EVALUATION OF THE COMBINED LIFESTYLE INTERVENTIONS COOL AND BEWEEGKUUR

Fattana Mohammad

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Evaluation of the Combined Lifestyle Interventions CooL and Beweegkuur

A qualitative study on the suitability and inclusiveness of the combined lifestyle interventions CooL and Beweegkuur based on experiences of clients and lifestyle coaches

Fattana Mohammad

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Maastricht University, Faculty of Health Medicine and Life Sciences
Supervisor: Dr. Ruben Drost r.drost@maastrichtuniversity.nl
Second Supervisor: Dr. Aggie Paulus a.paulus@maastrichtuniversity.nl
Universiteitssingel 40, 6229 ER, Maastricht
043 388 5655

Pharos Expertisecentrum gezondheidsverschillen
Supervisor: Dr. Karen Hosper, k.hosper@pharos.nl
Arthur van Schendelstraat 600, 3511 MJ, Utrecht
030 234 9800, info@pharos.nl

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Abstract

Background: Since January 2019, combined lifestyle interventions (CLI) are included in the Dutch basic insurance package. However, recent studies indicate several barriers in the implementation of the interventions. Additionally, not all clients have similar access to participate in the lifestyle interventions, particularly individuals with a migration background and individuals with lower socio-economic status.

Aim: This paper wants to investigate how suitable CooL and Beweegkuur are for clients and lifestyle coaches and how inclusive the interventions are for individuals with a migration background and low SES by investigating different areas of the interventions. Additionally, this paper aims to identify barriers and provide recommendations to improve the implementation of the CLI.

Methods: In-depth semi-structured interviews were conducted to collect data from clients and licensed lifestyle coaches in different regions in the Netherlands where the CLI is implemented. Data was transcribed manually. NVivo 12 Plus software for qualitative data analysis was used to analyze and code data through systematic text condensation.

Results: The current interventions lacked inclusiveness in the selection of clients with a migration background and low SES and lacked inclusiveness in the intervention's contents. There was a lack of referral from GPs as well. Clients primarily experienced a lack in guidance, group activities, and physical activities. Lifestyle coaches experienced an administrational burden and lack of compensation for the additional requirements of the interventions. The intervention's contents and materials were often too complex and unconcise (Beweegkuur) or left too much room for interpretation (CooL). Additionally, most clients and lifestyle coaches found that the individual and group sessions were too few.

Conclusion/ recommendations: The findings of this study indicate that the CooL and Beweegkuur interventions have barriers for clients and lifestyle coaches in different phases of the interventions. Multiple recommendations are provided, e.g. additional referrers to include individuals with a migration background and low SES, the inclusion of culturally diverse diets, and the provision of physical activity within the group sessions.

Keywords: combined lifestyle interventions, inclusiveness, suitability, barriers and recommendations, CooL, Beweegkuur

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Abbreviations

BMI	Body Mass Index
CBS	Central bureau of statistics (Centraal bureau voor statistiek)
CLI	Combined Lifestyle Intervention (Gecombineerd leefstijlinterventie, GLI)
CooL	Coaching on Lifestyle (Coaching op Leefstijl)
GP	General practitioner
GPA	General practice assistant (praktijkondersteuner huisarts, POH)
HBO	Higher professional education (Hoger Beroepsopleiding)
MBO	Secondary vocational education (Middelbare Beroepsopleiding)
NHG	Dutch GPs Association (Nederlandse Huisartsen Genootschap)
RIVM	National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieuhygiëne)
SCP	Social Cultural Plan bureau (Sociaal Cultureel Planbureau)
SES	Socioeconomic status

Definitions

Client	In this study, clients are individuals referred by the GP or medical specialist to participate in the combined lifestyle interventions (CLI) CooL or Beweegkuur.
Combined lifestyle interventions	The CLI focuses on weight reduction and lifestyle improvements. This is addressed through a combination of healthier dieting, more exercise and behavioral change (Voedingscentrum, 2020). Registered CLI in the Netherlands are CooL, Beweegkuur and SLIMMER.
General practitioner	The GP is the first contact person for candidates in the CLI referral chain.
Inclusiveness	*"The quality of including many different types of people and treating them all fairly and equally."* (Cambridge dictionary, 2020). In this study inclusiveness implies that all individuals eligible for the interventions should be reached and included and have equal access to the interventions, but also in that the contents and materials of the interventions should be inclusive and appropriate for all individuals participating, particularly for individuals with a migration background and low SES.
Lifestyle coach	Lifestyle coaches are health professionals who are licensed to offer one of the three CLI CooL, Beweegkuur or SLIMMER (lifestyle coaches of SLIMMER are not included in this study).
Low socio-economic status	This study used a demographic questionnaire for clients to assess low, middle or high SES based on the monthly income, highest obtained degree and current employment status of clients. Low income was indicated when the yearly income was lower than €9.250 per year (< €770 per month, middle income= 770- 2000 per month, high income >2000) (CBS, 2020a). Low education was

	indicated when the highest obtained degree was either primary education, Pre-vocational secondary education (vmbo), first three years of Senior general secondary education (havo) or Pre-university education (vwo), or Secondary prevocational education 1 (mbo1) (Volksgezondheidenzorg, 2020b). Individuals had a low SES when they had a low income along with a low educational level and or unemployment.
Migration background	This study used the central bureau of statistics' (CBS) definition of individuals with a migration background. According to the CBS individuals have a migration background when at least one of their parents is born outside of the Netherlands. The CBS differs between individuals with a first generation and second-generation migration background and between individuals with a western and non-western migration background (CBS, 2020b).
Socio-economic status	*"Socioeconomic status (SES) is the social standing or class of an individual or group. (...) Examinations of socioeconomic status often reveal inequities in access to resources, plus issues related to privilege, power and control"* (American Psychological Association, 2020). SES is often measured through income, educational level and current employment status (Volksgezondheidenzorg, 2020b). In this study SES of clients were measured through a demographic questionnaire including questions related to the income, education and employment of clients.

1. Introduction

Obesity and overweight are major health problems globally. Prevalence of obesity has doubled in recent years, causing obesity to be the second leading cause of premature death in Europe (Coupe, Cotterill and Peters, 2018). The percentage of overweight and obese Dutch adults have increased as well. In 1990, one out of three (35.1%) Dutch adults were overweight. In 2018 50.2% of Dutch adults were overweight and 15% were obese (Volksgezondheidenzorg, 2020a). Prevalence of overweight is higher in Dutch adult males while prevalence of obesity is higher in Dutch adult females (Volksgezondheidenzorg, 2020a). In children this percentage is 11.7% and 2.7%, respectively (Volksgezondheidenzorg, 2020a). In both males and females, the percentage of overweight increases with age and in both males and females the prevalence of obesity is relatively higher in individuals with a lower education (age group 45-65). The prevalence of obesity has doubled in individuals with a lower education compared to individuals with a higher education (age group 45-65) (Volksgezondheidenzorg, 2020a). Additionally, overweight and obesity are more prevalent in individuals with a migration background (RIVM, 2019a).

Being overweight or obese increases the risk of health complications such as cardiovascular diseases (CVD), diabetes mellitus type 2 (DM2), some types of cancer, comorbidities, and significantly reduces quality of life (QoL) (Berendsen et al., 2011). Overweight and obesity related health complications result in elevated health expenses as well. Medical costs due to overweight accounted for 1,6 billion euros in 2010 in the Netherlands (in 't Panhuis et al., 2012).

