A qualitative study on the perspectives of inhabitants and policy makers about the district health profile in the Netherlands

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Abstract *(274 words)*

Background: Socioeconomic inequalities in health are a growing problem worldwide. A district health profile can contribute to a better understanding of these inequalities on a local level and can be a starting point for connecting prevention and care in a district. The aim of this study was to explore the perspectives of the inhabitants and policy makers about the district health profile in the Stevenshof in the Netherlands and to compare their views.

Methods: A qualitative study design was used. Data on the perspectives of inhabitants (n = 10) and policy makers (n = 6) was collected through semi-structured interviews between April 2022 and May 2022. The data was analysed using thematic content analysis.

Results: Inhabitants and policy makers found the district health profile comprehensive because it provides a broad overview of the current health status of the district. Inhabitants and policy makers were satisfied with the social cohesion and involvement, and the physical activity options in the physical environment in the district. In general, they desired improvements for the physical and social environment. Inhabitants and policy makers consider the district health profile as an added benefit for district policy. Both groups agreed that they should collaborate with regard to district health policies and that the district health profile could be useful to strike up a conversation with an inhabitant.

Conclusion: The district health profile seems to be a promising tool for policy makers to get an integral overview of the health status in a local district and to involve inhabitants in decision making in health policies. Further research is required to examine how inhabitants with a migration background view the district health profile.

Keywords: Socioeconomic inequalities in health, Positive Health, district health profile, Public Health Services (in Dutch ‘GGD’), community-based approach

Introduction *(856 words)*

Socioeconomic inequalities in health are a global problem and one of the main challenges for public health nowadays (1, 2). Socioeconomic health inequalities are described as a discrepancy in health status or the distribution of health resources among different population groups, arising from the conditions in which people are born, live, grow, work, their age, or other demographic characteristics (3). These conditions influence chances of good health and all have an impact on mental and physical health and well-being (3, 4). For example, a lower socioeconomic status (SES) is associated with a higher prevalence of a cardiovascular disease (CVD), type 2 diabetes, and smoking-related cancers (4-8). These socioeconomic inequalities in health have significant consequences in social and economic costs, both to individuals and societies (9). Even in a rich country as the Netherlands, socioeconomic inequalities in health exist and are increasing (10-13). In the Netherlands, the difference in life expectancy, in perceived good health, among people with a low level of education is 19 years lower than people with a high level of education. The difference in healthy life expectancy between the lowest and highest income groups show the same pattern (10). Therefore, it is imperative to step up efforts to decrease socioeconomic inequalities in health in the Netherlands.

The causes of socioeconomic health inequalities are complex because of the interaction between multiple factors, such as employment, educational level, living environment, and social relations (6, 10). There is no one-size-fits-all approach for tackling health inequalities, and therefore the approach differs for all people (14-16). Several studies have shown that the approaches of 'Health in All Policies' (HiAP), a broader perspective on health, and a community-based approach, are promising approaches for reducing socioeconomic inequalities in health (10, 14, 16-18). HiAP is defined as the collaboration of policy sectors inside and outside the public health domain that systematically takes into account the health implications of decisions and harmful health consequences thereof, in order to improve public health and health equity (19). With the understanding that socioeconomic inequalities in health are influenced by various individual, socioeconomic, and environmental factors, HiAP is becoming more widely utilized in practice and well-known (16-18, 20, 21).

A broader perspective on health is needed, wherein healthcare is no longer just focused on the absence or presence of a disease, but also on environmental factors and on an individual's flexibility, self-management, participation, and quality of life (3, 22). In the Netherlands, this concept is known as 'Positive Health' (23). The concept is increasingly being used in healthcare practice in local communities and districts (24, 25). On a local level, Positive Health can be utilized to improve health equality in collaboration with inhabitants and policy makers (23, 25, 26); working with the individuals who are directly affected is a success factor for reducing socioeconomic inequalities in health (27). In many cases, policy makers are not in step with their constituents' needs, which highlights the importance of involving inhabitants in policy making (28, 29). The 'Well London program' is for example an experiment with a community-based approach in a district to improve health

inequality. One outcome is that involvement of the inhabitants contributes to creating support among individuals, and leads to measures that are more in line with their needs (27, 30).

To correspond to the inhabitants' needs on a local level, a community health profile and a City Health dashboard was developed in the United States (31-34). Both of them provide information about the health status and socioeconomic inequalities in health of a district or municipality (32, 35, 36). These profiles are recently established in the Netherlands. One of the Public Health Services (in Dutch 'GGD'), the GGD Hollands Midden, developed a district health profile for all the different districts and municipalities of the GGD Hollands Midden (37). These profiles offer a starting point for policy makers for connecting prevention and care in a district, reduction of socioeconomic inequalities in health, and stimulate collaboration between inhabitants and policy makers (24, 37).

To date, it is unknown how inhabitants and policy makers view the district health profile. Insights about the viewpoints of inhabitants and policy makers, collaboration, and communication between these two groups, will result in a greater knowledge of inhabitants needs. This information might lead to certain changes in the district and possibly increase inhabitants' contentment with the district's overall health. To our knowledge, this is the first study which aims to explore the perspectives of inhabitants and policy makers about the district health profile and compare their views. The data from the interviews were analyzed with four specific aims. First, we examined how the inhabitants and policy makers view the district health profile. Second, we assessed what inhabitants and policy makers think are important key aspects of the district health profile. Third, we investigated whether inhabitants and policy makers recognize the results from the profile. That is, do they think the same domains are doing well or could be improved upon as the profile indicates. Finally, we investigated how collaboration between these two groups could be improved and if the district health profile can be a useful tool to improve cooperation between the two groups.

