health care and being ill. Some providers who offer interventions in the field of mental health report that it is very difficult to recruit migrants for their intervention, because the whole subject of mental health is either unknown or taboo.

> "*People are afraid that others will think they are mad*."

There are also different ideas about the treatment of health problems. Various providers have stated that some migrants prefer to tackle their health problems by treatment by a 'proper doctor' than by actively participating in (preventive) health care activities themselves.

> "*Some might say: "Just give me a pill"".*

For all of the hindering factors mentioned above, – except for the cultural images of health (care) and being ill –, the providers find it hard to decide whether they are (more) related to ethnic background, or plainly to the (socioeconomic and cultural) position of migrants in society. The providers tend to rule in favour of the latter, but both explanations are used simultaneously. One provider provides an example of how the position of migrants in society (and the way in which they have been treated in the past) influences the way they participate in health care promotion now.

"*Turkish and Moroccan women have experiences with Dutch support organisations. They have developed an attitude like 'if you want to know something about me, you will have to give me something in return'. This has probably been caused by the way society has treated these groups in the past: they have offered them all sorts of support. This attitude means that, as a provider, you will have to be very specific about both your own role and their own responsibility*".

who argues that migrants are less visible in society and therefore are more difficult to reach than other (target) groups. This effect is enhanced when a migrant group, like e.g. the Chinese or the Turks, are oriented very much on other members of their ethnic group, rather than on people from other groups. This might also install fear in people of being talked about. In some groups, the fear of gossip might prevent migrants to participate in health promotion activities.

Lastly, several hindering factors were mentioned that apply to specific groups of migrants: young migrants might lack support from their parents when they want to participate in health promotion activities. Their parents are unfamiliar with either the intervention or the provider and fear that it will distract their youngster from e.g. school or homework. Some migrants do not have a legal permit to stay in the Netherlands. For obvious reasons, this hinders participation in health promotion activities. Some migrant women are oriented so much on taking care of their families, that they do not take the time to 'do something for themselves'. In addition, migrants who travel to their country of origin will often use health care facilities there. This in itself does not necessarily have to be a problem, but it often proves to be, as different treatments and health behaviour are advised.

Conducive factors on the level of migrants

We already explained that the emphasis of this subparagraph lays heavily on hindering factors. However, the providers mention a few conducive factors, too. First, some providers have argued that **religion** can be a conducive factor for migrants to participate in health promotion activities. This works in two ways. Firstly, religion might inspire people to take good care of their health: a healthy body is a god-given thing and thus should be treated with respect. Secondly, religious organisations may provide an opportunity to recruit migrants for interventions. This might also apply to non-religious migrant organisations. They, too, may provide a good location to find the target group, according to some providers.

Another conducive factor mentioned several times was **gender**: some providers agree that it is easier to reach migrant women than it is to reach men. Migrant women are more open to the idea that they could benefit form learning (more) about health or from participating in a health promotion intervention.

Finally, one provider argues that having lived in the Netherlands for only a short period of time constitutes a conducive factor. She argues that recent migrants have a more realistic view of the health care system and facilities in their home country than people who have migrated a long time ago. In her opinion, the latter group tends to idealise the situation in their country of origin and is thus more negative about the facilities and the system in the Netherlands.

> *"People who have lived here for a long time think that their home country is just like they left it over twenty or so years ago*".

3. Policies of organisations to improve the participation of migrants (organisational level)

In this chapter, we will first analyse the policies that organisations (providing the health promotion interventions of chapter 2) use to improve the participation of migrants. After that, we will draw on the hindering and conducive factors for the participation of migrants *on the organisational level.*

3.1. Organisational policies

We have asked the providers what kind of policies, measures, or activities their organisation pursues to improve the participation of migrants. As many interviewed providers are (mainly) involved in one or several interventions at most, and work in generally large and complex organisations, some found it difficult to answer this question. One provider does not have any knowledge of policies on this subject within his organisation. Ten providers stated that their organisation does pursue policies to improve the participation of migrants. These organisations are usually based in the larger cities in the Netherlands, where relatively high concentrations of migrant communities can be found. The policies are often called **'interculturalisation' policies**. These usually consists of actions to structurally adapt the organisation, the methods used, the (ethnic composition of the) staff, etcetera, to the more diverse composition of the target or customers' groups. Examples of measures that follow from interculturalisation policies are: hiring an ethnically diverse staff, organising courses for the staff on intercultural competences, and adapting existing interventions/methods to fit the needs of migrant groups. One of the interviewed providers is a paediatrician whose main task consists of developing, executing, and evaluating the interculturalisation process throughout the whole organisation.
Another provider states that policies to improve the participation of migrants stem naturally from the mission statement of the organisation.

"Our mission statement says that we want to reach all inhabitants of Rotterdam who are in need of support. 50% of our population consists of migrants, so 50% of our clients should consist of migrants, too".

Four providers mention that their organisation does not have special policies concerning the participation of migrants. Instead, these organisations have **policies concerned with the participation of so-called 'vulnerable' people**. By this, they mean people with a low socioeconomic status. These organisations acknowledge that there are (many) migrants among this group. One of the providers of such an organisation says:

> *"We choose not to look at ethnicity as such. We try to reach inactive people and convince them to participate in our programme. This inactivity is not a problem specific to migrants".*

Beside policies, nearly all providers have mentioned measures or activities of their organisation to improve the participation of migrants. These measures and activities are closely related to the interventions for migrants we have already described in chapter two. In other words: the interventions *are the result* of the measures and activities of organisations to improve the participation of migrants. Some providers, however, report measures and activities that transcend the interventions already described in chapter two. A few organisations actively develop new interventions especially designed for migrant groups. A few organisations also monitor the health situation of migrants and carry out research in this area. Many of the providers mention that, in their organisation, there is a permanent availability of (cultural) translators, who assist health care professionals when necessary.