Research indicates that combined lifestyle interventions (CLI) are effective in weight reduction and reduction of health complications such as diabetes mellitus type 2 and elevated blood pressure (Van der Meer et al., 2009). The CLI is an intervention focused on guiding clients into a healthy lifestyle. The intervention consists of several components: healthy dieting, physical activity, sleep and stress management and behavioral change (RIVM, 2019c). Individuals are eligible for the intervention when overweight (BMI>25) and at increased risk of health complications (e.g. cardiovascular diseases, diabetes mellitus type 2, arthritis and sleep apnea) or when obese (BMI>30). The eligibility criteria are based on standards from the Dutch GPs Association (Nederlandse Huisartsen Genootschap, NHG) and the Dutch Care Standard on Obesity (Zorgstandaard Obesitas) (RIVM, 2019c).

As of January 2019, the CLI is included in the basic health insurance package (basispakket) in the Netherlands. The Dutch National Institute for Health and Environment (Rijksinstituut voor Volksgezondheid en Milieu, RIVM) has currently qualified three interventions to be offered as a CLI: CooL (Coaching on Lifestyle), Beweegkuur and SLIMMER (RIVM, 2019c).

1.1. Problem statement

Since January 2019, health insurance companies have been increasingly contracting CLI providers in different municipalities. In December 2019, 810 practices offered one of the CLI (Volksgezondheidenzorg, 2020a). However, a recent study indicates that participants of lifestyle interventions do not always achieve desired weight reduction (Verberne, 2019). An evaluation of the CLI Beweegkuur showed no significant differences between participants of the lifestyle intervention and the control group when assessing weight reduction (Verberne et al., 2016). Recent reports also show barriers in the implementation of the CLI. There is a lack of referral and motivation from GPs and there are obstacles in the execution of the interventions by lifestyle coaches (RIVM, 2019a; Gutter and Stuij, 2019; Nederlandse Zorgautoriteit, 2019; RIVM, 2019b). Additionally, the current CLI do not offer an intervention for individuals with a migration background or with low SES. However, literature suggests that individuals with a migration background and a low socioeconomic (SES) often need more guidance when participating in lifestyle interventions (RIVM, 2019d). As overweight related health risks are also more prevalent in individuals with a migration background and lower SES, these individuals are more often in need of a CLI (CBS, 2018; Coupe, Cotterill and Peters, 2018; RIVM, 2019a; Volksgezondheidenzorg, 2020a).

1.2. Main research objective

The CLI is a popular subject for public health research. Previous research on the CLI, including research on the CooL and Beweegkuur interventions, has been widespread (Van der Meer et al., 2009; Berendsen et al., 2015; Van Rinsum et al., 2018a; Van Rinsum et al, 2018b; Verberne, 2019; Gutter and Stuij, 2019). Including research on the effective elements of the CLI (Preller and Schaars, 2016). The CLI in association with low SES has been investigated as well (Nagelhout et al., 2018; Mulderij et al., 2019). However, no research has been conducted on the suitability of the interventions CooL and Beweegkuur for clients and lifestyle coaches and the

inclusiveness of the interventions for individuals with a migration background and low SES so far. Inclusiveness in that all individuals eligible for the interventions should be reached and included and have equal access to the interventions, but also in that the contents and materials of the interventions should be inclusive and appropriate for all individuals participating, particularly for individuals with a migration background and low SES.

There is in particular a lack of research on qualitative in-depth evaluations of experiences of clients and lifestyle coaches in practice. This study aims to contribute to closing this research gap. The objective of this study is to investigate the suitability and inclusiveness of CooL and Beweegkuur by investigating different areas of the interventions through in-depth interviews. The different areas of assessment are the selection of clients, the referral of clients and the suitability of the interventions. Additionally, this study aims to identify barriers and provide recommendations to improve the implementation in areas where implementation has been less successful.

1.2.1. Research question and sub questions

How suitable are CooL and Beweegkuur for clients and lifestyle coaches and how inclusive are the interventions for individuals with a migration background and low SES? To answer this research question, several sub questions were formulated based on the areas of assessment:

- Selection of clients: *Which clients participate in the interventions? Are clients with a migration background and low SES included?*
- Referral of clients: *How are clients referred to CooL and Beweegkuur? What are the inclusion and exclusion criteria of GPs and lifestyle coaches?*
- Suitability of the interventions: *How do clients and lifestyle coaches experience the interventions and the materials used? Are the interventions and the materials used suitable and inclusive?*
- Barriers experienced: *What are barriers experienced by clients and lifestyle coaches?*
- Recommendations: *What are recommendations of clients and lifestyle coaches to improve CooL and Beweegkuur?*

2. Theoretical background and framework

2.1. The combined lifestyle interventions

In 2009, the CLI was approved as an effective lifestyle intervention for weigh related health risks in a report by the Dutch Health Institute (Zorginstituut) (Van der Meer et al., 2009; Latta and Van der Meer, 2018). However, the CLI was not implemented as the requirements of the intervention were unclear for health providers and health insurance companies. In 2018, the Dutch Health Institute published an addendum to the previous report to clarify the requirements of the CLI (Latta and Van der Meer, 2018; Zorginstituut Nederland, 2020). This was approved by the Dutch minister of Healthcare and Sports and initiated the implementation of the CLI in the basic health insurance package (Zorginstituut Nederland, 2020). The CLI is an intervention aimed at lifestyle improvement and behavioral change. The intervention consists of different components. Clients receive guidance on their dieting habits, on how to integrate physical activity in their daily lives, and on how to maintain a healthy lifestyle through behavioral change (Loketgezondleven, 2020). The intervention consists of an eight to twelve months period in which clients follow counselling sessions and an additional twelve months period in which clients are encouraged to achieve sustainable lifestyle changes (RIVM, 2019c). Clients' motivation is an important eligibility criterion. The interventions are offered by licensed lifestyle coaches (RIVM, 2019c). Individuals are only allowed to participate after referral from a general practitioner (GP) or medical specialist (Loketgezondleven, 2020).

2.1.1. Coaching on lifestyle

The CooL intervention consists of an intake and a treatment phase of six to eight months where a licensed lifestyle coach offers two individual sessions and eight group sessions to clients. This is followed by a maintenance phase of sixteen to eighteen months to promote sustainability of the intervention. The maintenance phase of the intervention contains two individual and eight group sessions as well. However, the sessions are distributed over a greater time period (Philippens and Janssen, 2018). The intervention is closed with an outtake assessment. The intervention is an open intervention. Lifestyle coaches are encouraged to organize the intervention based on preferences of the lifestyle coach and the clients (Philippens and Janssen, 2018).

The intervention is focused on behavioral change of clients. Lifestyle coaches guide clients to gradually achieve sustainable lifestyle changes in physical fitness, dieting habits and overall health and wellbeing (Expertise Leefstijlinterventies, 2020; Philippens and Janssen, 2018). Clients are in charge and are encouraged to set personal goals and corresponding activities related to lifestyle change. Unhealthy behavior is identified and replaced by healthy behavior. The role of the lifestyle coach is to support the clients in this process and guide where necessary (Philippens and Janssen, 2018). The target groups for the intervention are motivated adults who are overweight and have increased health risks and adults who are obese. Candidates can be excluded based on e.g. language competencies, behavioral issues and mental health problems (Expertise Leefstijlinterventies, 2020).