Methods *(1576 words)*

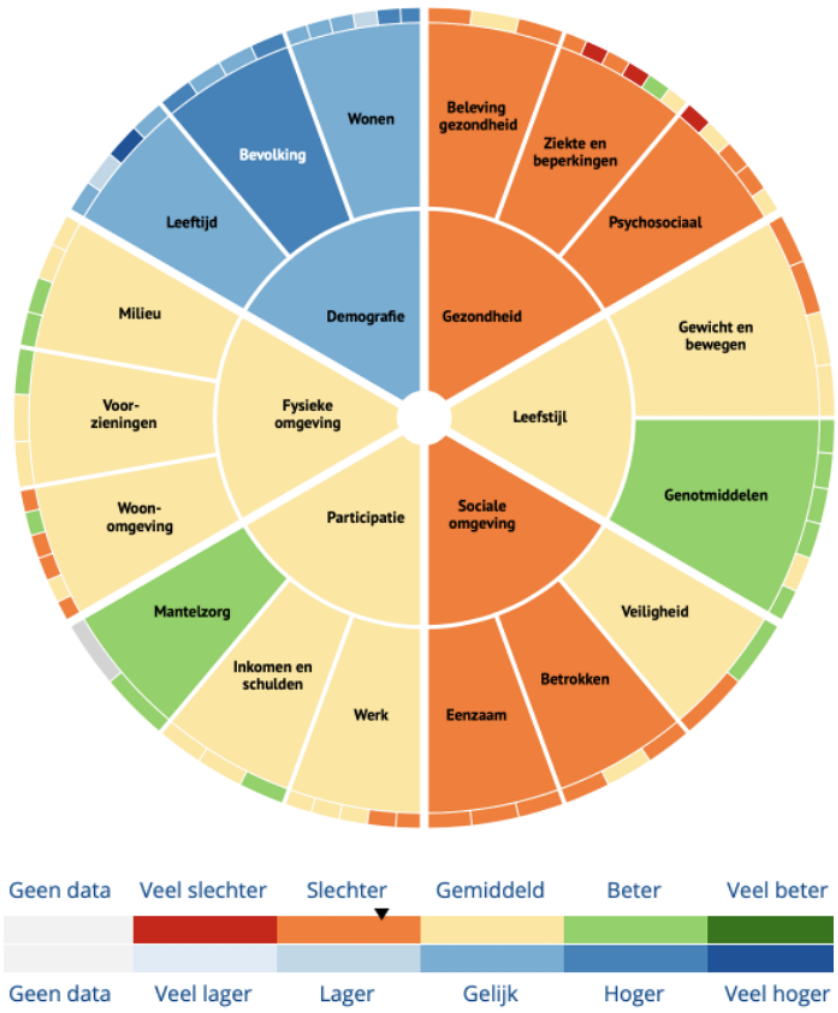
Study design

This study was conducted in a specific district for the GGD Hollands Midden, department of Health Promotion and Research, in the Netherlands. The district 'the Stevenshof' was chosen because the GGD Hollands Midden is organizing a session in this district later this year. This session is part of the district's ongoing project 'Stevenshof Vitaal' where professionals of the GGD and the Municipality of Leiden will talk about the district health profile during this session with the inhabitants of the specific district (38, 39). The results of this current study will be supportive in preparation for this session. For this study qualitative research was performed using an explorative approach. Semi-structured interviews were conducted because of the importance of gaining knowledge directly

from the two groups' perspectives on the district health profile (40). The Consolidated criteria for Reporting Qualitative research (COREQ) was used to check for completeness and transparency of the study (41).

District health profile

The area health profile is a visual tool which provides an overview of health in a municipality or district at a glance. The area health profile of a district is called the district health profile. The domains of this profile are based on the prevention toolkit of the National Institute for Health and Environment (RIVM) and Positive Health (figure 1) (37, 42, 43). The profile provides information (prevalences and report grades) about health and other health-related domains such as lifestyle, participation, social and physical environment, and demographics of inhabitants in a municipality or district. The scores in the profile originates from survey data, 'the Health Monitors', conducted by the GGD in cooperation with the RIVM and the Central Bureau of Statistics (CBS). The Health Monitors exist of the Health Monitor Adult and Elderly and the Health Monitor Youth which are large-scale four-yearly national surveys among people aged 18 years and over and secondary school students in grades 2 and 4, respectively. The surveys are focused on the social environment, lifestyle, and health of the Dutch population and are used to make health policy at the local, regional, and national level (44). Each domain in the district health profile is further divided into sub-domains which consist of several indicators. The domains, sub-domains, and indicators have a color from red to green (which indicate a score from much worse to much better) and from light blue to dark blue (which indicate a score from much lower to much higher) and which are compared to the regional average (the average of all the municipalities of the GGD Hollands Midden). Therefore, these profiles immediately provide information about the health status of a municipality or district. In addition, the profiles of different districts can be compared to gain insight about socioeconomic inequalities in health between districts. The profiles are available for the youth, adult, and elderly population, and for different years, which provide insight into health trends. For the adult and elderly population, profiles are at a municipality or district level and for the youth only on a municipality level. The district health profiles are intended for the GGD Hollands Midden and the municipalities. Health promoters of the GGD Hollands Midden uses the profile's scores to develop promotion programs and health advisors to advise the municipality. The GGD also uses the district health profiles as a supporting tool, in order to communicate with the municipality about the health of a district or municipality. The district health profile also gives policy makers access to data on the health of a district or municipality, which they can use to base their decisions (37).



Score per onderdeel

Gewicht en bewegen	Wijk	GGD HM
Gezond gewicht (%)	49	53
Obesitas (%)	16	13
Voldoet aan beweegnorm (%)	53	54
Wekelijks sporten (%)	55	57

Genotmiddelen	Wijk	GGD HM
Drinkt verantwoord (%)	47	40
Drinkt overmatig (%)	3	6
Zware drinker (%)	6	9
Rookt (%)	11	17
Gebruikt softdrugs (%)	7	8
Gebruikt harddrugs (%)	2,3	4,6

Figure 1: district health profile

Study population

The study population consisted of inhabitants who live in a district in Leiden, one of the municipalities of the GGD Hollands Midden in the Netherlands, and policy makers who worked for different departments of the local government in Leiden. Eligibility criteria were; 'inhabitants who live in a specific district in Leiden municipality, 'policy makers who work for the local government in Leiden', and 'participants [who] can speak and understand the Dutch language sufficiently'. Participants were not required to have prior knowledge of the district health profile. A purposive sampling was used to reach a wide variation of participants and provide deeper insight into the data.

Recruitment

The policy makers (n = 6) were recruited via the internal network of the local government. One of the policy makers asked his fellow policy makers from different departments by mail to take part in this study. For the inhabitants (n = 10), the community center in the district was used to invite inhabitants during coffee- and sport hours to participate in the study. The sport hours were held on a sports field in a park. Other inhabitants who were around the sports field were asked to take part in the study. An incentive was provided for the inhabitants.

Data collection

For data collection, semi-structured interviews were conducted at a convenient place for the inhabitants and policy makers. The policy makers were interviewed at their workplace and the inhabitants were interviewed at the community center or in their own home. The face-to-face interviews were conducted between April 2022 and May 2022. An interview guide with open questions was provided and developed by the author (appendix 1). The interview guide and topics used during the interviews were based on sensitizing concepts acquired via several sources: based on literature (43, 45), conversations with experts of the Public Health field, and for inspiration, the Positive Health framework (37, 43, 45). The interview guide included topics about 'perspectives on the district health profile', 'key aspects of the profile', 'positive experiences in the district', 'improvements in the district', and 'collaboration between inhabitants and policy makers'. The interview guide was first tested in a pilot with people in- and outside of the Public Health work field. Participants were not required to have prior knowledge of the district health profile. To inform them properly about the district health profile, prior to the interview, the participants were shown a two-minute informative film about the district health profile. A script was made by the researcher and the film was recorded by the researcher and two communication colleagues at the GGD film studio (appendix 6). Each interview started with questions about the socio-demographic characteristics of the study participant. Inhabitants were asked about their age, ethnicity, educational level, and employment. Policy makers were asked about their age, ethnicity, and which department they worker for. Ethnic background was established with reference to the country of birth, and the highest level of education completed was classified as either practical (lower educational level) or theoretical (higher educational level). The interviews were audio recorded and field notes were taken. The duration of each interview was approximately 30-60 minutes, with an average length of 46.09 minutes. During the interview a note taker was present and the interviews were transcribed verbatim (40).

Quality procedures

After each interview, short memos were written immediately regarding the overall impression and the atmosphere during the interview. For member check, a summary of the transcribed interview was sent to the participant. Specifically, the participants were asked whether they felt the report accurately reflected the conversations they had with the researcher (40). After each interview the interview guide was checked to see whether it needed

adjustments (40). The chance of personal bias was reduced by employing two other researchers to help analyze the first three interviews and discuss the themes that emerged from the analyses. Moreover, the inclusion of both inhabitants' and policy makers' perspectives ensured a more detailed and richer understanding and description of the topics which were considered in this study.

Data analysis

The computer-assisted qualitative data analysis software 'ATLAS.ti' was used to analyze the data (40, 46). Data was analyzed in a systematic way, using the thematic content analysis to determine the perspectives of the inhabitants and policy makers. The transcriptions and the audio were reviewed to create ownership. Therefore, research triangulation was applied in every phase of thematic content analysis (40). Data collection and data analyses were alternated, made it an iterative process (40). Interviews were open coded, by labelling fragments with descriptive codes. Firstly, four interviews were open coded to identify the initial categories of the perspectives of inhabitants and policy makers about the district health profile. Secondly, based on the open coding, axial coding was done by creating codes that reflect multiple fragments and codes were grouped together. A coding tree was provided from the obtained data (appendix 7). Finally, selective coding was done by constantly comparing codes and finding correlations between codes. The derived themes formed the base of the key elements of the results (40).