Not surprisingly, the interviewed providers judge the policies, measures and activities of their organisation positively. Most providers state that the fact that their interventions reach migrants is proof of the positive impact of the organisations' policies. Of course, they all see room for improvement: more capacity (staff, time, money, and knowledge) could be made available to reach migrant groups even better or to a larger extent, but all in all, they are positive about the impact of the policies on their interventions. Vice versa, some providers have mentioned that the results of their intervention influence new policies and measures of the organisation. One of the providers has reported that the results of interculturalisation activities are monitored systematically and that there are protocols to make sure that these results are translated into organisational policy.

3.2. Hindering or conducive factors on the organisational level

In the interviews, we have asked the providers what – in their opinion – are hindering and conducive factors on the organisation level for the participation of migrants in health promotion interventions.

Conducive factors on the organisational level

Many organisations report that they have a **multi-ethnic staff**. Professionals with a migrant background may speak the language of the target group, but in addition, providers also find it important to have a staff that reflects the ethnic composition of present-day society. Many providers, however, are quick to add that having a multi-ethnic staff as such is no guarantee for an increased participation of migrants.

As many providers agree, the diversity of potential migrant target groups is so large, that it will never be possible to employ people who are specialists with regard to all the different cultural backgrounds.

One provider argues that most of the organisations are not ready (yet) to truly cater to the needs and questions of migrants. Instead, he argues, they try to adapt a general programme to a new target group.

> *"We have to have a clear understanding of the living conditions of the people involved: what is going on in their daily lives, what makes living in a deprived neighbourhood uncertain, what are the obstacles for healthy living, and why and how problems accumulate. Just applying interventions that have proven to be effective for the general population to a deprived population does not work. We will have to take into account socioeconomic and cultural variables […]. Therefore, the search for effective methods and measures to combat health problems within these groups should start with getting to know the way people live, learning more about the way people experience their health, about their cultural beliefs, roles, and behaviour."*

Thus, apart from having an open and respectful attitude, it is important **to be part of relevant networks** of other professionals, organisations, and migrant groups. In this way, specialist knowledge can be 'borrowed' from the outside, to be introduced in the organisation when necessary. These networks might also prove to be relevant for signalling (new) health problems or health questions in migrant groups.

Three providers state that they think it is very important that the interventions **are accompanied by research**. This will contribute to a better understanding of health problems and health behaviour of migrants, but it will also improve the intervention on a regular basis. A

thorough knowledge of behavioural determinants in relation to health in migrant groups is also very important. Some of this research takes place 'in-company', but it is very important as well that national institutes and universities share their knowledge with professionals in the field.

As we have mentioned before, nearly all providers have had some form of **training or education in intercultural competences**. Often, the organisation offers courses and in-company training. Some providers organise team meetings on a regular basis, in which the methods and results of the interventions are evaluated. One provider structurally organises so-called "mirroring meetings". In these meetings, migrants are invited to share their experiences regarding the intervention with the professionals. The professionals are only allowed to listen and ask informative questions, in order to allow the experiences of the migrants to really contribute in a central way to the future improvement of the intervention.
The example above shows that some providers work very systematically on improving the intercultural competences of their staff. But even when this work is not organised systematically (yet), a provider mentions that health promotion professionals can learn a lot from each others' experiences. A simple checklist of do's and don'ts passed on from one professional to another might contribute considerably to the improvement of the participation of migrants.

Several providers have mentioned that it is of the utmost importance that **the organisation as a whole, and the board in particular, supports the special or extra attention paid to the participation of migrants**. If not, it will be difficult to invest the energy, time, and money into the activities needed to reach migrants and to offer them health promotion activities that 'fit'.

Lastly, one provider mentions that her organisation invests a lot in **educating health (promotion) students**. Investing in good relationships with schools, universities, and students will provide the organisation with the opportunity to have a good choice of well-trained and highly professional workers in the future.

"In my organisation, I have to start from scratch every day. The professionals all have to start at the beginning: they have no specific knowledge of working with diverse target groups. That is why we invest al lot of time and effort in educating students, especially on the subject of diversity! After all, these students are our future employees!"

Hindering factors on the organisational level

The interviewed providers have mentioned several impeding factors on the organisational level for the participation of migrants as well.

First of all, although training in intercultural competence is common in almost all of the organisations, these **trainings** are sometimes **only offered to staff who have already specialised in working with migrants**. This means that 'general' staff members, who work in programmes that are not especially designed for migrants, might not be offered this training at all. This may result in a lasting lack of access to 'general' interventions for migrants in the future, because these health promoters do not acquire the necessary skills to incorporate migrants into their intervention.

Secondly, many providers have stated that they invest in acquiring an ethnically diverse staff. Yet, not all of them succeed. There seems to be **a shortage of well-trained people** in some professions. In other cases, providers have noticed that there is ethnic diversity of the staff in the lower parts of the organisation, but **not at the managerial level and/or the board of the organisation.**

One provider explains that it is difficult to truly achieve ethnic diversity of the staff at all levels of the organisation:

> *"I can really understand that it is difficult. I mean, in a job description, there are so many things that are fighting for attention: does he or she fit in the team, does he or she have the skills to meet our high standards of work, does he or she have knowledge of the latest developments in research, etcetera. The ethnic background of a potential new staff member is only one of those things, and not always the most important one!"*

Thirdly, some providers have mentioned the fact that the **subject of diversity in health promotion is still very 'young**' and that there is a lot that we do not know yet. As a consequence, organisations might have the feeling that they have to 'invent the wheel'. Some providers stress, however, that this fact constitutes not only a hindering factor, but also a conducive one. Because there is still so much to learn, it inspires people to be inventive.

Finally, some of the health promotion organisations (especially those working in the field of mental health) have stated that their **organisations are either rather unknown to migrants, or suffer from a 'bad image**'. This image is related to the taboo that exists in some migrant cultural beliefs on mental diseases and mental problems. This can at times make it difficult to recruit migrants to participate in interventions.