The content and materials used are provided by Expertise center Lifestyle interventions (Expertisecentrum Leefstijlinterventie) who have ownership over the CooL intervention (Expertise Leefstijlinterventies, 2020). Competent health professionals who are experienced in coaching and lifestyle are eligible to become a lifestyle coach after successfully finishing the online training of CooL (Expertise Leefstijlinterventies, 2020). Licensed lifestyle coaches can be self-employed or employed by health organizations. However, for the implementation of CooL it is important that the lifestyle coach is easily accessible by clients (Loketgezondleven, 2020).

2.1.2. Beweegkuur

The Beweegkuur is an intervention embedded in the primary healthcare (Loketgezondleven, 2020). It is offered by a multidisciplinary team consisting of e.g. the GP, the lifestyle coach, the dietician or dieting professional, the physiotherapist or sports professional, the local sports coach, and the Beweegkuur instructor (Expertise Leefstijlinterventies, 2020). Additionally, local gym schools and sports providers are approached to make physical activity more accessible for clients (Huisvoorbeweging, 2020).

The intervention has three components: healthy dieting, physical activity and behavioral change. Behavioral change is important to ensure sustainability of the intervention's outcomes (Wagemaker, 2018). The lifestyle coach focuses on behavioral change in seven individual sessions with clients. The dietician/ dieting professional focusses on healthy dieting. The dieting component consists of an intake, group sessions and three consultations with a dietician (not insured by the CLI). The physiotherapist or sports professional focuses on the physical activity levels of clients and guides clients to integrate physical activity in their daily lives (Wagemaker,

2018). The Beweegkuur uses motivational interviewing to realize lifestyle change. The client is encouraged by the different health professionals to set goals and activities through self-management (Wagemaker, 2018).

The Beweegkuur intervention was implemented from 2011 to 2017, in 155 different locations. Some of these locations are contracted by health insurance companies (Loketgezondheid, 2019). Beweegkuur has been adapted over the years and currently consists of a treatment phase of twelve months and a maintenance phase of twelve months (Wagemaker, 2018; Berendsen et al., 2015; Expertise Leefstijlinterventies, 2020).

The target group of Beweegkuur are motivated overweight and obese adults (BMI 25-40) with increased health risks. Individuals are eligible with a BMI of 25- 30 with high waist circumference and or comorbidities; with a BMI of 30- 35; and with a BMI of 35- 40 without comorbidities (Wagemaker, 2018; Expertise Leefstijlinterventies, 2020). An additional inclusion criterion of clients is that their current lifestyle should be inadequate (Wagemaker, 2018; Expertise Leefstijlinterventies, 2019). Candidates with a BMI of 35- 40 are not eligible for Beweegkuur when having comorbidities such as hypertension, sleep apnea, diabetes, cardiovascular diseases, arthritis and dyslipidemia (Expertise Leefstijlinterventies, 2020). Guidance intensity is dependent on BMI, overweight related health risks and comorbidities (Berendsen et al., 2015; Huisvoorbeweging, 2020). Content and materials for the intervention are available at the Home for Movement (Huis voor Beweging) who also owns the intervention (Wagemakers, 2018; Huisvoorbeweging, 2020).

2.2. Current barriers to the implementation of the CLI

A quick literature search identified several barriers to the implementation of the CLI. Due to information fragmentation on websites it was difficult for candidates to have a complete overview of the CLI and the interventions offered (Nederlandse Zorgautoriteit, 2019). Furthermore, the CLI was not available in all regions yet and the number of lifestyle coaches offering the interventions were insufficient (Nederlandse Zorgautoriteit, 2019; RIVM, 2019b). Health insurance companies also showed a great variation in the number of CLI providers they had contracted. Some health insurance companies asked for additional requirements before contracting CLI providers, which the CLI providers could not always meet (Nederlandse Zorgautoriteit, 2019; Gutter and Stuij, 2019; RIVM, 2019b). Additionally, there was a lack of

networking and coordination between the different stakeholders, and a high administrative burden. The quality and effectivity of the CLI was difficult to assess as well (RIVM, 2019b).

Participation in the CLI is primarily dependent on referral from the GP. However, most GPs were not fully informed about the contents and availability of the CLI. There was a lack of referral from the GP and candidates often initiated referral to the interventions themselves (RIVM, 2019a; Nederlandse Zorgautoriteit, 2019; RIVM, 2019b). The RIVM reports that of all candidates eligible for the CooL intervention only 1,03% was referred by the GP (RIVM, 2019a). Dropout rates of clients also differed amongst the CLI, in CooL dropout rates were 23% while dropout rates in Beweegkuur were 19% (RIVM, 2019a).

The report by Gutter and Stuij (2019) about experiences of CLI health providers stated that health providers found the CLI to have been implemented too soon. Information, guidance and materials were lacking, such as a suitable declaration system for the different health providers involved in the CLI (Gutter and Stuij, 2019). Health providers also stated that the current reimbursement costs for the interventions were insufficient to cover all expenses, and the current sessions were too low in frequency to enable actual lifestyle changes (Gutter and Stuij, 2019; RIVM, 2019b). The reimbursement was in particular too low to provide sufficient physical activity. The health providers argued that more guided physically activity was needed for the intervention to be effective (Gutter and Stuij, 2019). Additionally, the competences of lifestyle coaches were questioned. The current training to become a lifestyle coach was found to be inadequate to solve complex medical problems of clients. It was argued that lifestyle coaches offering the CLI should have a medical background (Gutter and Stuij, 2019).

2.3. Inclusiveness of individuals with a migration background and low SES

Dutch adults with a migration background and with low SES are often less physically active and are more often overweight or obese (RIVM, 2019a). Sixty six percent of individuals with a low SES is overweight compared to 41% of individuals with a high SES. Obesity is also more prevalent amongst individuals with a low SES (23%) compared to individuals with a high SES (8,6%) (Volksgezondheidenzorg, 2020a). Literature also indicates that individuals with a migration background and with lower SES often require additional conditions for lifestyle interventions (RIVM, 2019d; Herens et al., 2015). These individuals are also more difficult to reach with physical activity and lifestyle interventions and have a higher dropout rate (Bertens and Kesteren, 2011; Bukman, 2016; Bukman et al., 2017).

Statistics on health and migration of the Dutch Central Bureau of Statistics (CBS) indicate that Dutch adults with a Turkish, Moroccan, Antillean or Surinamese background more often experience their health as poor. Prevalence of overweight and obesity is highest amongst adults with an Antillean background (45%), followed by adults with a Turkish (37%), Moroccan (32%), and Surinamese background (29%). Prevalence of obesity in Native Dutch adults is 21% (CBS, 2018; RIVM, 2019a).

2.4. Theoretical framework of this study

Based on the theoretical background a framework for this study was developed consisting of the implementation of the CLI and the different areas of assessment of CooL and Beweegkuur (figure 1). Main causes for the implementation of the CLI are the increased prevalence of individuals with overweight and obesity, increased health risks (e.g. CVD, DM2, comorbidities, and some types of cancer) and the elevated medical expenses due to this. The framework also displays the implementation of the CLI by stakeholders involved: health insurance companies, healthcare groups, municipalities, and health providers. Additionally, the framework shows the pathway through which the interventions function to obtain the desired short- and long-term outcomes. Individuals are eligible for the lifestyle interventions based on the CooL and Beweegkuur inclusion criteria after referral by the GP. The main elements of the CLI to achieve a healthier lifestyle are physical activity, dietary habits, sleep and stress management, and behavioral change. The main components of the interventions CooL and Beweegkuur interventions are displayed in the framework as well. The framework shows by whom the interventions are offered and what the treatment and maintenance phase of both interventions are. Short term outcomes of the interventions are increased physical activity, healthier dietary habits, behavioral change, and healthier lifestyle choices. Long term outcomes are reduced BMI, reduced risk of overweight related diseases and comorbidities, reduced health complications, improved quality of life, and reduced medical costs.

