The ROMCON study: Responsive Evaluation of a Community-based Health Intervention 'Buurtclub Leefstijl'

Master Thesis – Faculty of Medicine

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Abstract

Purpose: There is an increasing urgency to promote the health of older persons to ensure they are able to live at home longer in good health. In Amstelveen in the Netherlands, a citizen has developed a promising bottom-up, community-based health promotion intervention, called Buurtclub Leefstijl [Neighbourhood Club Lifestyle], inviting older persons in the neighbourhood to strengthen their functioning and improve their well-being. The aim of this study was to gain insights into the perspectives of all stakeholders into (1) the essential elements of Buurtclub Leefstijl and (2) the enablers and barriers for scaling up and implementing Buurtclub Leefstijl in other neighbourhoods.

Methods: This exploratory study used a responsive evaluation approach to gain insights into the perspectives and experiences of all stakeholders. Data was collected through a document study, observations of the meetings (n=7), semi-structured interviews (n=11) and a focus group discussion.

Results: Seven essential elements were identified: facilitating a social network, personal goal-setting, designing the content together with the participants, a relaxed and informal atmosphere, community-based, exercise with each other and the competences of the coach. For scaling up and implementing Buurtclub Leefstijl, enablers were a strong local (informal) network and support from policymakers. Barriers for scaling up and implementing were unknown of the initiative and insufficient budget.

Conclusion: This study has shown that Buurtclub Leefstijl encompasses a combination of essential elements that seem to promote a long-term improvement in functioning and well-being among participants. Since this was a small exploratory study, a more thorough evaluation study is needed into the effects on functioning and well-being of the participants.

Introduction

By 2040, 26 percent of the Dutch population will be aged sixty-five or older (1), whereas in 2020 the share of persons aged sixty-five or older was 19,8 percent (2). The consequences of the ageing population for public health and health care are major. As life expectancy is still increasing, the number of older persons will continue to increase (1) and the number of persons with one or more chronic diseases will also increase (3). Besides, the increase of older persons is one of the contributing factors in the rise of already high healthcare expenditures and pressure on healthcare personnel and informal caregivers (3,4).

To keep the health care system sustainable, scholars advocate for greater focus on health promotion leading to longer healthy life expectancy (4). Healthy life expectancy implies more than ageing without disease. The World Report on Ageing and Health by the WHO (5) defines 'healthy ageing' as: "the process of developing and maintaining the functional ability that enables well-being in older age" (p. 28). According to the report, functional ability encompasses being able to be and to do what older persons have reason to value and well-being encompasses domains such as happiness and fulfilment. By this definition, health promotion for older persons should be aimed at actively promoting health and fostering functional ability rather than at reducing risk factors and preventing diseases.

An interesting example of this participatory society is an intervention emerged from a citizens' initiative in Amstelveen,'Buurtclub Leefstijl' ['Neighbourhood Club Lifestyle'] (throughout the paper referred to as BL) which aligns with the aim of health promotion for older persons of the WHO. This citizens' initiative started as a 'dream'. Citizens of Amstelveen were invited to submit a dream to make living in their neighbourhood more enjoyable. The initiator of

BL submitted the following dream: to create a group of close-to-retirement or retired neighbourhood residents who want to improve their health together. In the follow-up, the initiator invited eight interested neighbourhood residents. Together they discussed the concept of health and topics and activities that they consider important to age healthily, in line with the concept of Positive Health by Huber (6). This definition is internationally well accepted, as it emphasis a persons' functioning and resilience and not merely a persons' disease or disability. In September 2019 the first group meeting of the intervention took place.

In short, BL is an intervention in which community citizens meet twice a month to work on their functioning together, in an informal way. The aim of BL is to strengthen the functioning and therewith health and well-being of the participants. Although the name might imply otherwise, the aim of the intervention is thus broader than solely a focus on lifestyle. In Box 1 a more detailed intervention description is given.

Box 1: Intervention description of Buurtclub Leefstijl (BL)

In brief: BL is a community-based health promoting intervention. Currently, BL is executed in two neighbourhoods in Amstelveen: in Stadsdorp Elsrijk and in De Bolder. BL Elsrijk started in September 2019 and BL De Bolder started in June 2021. Each BL-group consists of 6 to 12 participants.

Aim: The aim of the intervention is to age healthier together. The participants formulate individual goals, e.g. to exercise more or to increase the number of social contacts.

Target group: There are no criteria for inclusion. Everyone who is interested in health and who is willing to give and ask support to the other participants is welcome. The target group was initially aimed at people who want to retire in good health (55 years and older). In practice, the target group consists mainly of women who are already retired.