4. Governmental policies to improve the participation of migrants (institutional level)

In this chapter, we will first describe the policies of the (local) government to improve the participation of migrants, as mentioned by the interviewed providers. After that, we will examine the hindering and conducive factors *on the institutional level* for the participation of migrants in the providers' view.

4.1. Governmental policies

As described in chapter one, the national government and local authorities, especially those of the cities with (large) migrant groups, pursue policies to improve the health of and health care for risk groups in general or migrants in particular and also to improve the participation of migrants. According to the interviewed providers, all the municipalities or regions in which the interviewed providers are working have policies to improve the health of and health care for migrants, and/or their participation as well, except for one, which only focuses on people with a low socioeconomic status. The interviewed providers consider these policies to be very supportive.

For example, the city of Almere gives priority to improving its health care for migrants. According to the interviewed provider, it has a stimulating effect that this group has been actually designated in the local policy. Another example is the policy of the district council of Amsterdam Zuid-Oost to improve the participation of migrants. Thus, an initiative for a walking club was favourably received by the council. Yet, another example is the policy of the municipality of The Hague to diminish health inequalities. The migrant confidential counsellors' project has been supported for eight years and it was one of the projects in the municipality's public health trial. A last example is the city of Rotterdam. Rotterdam gives much priority to the subject, which is very supportive in itself. For example, the intervention of the interviewed provider is part of the large municipal programme of long-term interventions for high-risk groups for diabetes and depression, aimed at diminishing the risks or the consequences. Furthermore, the municipality attempts to make connections between different types of offers that are all aimed at the promotion of a healthy lifestyle (among migrants). Furthermore, the provider considers the before-mentioned parent con-

sultants at primary schools in Rotterdam as being very supportive. According to the provider, the municipality gives room to new approaches and activities for risk groups and can be considered as a 'precursor' with regard to such initiatives.

Furthermore, the national and local policies to improve disadvantaged districts support the community/neighbourhood approach of some of the interventions, and vice versa. For example, a mental health care organisation in which one of the interviewed providers works, attempts to link up with the neighbourhood approach of the municipality of Nijmegen by offering the courses from within the neighbourhoods. Another example is that the exercise programme is partly financed within this policy. The provider of this programme also mentioned that the intervention serves often as a good example in national policy.

4.2. Hindering or conducive factors on the institutional level

Important hindering and conducive factors as mentioned by most providers concern the (local) policies, co-operation between stakeholders, and the financial system.

As stated above, an important conducive factor on the institutional level is **the priority in policies to the improvement of migrants' health and of existing health care for migrants, as well as the participation of migrants**. However, as one of the interviewed providers stated, migrants are a priority group in the local governmental policy, but no extra financial means are provided.

According to several providers, another conducive factor is the **association and co-operation with partners** in the neighbourhood or on the local level, such as welfare- and migrant organisations. For example, in the case of the exercise programme, the association with welfare is very conducive. However, that several organisations are offering health promotion interventions and that an overlap exists between the offers is sometimes also viewed as a hindering factor. This leads to competition between the organisations to get their activities financed.

In the view of the providers, a related hindering factor is the **lack of structural financing and the uncertainty about future funds**. Several of the described interventions are only

financed on a project basis. Furthermore, there are recent changes in the financial system (the new Social Support Act) and new and ongoing **local and national developments regarding prevention and (health) care**, such as the formation of regional networks for elderly care and the strengthening of prevention in general health care. These developments are viewed as both hindering and conducive. They are seen as conducive, because these developments offer new chances for the interventions to be financed on the long term and for co-operation between different stakeholders. They are seen as hindering, because these developments are not yet crystallised. It is still unclear who is responsible for what and how the activities will be financed. According to one of the interviewed providers, for example, the funding of preventive activities is a problem in her municipality because these should be financed within the new Social Support Act. Municipalities all develop their own policies. How much money will be available for health promotion activities, will depend on the priority given to prevention.

Another possibility to get health promotion activities financed, especially those targeting high-risk groups, is to **include health promotion in the basic (obligatory) health insurance package**. However, the inclusion of health promotion activities in health care insurance could also be a hindering factor with regard to accessibility. Health insurance companies need exact information from the participants, also from those who only attend an information meeting. Because of **the loss of anonymity** people might decide not to participate, even though the intervention appeals to them. Furthermore, some interventions require that the participants themselves pay a contribution. For participants with a low income this could constitute an impediment.

Two providers mentioned the general policy **not to translate information** (anymore) in the migrants' languages As a factor that is hindering and conducive at the same time. Texts are not translated because it is governmental policy to approach migrants in Dutch when promoting their participation. This could be hindering in the short run, but conducive in the long run, because it will stimulate people to learn the Dutch language sooner.

Another factor that is either hindering or conducive is either the lack or the availability of **information about the health of and health care for migrants**. One provider mentioned the availability of information about the health status and problems of youngsters as a conducive factor. The youth monitor of the public health service provides insight into the

health status of individual pupils of a school. When a school has a high number of pupils with physical or psychosocial health problems, the organisation offers interventions focusing on these problems. This information clears the way for an active approach, according to the provider. For another provider, the lack of information on the local level constitutes a hindering factor. A health survey gathers information on the regional (provincial) level, but it is difficult to get information out of these data on the local level. Furthermore, the results give no insight into the health (care) of migrants, due to the small size of migrant groups studied in the health survey.

As mentioned by one of the providers, a conducive factor to improving the accessibility for migrant women in particular is that the municipal swimming pool has opening hours exclusively for women, and that the municipality maintains a fitness club for women.

Lastly, one provider mentioned the lack of cultural sensitivity and culture-specific information and instruments among co-operating (referring) organisations and professionals.