Consent and ethical considerations

This study was outside the scope of the Medical Ethics Review Committee (METC) because it did not concern medical scientific research about illness and health, nor did the content or methods cause an (in)direct risk for participants. However, the privacy protection of the participants was taken into account. The participants received an information letter and prior to the interviews the informed consent was signed by the participant (appendix 2-4). The information letter included information about the content of the interviews as well as the purpose of the study. Participation was voluntary and participants were free to quit at any time during the research. On top of that, the researcher signed a privacy statement (appendix 5). After each interview, the auditory data was transcribed and coded and deleted afterwards. All personal information that could be traced back to the participants was anonymized (46).

Results *(3981 words)*

Table 1 presents the characteristics of the inhabitants and policy makers who took part in the semi-structured interviews. Ten inhabitants and six policy makers were interviewed. The mean age of the inhabitants and policy makers was 54.8 years and 32.7 years, respectively. For both study groups, the majority of the participants were female. All participants, except for one inhabitant, were of Dutch ethnicity. For the inhabitants, the educational

level was quite equally distributed for practical education (60%) and theoretical education (40%). There was diversity in the departments the policy makers worked for.

Table 1. *Socio-demographic characteristics of the study participants* (total *n* = 16)

Inhabitants (total *n* = 10)	
Age in years, mean *(range)*	54.8 *(27-79)*
Gender, *n (%)*	
Female	7 *(70.0)*
Male	3 *(30.0)*
Ethnicity, *n (%)*	
Dutch	9 *(90.0)*
Moroccan	1 *(10.0)*
Educational level, *n (%)*	
Practical	6 (60.0)
Theoretical	4 (40.0)
Employment status, *n (%)*	
Employed	4 (40.0)
Unemployed	1 (10.0)
Retired	5 (50.0)
Policy makers (total *n* = 6)	
Age in years, mean *(range)*	32.7 *(28-47)*
Gender, *n (%)*	
Female	4 *(66.7)*
Male	2 *(33.3)*
Ethnicity, *n (%)*	
Dutch	6 *(100.0)*
Department, *n (%)*	
Sport	1 *(16.7)*
Youth	1 *(16.7)*
Welfare	2 *(33.3)*
Income and debt	2 *(33.3)*

Five main themes emerged out of the analyses of the interviews that captured the perspectives of the inhabitants and policy makers about the district health profile: 1) view of inhabitants and policy makers about the district health profile; 2) key aspects of the district health profile; 3) positive experiences in the district; 4) improvements in the district; and 5) collaboration between inhabitants and policy makers.

View of inhabitants and policy makers about the district health profile

In response to the question on how they view the district health profile, policy makers generally found the profile to be clear and well-organized. Policy makers stated that having an overview of the health status of the district population across several health related (sub)-domains was beneficial because they could immediately see what is

going well and what is not in the district. Furthermore, they indicated to be able to form links between the various domains and the district health profile provided them information on which improvements are required in the district. One policy maker shared his view of the profile:

> *Policy maker (6) – 'I find the profile well-organized and clear. It is nice because the profile gives information of all the various domains that influence health'.*

Policy makers stated that they are familiar with the different domains of the district health profile through their profession and hence understand them well, however this may not be the case for an inhabitant. Even though the policy makers understand the district health profile and find it to be beneficial, they generally indicated that they barely use it because they are also preoccupied with other tasks, and it simply takes a lot of time to thoroughly examine all the different domains of the district health profile. One policy maker shared her view of the profile:

> *Policy maker (12) – 'I am preoccupied with other tasks for the department I work for… I don't use the profile often. If you want to have a thorough understanding of all the domains, you need to take time to carefully examine each of the domains of the profile. And I don't have enough time to do that in a systematic way'.*

When asked what inhabitants thought of the district health profile, they needed time to comprehend all the different domains in the profile. They mentioned that they had no previous knowledge about the district health profile, and they found the profile comprehensive and detailed, so it took time to understand all the different domains of the profile. One inhabitant shared his opinion about the district health profile:

> *Inhabitant (8) - 'Very detailed profile. You need to take a close look at everything to understand what everything stands for. I had no previous knowledge about this profile, and therefore it won't come to life directly'.*

When looking at the district health profile for the district in which they live (inhabitants) or work (policy makers), all of the inhabitants and policy makers indicated that they knew how to determine whether a domain scored better (green) or much worse (red) compared to the regional average. The average score yellow, produced confusion among some inhabitants and policy makers because it is neither a better score nor a worse score, making it difficult to assess whether the domain should be improved in the district. Furthermore, many inhabitants and policy makers were skeptical about the demographics domain in the profile because it used a different color, blue instead of green and red, and a different scoring system, lower to higher instead of better or worse, than the other domains in the district health profile. Policy makers stated that the demographics domain, on the other hand

provides a clear image of the district's structure, and links across the different domains in the profile can be constructed. A policy maker explained that, if the district's population is, on average, older, you can explain why there are so many chronic diseases in the district. One policy maker expressed his thoughts on the clarity and comprehensibility of the profile:

> *Policy maker (7) – 'I don't believe it is immediately obvious. It is not that you can just look at it and figure out what it is. Furthermore, the color yellow, which stands for average, creates concerns. It's a little vague, but it's neither better nor worse. Then there's blue, which is an entirely different color and has its own score bar. That seems complicated'.*

Several ideas were given in response to the question of whether the district health profile was complete or whether anything was still missing. Several inhabitants indicated that several domains of the district health profile were broadly defined, which raised questions about what exactly belongs under the domain. Some inhabitants and policy makers told that by simplifying the different domains of the district health profile, it could be made more approachable, making it easier for a policy maker to start a conversation with an inhabitant. Policy makers stated that literacy level and dietary habits can be added to the profile in order to make the profile more integral. One policy maker explained how to define a domain of the district health profile more easily:

> *Policy maker (12) – 'The term 'participation' has a broad definition. It will raise concerns. The same as 'psychosocial', 'How do you feel' is a better name for it'.*

Key aspects of the district health profile

When policy makers were asked which important key aspects of the district health profile were most important to them, they explained that they focused mainly on the domains that influence health which they had experience with within their field of work. They told that they focused on these domains because they are knowledgeable with how to approach and improve them. They stated that it was beneficial that the profile provides an integral overview because different domains influence health. Moreover, policymakers found the integral overview of the profile good because they increasingly take a more integral approach when making policy. Two policy makers stated the following about the integral approach of the profile:

> *Policy maker (7) – 'This profile excites me because it gives a clear and integral overview of all the domains that affect health'.*

> *Policy maker (12) – 'I am working by the department 'debts and income'. I am now inclined to approach the rest of the profile from this domain and try to make connections between the other domains of health'.*

When asked what the important key aspects of the district health profile were, some inhabitants were more likely to focus on the domains that scored worse (red) compared to the regional average. Inhabitants stated that the worst score (red) caught their attention the most because it indicated that the domain is not working well and need improvement in the district. An inhabitant said:

> *Inhabitant (2) – 'When I look at the district health profile, I start by looking at the domains with the lowest scores. In my opinion, what is worse should be improved'.*

However, some inhabitants were more likely to concentrate on the domains, which are relevant in terms of their own experiences or what was going on with their family, friends, or in the street, rather than the entire district. They explained that they had no prior knowledge or experience with the different domains, so they focused on their local surroundings. An inhabitant explained his way of thinking when questioned about key aspects of the profile:

> *Inhabitant (14) – 'When I look at the profile…and you asked me what the important key aspects of the profile are… I have no knowledge about all these domains. I base my answer on my personal experience or what I see in my local surroundings'.*