Facilitator: The coach is a volunteer who guides the meetings of BL twice a month and maintains contact with the participants and the coach. The coach does not need to be specifically educated in health, but affinity with health is a requirement. As a way of training, the coaches conduct the first meeting together with the initiator of BL.

Structure of the intervention:

- The participants come together twice a month under the guidance of a coach.
- The first two meetings consist of an introduction with the intervention and the participants. In the first meeting the participants and coach introduce themselves and the participants are introduced to the concept of Positive Health. At the end of the meeting, the participants are given 'homework' to formulate their personal health-related goals. In the second meeting, the participants' health-related goals and the participants' wishes and needs for the meetings are discussed.
- Once a month, a 'do-meeting' is organised, in which participants are introduced to different forms of physical exercise. The other time, a 'talk-meeting' is organised, in which the participants learn about different themes concerning health and healthy behaviour. Sometimes a professional (a dietician, a sports coach, etc.) is invited to organise a meeting, other times the meetings are organised by the coach or participants themselves.
- The content of the meetings is based on the wishes and needs of the participants at that specific moment. Within the intervention, meetings can have different content at different times.
- The meetings of BL mainly take place in a community centre, a local gym or local outdoor facilities.
- Participation in the intervention has no minimum or maximum duration.

As the initiative gained the attention from local policymakers, due to the commitment of the initiator and enthusiastic reactions of participants, the need to explicate this enthusiasm grew. Therefore, the aim of this study is to gain insights in the perspectives of different stakeholders into (1) the essential elements of BL and (2) the enablers and barriers for scaling up and implementing BL in other neighbourhoods. Essential elements can be defined as the elements within an intervention that can be specifically, rather than incidentally, linked to its effect on outcomes of the intervention (7).

Positive Health as Theoretical foundation

The WHO definition of health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (8). According to many, this definition from 1948 has a number of shortcomings: the definition would be too static with the word 'state' and too idealistic with the word 'complete' (9). Life expectancy has increased, and as described in the introduction, this has been followed by an increase in the number of people with chronic diseases. According to the WHO-definition, people with chronic diseases are considered unhealthy because they do not have a state of complete physical well-being. In addition, striving for a certain 'stable endpoint' has a medicalising effect (10). Therefore, Huber et al. (11) argue for a more dynamic concept of health: "the ability to adapt and to self-manage in the face of social, physical, and emotional challenges". In order to make the concept measurable, Huber et al. (6) performed an exploratory study to identify indicators of health. Afterwards, the health indicators were categorised into six dimensions: bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social participation and daily functioning. This concept is referred to as ‘Positive Health’, also to avoid confusion with health as the absence of disease. Positive Health emphasises a person’s functioning, resilience and self-management, which is in line with the aim of health promoting interventions for older persons, namely to foster functional ability (5).

Methodology

An exploratory responsive evaluation was used, including a document study (e.g. intervention description by the initiator), semi-structured interviews, participatory observations and a focus group discussion, to gain insight into the perspectives and experiences of different stakeholders. A benefit of the responsive evaluation approach is that it includes the context and the process in the outcome of the evaluation (12). Since BL is not a linear process with a predetermined program, the context and process are especially important to the outcome.

Participants and recruitment

For the semi-structured interviews, stakeholders, including participants and coaches of BL, policymakers and local care professionals, were recruited in the first two weeks of September 2021. In view of time available for the study, fifteen stakeholders were initially invited. Stakeholders were selected by the research team on their involvement in the development of BL. The participants of BL were also seen as stakeholders and were selected in consultation with the initiator of BL. Ten out of fifteen stakeholders accepted the invitation. Later in the process, an expert on citizens’ initiatives was interviewed on the recommendation of one stakeholder. The eleven stakeholders included participants of BL (n = 5), initiator/coach of BL (n = 1), coach of BL (n = 1), a healthcare purchaser at an insurance company (n = 1), a municipal advisor (n = 1), an expert on citizens’ initiatives (n = 1) and a dietician/lifestyle coach (n = 1).

Data collection

Data was collected through a document study, semi-structured interviews, participatory observations and a focus group discussion.

At the start, a *document study* was conducted to develop a first understanding of the intervention. The documents included an intervention description by the initiator, an inventory of activities and evaluations of the participants.