5. Conclusions

5.1. Provider/intervention level

Conclusions concerning the actual participation of migrants and living conditions

We have studied sixteen interventions. Ten of these interventions are especially aimed at migrant groups. The other six interventions do not have ethnic target groups, which does not necessarily imply that migrants do not participate. In fact, migrants do participate in three out of these six interventions. These three interventions are aimed at people with a low socioeconomic status. As many migrants belong to this category, these interventions succeed at including migrants. The other three interventions, – which do not reach migrants –, do not have a special focus on migrants and/or low-income groups.

The interventions that aim at migrant target groups do not differ very much in scope from the interventions that are meant for a 'general' public. Both types of interventions may involve health education, sometimes combined with physical exercise, psycho-education, information meetings, counselling, and support.

The migrants that participate in the interventions are ethnically very diverse. Some interventions aim to reach all migrants, including refugees. More specific target groups are people who originate from Turkey, Morocco, Suriname, The Dutch Antilles, and sub-Sahara Africa.

The participating migrants can be characterised as having a low socioeconomic status. This includes both the financial situation of the household and the living conditions (housing, neighbourhood, etcetera). Generally, the providers have described the living conditions of the participating migrants as being more negative than those of the general population. Many migrants are unemployed and have little (financial) resources.

A lot of the migrants who participate in the health promotion interventions have been living in the Netherlands for quite a long time (30-40 years). These are the migrants that originated from Turkey, Morocco (labour migrants), Suriname and the Dutch Antilles (former colonies). Not all migrants who originate from one of the before-mentioned countries have been living in the Netherlands for a long time: more recent migration movements involve

family (re)unions. Then there are refugees as well, who have been fleeing to the Netherlands since the early Nineties.
There is a wide variety with regard to the level of integration or acculturation among and within these migrant groups. First-generation migrants from Turkey and Morocco often do not speak Dutch well and can generally lead an existence that is quite isolated from Dutch society. The Surinamese and Dutch Antilleans generally do not have problems with the Dutch language.

The health status of migrants is generally less favourable than that of the general population. Some providers make a connection between the low socioeconomic status of migrants and their health needs. Health problems of migrants that are often mentioned are: obesity, diabetes, depression/stress, cardiovascular diseases, sleeping disorders, addiction to medication, etcetera. Some providers also mention that the knowledge of, and trust in, the Dutch health care system is particularly weak within some migrant groups. In addition, migrants who are not (fully) integrated into Dutch society often have other systems of reference when it comes to the subject of health, healthy living, mental health, etcetera.

Conclusions concerning hindering and conducive factors in the interventions

On the **intervention level,** the most decisive factors for the participation of migrants are:

- Recruitment strategies: we have found that interventions that do not have specific strategies to recruit either migrants or people with a low socioeconomic background fail to reach migrants. The interventions that do recruit migrants successfully put a lot of effort into this. The word that is often used to describe these efforts is ‘outreaching’. The providers have found that the migrants that they hope to recruit will not ask for help or support themselves. They will have to be explicitly invited, preferably in a very personal and face-to-face approach. A thorough knowledge and understanding of the living conditions of these migrants is necessary to recruit them successfully. Therefore, in most interventions, some kind of co-operation or joining of forces with migrant groups is established. These migrant organisations can play a part in introducing the intervention in migrant groups, but they also possess specific knowledge about the migrant group that will enable the health promoter to work more effectively.

- Intervention methods: interventions that have been developed for a 'general' public often are too 'theoretical' or too 'verbal' for migrants who might not have a full understanding of the Dutch language. Apart from language skills, the general level of education and the ability to understand and work with abstract concepts that is presumed in interventions is too complex for quite large parts of the (general) population. Therefore, the interventions consist of methods that are less verbal, more interactive and more practical. Health education in combination with physical exercise has proven to be very successful for some migrant groups, especially since health exercising is very popular. The examples used in the intervention should be easy to relate to for the participants. In this respect, sharing common experiences or health problems in a group setting works very well.

- The availability of materials or communication facilities: in general interventions and interventions aimed at migrant groups alike, materials and communication facilities should be available that fit the target groups in all stages of the intervention (from the development, the recruitment, the execution, to the evaluation). If necessary, leaflets, 0letters, and other promotional materials should be available in the migrants' own languages. When effective communication with migrants requires the availability of (cultural) translators, there should be the possibility to make use of those. For a part of first-generation migrants in the Netherlands, communication facilities in the migrants' languages are certainly necessary. The same applies for cultural translators, or intermediaries. Since many migrants are unfamiliar with health promotion interventions and organisations, it can be very helpful to have people in the intervention team that share the same ethnic/cultural background.

- The intervention setting: we have already shown that often very personal and outreaching recruitment strategies are necessary to reach migrant groups. It is important that the interventions take place in a setting that is very close or familiar to the participants (e.g. their own neighbourhood, community centre, mosque, school, etcetera) and at a suitable hour. Again, a close 'fit' between the living situation and the intervention should be the goal.

- Costs: as many migrants have a less favourable socioeconomic status, it is important that participating in interventions does not cost (a lot of) money. This will scare people off, especially those for whom participating in a health promotion intervention is new and unknown territory.

At the **provider level,** the most decisive factors for the participation of migrants are:

- Professional competences: working for and with diverse target groups means that it is impossible to be an expert on the cultural background of all. Therefore, it is important to have high professional standards with regard to meeting the demands of the people that the intervention is aimed at. This also presupposes an open, flexible, and respectful attitude.

- Intercultural competences: although the providers agree that high professional standards will meet the demands of different target groups to a great extent, the providers see the training of intercultural competences as an important asset. This gives them a chance to learn about (proven) strategies to recruit, council and support migrants in health promotion interventions.