Positive experiences in the district

When inhabitants were asked if the domains that scored better in the district health profile matched their own experience, they stated that it is dependent on where you reside, how you experience the district and whether you are positive or negative about the different domains of the profile. In general, the domains that scored well in the district health profile corresponded to the experiences of the inhabitants. However, with regard to the domain of the social environment in the district health profile, more specifically the social cohesion, it did not correspond. The profile indicates a score for social cohesion which is much worse compared to the average in the region, while according to the inhabitants' own experience they consider the social cohesion and involvement among inhabitants in the district positive. Several inhabitants mentioned that the community center provides many activities in the district. Because of these activities in the community center, they consider the social cohesion and involvement among inhabitants in the district as positive. Also, several inhabitants who had already retired, explained that the informal care in their district was beneficial for their health and that this also created a sense of connection among inhabitants in the district. In this study, informal care was seen as unpaid care provided to older and dependent persons by a person with whom they have a social connection, such as a child, friend, other relative, neighbor, or other non-kin. On the other hand, inhabitants who were still working claimed that they were less involved with informal care. Inhabitants explained that it depends on your age, because people in working

age are less likely to do this than the elderly. An inhabitant said the following about social cohesion and involvement among inhabitants in the district:

> *Inhabitant (3) – 'I get a sense of community in this district. However, it depends on where in the district you reside'.*

Similar to the inhabitants, the policy makers own experiences corresponded, in general, with the domains that scored well in the district health profile. However, this was not the case with regard to the domain of the social environment. Policy makers indicated that they believed that the district feels as a district where social cohesion and involvement among inhabitants is positive, which is not in line with the score of the social environment in the profile. Policy makers stated that nowadays, people have a more individual approach than in the past. According to one policy maker, there is more widespread, forced rivalry in society today, and as a result, people's trust in one another is decreasing. But in this district, this is less of an issue in their experience. Policy makers indicated that this is because inhabitants in this district have lived there for a long time, which foster a sense of community. Policy makers also mentioned that they recognized that the district has a variety of activities to offer, and they aim to come up with new ideas in co-creation with the inhabitants which might also foster a sense of community. One policy maker explained why he believes that the social involvement is positive in this district:

> *Policy maker (6) – 'The social involvement, in my opinion, is high. At least that is what I have been told by the locals. There are many inhabitants who have lived there all of their lives, which really give them a sense of belonging. For instance, I don't feel like a local inhabitant in my own district. However, I get the impression that the inhabitants in this district are more like real inhabitants of their district'.*

With regard to the physical activity indicators in the district health profile the scores correspond quite well to the inhabitants' own experience. The profile indicates scores which are relatively good (average) compared to the region, which is quite in line with the inhabitants' own experience. They indicated that they were positive about the variety of physical activities in the physical environment in their district. Some inhabitants spoke positive about the walking path that circles the district and found the options for physical activity in green surroundings positive. In addition, the inhabitants believe that the local government is making efforts to increase the options for physical activity in green spaces. An inhabitant described his experience about physical activity and the physical environment in the district:

> *Inhabitant (15) – 'There is now a path for walking around the district. This is employed widely. You are being physically active and at the same time in green surroundings. It seems like a good combination. I believe they gave that some good thought'.*

Policy makers agreed that the attention they are paying to physical activities in the physical environment is a positive development in the district. They also explained that they have good experience with some projects where the physical activity offer in the district was altered in co-creation with the inhabitants, because the inhabitants really felt that the local authorities have listened to their needs. However, some policy makers did note that many projects are just temporary due to financial constraints, which is unfortunate for the inhabitants. One policy maker said the following about co-creation:

> *Policy maker (5) – 'The project 'Stevenshof Vitaal' was in co-creation with inhabitants. I have the feeling we have listened to the inhabitants' needs. I think that is a great base to build on'.*

Improvements in the district

Also, when inhabitants were asked if the domains that scored worse in the district health profile matched their own experience, they stated that it is dependent on where you reside, how you experience the district and whether you are positive or negative about the different domains of the profile and what domain the policy maker was involved in during his or her work. In general, the domains that scored worse in the district health profile corresponded to the experiences of the inhabitants. With the regard to the domain of the physical environment the profile indicates a score which is worse compared to the average in the region. This corresponded to the inhabitants' experience because, in general, they desired improvements for the physical environment in the district. The majority of the inhabitants indicated that the district should be improved in terms of physical environment such as traffic safety, traffic flow, and parking. The district is commonly seen as congested because there are few access roads to the district and there are many cars and few parking spots. Inhabitants stated that it is difficult to deal with the parking issue because more parking places equal less greenery. Thereby, inhabitants had different opinions about the number of green spaces. Some inhabitants indicated that the district is fairly green, while other inhabitants stated that it is petrified in some spots in the district. One inhabitant shared her opinion about the number of green spaces in the district:

> *Inhabitant (1) – 'In this district, there are some green spaces and some that are be rather petrified. The amount of green in the district varies, in my opinion'.*

Also, with regard to the domain of the social environment inhabitants desired improvements. More specifically, inhabitants largely agreed that the general safety in the district was satisfactory. However, numerous inhabitants stated that young people caused a lot of annoyance and, as a result, gave them sometimes a sense of unsafety which corresponded to the indicator safety which scored worse in the district health profile. Many of the improvements that have recently been made in the district, according to inhabitants, have primarily benefited the

elderly, while young people have gotten less attention in this regard. Adjustments were, for example, improving the number of activities in the community center for the elderly. The policy makers also noted that young people needed more attention in the district. Some policy makers said that nuisance is a challenging problem because it belongs partly to the adolescent age. They stated that social workers can also assist in finding a solution because they are more knowledgeable about challenges faced by young people. An inhabitant said the following about nuisance and unsafety:

> *Inhabitant (13) – 'Nuisance is a persistent issue… that might make you feel unsafe. The adolescents deserve more attention'.*

With the regard to the indicators of loneliness the profile indicates scores which are average compared to the average in the region. Even though the scores are average they show that a large part of inhabitants are struggling with loneliness. This corresponded quite well to the inhabitants' experience because, in general, they desired improvements in loneliness. Policy makers indicated that activities in the district have a positive impact on loneliness and social cohesiveness among inhabitants. Despite the wide choice of activities available in the district, numerous inhabitants and policy makers questioned whether this would reach all inhabitants, particularly the lonely. Inhabitants and policy makers widely agreed that loneliness is often an invisible problem and desired improvements for the indicator loneliness. Inhabitants who are not lonely stated that they try to reach out to lonely persons in their district. Inhabitants who experienced loneliness claimed that they did not always want to interact with others or that the barrier was too high. It is also tough for policy makers to reach out to this population. They argue that the deployment of key figures, such as social workers from the community center, can be helpful. An inhabitant said the following about loneliness:

> *Inhabitant (9) – 'Loneliness is a common occurrence. Not just in this district, but all over the Netherlands. However, you don't always see loneliness, which makes it a challenging and important issue'.*

With regard to the domain health in the district health profile the scores correspond quite well to the inhabitants' own experience. The profile indicates several scores which are worse compared to the region, which is quite in line with the inhabitants' own experience. Many inhabitants indicated that the domain health merits attention and that efforts should be made to improve health. Some inhabitants also deal with a chronic disease or know others who have a chronic disease. They also suggested that the district's access to healthy food could be enhanced. Similar to the inhabitants, the policy makers own experiences corresponded with the domain health. Policy makers are aware that this district has a high prevalence of chronic diseases, especially cardiovascular disease. As one policymaker said:

Policy maker (11) – 'The Leiden University Medical Centrum informed us that this district has a high prevalence of cardiovascular diseases. This was a reason for addressing 'health'. However, the environment has a significant impact on this…The food supply, for instance, may be better in this district'.