Semi-structured interviews: eleven interviews were conducted between 14-09-2021 an 01-10-2021. The interviews with the participants (n = 5), the coaches (n = 2) and the other stakeholders (n = 4) were held according to three different topic lists. The interviews were held at different places, depending on the preference of the participant. Five interviews were held via Zoom, an online video platform for meetings, one interview was conducted by telephone and five interviews were held face-to-face at the house of the participant (n = 2), at the location of the intervention (n = 1) and at a sports complex in Amstelveen (n = 1).

Participatory observations were performed between 07-09-2021 and 19-10-2021 during seven meetings at two different locations of BL. Throughout the meetings, informal interviews with the participants were undertaken to better understand the experiences of the participants.

After the interviews and observations, one *focus group discussion* with 5 of the 11 interviewees was performed on 28-10-2021 via Zoom to validate the results, to deepen the understanding of the findings and to co-create recommendations for further research and implementation of the findings.

Data analysis

The interviews were all audio-recorded and transcribed verbatim. During the participatory observations, field notes were made in writing and the notes were written up in detailed reports immediately afterwards. The data coding was done manually, following a basic content analyses. The codes of two interviews were discussed with the supervisors (SV and CD), through which codes were renamed and again discussed in the research team. With these new codes, all data was reviewed. After open coding, the codes were subdivided into categories that represent the essential elements and enablers and barriers for scaling up and implementing of BL.

Ethical considerations

Since it is not clearly defined when scientific research is 'medical' in nature, it is not certain when social scientific research is potentially subject to the Dutch Medical Research Involving Human Subjects Act [Wet medisch-wetenschappelijk onderzoek met mensen] (WMO) (13). Therefore, this research was submitted to be reviewed by the medical research ethics committee (MREC) VUmc. The research was considered not being subjected to the WMO. Furthermore, the general ethical standards of the department were followed. Informed consent letters were handed out during the meetings of BL and during the interviews. Before each interview, the interviewees were asked again if they agreed to audio-recording the session. It was emphasised that participation is voluntary and anonymous. To maintain anonymity, the participants were given a code during transcription and observation (Participant 1, Participant 2, etc.). In this article, participants were also given a code (Participant A, Participant B, etc.) and identifiable information of the participants was removed.

Results

In total, eleven stakeholders were interviewed: two coaches, five participants, a municipal advisor, a healthcare purchaser at an insurance company, an expert on citizens' initiatives and a

dietician/lifestyle coach. Ten stakeholders were female, one stakeholder was male. Table 1 provides an overview of the interviewed stakeholders. Table 2 provides an overview of the characteristics of the interviewed participants of BL.

Table 1: Overview of the interviewed stakeholders

Participant	Description
A	Initiator/coach of BL
B	Coach of BL
C	Participant of BL
D	Participant of BL
E	Participant of BL
F	Participant of BL
G	Participant of BL
H	Healthcare purchaser at an insurance company
I	Municipal advisor
J	Expert on citizens' initiatives
K	Dietician/lifestyle coach

Table 2: Characteristics of interviewed participants of BL

Participant	Male/ female	Age in years	Location BL	Participant since…	Motivation to join BL
C	Female	73	A	02-2020	Not specified, was introduced to BL by the initiator through another club for elderly.
D	Female	65	A	09-2020	To lose weight.
E	Female	81	B	06-2021	To find a walking buddy.
F	Female	82	A	05-2020	To not become isolated because of the lockdown due to the COVID-19 pandemic.
G	Female	58	B	06-2021	Referred by dietitian.

The five participants of BL were all Dutch female, aged 58 – 82 years. Participants C and D lived with their partner, participants E, F and G lived alone. The interviewed participants are representative for the non-interviewed participants in the sense that all participants of BL are females aged 58-82 years.

Perspectives of the stakeholders

A. Essential elements

The following essential elements emerged from the interviews with all stakeholders and the participatory observations: facilitating a social network, personal goal-setting, designing the content together with the participants, a relaxed and informal atmosphere, community-based, exercise with each other and the competences of the coach. In order to understand the role of these essential elements in practice, a more detailed description per element is given below:

a. Facilitating a social network: "the support, from each other, with each other"

Participants described in the interviews that their social network is expanded as a result of their participation in BL:

> Participant F: "You lose a lot of friends when you get older and you do not make many new friends anymore, so it is a wonderful way to still meet up with others, it may not be those bosom friends from before, but still contacts."

In addition, participants mentioned different ways in which they experienced support from this social network. Figure 1 shows these mentioned supports schematically. The arrows in the atomic figure work both ways: the social network causes participants to experience support in different ways, and as participants support each other, the relationships within the social network are strengthened.