To close the research gap, both interventions were assessed on their suitability and inclusiveness in four areas of assessment (selection of clients, referral of clients, suitability of the intervention and barriers experienced). To obtain data on the suitability and inclusiveness of CooL and Beweegkuur, in-depth interviews with clients and lifestyle coaches were conducted individually. The four areas of assessment of CooL and Beweegkuur (selection of clients, referral of clients, suitability of the interventions and barriers experienced) include the

sub questions related to each area. Additionally, the framework shows the pathways through which recommendations on suitability and inclusiveness are obtained based on the outcomes of the four areas of assessment. Results of each area of assessment are discussed in chapters four to eight.

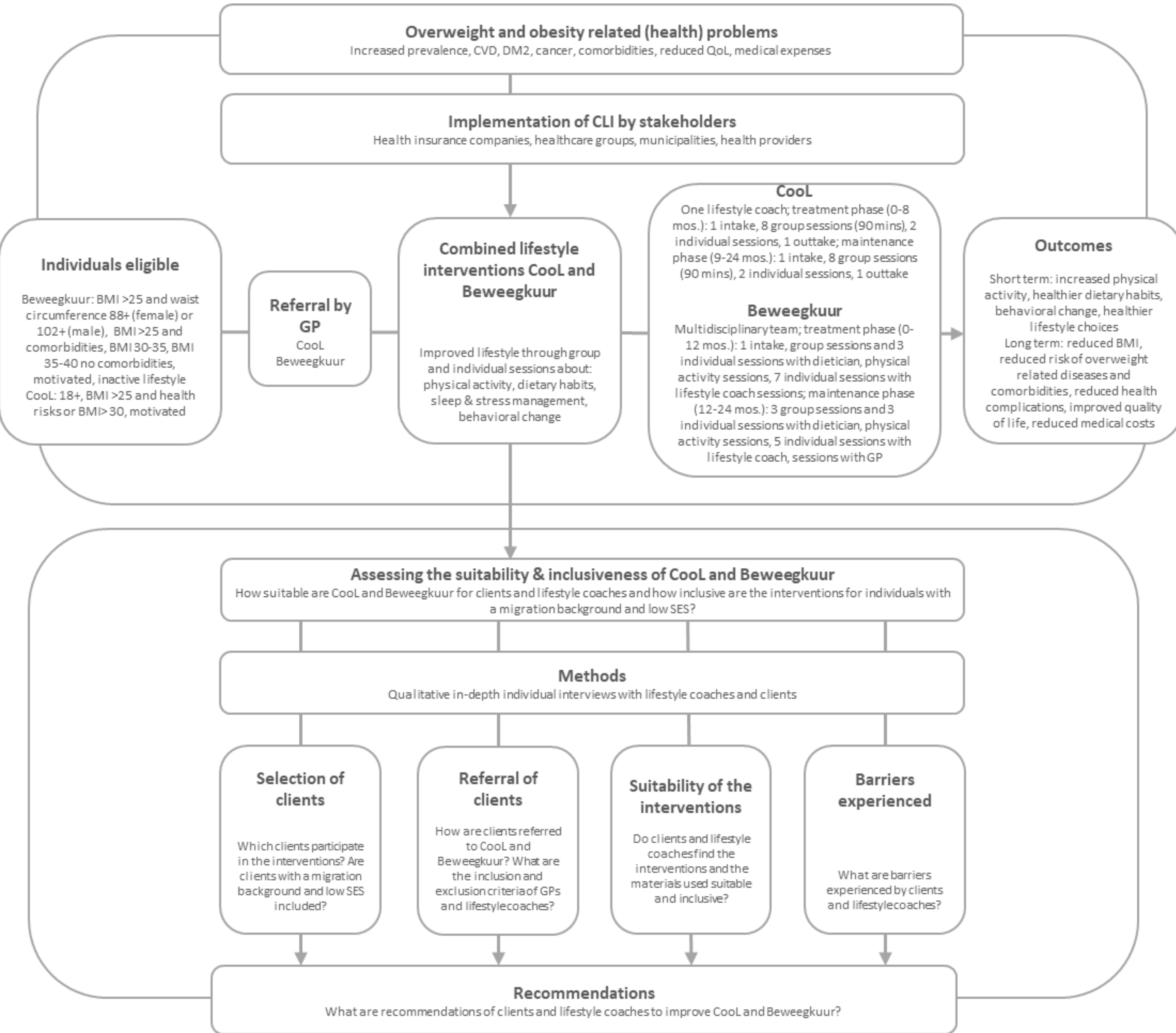

Figure 1. Theoretical framework of the implementation of the CLI and the assessment of the suitability and inclusiveness of CooL and Beweegkuur

3. Methods

3.1. Study design

This study used the qualitative description (QD) research approach to explore the suitability and inclusiveness of the CLI CooL and Beweegkuur in different regions in the Netherlands. Qualitative description is an inductive approach which is often used to present data in a descriptive and interpretive valid way, particularly when time and resources are limited (Sullivan-Bolyai, Bova and Harper, 2005; Bradshaw, Atkinson and Doody, 2017)). General themes emerge from the data which are investigated considering what is already known about the subject. Researchers use QD to give a rich description of experiences or events in a clear language (Sullivan-Bolyai, Bova and Harper, 2005).

3.2. Study population

Purposeful sampling and snowball sampling were used to find suitable study participants for the interviews. Snowball sampling is used when study participants are difficult to find. Snowball sampling consists of primary data sources referring the researcher to additional primary data sources in a chain of referral (Research-Methodology, 2019b; Martinez- Mesa et al., 2016). Purposeful sampling is used to identify information rich study participants in qualitative research when resources are limited (Palinkas et al., 2015). A total of 10 study participants (clients n=5, lifestyle coaches n=5) participated in this study (table 1).

Lifestyle coaches were invited for participation through purposeful sampling through the CooL and Beweegkuur official websites (leefstijlinterventies.nl and huisvoorbeweging.nl) which included a list of all licensed lifestyle coaches offering CooL or Beweegkuur. Lifestyle coaches from different districts were invited for participation in this study, including districts with low SES. Districts with low SES were identified through statistics from the Social Cultural Plan bureau (SCP) on SES per district in the Netherlands (Volksgezondheidenzorg, 2020b). The SCP measures the social status score of districts based on the education, income and employment status of its residents (Sociaal en Cultureel Planbureau, 2020). The CLI SLIMMER was excluded from this study due to time restraint and difficulty finding licensed lifestyle coaches in low SES districts. Five lifestyle coaches (Beweegkuur n=2, CooL n= 3) were included from different provinces. Three lifestyle coaches were from districts in the

Randstad (megalopolis in central-western Netherlands): North Holland and South Holland; and two lifestyle coaches were districts in other provinces: Gelderland and Friesland. Most lifestyle coaches were also dieticians (table 1).