Collaboration between inhabitants and policy makers

When discussing the collaboration between inhabitants and policy makers, some inhabitants stated that they wanted to provide input into policy making in the district because they know the best about what is going on in the district. There are, however, some inhabitants who do not want to give input because they have had negative experiences with providing input into policy making or that they just do not have the time or need to do so. All inhabitants agreed that inhabitants must be involved in district policies and that the district health profile can be a useful tool to start a conversation with inhabitants in a district. One inhabitant shared her negative experience about involvement:

Inhabitant (13) – 'It is important for policy makers to collaborate with an inhabitant. But it isn't necessary for me. Because you may receive involvement from the municipality from time to time. That happened to us as well recently…we were asked to give our opinion about the parking problem, what we did. Then you don't hear anything further about it. The implementation, on the other hand, turns out to be rather different'.

Likewise, all policy makers stated that it is important that policy makers and inhabitants work together in a district because inhabitants know best what is happening in the district and the policy made is intended for the inhabitants. All policy makers stated that the district health profile can be useful to strike up a conversation with an inhabitant. They recognized that the district health profile provides an overview of the population's health at a glance and that it is therefore simple to ask inhabitants whether they identify with these scores. Policy makers mentioned that it is difficult to make first contact with an inhabitant and start a conversation. Especially, it is difficult to reach the people who experience a certain problem and to find the time to do this in a systematic way. They explained that they want to talk to persons who experiencing problems, otherwise it quickly becomes talking about someone else's problems. Some policy makers explained that key figures, such as social workers from the community center, may be used more in this regard because they know better what is going on in the district and how to reach the right people. A policy maker said the following about reaching the right people:

Policy maker (16) – '… I believe you should be aware of which inhabitant you ask about specific topics. I would like to speak. But suppose… you are talking about loneliness. I'm not lonely. So, do you need to

speak with me about this topic? No, I don't believe so. Then I sit down and talk about the problems of others.

All the inhabitants indicated that it is important that they feel heard. The municipality can accomplish this by informing inhabitants why certain choices have been made. This enables inhabitants to keep track of the municipality's plans and implementations in their district. Also, they want to be informed if, for example, a plan is not carried out and why. As one inhabitant said:

Inhabitant (4) – 'The municipality should evaluate it properly afterwards. That they inform you what has been decided and why. Even if it isn't successful. I think it gives more confidence and collaboration'.

Policy makers said that they are aware that inhabitants want to be informed about plans. They do, however, run into the problem of determining whether or not to involve an inhabitant in the policy making. They have also noticed that inhabitants' expectations are not always realistic. Policy makers claimed that they must always consider if a policy is feasible and that they must adhere to several norms and laws. They believed that inhabitants are not always aware of this, and that as a result, expectations can differ greatly. Two policy makers said the following about collaboration with inhabitants:

Policy maker (11) – 'Yes…I believe we need to build in a lot more input from the inhabitants and make it clear from the beginning what degree of participation we desire. So, are you asking for their opinion, or is it more informative…or the other approaches, such as consultation and advising'.

Policy maker (16) – 'An inhabitant is not always aware of the numerous rules that must be followed, and yes, there are costs involved'.

Various inhabitants and policy makers have stated that mutual understanding is required. So that an inhabitant understands that not everything within the municipality is achievable, and that the inhabitant wants an honest answer and the opportunity to be heard. As a policy maker stated:

Policy maker (5) – 'I believe there will be mutual respect if every inhabitant feels that their knowledge, opinion, or voice is important to the municipality and if there is mutual understanding of the other's stance in a conversation. As a policy maker, I can understand where the person and an idea come from, but the inhabitant should understand that an idea is not always possible to realize. So that inhabitants do not assume that the municipality never listens to them…And inhabitants should keep in mind that districts improvements can take a while to accomplish'.

Discussion *(2502 words)*

In this study, we explored the perspectives of inhabitants and policy makers about the district health profile and compared their views. Inhabitants and policy makers consider the district health profile as an added benefit for district policy. Inhabitants and policy makers found the district health profile comprehensive because it provides a broad overview of the current health status of the district. They knew how to determine whether a domain scored better than the region. Inhabitants found the district health profile detailed and therefore it took time to understand all the different domains. Policy makers, on the other hand, found the district health profile well organized because they were familiar with the different domains through their profession. Key aspects of the district health profile, were, according to most inhabitants, mainly based on their own personal experiences or the experiences of family members or neighbors with certain domains, and not based on the aspects that were most important for the entire district. Other inhabitants focused more on the domains that scored worse on the profile. Policy makers found the most important aspect of the district health profile the integral overview of the profile. With regard to which domains are going well, inhabitants and policy makers were satisfied with the social cohesion and involvement in the district, and the physical activity options in the physical environment. In general, inhabitants and policy makers desired improvements for the physical and social environment in the district. Inhabitants and policy makers both agreed that they should collaborate with regard to district health policies and they highlighted that it is important for both sides to be aware of their expectations for optimum collaborations. Both groups stated that the district health profile could be useful for policy makers to strike up a conversation with an inhabitant and thus improve the collaboration between the two groups. However, policy makers found it difficult to reach the right target group in the district.

Interpretation of results

Our study showed that policy makers and inhabitants consider the district health profile as an added benefit for district policy. The district health profile is based on quantitative data and this current study provided a deeper understanding of the perspectives of the inhabitants and policy makers about the district health profile. Other studies reported that, in addition to quantitative data, qualitative data is needed to better understand the experiences and beliefs of individuals in order to be able to better connect and reflect to the perspectives of an individual (47-50). Our study showed that, in general, the scores of the district health profile corresponded to the experiences of the inhabitants and policy makers but that this was not always the case. Inhabitants generally view the profile in context of their own experiences, which can differ from the scores of the district health profile. This difference may be explained by the fact that most of the inhabitants who participated in the interviews, were already engaged in district activities. They often had more positive experiences with the different domains of the profile than the scores in the profile suggest. The results might not have been different if the inhabitants who are having problems had been interviewed. These results underline how crucial it is to interact with different

inhabitants in order to comprehend their perspectives. By engaging with different inhabitants, the district health profile can therefore assist policy makers in interpreting the quantitative data of the profile and to meet the inhabitants' needs. Our study showed that some improvements should be made to make the district health profile more approachable for inhabitants and policy makers. The different domains in the district health profile appeared to be presented in a manner too difficult to understand mainly for the inhabitants with a practical educational level and might benefit from text simplification. This finding is in line with another study where the perspectives of inhabitants were investigated on a comparable model based on the domains of Positive Health in which were recommended to simplifying textual elements (51). Another study on the Positive Health model of health perceptions of people with low SES has found that it is crucial that the content has a connection to the users' lives (26). Despite the fact that policy makers found the district health profile to be beneficial because it provides an integral overview of the health status in a local district, they hardly ever utilize it because they are preoccupied with other tasks, and it also take time for them to thoroughly comprehend each of the profile's domains. This can be explained by the low priority given to health prevention in terms of policy (52, 53). A suggestion would be that public health experts from the GGD Hollands Midden educate policy makers on the need of prevention in public health.

In our study, inhabitants responded to questions about 'view of the profile' and 'important key factors of the profile' primarily based on their own personal health related experiences and similarly, policy makers focused mainly on the domains that influence health which they had experience with within their field of work. This finding is consistent with some other studies that examined how professionals and patients processes information, namely that people's perceptions to health are greatly influenced by their general knowledge and beliefs (54-56). When new information does not fit existing knowledge and beliefs, as was the case for some of the inhabitants, it is likely that new information does not have much value for people (57). Another study showed that the approaches in policy making differs for policy makers and inhabitants. Policy makers are more inclined to have an objective approach, while inhabitants have a more subjective approach (48, 58, 59).