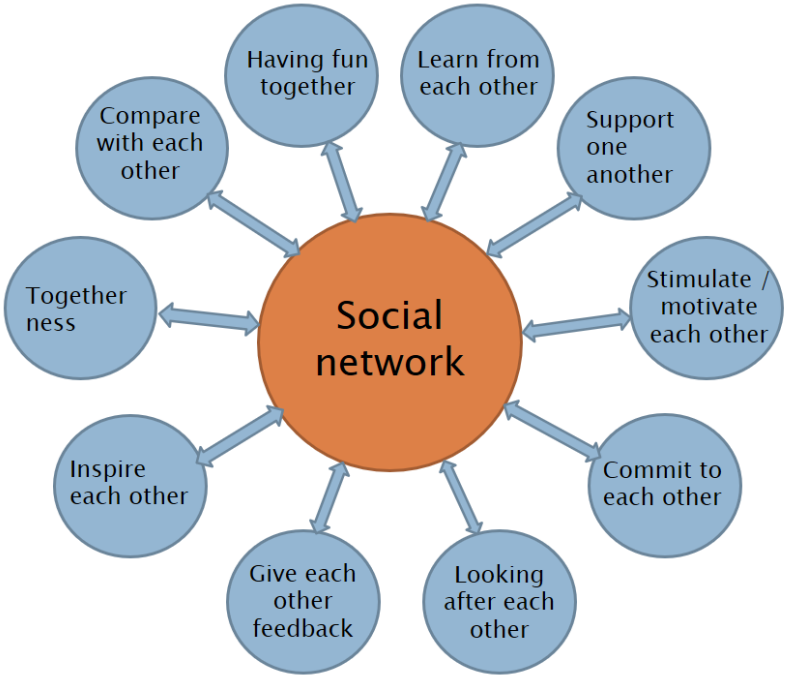

Figure 1: Atomic figure of the experienced support from the social network.

The following quotes illustrate some of the experienced support from the network:

> Participant F: "In itself, it is also nice for the person who is sick to know that there are at least 6 or 7 people thinking of what gesture we can think of. Well, you don't find that any more when you get older." (looking after each other)

> Participant A: "We always have a little bit of competition in us, like if she succeeds, then I have to succeed too." (compare with each other)

> Participant C: "And during the corona period, yes, indeed, she would come up with all kinds of things and then one would be inspired by the other, and that way every two weeks there would be something." (inspire each other)

Whereas others believe homogeneity in a group would be more helpful to create support, the participants and coaches acknowledge the diversity in the group. The diversity allows the participants to learn from each other:

> Participant D: "I like being in a group of people who don't all have to become your friends, because I actually have enough friends, but they all bring something from their lives. I find that kind of enriching."

b. *Setting "your" goals*

Participants mentioned a variety of motivations for participating in BL. Some participants mentioned specific goals before participating: to lose weight, to find a walking buddy. Other participants mentioned less explicit goals, such as to increase motivation through others and to not become isolated. The participants are given the opportunity and tools, such as a printout of the six dimensions of Positive Health, to become aware of how they perceive their health and to formulate their health-related goals. Sometimes this awareness arises when a participant compares their health behaviour to other participants:

> Participant A: "You are confronted with your own, incapacity sounds so black and white, but you are also confronted with things that others do, that you neglect a little bit. And that gives you an encouragement to pick it up again."

Participants experience the fact that everyone has a different goal as an enrichment for their own process:

> Interviewer: "What do you think about the fact that everyone has a different goal, so a different goal to work with? Is that something that gets in the way within Buurtclub Leefstijl?"
>
> Participant D: "No that is totally fine, that is logical, because lifestyle is personal, it's natural you are not all doing the same thing either, and not everyone has a weight problem. There are also people with other desires and other areas that they want to develop."
>
> (...)
>
> Participant D: "No, no, it can actually help even more I think, that you just get to know other areas, with their own experts, and their own topics I will say, because you can also use those again for your weight loss."

In addition to individual goals, participants have an overarching, common goal: to work together to age healthy. The common goal is seen as a first unifying and binding factor within the group:

> Participant A: "When getting to know each other, the participants have a lot of prejudices and wonder if they belong together, but because they are connected with lifestyle, it connects them."

c. *Designing the content together with the participants*

At the end of a meeting, the coach and the participants look ahead to the next meetings; the participants are asked what wishes or ideas they have for the content of the following meetings. Participants are also given the opportunity to organize their own meetings. This allows the participants to share their competences and interests, revealing a piece of their personality to the rest of the group:

> Participant D: "I think that appeals to everyone, that you just integrate people's strengths in a club like that, so, yes, that it just works deeply on a personal level, think that will appeal to a lot of people."