Clients were recruited through snowball sampling by lifestyle coaches. After each interview, lifestyle coaches were asked to distribute information flyers in the group sessions about participation in this study (Appendix I). Two out of five lifestyle coaches interviewed actively distributed the flyers in their groups. Clients were included when participating in CooL or Beweegkuur offered by the interviewed lifestyle coaches and when being adult (18+). Seven clients responded to the invitation of which five clients were included in this study, two clients were excluded based on nonresponse (table 1). Clients participating in this study received a voucher for participation.

	Combined lifestyle intervention	**Province**	**Other competencies**	**Clients responding**	**Clients participating**	**Total number of study participants per lifestyle coach (incl. lifestyle coach)**
Lifestyle coach 1	CooL	South Holland	Dietician	3	3	4
Lifestyle coach 2	CooL	North Holland	Dietician	0	0	1
Lifestyle coach 3	Beweegkuur	Friesland	Dietician	0	0	1
Lifestyle coach 4	CooL	Gelderland	Background in health and prevention	4	2	3
Lifestyle coach 5	Beweegkuur	South Holland	Dietician	0	0	1
Total n=5	CooL n=3 Beweegkuur n=2	Randstad n=3 Others n=2	Dietician n=4 Other n=1	N=7	N= 5	N=10

Table 1. Characteristics of lifestyle coaches and the recruitment of clients

3.3. Data collection

Data was collected through in depth semi-structured interviews with open ended questions. Open ended questions provided more insight into the participants' thoughts and perceptions (Mack et al., 2005). Participants' were able to share information that were not captured in the interview questions. In-depth semi-structured interviews also provided more insight into the participants' individual experiences. All interviews with clients and lifestyle coaches were performed individually and audio recorded using a recording application.

Separate questionnaires were prepared for lifestyle coaches (Appendix II) and clients (Appendix III). The questions were structured according to the four areas of assessment: selection of clients, referral of clients, suitability of the intervention, and barriers experienced. Interviews with lifestyle coaches were mainly focused on the selection and referral of clients, the suitability of the intervention, and the barriers experienced. Interviews with clients were mainly focused on the referral process, the suitability of the intervention, and the barriers experienced. Clients' SES was assessed at the start of each interview with a demographic questionnaire to assess low, middle or high SES based on the monthly income, highest obtained degree and current employment status of clients.

3.4. Data analysis

All audio recordings of the interviews were transcribed manually. Transcriptions of the interviews were coded through the NVivo 12 Plus software for qualitative data analysis (QSR International Pty. Ltd., 2020). Interviews were analyzed through systematic text condensation. Systematic text condensation is a descriptive and explorative cross-case thematic analysis method for qualitative data, most often used for interviews and observations (Malterud, 2012). Systematic text condensation consists of four phases. In the first phase, the transcriptions were examined to identify general themes and gain a full impression of the data (Malterud, 2012). All transcribed interviews were read thoroughly, and general themes were noted down. In the second phase of the analysis meaning units related to the general themes and related to the study purpose, were systematically identified to create codes. This was done through the NVivo 12 Plus software for qualitative data analysis. All interview transcriptions were imported to the NVivo 12 Plus software to identify the meaning units related to the general themes and create codes. During the third phase the meaning units of the codes were systematically extracted on the NVivo 12 Plus software through text condensation to create thematic code groups and subgroups. Transcriptions of the first four interviews assisted in coding the subsequent interviews. Systematic text condensation allows for flexibility in changing meaning units, codes and code groups throughout the analysis procedure (Malterud, 2012). Based on the subsequent transcriptions few codes and code groups were changed to accurately describe the contents. In the last phase of systematic text condensation, data was reconceptualized to create description and meaning out of the subgroups which subsequently answered the sub questions of the four areas of assessment (Malterud, 2012).

3.5. Reliability and validity of data

Reliability of qualitative data is achieved when data is replicable with the methods used (Leung, 2015). To increase reliability of data, all interviews were systematically structured. All lifestyle coaches and all clients received the same set of questions. Additionally, all data collected was transcribed and coded systematically, with the inclusion of outliers. Data was analyzed in a consistent manner by making use of the NVivo 12 Plus software for qualitative data and a stepwise description of systematic text condensation by Malterud (2012). Validity in qualitative research consists of appropriateness of methods (Leung, 2015). To achieve validity, various research methods were examined to find out which was more appropriate for this study. For the purpose of this study, in-depth semi-structured open-ended interviews and systematic text condensation were found to be most appropriate to obtain the desired outcomes. Additionally, to increase validity, data collection and data analysis were documented comprehensively and described in a transparent manner (Leung, 2015).

3.6. Ethical considerations

All study participants were asked to provide verbal and written consent on the voluntarily participation in this study (Appendix IV). Study participants were informed both verbally and on information sheets about the study purpose, voluntarily participation, privacy guidelines on anonymous use of personal data and data storage before start of each interview (Appendix V). Data was anonymized by assigning numbers to study participants and excluding data that could reveal the identity of study participants. All data obtained is stored on Pharos' secure database only accessible after receiving permission to access the files. This study was approved by the medical ethical committee board of Maastricht University and registered under FHML/HPIM/2018.33/FHML-REC/2019/075.

4. Selection of clients

Which clients participate in the interventions? Are clients with a migration background and low SES included?

4.1. Demographic questionnaire

To assess the SES of clients, clients interviewed received a demographic questionnaire (table 2). All clients interviewed were female (n=5). Both clients and lifestyle coaches interviewed confirmed that most clients within the groups were female as well. Lifestyle coaches admitted that the number of male clients were low in all of their groups. Two lifestyle coaches thought the intervention to be more attractive to females.

> Lifestyle coach 1 (CooL): *"It seems to be something that is more attractive to women than man, but I am not sure if that is really the case."*

In all groups, the age distribution of clients ranged from 40 to 65 with outliers of clients aged under 40 (n=1) and above 65 (n=2). The mean age of the clients interviewed was 59.

Most clients were native Dutch (n=3) with no migration background except for two clients of which one or both parent(s) had immigrated to the Netherlands. Both clients had a second-generation migration background of which one had a western migration background and one a non- western migration background. Most clients were married (n=3). Two clients were divorced of whom one still lived with her ex-husband (client 3).

Most clients interviewed had graduated in administrative studies (n=4) at secondary vocational education level (mbo) (n=4) except for one client who had graduated in nursing at higher professional education level (hbo). Based on the results, most clients interviewed were unemployed or retired (n=4), except for one client who worked as a shop assistant. Clients' income varied between 770 and 2000 euros a month. Most clients lived with a partner (n=3) or by themselves (n=1) except for one client (client 5) who lived with her partner and children.

Based on results, clients mostly had a middle SES (n=4), except for one client (client 3) who showed several indicators of low SES including financial problems caused by her health insurance's deductibles after joining CooL, and housing problems. This client was forced to quit CooL due to financial problems. Middle SES was calculated through the monthly income

(770- 2000). Although, most clients had a low educational level (secondary vocational education level, mbo), this was not an indicator for low SES as they had a middle income.