- An ethnically diverse group of health promoters: although the providers agree that having an ethnically diverse staff does not in itself guarantee a better recruitment or intervention when it comes to migrants, they argue that it is important that the staff is a reflection of the ethnic composition of society. In addition, people with a variety of backgrounds bring a variety of views, experiences, and knowledge to the team.

At the **migrant level,** the most decisive factors for the participation of migrants are:

- A poor socioeconomic situation: the single most important characteristic that has been mentioned in the interviews is the poor socioeconomic background of many migrant groups. The providers characterise the living conditions of migrants as one of relative deprivation. Most of the participating migrants have a low educational background. General health promotion programmes often prove to be too complicated or too abstract for this group. Besides, people who live in poor circumstances have a lot of problems to worry about. Health is only one of them and for most, it is

not at the top of their priority list. Participating in health care promotion usually costs (some) money. Not all migrants can afford this. Migrants who live in deprived circumstances also run higher risks for some health problems, like smoking, obesity, etcetera.

- Different concepts of health, healthy living, being ill, and cure and care. The interviewed providers have reported that the participating migrants often have different ideas, beliefs and values when it comes to health. Obesity is seen as a health hazard in Western medicine, but in some migrant groups, it is looked upon as a positive thing, or even as a sign of 'being healthy'. The same goes for definitions of being ill, and diseases. Mental health problems can be difficult to address directly in some migrant groups. This might be caused by a lack of knowledge about a subject, but mental health problems are often taboo, and confused with 'being mad'. Lastly, in migrant groups there might be different ideas on the treatment of diseases, or on the prevention of illness. Going to the doctor and being given medication is sometimes seen as a much more logical response to health problems than actively taking part in interventions aimed at combating health problems.

- A lack of self-efficacy: the fact that, in some migrant groups, the idea of self-management of diseases or health problems is rather unfamiliar goes together with a lack of self-efficacy: a lack of awareness or confidence that one can take charge of one's own life and carry responsibility for one's own (health) behaviour.

- Acculturation / integration in Dutch society: the lack of a legal permit to stay in the Netherlands obviously seriously impairs the possibilities to integrate into Dutch society. This applies, however, only to a small number of the participating migrants. Usually, the migrants have been living in the Netherlands for quite a long time. Yet, time is not the only factor when it comes to integrating in Dutch society. Some migrant groups, like the Chinese or the Turks are very strongly oriented on other members of their own ethnic group, rather than on people from other groups. This might cause people to fear they will be talked about. In some groups, the fear of gossip might prevent migrants from participating in health promotion activities. But strong bonds within migrant communities also offers chances for health promotion participation, as health promoters might co-operate with migrant organisations to

recruit and offer health care interventions. Religious organisations sometimes prove to be good 'channels' for this purpose.

Conclusions concerning good practices

We have asked the providers whether they consider their intervention to be a good practise with regard to accessibility and use by migrants. Most of the providers whose interventions reach migrants state that their intervention can be considered a good practise. This is no surprise, as these providers have invested a lot of time and effort in incorporating migrants in their interventions and they have all succeeded, to a various extent. Nevertheless, they have also mentioned areas of improvement. The following good practices can be derived from the interviews with the providers:

- The involvement of migrant(s') groups in the intervention: ideally, migrants or organisations of migrants should be involved in all stages of the intervention, from the development stage to the execution of the intervention and its evaluation. This approach ensures that the intervention will be compatible with the demands and health questions of the target group, but also that it will contribute to a process of empowerment. In some interventions, migrant proto-professionals or migrant intermediaries are involved. Some are involved primarily in the recruitment of migrants, while others are co-working with the professionals in developing and executing the intervention. Yet others work as 'cultural brokers', intermediaries who speak both the language of the professionals and the language of the migrants.

- The adaptation of general interventions for migrant groups: the participation of migrants in health promotion interventions can be greatly enhanced when these are effectively adapted to the needs and health questions of migrants. This adaptation concerns the recruitment strategies as well as the methods and activities of the interventions. There must be a 'fit' between the content of the intervention and the (cultural) perceptions and life stories of migrants. The setting in which the intervention takes place is important as well, preferably in a community setting, 'close to home'.

- The intervention is part of a chain of support or care: for the recruitment for health promotion interventions, this means that health professions refer migrants to the in-

terventions. For the intervention itself, this means that participating migrants can be easily referred to other organisations if they are in need of further help or support. This way of operating ensures that people are not left to their own devices after they have finished the programme.

- The combination of health education and physical activities: exercise transcends language barriers and maybe some cultural barriers as well. Combined with the fact that migrants often have a strong desire to exercise, the formula of education and sports proves to be successful.

5.2. Organisational level

Conclusions concerning organisational policies

Since many interviewed providers are (mainly) involved in one or several interventions at most and work in generally large and complex organisations, some found it difficult to answer the question whether their organisation pursues policies to improve the participation of migrants. However, most providers are aware of such policies. The policies concentrate either on migrants, or on people who live in deprived circumstances. The first category of policies is often called ‘interculturalisation’ policies. These usually consists of actions to structurally adapt the organisation, the methods used, the (ethnic composition of the) staff, etcetera, to more diverse target groups or customers. Examples of measures that follow from interculturalisation policies are: hiring an ethnically diverse staff, organising courses for the staff on intercultural competences and adapting existing interventions/methods for migrant groups. The interviewed providers judge the policies, measures and activities of their organisation positively. Most of the providers state that the fact that their interventions reach migrants is proof of the positive impact of their organisation’s policies. Of course, they all see room for improvement: more capacity (staff, time, money, and knowledge) could be made available to reach migrant groups even better, or to a larger extent.