Being able to organize meetings themselves also appeals to the participants on a group level: it gives a sense of co-ownership of the intervention and it promotes social cohesion as participants share their competences and interests:

> Participant E (in the focus group discussion): "[The coach] was always busy filling the evenings and then I thought we are just sitting here and we have to fill it as well. (...) One person wants to do this, another wants to do that and then you get a really nice group formation."

Participant J believes that more health gains are achieved when participants come up with their own ideas: "You see that when people bring something in and it is taken up, by whoever, that

works best. You shouldn't impose." Nevertheless, participants also appreciate the meetings that are organized by professionals. The participants experience the meetings by professionals as useful for their process: "the expertise that we do not have and they do, that is also of added value."

d. "It also has to be enjoyable"

The Dutch word "gezelligheid" [a relaxed and informal atmosphere] was often mentioned in the interviews. The relaxed, informal atmosphere is what causes participants to adhere to BL. For example, when asked why she keeps going to BL, Participant C literally said, "more for the a relaxed and informal atmosphere." Medical or serious was mentioned as a counterpart to sociability, in which case BL is being seen as a sociable intervention and not a serious or medical intervention. Participants indicated that they would drop out if the intervention became too serious/medical:

> Participant D: "At the same time, if it becomes too serious, uhm, people can also walk away, because then they also have to take responsibility for their own wish. So Buurtclub Leefstijl does not just raise awareness of your goals, but also just sociability and input from fun impulses that you have in your life anyway, that you think that is nice, that you would like to do something with it, you know, so it is not good if it is just very serious. It has to be interesting and it also has to be enjoyable."

Also in the focus group discussion, the importance of a relaxed and informal atmosphere was discussed:

> Participant B: “No that is not wat I mean, I mean that beforehand you come to chat with a cup of coffee and that’s important before we go to the serious part.”
>
> Participant E: “Yes.”
>
> Participant B: “Suppose you cannot chat with anyone then you will not come either I think?”
>
> Participant E: “No, no, you are absolutely right about that.”

e. “Focusing on exercising together”

The participants expressed that they appreciate the fact that attention is paid to exercise. Despite the fact that prior to the 'do-meetings' some participants experience resistance, "I don't feel like it at all", the participants experience a lot of fun during exercise: there is a lot of laughter and the participants become fanatical when there are points to be won. At the beginning of an activity it is often emphasized that everyone can participate at their own pace; one can also swing to the music sitting down. Activities offered in BL, such as exploring the fitness route through the city, are also used by participants, either alone, together with their partner or together with other participants, beyond BL. Two participants explicitly explained that they have increased their exercise-routine as a result of their participation in BL:

> Participant F: "I do not like sports at all. I have never exercised as much in my life as I have in the past year."

Single participants mentioned benefits of being able to exercise with other participants:

> Participant F: "Even if you do not feel like it, you think well, I will do it anyway, because I cannot let the other person down. That is just a motivation to do more than you would otherwise do on your own."
>
> Participant G: "I am not going to look there, because that is not fun on your own or you cannot do that on your own, but what you then could do together or in the group, I find that very fun."

f. "Together in the neighbourhood"

All participants could walk or bike to the meeting at the community center or local gym, suggesting that the intervention is easily accessible to participants. The coaches and other stakeholders mentioned more advantages of the community-based character of the intervention. Participant H and Participant I consider the increase of social cohesion in the neighbourhood as a great advantage of the community-based intervention:

> Participant I: "These neighbourhood initiatives actually run on volunteers and these residents, who have great ideas and do fun things with each other, that is very good of course for social cohesion, and therefore also very healthy."

> Participant H: "Community-building is in my opinion the most essential step we can make in the Netherlands, (...) the development of how you cannot have coffee with the doctor, but coffee with the neighbour."

In addition, cooperation with partners in the neighbourhood is mentioned as an advantage for the intervention. Participant A explains the importance of cooperation with the community coach:

> Participant A: "She also knows people from the neighbourhood, who are interested, or who would fit in, so she can, if she knows them and meets them in the community center, motivate them to just join".

Participant K also sees advantages for the participants in a cooperation between BL and local (care) professionals:

> Participant K: "Then you choose locally, (...), then you choose them for that project, for that Buurtclub. I think that is an added value, because if someone then says I want to talk to you about it 1 on 1, then you can go to the dietician or physiotherapist locally."

g. Competences of the coach

In many interviews, it emerged that the competences of the coach have an impact on the intervention. First, experience in leading groups and knowledge of group dynamics is mentioned as an important competence. Within this competence, the coach's task is to maintain a balance between providing structure to the group and to give space to the group. In the focus group discussion it was clarified that knowledge of group dynamics allows more depth and connection in the group. Second, the coach must be able to create space for the group, so the intervention could be co-created with the participants:

> Participant A: "If you are rational and you are all about structure, and you are very much about rules, and you are very much about processes, and this is the program and this is what we are going to do now, that is not possible."