	Gender	Age	Migration background	Marital status	Highest obtained degree	Current employment status	Monthly income	Living situation	SES
Client 1	Female	57	Second generation, western migration background (one parent born outside of the Netherlands	Married	Secondary vocational education (mbo), administrative	Employed	770- 2000	With partner	Middle
Client 2	Female	73	No	Married	Secondary vocational education (mbo), economical, administrative	Retired	770- 2000	With partner	Middle
Client 3	Female	68	No	Divorced	Secondary vocational education (mbo), financial, administrative	Retired	770- 2000	With ex-partner	Low/ Middle
Client 4	Female	59	No	Divorced	Secondary vocational education (mbo), economical, administrative	Unemployed, incapacity benefit (WIA benefit)	770- 2000	Alone	Middle
Client 5	Female	37	Second generation, non-western migration background (both parents born outside of the Netherlands	Married	Higher professional education (hbo), nursing school	Unemployed	770- 2000	With partner and children	Middle
Total n=5	Female	Mean (μ) = 58,8	No migration background n=3 Migration background n=3	Married n= 3 Divorced n= 2	Secondary vocational education n= 4 Higher professional education n=1	Employed n=1 Unemployed/ retired n=4	770- 2000	With partner n=4 Alone n=1	Middle n=4 Low/ middle n=1

Table 2. Outcome of the demographic questionnaire of clients interviewed

4.2. Client's health and wellbeing

Based on results, all clients interviewed were highly motivated to join the intervention and motivated to lose weight. Medical conditions of clients were the main incentive to lose weight. All clients interviewed mentioned to have been troubled by their weight most of their lives and to have tried different methods without success. Two clients mentioned experiencing the "yoyo effect" where they would lose weight for a short period only to regain weight shortly after. One client mentioned that all her group members had experienced this effect while dieting.

Client 1 (CooL): *"It's the famous yoyo effect. You wouldn't hear any different story in the group, all of them* (group members) *have experienced it."*

Clients interviewed experienced varying health problems along with overweight. Health problems of clients included diabetes, hernia, fatigue and sleep apnea. Overweight and health problems hindered the clients in their daily life's activities.

Client 1 (CooL): *"Being overweight is just bothering me in all daily activities I can't reach my feet that well or tie my shoelaces."*

4.3. Migration background

Most lifestyle coaches confirmed having few or no clients with a migration background (n=4). The location of the lifestyle coach was a determining factor in the number of clients with a migration background. There was a contrast in cultural diversity in the CLI in densely populated regions in the Randstad compared to Friesland, a northern province of the Netherlands which is less densely populated. Friesland had less individuals with a migration background.

Interviewer: *"Do you have individuals with a migration background in your groups?"*
Lifestyle coach 3 (Beweegkuur): *"Well no, we are just not so "multiculti" in here, it is just all a bit of Fries."* (Fries referring to Friesland)

Amongst the lifestyle coaches there were two lifestyle coaches (lifestyle coach 2 and 5) who had relatively more clients with a migration background. Both lifestyle coaches had a migration

background as well. One of them (lifestyle coach 2) stated that her groups primarily consisted of clients with a migration background as those were her target group. The lifestyle coach offered the CooL in the province North- Holland (part of Randstad).

4.4. Low socio-economic status

Based on results, lifestyle coaches (n=4) had few or no clients with a low SES, except for lifestyle coach 2 who stated that she recruited individuals with a low SES through the GP and social aid workers in the neighborhood. Four out of five lifestyle coaches interviewed, mentioned that reaching individuals with a low SES for the interventions was more challenging to them. Lifestyle coaches had different theories for the low participation rate of individuals with a low SES in their groups. Lifestyle coaches 1 and 3 thought that individuals with a low SES were difficult to reach because they did not frequently go to the GP and might not consider overweight as a health problem. Lifestyle coach 4 thought that individuals with a low SES would be less interested in the CLI as they might think that they would have to follow an expensive diet and apply for gym membership which they could not afford. Lifestyle coach 1 also speculated that overweight individuals with a low SES had more urging problems than their lifestyle and would therefore not think of applying for lifestyle interventions.

> Lifestyle coach 1 (CooL)*: "I think that it's a difficult to reach group anyway. Those are people who don't go to the GP that often. They might think being overweight… is that really so important."*

4.5. Conclusion

All clients interviewed were female with a mean age of 59. Clients mostly had no migration background (n=3), were married (n=3), had Secondary vocational education as the highest obtained degree (n= 4), were unemployed or retired (n=4), lived with a partner (n=4), and had a middle SES (n=4). One client showed indicators of a low SES, due to financial and housing problems. However, as all clients had a moderate income of 770- 2000 per month, low SES was difficult to indicate. Clients applying for the intervention were experienced with weight loss and overweight related health complications. Two clients interviewed had a second-generation migration background, of which one had a western and one a non-western migration background. Most lifestyle coaches (n=3) experienced a lack of individuals with a migration

background and low SES. Lifestyle coaches (n=2) who did have individuals with a migration background had a migration background themselves and lived in more densely populated regions (Randstad). One of those lifestyle coaches (lifestyle coach 2) also mentioned to have individuals with low SES in her groups.

5. Referral of clients

How are clients referred to CooL and Beweegkuur? What are the inclusion and exclusion criteria of GPs and lifestyle coaches?

5.1. GPs as the first point of contact and referral

GPs and medical specialists are the first points of contact and referral for clients in the CLI referral chain (Loketgezondleven, 2020). However, based on results the general practice assistants (GPA) often took over the role of the GP in referring clients to the interventions. Two lifestyle coaches (lifestyle coach 3 and 5) mentioned that the GPs in their neighborhood did not actively contribute to the recruitment of clients. They mentioned that GPs did not prioritize lifestyle interventions and often thought it is not their responsibility to recruit clients for the interventions. Lifestyle coach 3 argued that GPs often found that the CLI was a preventive approach and not a part of the GPs curative treatment.

Lifestyle coach 3 (Beweegkuur): *"The GP was like: no, I am not really into that. It is not my job. (...) The GP also didn't feel like addressing people's weight when they did not come for weight related issues. So, if someone would visit the GP for knee pain, they would only look at their knee and wouldn't mention: oh, but maybe you have issues with your knee because you are overweight and we have a nice intervention for that."*

Lifestyle coach 5 mentioned that GPs were often too busy and that some GPs would have preferred other health professionals as the first point of contact and referral for the CLI.

Lifestyle coach 5 (Beweegkuur): *"One of the GPs mentioned: yes, but why can't sports coaches manage the referrals. They also receive many people, but we are the ones having that responsibility every time."*

Additionally, lifestyle coaches (n=3) mentioned that some GPs or GPAs would refer more clients to them than others based on the GPs or the GPAs preference for preventive methods and lifestyle interventions. If GPs and GPAs were not "prevention-minded" they were less willing to advise a preventive approach to their patients. Some lifestyle coaches (n=3)

mentioned that GPs were often not fully informed about the contents of the CLI. Nonetheless, most lifestyle coaches (n=4) stated that they would not like to change the role of the GPs and GPAs as the first point of contact and referral, except for lifestyle coach 5. Lifestyle coach 5 found that clients did not have to be referred to the CLI by GPs or GPAs. She mentioned that most lifestyle coaches conducted an extensive intake procedure that filtered out clients who did not meet the inclusion criteria and GPs and GPAs often referred their patients without assessing their eligibility for the interventions.