Our results showed that the inhabitants were able to identify, based on the district health profile, what was going well and what should be improved in the district. In accordance with other studies, we found that how people experience the district and whether you are positive or negative about the different domains of the profile depends on where people live in the district (60-62). Some inhabitants based their answers on their own experiences or the experiences of their local surroundings. Nevertheless, many inhabitants were also able to indicate what should be improved and what was going well based on the colors of the district health profile. When inhabitants were asked if the district health profile was complete, inhabitants were unable to provide suggestions for changes because they lacked professional knowledge of the domains of the district health profile. When policy makers engage with inhabitants, they should be aware that an inhabitant has no professional knowledge of the

district health profile and that an inhabitant's place of residence in the district matters since it influences his or her experiences of the overall health of the district.

Our results underscored the importance of good collaboration between inhabitants and policy makers to create mutual understanding of the best ways of collaboration in a district towards shared decision making in health policies, which is in line with the literature (63). Thereby, as inhabitants become more engaged and empowered to shape their local services, their own health and wellbeing, and community health would also improve (64). Our findings showed that inhabitants not always want to provide input into policy making because of limited time, or if their involvement was not followed up on. The literature adds the factor stress during collaboration as a reason why inhabitants do not provide input into policy making (63). Another study reported that a linguistic barrier was an obstacle for engagement in district policy (65, 66). Our study also showed that some inhabitants had unpleasant experiences with providing input into policy making. The inhabitants were asked to provide input into policy making, they received no feedback or information, and the implementation ended up being completely different. According to the literature, policy makers frequently request input from citizens and do nothing with the provided input (67). It is crucial that policy makers are aware of this and hence only requests input from inhabitants if they intend to act on it. Otherwise, the threat of tokenism exists, which decreases public trust in policy making (49, 67). Literature showed that citizen participation is defined differently among individuals, healthcare professionals, and policy makers (68). Our results showed that policy makers suggested that it is important to decide which form of citizen participation you apply and clearly communicate this to inhabitants from the beginning. A previous study showed that inhabitants want to be informed about the degree of participation from the beginning and will be more motivated as a result (69). Our results showed that the district health profile can be useful to strike up a conversation with an inhabitant and thereby play a role in the collaboration between policy makers and inhabitants. The district health profile can be utilized as a conversation tool to investigate how inhabitants view the overall health of the district. Other findings of our study suggested that policy makers are aware that they need to talk to those who are experiencing the problems themselves and explore what they need but that they found it difficult to reach them. This is consistent with the literature, which asserts that socioeconomic inequalities in health will only get worse if the people who experience the problem are not reached (70-74). Another study described the importance of engaging individuals on problems with which individuals had personal experience. Asking individuals to engage with ideas that are abstract from their personal experiences places a burden on individuals to learn about the problems they were engaging about, which might also diminish the importance of their values, preferences, and lived experience if they are unable to relate them to the problem (66). According to our results and other studies, prominent key figures in the district, such as social workers from the community center, can be utilized to reach the people who experiencing certain problems (64, 75, 76). In addition, a study reported that in order to better reflect and connect with the district population a demographically and culturally

diverse staff on a local level is needed and thereby tailor strategies to inhabitants' needs and preferences, for example the language and that sessions will be held at the times that the inhabitants desire (64, 66, 72).

Strengths and limitations of the study

The results of this study should be considered in the context of its strengths and limitations. One notable strength is that this study, to our knowledge, is one of the first studies that investigated the perspectives of inhabitants and policy makers about the district health profile. Furthermore, the inclusion of both inhabitants and policy makers as participants in this study, we ensured the extant understanding of how both inhabitants and policy makers view the district health profile and were therefore able to validate the quantitative data from the district health profile. Another strength was that the interviews were one-on-one interviews, so we were able to go in depth into the experiences of both study groups and ensured we got thorough information of all participants. Another strength of this study was, that the chance of personal bias was reduced because two other researchers assisted by independently analyzing the first three interviews and discussing the themes that emerged from the analyses.

Because of the limited number of study participants and that the study was limited to a single district, these findings cannot be applied to other districts or municipalities. Besides, there was an underrepresentation of participants of other ethnicities. People with other ethnicities have a higher likelihood of experiencing negative health effects. The experiences of the persons who experiencing health related problems are needed to have a better understanding of their needs. We were unable to reach this group for this study, therefore we are unaware of their needs. The reason for this underrepresentation was that recruiting during coffee- and sport hours was time-consuming. All people refused to participate in the interview the first two times. When the word 'municipality' or 'local government' was used, all people left, and it took a long time to regain confidence by inhabitants, necessitating the creation of extra material, such as an information film. For various groups, such as people with a migration background, meetings were held at another location in the district. Because of a linguistic barrier, establishing confidence was even more important in this group, however it was too time consuming with this limited time of research. On the other hand, there was a wide variation of educational background, which is one of the factors that can be essential when it comes to socioeconomic inequalities in health. Consequently, because of our conversations with those with a practical education level, we have now a better understanding of their needs.

Recommendations for policy, practice, and research

We identified some key elements that can be used in order to increase collaboration between inhabitants and policy makers and to make the district health profile more understandable for all inhabitants, including inhabitants with practical education. First of all, the results of our study showed that it is important to define the different domains of health in the profile more easily to engage different inhabitants. Our results and literature also showed

that prominent figures can be utilized to reach the people who experiencing certain problems and to strike up a conversation with different inhabitants in the district (64, 75). Furthermore, policy makers should consider which form of citizen participation, such as informing, advising or co-decide e.g., they aim for and communicate this to the inhabitants from the beginning. Collaboration with inhabitants from the beginning of a project will increase the sense of owner- and partnership among inhabitants (29, 69). It is recommended to investigate the use and usability of the district health profile in other districts and municipalities, and, if necessary, adjust the district health profile accordingly. Moreover, it is advisable to develop a tool for policy makers for entering into a dialogue with inhabitants based on the district health profile and a tool for policy makers to communicate with one another about the profiles, which is necessary for an integrated health policy in the district. Finally, it is recommended to assess whether the scores of the different domains of the district health profile have improved or not based on the results of the health monitor questionnaires that are completed every four years.

Conclusion

This study has showed that the district health profile appears to be a promising tool for policy makers to get an integral overview of the health status in a local district and to involve inhabitants in decision making in health policies. Further research is required to examine how inhabitants with a migration background view the district health profile.

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Notes on contributors

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Appendix 1: Interview guide

Interview guide

Opening:

- Welkom, en heel erg bedankt dat u wilt meedoen aan het interview.
- Korte introductie van mij zelf.
- Het interview wat ik zo bij u af ga nemen, zal opgenomen worden en de gegevens zullen anoniem worden verwerkt. Daarnaast wordt er een geluidsopname gemaakt, zodat ik het interview goed kan verwerken. De opname wordt daarna verwijderd.
- In het interview ben ik nieuwsgierig naar hoe u als inwoner van deze wijk of als beleidsmaker de gezondheid van de Stevenshof ziet. We zullen samen het profiel en de gezondheid van de wijk bekijken. En ik zal hierover vragen stellen aan u (informatiefilm over het gebiedsprofiel laten zien).
- Het interview zal 30 tot 60 minuten duren.