The coach will be asked to take on a supporting, coaching role so that the participants feel encouraged to co-create the intervention. Participant B explains: "It is indeed more than just a pleasant conversation. The training in coaching we received during the study is very useful." Thirdly, the ability to give and receive feedback is mentioned as an important competency:

> Participant A: "They [the coaches] must also be prepared to look at themselves, and be prepared to let the participants' criticism pour over them, because that also happens of course. And be able to do something with that."

Moreover, the coach must be someone with a genuine interest in people and feel a certain commitment to the participants. For example, Participant B explained that, when participants

had previously failed to show up to a meeting, she would call the participants the day of the next meeting to actively involve the participants again. This commitment is also noted by the participants: “one driving force [the coach] who really keeps an eye on everything and anyone.”

B. Factors for scaling up and implementing

In the interviews, all stakeholders were asked for their perspectives on the enablers and barriers for scaling up and implementing BL in other neighbourhoods. A detailed description per enabling and hindering factor are given below:

Enabling factors

The following enabling factors emerged from the interviews with all stakeholders: a strong local (informal) network and support of polic-makers.

a. A strong local (informal) network

An already strong local network that BL can cooperate with, is seen an enabler for scaling up and implementing. Welfare providers within the network (e.g. the community coach, physiotherapists and family doctor) could refer participants to BL. Participant K did refer two of her patients to BL. She explains the added value of participation in BL for her patients: "I think lifestyle is very important of course and I see: you can do a bit in the consulting room, but a lot more outside of it." Cooperation in the neighbourhood can be promoted by organizing neighbourhood network meetings. The purpose of these meetings is for the municipality and welfare providers to get to know each other and find each other more quickly. Also, a strong informal network, in which a lot of word-of-mouth advertising takes place, can ensure that more people participate in BL, allowing BL to be scaled up. For example, Participant F told she came to BL via Participant C and Participant B told she had forwarded the vacancy for coach to her former fellow students at the Health and Lifestyle study.

b. Support of policymakers

BL is developed from a dream of one resident to a promising health promoting intervention. Whereas the bottom-up origin of the initiative appealed to the stakeholders: "the most crucial facet is that it originated from the bottom up, so it apparently connects to a wish or idea that exists among residents", a promising concept is not simply transformed into an effective intervention. Policymakers, e.g. municipality advisors and health insurers, can support interventions by increasing and strengthening their (local) network and by providing advice and funding to professionalize the intervention. With the support of policymakers, BL was able to further develop and to scale-up and implement to another neighbourhood.

Barriers

Besides enablers, two barriers were found for scaling up and implementing BL in other neighbourhoods: unknown of the initiative and insufficient budget.

a. Unknown of the initiative

Unknown of the initiative will result in a vicious downward spiral, in which less funding, fewer coaches and fewer participants will result in the intervention to slowly extinct. The intervention could remain successful locally, but the opportunities for scaling up and implementation will be hampered. Also, when not enough coaches connect with BL, there is the risk that the initiative will remain too closely linked to the initiator. Participant A explains the upward spiral of being well-known:

"Well look, if Buurtclub Leefstijl, if the concept is a bit stronger, if we are a bit clearer, (...) then people are probably also more willing, or see it more as a challenge to guide such a club, than now. (...) It is therefore important that we become better known, that we are better positioned, that we have better identity, because then they are also willing to pay more money, and then more people are interested, then we come up in such a vicious spiral."

b. Insufficient budget

When asked what would be an enabling factor to implement the concept of BL to another neighbourhood, Participant J said without hesitation: "Money!". A sufficient budget is necessary to establish preconditions to conduct the intervention. Preconditions include renting a facilitation, involve professionals for guest lectures and organizing activities and possibly. In addition, budget will be needed to professionalise the intervention. The stakeholders mentioned different ways in which BL could professionalise: setting up an adequate marketing strategy, providing a volunteer fee for the coaches and setting up 'Programma Buurtclub Leefstijl (BL)' [Programme Neighbourhood Club Lifestyle]. In 'Programme BL' various health-related themes are described in a modular way, verified by professionals. In the future, coaches will be able to use 'Programme BL' for content of the meetings.