Conclusions concerning hindering and conducive factors in the organisations

At the **organisational level,** the most decisive factors for the participation of migrants are:

- An (ethnically) diverse staff that is trained in intercultural competences: professionals with a migrant background may speak the language of the target group, but providers also find it important to have a staff that reflects the ethnic composition of present-day society. Ethnic diversity of the staff as such is, however, no guarantee for an increased participation of migrants. The staff needs to be highly professional and competent, and must also be flexible and have an open, respectful attitude. In some organisations, only the staff that is already involved in working with migrant groups are offered training in intercultural competences. This means that 'general' staff members, who work in programmes that are not especially designed for migrants, do not benefit from these trainings. A lack of access to 'general' interventions for migrants might be sustained in the future, because these health promoters do not acquire the necessary skills to incorporate migrants into their intervention.

- The organisation is part of a network: the diversity of potential migrant target groups is so large, that it will never be possible to employ people who are specialists with regard to all the different cultural backgrounds. Therefore, it is important to be part of relevant networks of other professionals, organisations, and migrant groups. In this way, specialist knowledge can be 'borrowed' and introduced into the organisation from the outside whenever necessary. These networks might also prove to be relevant for signalling (new) health problems or health questions in migrant groups.

- Interventions and policies are accompanied by research: research contributes to a better understanding of the health problems and health behaviour of migrants, but also provides the information needed to improve the intervention on a regular basis. A thorough knowledge of behavioural determinants in relation to health in migrant groups is also very important. Some providers have mentioned that the subject of (ethnic) diversity in health promotion is still very 'young', so many things are as yet unknown. This underlines the importance of innovative research.

- The board initiates and supports policies for improving the participation of migrants: when there is a lack of support of the board for the special or extra attention paid to the participation of migrants, it will be difficult to invest energy, time, and money into activities needed to reach migrants, offering them health promotion activities that 'fit'.

Conclusions concerning conditions on the organisational level

The following conditions on the organisational level are thought necessary by providers to improve the accessibility for and use of health promotion interventions by migrants.

- Good working relationships and networks with migrant organisations, as well as neighbourhoods or communities.
- Intermediaries, translators, and other intercultural experts should be available when needed in all parts of the organisation.
- Knowledge of and experiences with working with migrant groups should be shared within the organisation and with other professionals and organisations. Research also plays an important role in this.

5.3. Institutional level

Conclusions concerning governmental policies

The national government and local authorities, especially those of the municipalities with (large) migrant groups, pursue policies to improve the health of and health care for risk groups in general or migrants in particular, and policies to improve the participation of migrants. The interviewed providers consider these policies as being very supportive. Furthermore, national and local policies to improve disadvantaged districts support the community/neighbourhood approach of some of the interventions.

Conclusions concerning hindering and conducive factors on the institutional level

On the institutional level, the most decisive factors were:

- The priority given in policies to the improvement of the health of migrants, health care for migrants, and the participation of migrants. However, these priorities should be translated into adequate (additional) financial means.

- The association and co-operation with partners in the neighbourhood or on the local level, such as welfare and migrant organisations. However, the existence of several organisations offering health promotion interventions and the overlap between their

offers also leads to competition between the organisations to get their activities financed.

- A lack of structural financing and obscurity about future funds. Several of the described interventions only receive funds on a project basis. Furthermore, there are recent changes in the financial system (the new Social Support Act) and new and ongoing local and national developments regarding prevention and (health) care, such as the formation of regional networks for elderly care and the strengthening of prevention in general health care. These developments are viewed as both hindering and conducive. They are seen as conducive, because these developments offer new chances for the interventions to be financed on the long run and for co-operation between different stakeholders. They are seen as hindering, because these developments are not crystallised yet. It is still unclear who is responsible for what and how the activities will be financed. Municipalities all develop their own policies. It depends on the priority given to prevention, how much money will be available for health promotion activities (for migrants).

- Information about the health of and health care for migrants. In the Netherlands, health and health care are monitored on the local/regional level. However, this information has to be specific enough with regard to migrants. If necessary, additional surveys should be conducted among migrants.

- A lack of cultural sensitivity and culture-specific information and instruments among the co-operating or referring organisations and professionals.

Conclusions concerning conditions on the institutional level

On the institutional level, the most important conditions were:

- Financial means. An important condition on the institutional level is the provision of adequate financial means. Local governments should translate their policies into sufficient financial means. To guarantee the further development and continuity of the activities, more structural and longer-term financial means are necessary. Furthermore, one provider would also like to have the financial means to develop expertise and new interventions whenever new problems arise among (migrant)

youths, instead of being dependent on what is developed by the public health service or national institutes. Not only the public health services, but also general health care should offer health promotion interventions. Health promotion interventions could be included in the basic (obligatory) health insurance package. However, the inclusion of health promotion activities in health care insurance could also be a hindering factor with regard to accessibility. Health insurance companies need exact information from the participants, also from those who just attend an information meeting. Because of the loss of anonymity, people might decide not to participate.

- Information. On the local level, information is needed concerning the health of and health care for migrants, as well as concerning all the organisations working on the same problem (a social map). Information on providers and interventions would make it easier to find partners. Furthermore, local and regional information on the health of migrants and health care for migrants is needed. This information makes it easier to actively approach risk groups, with adequate interventions.

- Interculturalisation. Last but not least, attention for interculturalisation and taking into account diversity is necessary in the whole field of health promotion and preventive health care. More insight and expertise is needed with regard to migrant groups. The needs of participants or clients should be the starting point. Health workers should account for the different attitudes to and perceptions of the health of and health care for people with a different background, such as people with a low socioeconomic status, non-Western migrants, and older generations.

6. Summary

Migrants belong to the most vulnerable and exposed social strata in society and require special consideration in public health strategies. The overall health status of migrants is remarkably poorer than that of the general population. This is related to the fact that migrants are more exposed to risks that have an impact on health, such as poverty, bad living conditions, restricted access to the labour market and health services, etcetera.
Additionally, a lack of information and, last but not least, communication problems create barriers for getting access to health promoting interventions. Thus, an equal accessibility and quality of the general health services are essential for enhancing the health level of migrants. This does not only apply to health care services, but also to prevention strategies and health promotion interventions.