Start opname

Algemene gegevens noteren:

- Inwoner (leeftijd, geslacht, etniciteit, opleidingsniveau (theoretisch/praktisch geschoold))
- Beleidsmaker (leeftijd, geslacht, afdeling binnen de gemeente)

Open vragen:

- Wat valt je op aan het gezondheidsprofiel van de wijk? Kan je eens twee of meer punten opnoemen die eruit springen voor jou als je dit profiel zo ziet?
    - Waarom springen deze punten eruit voor jou? Hoe denk je dat het komt dat deze punten eruit springen?
    - Ervaar je dit zelf ook zo in de wijk? En waarom ervaar je dat zo?
    - Is het profiel herkenbaar voor u? En waarom is dit profiel wel of niet herkenbaar voor u?
- Wat vind je al goed gaan in de wijk? Waarom vind je dit al goed gaan in de wijk?
    - Vind je dat deze punten de laatste tijd verbeterd zijn of juist verslechterd? En waarom denk je dit?
- Wat vind je minder goed gaan in de wijk? Waarom vind je dit minder goed gaan in de wijk?
    - Vind je dat deze punten de laatste tijd verslechterd of juist verbeterd zijn?
- Welke domeinen of sub-domeinen zou je willen verbeteren? Waarom zou je deze willen verbeteren?
- Zou je betrokken willen zijn in de wijk bij het beleid? Waarom zou je wel of niet betrokken willen zijn?
    - Vind je het belangrijk dat inwoners betrokken worden in de wijk? Waarom vind je het wel of niet belangrijk dat inwoners betrokken worden bij het beleid in de wijk?

- Heeft u ervaringen dat er dingen bedacht werden voor de wijk waar inwoners eigenlijk niks aan hadden? Of ervaringen waar inwoners juist wel wat aan hadden? En waarom had u er wel of niet wat aan?

- Hoe denkt u dat we de samenwerking tussen deze twee groepen kunnen verbeteren in de wijk?
  - Hoe zou deze samenwerking eruit moeten zien volgens u? En waarom denkt u dat de samenwerking er zo uit zou moeten zien?
  - Wanneer zou u tevreden zijn over de samenwerking?
  - Wat zou er wel werken en wat niet? En waarom?
- Denkt u dat de beleidsmaker en inwoner dezelfde antwoorden zullen geven op bovenstaande vragen? Waarom denk je dat wel of niet? Wat zullen de verschillen zijn? En wat zullen de overeenkomsten zijn? En waarom denkt u dit?

Topic list

Topic	**Sub-topic**	**Sub-sub-topic**	**Sub-sub-subtopic**
General	Function/department		
View of the profile	Notice		
	Recognizable		
	Remarkable		
Key aspects and improvement	Social environment	Safety	Neighborhood safety Victim of domestic violence
		Loneliness	Emotional/ Social/ serious loneliness
		Involved	Volunteer work Inhabitants Social cohesion in the neighborhood
	Lifestyle	Stimulants	Drugs Smoking Alcohol
		Weight and movement	Healthy weight Obese Meets exercise standard Weekly sports
	Health	Experience health	Vital Good perceived health Control over own life
		Illness and limitations	Chronic diseases Hindered by health

			Functional limitations Use of primary care GPs
		Psychosocial	High risk of anxiety disorder or depression Experiences a lot of stress Suicidal thoughts Phycological problems Use of basic GGZ/POH
	Demographic	Living	Average house value Household composition Buy/rental houses
		Age	15-25-year 25-45-year 45-65-year 65+
		Population	Population (density) (non) western migration background
	Physical environment	Milieu	Insufficient cooling in the house, garden, or neighborhood Serious sleep disturbance Serious noise pollution Risk due to moisture/mold
		Services	Services Distance to large supermarket / general practitioner
		Living environment	Physical environment Houses Plenty of greenery nearby Satisfaction with greenery nearby/ house/ living environment
	Participation	Informal care	Informal care giver Burdened by giving informal care
		Employment	Benefits (AOW e.g.) Self-employed Paid work
		Income and debt	Great difficulty getting by Risky or problematic debt
Collaboration			

References: (24, 37, 43, 45).

Appendix 2: Information letter for the inhabitants

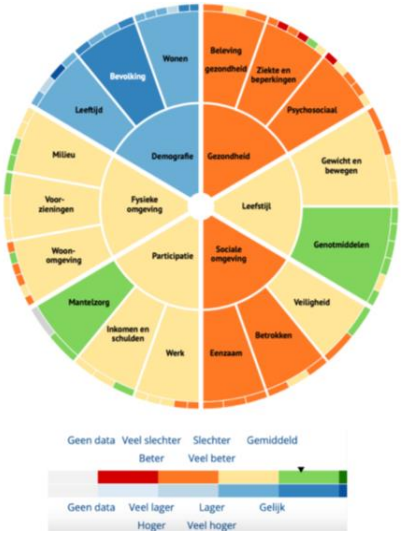
Information letter

Leiden, 28/03/2022

Beste bewoner van de Stevenshof,

Ik ben Linda van der Marel en doe voor mijn studie gezondheidswetenschappen onderzoek bij de GGD Hollands Midden. Ik ga uitzoeken hoe u als bewoners van de Stevenshof uw gezondheid ervaart en wat volgens u moet gebeuren om de gezondheid en het welzijn van uw wijk te verbeteren.
Daar heb ik uw hulp en mening voor nodig! Ik nodig u dan ook van harte uit om deel te nemen aan een van mijn interviews. Ik heb ongeveer 10 inwoners nodig en elke deelnemer ontvangt voor de moeite een bedankje.

Mijn onderzoek naar de wijkgezondheid.
De GGD doet elke vier jaar via vragenlijsten onderzoek naar de gezondheid van inwoners en geeft de resultaten hiervan per gemeente en per wijk weer in een zogenaamd profiel met 'taartpunten' (zie afbeelding en resultaten in *https://eengezonderhollandsmidden.nl/ghm-profieltaart.aspx*.) Zoals u ziet wordt hoe gezond je je voelt, beïnvloed door verschillende dingen: je fysieke gezondheid, je leefgewoonten/leefstijl, de kwaliteit van je sociale omgeving, de mate van meedoen in de maatschappij en hoe je omgeving eruitziet: voldoende groen, mate van geluid etc.
Dit profiel geeft dus inzicht in de ervaren gezondheid van de inwoners. Het helpt de gemeente, de zorgorganisaties in de wijk maar ook de inwoners om het aanbod en de leefomgeving aan te passen in de wijk. Door samen de juiste keuzes te maken wordt de Stevenshof wellicht een van de meest gezonde wijken van Leiden.



In gesprek met u
Voor mijn onderzoek ben ik nieuwsgierig naar hoe u als inwoner van deze wijk de gezondheid van de Stevenshof ervaart. We bekijken samen het profiel en de gezondheid van de wijk. En vraag ik u bijvoorbeeld: herkent u de (in de 'taartpunten') geconstateerde gezondheidsuitkomsten in de wijk? Wat valt u op? Wat vindt u belangrijk? Wat zou **u** veranderend willen zien? Welk aanbod mist **u**?

Wanneer
De interviews wil ik afnemen in april en mei 2022. Dit kan zowel overdag als in de avond, wat u het beste uitkomt! Daarnaast kan dit online of live.

Resultaten onderzoek
Wat wordt er gedaan met de uitkomst? Met uw ideeën krijgt de gemeente een idee wat er beter kan in uw wijk en kan hierover in gesprek gaan met u.

Privacy

Het onderzoek is vertrouwelijk en de gegevens worden anoniem verwerkt. Daarnaast wordt een geluidsopname gemaakt (mits u hiermee akkoord bent), zodat ik het interview zo betrouwbaar mogelijk kan verwerken. De opname wordt na afloop verwijderd.

Indien u vragen heeft kunt u die uiteraard stellen!

Wilt u meedoen? Heel fijn!
Vul dan bijgaande aanmelding in en stuur mij die terug voor 29 april.
Wanneer u niet wilt deelnemen, hoor ik dit ook graag van u via mijn mail.

Alvast bedankt voor uw medewerking.