> Lifestyle coach 3 (Beweegkuur): *"There's a really extensive questionnaire. We ask what kind of medication someone uses, what they have done already, medical problems (...) And then we assess if someone is eligible. And this is way more extensive then the GP. The GP will say: oh, you're here for the CLI, well I don't know much about it, but I also don't get any compensation for it, so here is the referral. (...) How is that even useful?"*

5.2. Clients initiating referral

Based on results, most clients (n=3) interviewed initiated the referral to the intervention themselves. Client 1 asked for a referral after hearing from family about the intervention. Client 3 stated that she had looked up information about the intervention by herself and subsequently asked for a referral at the GP. Client 4 mentioned that she went to her GP to ask what she could do to lose weight. Most lifestyle coaches (n=4) interviewed also mentioned that many of their clients initiated referral to the intervention after hearing about it from friends or family or reading about it online. Two clients mentioned that they had not heard about the CLI before. Client 5 first heard about the CooL intervention when she was referred by the GP. Client 2 heard about the CooL intervention through her dietician who had just started as a lifestyle coach. She stated that the dietician arranged for her to start the intervention and she did not have to go to the GP herself to get a referral. Lifestyle coaches (n=3) mentioned that clients who initiated the referral were more often clients who were higher educated.

Based on results, most clients interviewed did not receive information about the intervention (n=3) or assistance in looking for the lifestyle coach (n=5) from the GPs or GPAs. The GP or GPA referred most clients (n=4) but were not involved in other aspects related to the intervention unless the client had to go for periodic blood tests and updated the GPA by own initiative.

5.3. Inclusion and exclusion criteria

Clients were included in the CLI by lifestyle coaches based on the CooL and Beweegkuur inclusion criteria which were assessed during the intake procedure. The intake procedure of Beweegkuur was more extensive and consisted of a comprehensive questionnaire including the client's dietary habits and physical activity levels. Lifestyle coaches (n=4) mentioned to assess client's motivation levels as well. Clients' motivation was an important inclusion criterion for both CooL and Beweegkuur.

Reasons to exclude clients were mainly based on the exclusion criteria set by CooL and Beweegkuur. Other reasons to exclude clients were traveling distance, clients with mental health problems such as anxiety or panic disorder, and overweight clients who already maintained a healthy lifestyle. Based on the Beweegkuur intake clients who were overweight and experienced health problems were excluded if they were physically active and maintained a healthy diet. The Beweegkuur questionnaire included an assessment to rate daily physical activity levels of clients from one to five. Scoring one indicated a low motivation for physical activity while scoring five indicated that the client already moved sufficiently by themselves. Both scores one and five indicated that the client was not eligible for the intervention.

Lifestyle coach 3 (Beweegkuur): *"If you move enough (...) than you are not eligible. So, if I am a diabetic, but I take a walk 45 minutes a day, then I wouldn't be eligible for the Beweegkuur."*

Lifestyle coach 3 also mentioned that Beweegkuur excluded clients with complications which could compromise their performance in the intervention. It was recommended by Beweegkuur that clients should solve underlying problems before joining the intervention.

Lifestyle coach 3 (Beweegkuur)*: "It's mentioned at the training of Beweegkuur: you shouldn't include people who have a lot of stress, who are in debt or whatever. They should actually solve those problems first, so it isn't a stress factor anymore and then they might be able to improve their lifestyle."*

5.4. Dropouts

Lifestyle coaches varied in the number of groups they had, the number of clients per group, and the total number of clients per lifestyle coach. The average number of groups per lifestyle coach

was 3, the average number of clients per group per lifestyle coach was 12, and the average total number of clients per lifestyle coach was 36 (table 3). Dropouts were relatively low in all groups. The average dropout per lifestyle coach was three. Lifestyle coach 1 mentioned to be surprised by the low number of dropouts in her groups. Lifestyle coaches (n=3) also mentioned that few of their clients (temporary) quit the intervention because of personal circumstances. Based on results, none of the dropouts were related to the migration background of SES of clients. Most occurring motives for dropouts of clients were achieving a stable weight, wanting a different approach to losing weight, not being motivated, and being too busy.

Most clients (n=4) interviewed were still enrolled in the CLI and were not intending to quit, except for one client. Client 3 had dropped out of the intervention shortly before the interview. She quit the intervention due to the high deductible costs from her health insurance company after joining CooL. The health insurance company had confirmed to pay 75% of the total costs of the intervention as the insurance company had no contract with the lifestyle coach. However, the actual costs of participation were higher than the estimated costs. The client was under a lot of pressure because of this.

Client 3 (CooL): *"And if they* (lifestyle coach) *are going to ask more, than I have to pay that, and I am having a lot of trouble with that. And meanwhile it is all more expensive than they had told me on the phone, but they don't go into that. (...) And I can't prove it, because I don't have it on paper."*

	Number of groups per lifestyle coach	**Number of clients per group per lifestyle coach**	**Total number of clients per lifestyle coach**	**Number of dropouts per lifestyle coach**
Lifestyle coach 1	4	12	48	2
Lifestyle coach 2	5	12	60	4
Lifestyle coach 3	1	6	6	3
Lifestyle coach 4	4	12	48	1
Lifestyle coach 5	1	20	20	3
Total	15	62	182	13
Mean (μ)	3	12,4	36,4	2,6

Table 3. Number of groups, number of clients per group, number of clients per lifestyle coach, and number of dropouts

5.5. Conclusion

Most GPs did not have an active role in the CLI. GPAs often took over the role of the GPs as the referrers of clients to the interventions. Two lifestyle coaches stated that some GPs and GPAs did not prioritize the CLI. Two lifestyle coaches also mentioned GPs lacked information about the contents of the CLI. Three lifestyle coaches stated that GPs and GPAs who were less prevention- minded would refer less clients to them. Most clients (n=3) initiated referral to the interventions themselves. Clients were included or excluded based on the CooL and Beweegkuur inclusion criteria. Additional reasons to exclude clients were travelling distances, mental health problems and healthy lifestyle of clients. The intake procedure of Beweegkuur was more extensive and included a physical activity assessment. Individuals could also be excluded based on complex underlying issues which could compromise their performance. The average number of clients per lifestyle coach was 36 and the average drop out per lifestyle coach was three. Reasons for dropout were e.g. not being motivated and being busy. All clients interviewed were still enrolled in the interventions, except for client 3 who quit CooL due to financial problems.

6. Suitability of the interventions

How do clients and lifestyle coaches experience the interventions and the materials used? Are the interventions and the materials used suitable and inclusive?

6.1. Intervention contents and materials

Lifestyle coaches interviewed offered contents of CooL (n=3) or Beweegkuur (n=2). Contents of most group sessions were focused on education about healthy diets and behavioral change. Other components of the CLI such as physical activity, and sleep and stress management were less frequently discussed during group sessions. Most clients mentioned (n=4) to have had one session about physical activity and one session about sleep and stress management. Two clients (client 3 and 4) found that the sessions about physical activity and sleep and stress management did not contribute much to their knowledge.

Both CooL and Beweegkuur have their own materials and equipment for lifestyle coaches (e.g. handbooks and guidelines). However, in both CooL and Beweegkuur, lifestyle coaches (n=5) used their own additional materials for the interventions (e.g. handbooks, presentations, sports equipment, group activities) which were created by themselves or were contents from their dietician practices. Due to this, contents of the interventions varied per lifestyle coach. Some lifestyle coaches (n=3) found their own materials to be more suitable. This was particularly the case for Beweegkuur. Lifestyle coaches 3 and 5 from Beweegkuur stated that the materials they received from Beweegkuur were often complex and extensive. Lifestyle coaches offering the CooL intervention were free in organizing the intervention as they preferred so long as it was related to lifestyle change. Lifestyle coach 2 did cooking sessions and tasting sessions where clients could taste different types of healthy foods which they otherwise might have avoided.