Healthy Inclusion is an international project carried out within the Public Health Programme 2003-2008 and co-funded by the European Commission, DG Health and Consumers, and Public Health (EAHC). The general objective of the project is to contribute to the increase of the participation of migrants in health promotion interventions. The results contribute to the development of innovative concepts for the planning of health promotion interventions that touch the needs of migrants and will be compiled as recommendations for integrating socio-cultural standards in municipal health promotion interventions.

This national report describes the results of the literature analysis and the analysis of the interviews with 15 representatives of organisations providing health promotion interventions in the Netherlands.

The performed interviews focused thematically on the barriers for the inclusion of migrants in health promotion initiatives through the following guiding **research questions**:

1. Do migrants participate in health promotion activities?
2. What are hindering and conducive factors for participation of migrants in health promotion initiatives? What is the influence of images of health/disease on the use of health promotion initiatives?
3. Which strategies and solutions are used to improve access of migrants?

Provider/intervention level

Ten of the sixteen studied interventions are especially aimed at migrant groups. In three of the other six interventions migrants do participate. These three interventions are aimed at people with low socio-economic status. As many migrants belong to this category, these interventions succeed at including migrants. The interventions aimed at migrant groups do not differ very much in scope from the interventions that are meant for a 'general public'. The migrants that participate are ethnically very diverse and can be characterised as having a low socioeconomic status. A lot of them have been living in the Netherlands for quite a long time (30-40 years). There is a wide variety with regard to the level of integration or acculturation among and within these migrant groups. Their health status is generally less favourable than that of the general population.

Hindering and conducive factors for participation of migrants in the interventions are concerned with recruitment strategies (personal and outreaching) intervention methods (interventions for a 'general public' often are too 'theoretical' or too 'verbal'), the availability of materials and communication facilities in the migrants' own languages (leaflets etcetera, cultural translators or intermediaries, people in the intervention team that share the same ethnic/cultural background), the intervention setting (close to or familiar to the participants), and costs (no or low costs).
At the provider level the most decisive factors for the participation of migrants are professional and intercultural competences and an ethnically diverse group of health promoters. High professional standards are important in meeting the demands of the people the intervention is aimed at, and an open, flexible and respectful attitude, together with a training in inter-cultural competences to learn about (proven) strategies to recruit, counsel and support migrants.
At the migrant level the most decisive factors for participation are a poor socioeconomic status, different concepts of health, healthy living, being ill, and cure and care, a lack of self-efficacy and acculturation/integration in Dutch society.

The following good practices can be derived from the interviews with the providers:
The involvement of migrant('s) groups in all stages of the intervention; the adaptation of general interventions to health needs and questions of migrant groups; the intervention is

part of a chain of support or care; and the combination of health education and physical activities.

Organisational level

The policies of the organisations of the interviewed providers concentrate either on migrants (’interculturalisation policies’) or on people who live in deprived circumstances. Most of the providers consider the fact that their interventions reach migrants is proof of the positive impact of these policies.
Conducive factors are an (ethnically) diverse staff that is trained in intercultural competences; the organisation is part of relevant networks with other professionals, organisations, and migrant groups; interventions and policies are accompanied by (innovative) research; and the board initiates and supports policies for improving the participation of migrants.

According to the providers the following conditions on the organisational level are necessary to improve the accessibility for and use of health promotion interventions by migrants: good working relationships and networks with migrant organisations as well as with neighbourhoods or communities; availability of intermediaries, translators, and other intercultural experts in all parts of the organisation; and sharing knowledge of and experience with working with migrant groups within the organisation and with other professionals and organisations. Research also plays an important role in this.

Institutional level

The national government and local authorities, especially those of the municipalities with (large) migrant groups, pursue policies to improve the health of and health care for risk groups in general or migrants in particular, and policies to improve the participation of migrants. The interviewed providers consider these policies as being very supportive. Furthermore, national and local policies to improve disadvantaged districts support the community/neighbourhood approach of some of the interventions.

The most decisive factors were: the priority given in policies to the improvement of the health of migrants, health care for migrants, and the participation of migrants; the association and cooperation with partners in the neighbourhood or on the local level; a lack of structural financing and obscurity about future funds; information about the health of and health care for migrants; and lack of cultural sensitivity and culture-specific information and instruments among the cooperating or referring organisations and professionals.

On the institutional level the most important conditions were: the provision of adequate and long-term financial means by local governments to guarantee the further development and continuity of the activities; information on the local level concerning the health of and health care for migrants, as well as a social map; attention for interculturalisation and taking into account diversity in the whole field of health promotion and preventive health care. More insight and expertise is needed with regard migrant groups. The needs of participants and clients should account for the different attitudes to and perceptions of the health of and health care for people with a different background.

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Annex

Table 1 Overview of characteristics of the organisations and intervention(s)