Discussion

Since BL is being embraced with great enthusiasm by local policymakers and by the participants of BL, the aim of this study was to gain insight into the essential elements and enablers and barriers for scaling up and implementing BL by performing a small-scale exploratory study. To improve people's health and well-being, national health policymakers focus on health interventions (14). This bottom-up initiative is different from other health interventions, such as Combined Lifestyle Interventions (CLIs) (15). First, BL is not reimbursed from the basic health insurance package, whereas the CLIs are reimbursed. Second, BL does not have inclusion criteria, everyone is welcome to participate, whereas the CLIs have criteria for inclusion, such as participants have obesity with a BMI ≥ 25 kg/m2 with an additional risk factor, e.g. Diabetes Mellitus Type 2. Third, in BL, the content of the meetings is not predetermined, whereas the CLIs have a predetermined programme. Last, the aim of BL is to actively promote health in line with the definition of Positive Health (holistic approach), whereas the aim of the CLIs is to reduce health-related risk factors by adopting a healthy lifestyle, such as a healthy diet and exercise pattern (specific approach).

So, BL does not focus on one dimension of health, such as exercise or increasing social skills, but focusses on all dimensions of health according to the concept of Positive Health: bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social participation and daily functioning (6). During the first meeting of BL, the participants are introduced to the six dimensions of health. Afterwards, the participants reflect on their health and health behaviour and formulate their personal health goals. In addition, the concept of Positive Health allows flexibility to the content of the meetings: one participant may wonder whether a meeting about music is related to health, while another participant may experience increased enjoyment through music, which in turn leads to an increased quality of life and health.

In short, BL is an innovative health promotion intervention, which is being embraced with great enthusiasm by participants and local policymakers. The section below describes the most important findings of this study:

This study has shown that the participants experience many benefits by doing the intervention together in a social network. Berkman et al. (16) describes four ways in which a

social network can influence someone's health (behaviour): (1) social support; (2) social influence; (3) social involvement and attachment; and (4) access to resources and material goods. Each of these elements were described by the participants in their evaluation. Social support was described as supporting each other, looking after each other and giving each other feedback. Social influence was describes as stimulating/motivating each other, inspiring each other and comparing each other. Social involvement and attachment was described as looking after each other, 'feeling together', having fun together and committing to each other. Access to resources and material goods was not specified by the participants. In like manner, the French sociologist Bourdieu describes having a social network as social capital, whereby people can use resources from the network at an individual level to become and remain healthy (17). Moreover, Koutsogeorgou et al. (18) concludes that health promotion interventions based on social capital building may lead towards better health and well-being for older persons. Facilitating a social network is clearly one of the main essential elements of BL.

Being part of a social network also affects the participants' exercise-routine; since participants are able to exercise together, they motivate each other to exercise more and that they are able to do more sorts of activities than they were able to do alone. These results support the idea of the influence of social support on physical activity suggested by previous studies: social support encourages persons to participate in physical activity more easily and for a longer period of time (19–21).

The differences in participants' self-set health goals allow the participants to be introduced to more aspects of health than merely the aspects of health relevant to their own goal. For example, a meeting about mindfulness may help a participant in their process of losing weight. In addition, previous research demonstrated that goal setting is an effective health behaviour change strategy (22,23). Strecher et al. (23) describes that both self-set and coach-set goals have their benefits. A trained coach may set more realistic goals, whereas participants may set goals which are either too easy or too difficult. On the other hand, participants can set their goals more realistic because they know better what goals are attainable in this phase of their lives. Also, participants may be more motivated to achieve goals if they have set them themselves. Pearson (22) describes the importance of making goals specific. Having specific goals ensures that there is a specific outcome associated with them, which has a positive influence on self-efficacy when this goal is achieved. Not all participants of BL had a specific and thereby measurable goal. In the future, the outcome of the intervention could be improved by specifying the goals of all participants more thoroughly.

The participants experience co-ownership of BL, as the content of the intervention is designed together with the participants: they individually determine their health goals and they collectively determine the content of the meetings. Because the participants have a choice in this, it possibly appeals to their sense of autonomy (24). In addition, the participants have the possibility to organise their own meetings. The use and acknowledgement of their qualities and talents does justice to the competences of people through the positive feedback the participants receive (24). Besides, because the participants co-create the intervention, it seems possible that the concept of BL can easily be transferred to other contexts, such as other neighbourhoods or target groups. Often simply copying the intervention, without adaptations, to other contexts does not lead to the desired effect (25). However, BL may already be sufficiently adapted to other contexts as the participants determine the content of the intervention.