Met vriendelijke groet,

Linda van der Marel

Mail: x
Telefoon: x

Mail: x
Telefoon: x
X is mijn stagebegeleider bij GGD Hollands Midden en werkt ook mee aan het project Wijzer in de Wijk
https://www.awpgnzh.nl/wijzerindewijk/

Appendix 3: Information letter for the policy makers

Informatiebrief

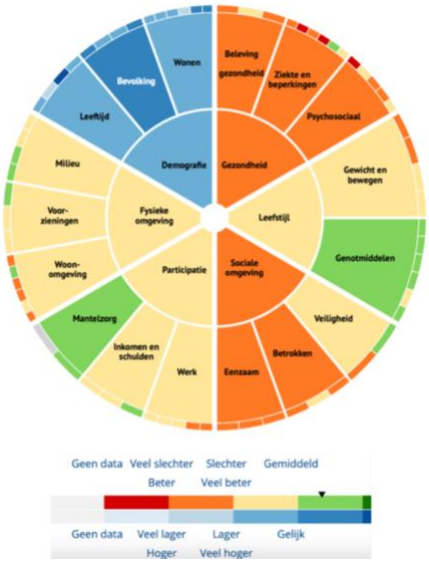
Leiden, 23/03/2022

Geachte mevrouw/meneer,

Ik ben Linda van der Marel, master student Public Health & Prevention aan de Vrije Universiteit van Amsterdam. Op dit moment studeer ik af bij de GGD Hollands Midden. Middels deze brief wil ik u informeren over mijn afstudeeronderwerp en uitnodigen om deel te nemen aan één van de interviews.

Ik schrijf mijn scriptie over het volgende onderwerp: 'hoe kunnen gebiedsprofielen bijdragen aan integraal beleid van de gemeente aan de hand van de perspectieven en ervaringen van beleidsmakers van de gemeente Leiden en inwoners van de Stevenshof. Aan de hand van 1 op 1 interviews wil ik ervaringen ophalen van inwoners en beleidsmakers. Mogelijk bent u nog onbekend met de gebiedsprofielen en het idee achter mijn onderzoek. Ik zal in het kort toelichten wat de aanleiding van mijn onderzoek is.

Tegenwoordig is gezondheid niet meer alleen de aan- of afwezigheid van ziekte, maar wordt er ook gekeken naar; lichaamsfuncties, dagelijks functioneren, meedoen, kwaliteit van leven, zingeving en mentaal welbevinden. Deze nieuwe definitie wordt ook wel 'positieve gezondheid' genoemd. Dit nieuwe beeld op gezondheid is in het gezondheidsbeleid terug te zien. Er wordt steeds meer aandacht besteed aan een integraal gezondheidsbeleid, oftewel gezondheid zie je in verschillende domeinen terug. Het kan bijvoorbeeld zijn dat een inwoner zich niet gezond voelt omdat hij of zij zich eenzaam voelt of bijvoorbeeld geldzorgen heeft. Aan de hand het model van positieve gezondheid heeft de GGD Hollands Midden gebiedsprofielen opgesteld van alle wijken en gemeenten van de regio Hollands Midden *(zie afbeelding en link: https://eengezonderhollandsmidden.nl/ghm-profieltaart.aspx)*. Deze profielen geven een overzicht van de gezondheid van de inwoners en kan de beleidsmaker helpen om beleid te bepalen. Daarnaast wordt er ook steeds meer een wijkgerichte aanpak gehanteerd. Het bekendste voorbeeld in de gemeente Leiden is 'Stevenshof Vitaal' *(https://stevenshofvitaal.nl)*. Ik ben nieuwsgierig naar de ideeën en gedachten over hoe een beleidsmaker en een inwoner over(de waarde van) dit profiel denken. Het interview heeft de volgende doelen; 'wat valt inwoners en beleidsmakers op aan het profiel', 'wat vinden inwoners en beleidsmakers belangrijke punten uit het profiel' en 'Op welke onderwerp zou de inwoner of beleidsmaker inzetten'.



Voor dit interview ben ik op zoek naar inwoners en naar beleidsmakers werkzaam bij de gemeente Leiden. Ik ben op zoek naar verschillende beleidsmakers (sport (maatschappelijke) zorg, wonen, leefomgeving, financiën, werk etc.). Het zou fijn zijn als jullie mij willen helpen. Als ik klaar ben met het onderzoek en u bent geïnteresseerd in de resultaten dan deel ik deze graag.

Wat wordt er gedaan met de uitkomst? Het onderzoek is volledig vertrouwelijk en de gegevens zullen anoniem worden verwerkt. Ik zal alleen de antwoorden op vragen, met daarbij ook de algemene gegevens, opnemen in ons onderzoek. Daarnaast zal er ook gebruik gemaakt worden van een voice-recorder (mits u hiermee akkoord bent), zodat ik het interview en de verwerking daarvan zo betrouwbaar mogelijk kunnen later verlopen.

Indien u vragen heeft aan mij kunt u die altijd stellen! Ik zal onderaan deze brief mijn e-mailadres en telefoonnummer vermelden.

Indien u beslist om mee te doen, vraag ik u om de toestemmingsverklaring in te vullen en terug te sturen naar mij of in te vullen voorafgaand aan het interview. Indien u niet meedoet dan verneem ik dit ook graag van u.

Alvast bedankt voor uw medewerking.

Met vriendelijke groet,

Linda van der Marel

Mail: x
Telefoon: x

Appendix 4: Consent form

TOESTEMMINSVERKLARING

Titel onderzoek: onderzoek naar de perspectieven van bewoners en beleidsmakers over het wijkgezondheidsprofiel van een wijk.

In te vullen door de deelnemer

Ik heb de informatiebrief gelezen en ik verklaar op een voor mij duidelijke wijze te zijn geïnformeerd over het onderzoek. Ik weet dat er met de gegevens op vertrouwelijke wijze zal worden omgegaan. Mijn vragen zijn genoeg beantwoord en het is op geheel vrijwillige basis dat ik hieraan meedoe.

Bij deze geef ik toestemming om mijn gegevens te gebruiken voor het onderzoek '…' en ik stem geheel vrijwillig in met deelname aan dit onderzoek.

Naam: ……

Datum: ……

Handtekening: ……

In te vullen door de uitvoerende onderzoeker

Ik verklaar hierbij dat ik de deelnemer volledig heb geïnformeerd over het onderzoek. Als er tijdens het onderzoek informatie bekend wordt die de toestemming van de proefpersoon zou kunnen beïnvloeden, dan breng ik hem/haar daarvan tijdig op de hoogte.

Naam: ……

Datum: ……

Handtekening: ……

Reference: (46).

Appendix 5: General privacy statement

Algemene privacyverklaring

Voor het interview in het kader van Kwalitatief Onderzoek waar met niet anonieme gegevens wordt gewerkt.

Ondergetekende verklaart hierbij:
- Zorgvuldig om te gaan met privacygevoelige gegevens, te weten:
o Het verwijderen van de audio-opname van de mobiele telefoon zodra deze op de computer is gezet
o Het verwijderen van de audio-opname van de computer zodra dit tot een transcript is verwerkt
o Het anonimiseren van transcripten tijdens het uitwerken van het interview (geen NAW gegeven of andere herleidbare informatie in het transcript opnemen)

- Privacygevoelige gegevens niet aan derden te zullen geven of met derden te bespreken. Derden zijn alle niet direct bij het deelonderzoek betrokken personen.

Naam: ……
Studentnummer: ……
Datum: ……
Handtekening: ……

Reference: (46).

Appendix 6: Hyperlink information film

Prior to the interview, the information film about the district health profile was shown. Below the hyperlink of the information film: https://vimeo.com/704132178/223316f726

Appendix 7: Code tree