Number	Type of organisation	Main financial resources	Groups/populations	Settings
1.	Public Health Service	Local government	Local authorities and professionals, people in the region Midden Gelderland	School, neighbourhood, community centre, etcetera.
2a/b	Public Health Service	Local government	People in Amsterdam, Aalsmeer, Amstelveen, Diemen, Ouder-Amstel and Uithoorn	School, neighbourhood, community centre, sports club, health care centre, etcetera.
3.	Health care centre	National government (Intervention: Healthcare Insurance Company, local government, participants)	People of Utrecht neighbourhood Overvecht	Health care centre, neighbourhood, community centre, sports accommodations, etcetera.
4.	Expertise centre for smoking prevention	-Public: national government -Private: three foundations*	Smokers	School, community centre (public health service), media
5.	Mental health care centre	National government	People with mental problems and their family	School, neighbourhood, health care centre
6.	Public Health Service	Local government (Intervention: sometimes Health Care Insurance Company)	Citizens of Utrecht	School, community centre, neighbourhood, etcetera.
7.	Academic Medical Research Centre	National government Intervention: ZonMw, health care centres and local government of Amsterdam South East, foundation GAZO	Patients	Neighbourhood, health care centre, schools, etcetera.
8.	Health care centre	National and local government	People in the city of Almere	Health care centre, home, community centre, school, etcetera.
9.	Organisation for (home) care	National and local government	Elderly people	Home, care centre, preventive health care centre for older people, community centre
10.	Organisation for Youth Care	National and local government	Children (and their families) with problems in the field of development, behaviour and family relations	Ambulant youth care centre
11.	Foundation for support of health care and social services within the city of The Hague	Local government	Citizens of disadvantaged neighbourhoods in The Hague and professionals	Neighbourhood, community centre, health care centre, etcetera.
12.	Mental health care organisation	National and local government	People with mental problems in the regions Rotterdam Rijnmond and Nieuwe Waterweg Noord.	School, mental health care centre, community centre, etcetera.
13.	Mental health care organisation, Centre for addiction prevention and care	National government (Intervention: local government)	People who have problems with drugs, alcohol and gambling (and their family)	Neighbourhood, health care centre, mosque
14.	Public Health Service	Local government	People in the region Ijssel-Vecht	School, neighbourhood, community centre, etcetera.
15.	Mental health care organisation, prevention department	National and local government	People in Rotterdam with psychological problems or questions about a healthy lifestyle	School, neighbourhood, community centre, etcetera.

Table 2. Interventions

Number	Type of Intervention	Target group	Form	Frequency	Number of participants	Approach	Setting of intervention
1.	Course for obese children	Children between 9 and 12 and their parents	Briefing meeting, courses, classes, teaching for teachers.	10 meetings in a course	?	OPUS model (project management model)	School, neighbourhood
2a.	Community-based subsidy for migrants' organisations to make HIV the subject of conversation	Migrants' organisations (in the end: people from the sub-Sahara, Africa, Suriname and Netherlands Antilles, age 16+)	Subsidy, providing support: counselling, giving training, helping in developing and evaluating the intervention.	?	?	Working with migrants' organisation as intermediary, bottom-up	Migrants' organisations
2b.	Intervention research about overweight and prevention	Turkish and Moroccan women with overweight, aged 25-45.	Problem inventory, developing the intervention, evaluation.	?	?	Bottom-up, migrants are actively involved in every phase of the intervention	Neighbourhood
3.	Exercise programme	People with health problems	Exercise groups	?	?	Promotion of healthy behaviour instead of the prevention of disease	Neighbourhood, heath care centre
4.	Campaign to help smokers quit smoking	Turkish smokers	Education, working with migrants' organisations to establish personal contact, sms campaign, briefing meetings	?	Sms campaign: 28000 people. 1746 people quit smoking for a day	Social network method	Neighbourhood, media
5.	Course about dealing with depression	Migrant women with symptoms of depression	Courses	2 or 3 courses a year	?	Psycho-education focused on empowerment	School, community centre
6.	Health education meetings in migrants' own language and culture	Migrant women	Meetings	A total of 400 meetings yearly	?	Briefing meetings in migrants' own language and culture	School, community centre, at the home of participants, accommodations of migrants' organisations
7.	Patient-focused culture specific education method for migrants with hypertension	Assistants, (in the end: patients with hypertension from Suriname, the Dutch Antilles and Ghana)	Courses, conversations with professionals, expert meetings, articles, congresses	Every day	?	Explanatory models (Kleinman)	Health care centre

8.	Acquaintance home visit for pregnant women by youth health care nurse	Migrant families (pregnant women and mothers of young children)	Home visits	One home visit	At least 30 participants have been visited	Outreaching method	At home
9.	Preventive health centre for the elderly	Elderly people 50+	Individual consultation (one hour yearly)		About 18 consultations every week		Preventive health centre, community centre
10.	Programme for obese children, psycho-education: dealing with being obese	Children 6-18 years with overweight and their parents	Information concerning nutrition and diet, training in physical action and cognitive therapy for children. Education, psycho-education and group meetings for parents	Programme takes one year with frequent meetings for both children and parents	?	Demand-driven, competence-driven, family focused, behaviour therapy method and system theory.	Youth care centre
11.	Migrant confidential counsellors	Migrants in disadvantaged neighbourhoods with psycho-social problems	Confidential counsellor: listening, mediation, guidance to social worker, advice, help, etcetera.	As required	2007: 80 clients 2008: 145 clients	Bottom-up and from within the community. Making use of what already exists	Neighbourhood
12.	Group course for youngsters with depressive symptoms	Youngsters (aged 13-17) with depressive symptoms	Group course (and briefing meeting for the parents)	8 meetings	10-12 young people within each group	Focus on the prevention of heavy mental problems	School
13.	Intercultural confidential counsellor	Moroccans	Briefing meetings and individual conversations	Twice a week	Briefing meetings in mosque: 150 men and also an unknown number of women. Group course: 20/30 people. Education: 2/3 persons	Outreaching, easily accessible, on different locations close to the focus group, good timing.	Neighbourhood, health care centre, mosque
14.	Briefing meetings (home party) and supermarket guided tour about healthy food	Mothers in two neighbourhoods of Zwolle	Briefing meetings and supermarket guided tour	There have been 8/9 group project in half a year and each group project consists of 3 meetings	8 to 10 women in a group	Using intermediary who hosts the home party/briefing meeting	School, neighbourhood, community centre, supermarket and at the home of a participant
15.	Training for migrant women who are inactive and (thus) run a higher risk of suffering from depression	Migrant women aged between 20 and 60, who have problems with becoming active	Briefing meetings combined with exercise activities	25 groups annually	8-10 women in one group	Combination of psycho-education with physical exercise	School, neighbourhood, community centre