BL provides an intimate, non-judgemental context in which everyone is welcome to participate. Moreover, differences between the participants are acknowledged and actively used. For example, participants explain that they learn from each other; the life knowledge, experience

and wisdom of others is an enrichment to their own lives. Because of the absence of inclusion criteria, the participants perceive BL as 'not medical'. Participants associated a 'medical' intervention with performances and something serious. They also indicated that if an intervention became too serious or too coercive, this could be a reason to no longer participate. Participants associated the intervention with having fun and a relaxed and informal atmosphere, which they mentioned as reasons to continue participating in BL. These results are in line with previous studies in which enjoyment of social interaction supports long-term participation in a health intervention (26,27).

Participants of BL walk or bike to the facility where the meeting takes place, suggesting that the intervention is easily accessible to them. Devereux-Fitzgerald et al. (27) explains that interventions are more acceptable to older persons if the intervention takes place closer to home. Moreover, a number of studies have indicated that community-based interventions, rather than medical interventions, allow participants to continue their behaviour as the behaviour was adapted in a familiar setting (22,27). Within the study, a contradiction was found regarding the relationship between implementation of the intervention and social cohesion in the neighbourhood. On the one hand, implementation of the intervention is expected to strengthen social cohesion in a neighbourhood. On the other hand, social cohesion in a neighbourhood is expected to be an enabler for implementing the intervention in the neighbourhood. According to these results, the intervention, which would increase social cohesion in the neighbourhood, is most likely to succeed in a neighbourhood where there is already social cohesion. Further research is needed to clarify this relationship.

This study has shown that importance of acknowledgment of competences, co-ownership of the intervention, the sense of autonomy and doing the intervention with each other are important to the participants. These needs correspond to the three basic psychological needs - competence, autonomy, relatedness - which, according to Deci & Ryan's Self-Determination Theory (24), when satisfied, lead to increased intrinsic motivation to achieve goals and persist in new behaviours. This can cause people's effective functioning and well-being to increase. In line with the Self-Determination Theory, the approach of BL provides an environment for participants in which they strengthen their functioning and experience more well-being.

Limitations and future work

This study provides insights into the perspectives of participants and other stakeholders on the essential elements and enablers and barriers for scaling up and implementing BL, although some limitations warrant considerations. First, the interviewed participants of BL were selected in consultation with the initiator. These participants might be more actively involved in BL. This may have caused selection bias, which may have under-emphasised insights from other, possibly less motivated, participants (28). However, the likelihood of selection bias was reduced by conducting informal interviews with other participants during the participatory observations. Second, the attendance of the focus group discussion was lower than expected. Despite the fact that all interviewees were invited a month in advance and the focus group discussion was via Zoom, which eliminates travel time and costs, only five of the eleven stakeholders were able to participate. Further study should assess the enabling and hindering factors for scaling up and implementing on large scale. This study should be focussed on both scaling up and implementing BL in different neighbourhoods and scaling up and implementing BL for different target groups. It is likely that BL could be effective for more target groups, such as persons with mental health problems or younger persons, as these groups may also benefit from consciously reflecting on

their health together with a social network. Lastly, the findings of the study seem to indicate that participating in BL could increase the participants' well-being on a social, mental and physical level. However, further evaluation research is needed to determine the actual effect of the intervention on the health of the participants. It would be interesting to use a mix of quantitative and qualitative methods. Quantitative methods can be used to evaluate the extent of change in functioning and perceived health. Qualitative methods can be to understand 'how' and 'why' – possibly as a result of social capital, achievement of health goals, increased sense of purpose, etc. - participants experience changes in functioning and perceived health.

Conclusion

BL is designed with, for and by a club of local residents (bottom-up) with a common goal: to age healthier together. BL appears to be a simple intervention: local residents come together twice a month to participate in activities to strengthen their health. However, this study has shown that BL consists of a complex combination of essential elements: facilitating a social network, personal goal-setting, designing the content together with the participants, a relaxed and informal atmosphere, community-based, exercise with each other and the competences of the coach. These elements combined provide a new approach to promote sustainable change in participants' functioning and health behaviour. Participation in the intervention appears to lead to increased intrinsic motivation, increased social capital and increased sense of purpose. Even more, the findings of this study suggest that the participants achieve their health-related goals and that their well-being improves. Further research is needed to determine the effectiveness of the intervention on the functioning and well-being of older persons in line with 'healthy ageing' as defined by the WHO. Consequently, if results show that BL is an effective intervention in promoting 'healthy ageing', large-scale implementation of BL could potentially contribute to the sustainability of healthcare.

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