> Lifestyle coach 2 (CooL): *"Cooking together (...) and eating together and during the cooking session I will also address food statements to assess their knowledge. Some say they don't like to eat this or that, so then we will prepare a meal and let them taste it."*

Lifestyle coaches 1 and 4 also planned a group walk and gave clients exercises which they could do at home. They also invited a sports professional to educate clients about physical activity

during a group session. Other lifestyle coaches (lifestyle coach 2, 3 and 5) worked together with a sports coach or physiotherapist to offer one or more physical activity sessions. Lifestyle coaches 1, 2 and 3 used food diaries or diet tracking apps. Lifestyle coach 4 used small notebooks where clients could write down their weekly goals and how to achieve these. Lifestyle coaches 1, 4 and 5 also handed out information maps to clients and information sheets after each group session. Two of them (lifestyle coaches 1 and 4) also used PowerPoint presentations, which they would email to the clients. All lifestyle coaches from both interventions stated that sometimes it was a trial and error for them to find out what works for them and for the clients. Lifestyle coach 1 stated that she sometimes lacked knowledge about certain aspects of the intervention and would have liked more guidance on topics she was less familiar with as a dietician (e.g. sleep and stress management).

> Lifestyle coach 1 (CooL): *"Sometimes it feels a bit like a pilot to us. We are like yeah, let's just try this out and we'll see how many people will join the intervention."*

6.2. Group and individual sessions

Based on results, the group sessions were very important to some clients (n=3). Clients 1, 2 and 4 mentioned the group sessions motivated them to be more persistent and stimulated them to lose weight. They found that the group made them feel like they were not alone in the process. Most clients interviewed (n=3) had a good group connection, except for client 3 and 4.

> Client 1 (CooL): *"Especially the group dynamic is very important. The program is only as good as its group."*

All clients had a group chat on WhatsApp to keep in touch with other group members and the lifestyle coach, share their process or share recipes. Clients 3 and 4 mentioned they did not bond well with the group which also hindered their participation in the intervention. Client 4 was in particular bothered by the lack of group connection she experienced amongst the group members and between the group members and the lifestyle coach. She mentioned she attempted to bond with the group by posting dieting tips or recipes in the group chat, but the group members and lifestyle coach would not respond to her posts. She mentioned to be very bothered

by this and would have preferred the lifestyle coach doing more to encourage the group cohesion.

> Client 4 (CooL)*: "Well, the group I am in, at the beginning I tried to be like: hey guys, good morning, how is it going? But nobody would reply.*"

One lifestyle coach (3) stated that her clients disliked group sessions overall. She continued that most individuals in the region (Friesland) were not open to participation in group sessions where they would have to share their feelings and would rather participate in individual sessions.

> Lifestyle coach 3 (Beweegkuur)*: "I think here in Northern Netherlands, people are not fitted for doing a lot in groups (…) to do group sessions with a dietician and having to talk a lot about yourself. (…) People are not so used to think and talk about themselves (…) I would have to tell them what to do."*

Some lifestyle coaches (1 and 3) found that the individual sessions provided them with more possibilities for coaching the clients and would be more efficient in changing lifestyles. Lifestyle coach 1 also mentioned that clients were able to shape the contents of the individual sessions themselves based on their preferences. Based on results some clients (n=3) interviewed found the individual sessions not to be efficient for them. They found that the individual sessions were often too short and too low in frequency to contribute to lifestyle changes of the clients.

> Interviewer: *"And how are the individual sessions?"*
> Client 4 (CooL): *"It's a nice chat, but they* (the individual sessions) *are so short. You're outside the room before you know it."*

6.3. Accessibility and waiting times

The interventions CooL and Beweegkuur are offered in most regions in the Netherlands but in some districts only one of the two interventions were offered to clients. Based on results all

clients interviewed could easily access the interventions and did not have long traveling distances. Most lifestyle coaches (n=4) offered the intervention in multiple locations. Lifestyle coach 1 and client 3 mentioned that lifestyle coaches usually only accepted clients within the municipality. Applications of clients from other municipalities were rejected due to traveling distance or if lifestyle coaches received too many applicants. Most clients (n=4) interviewed had already been participating in the intervention for several months, except for client 5 who had recently started with the CooL intervention. Waiting times of clients differed. While some clients could start immediately (client 2 and 5), others (client 1, 3 and 4) had to wait several weeks before starting the intervention. This was due to the intervention not having been implemented in some regions.

6.4. Lifestyle coaches' competences

All lifestyle coaches were new to the CLI and did not have much experience as a lifestyle coach. However, most lifestyle coaches (n=4) were experienced dieticians. Lifestyle coaches (n=2) offering Beweegkuur preferred offering the intervention in an interdisciplinary team of health professionals while lifestyle coaches offering CooL (n=3) thought the intervention performed better with one lifestyle coach. Most clients (n=4) did not have a preference for one lifestyle coach (CooL) or an interdisciplinary team of health professionals (Beweegkuur), except for client 3 who participated in CooL but preferred an interdisciplinary team of health professionals.

Having a good network of health professionals was essential for the implementation of the interventions for all lifestyle coaches. Some lifestyle coaches (n=3) focused more on networking than others. Two lifestyle coaches admitted that they needed to focus more on networking to reach more clients but also to refer clients more efficiently when needed.

Based on the findings most clients (n=3) had a good connection with the lifestyle coach, except for client 3 and 4 who did not bond well with the lifestyle coach. Most clients (n=3) mentioned they felt understood by the lifestyle coach and thought the lifestyle coach helped them with problems related to the intervention or their lifestyle. All lifestyle coaches (n=5) responded positively about their connection with the clients as well. Few clients (n=2) found the lifestyle coach to be inexperienced. One client (1) mentioned she would have rather worked with a lifestyle coach who personally struggled with weight loss herself.

Client 1 (CooL): *"It's nothing personal, but with her I was like you're so young and skinny. (...) You don't have enough life experience and don't know how it is to struggle with weight loss for so long."*

Client 3 agreed with that she rather worked with a lifestyle coach with more experience. She continued that the lifestyle coach was more like a dietician which she only saw occasionally.

Client 3 (CooL): *"And then I am thinking, who is the coach? I miss that. I think we have bad luck because we are the first course and they still have to get experienced."*

Other clients (n=3) did notice a difference between sessions with a dietician and a lifestyle coach. Client 2 replied that the group sessions with the lifestyle coach were more motivating to her and client 4 replied that dieticians were often more specific and in depth about what is allowed and what is not. She mentioned that the lifestyle coach did not interfere much with her dietary habits. Client 5 replied she preferred the lifestyle coach as it focused on weight loss through different areas.

6.5. Individuals with a socioeconomic status

All lifestyle coaches interviewed were asked if they saw differences in clients' performance and understandability of the intervention based on their SES. However, most lifestyle coaches (n=3) found it difficult to answer questions related to the clients' SES. This was due to: 1. lifestyle coaches could not indicate the SES of their clients; and 2. lifestyle coaches could not evaluate whether clients with a lower SES found it more challenging to participate in the intervention. Lifestyle coach 2 mentioned that differences in education or employment were prevalent in her groups but were no indicators of a low or high SES of clients. She stated that differences in education and income between clients were not a barrier to intervention performance as the intervention was aimed to be accessible to all.

Lifestyle coach 2 (CooL): *"And of course, you notice differences in educational levels, but we try to make it as accessible as possible, so everyone will be educated."*

Lifestyle coach 3 stated that differences in SES within the groups could be challenging if the level of education of clients were too different. Particularly for clients with higher educational levels the sessions could become slow and repetitive. However, lifestyle coaches (n=5) expressed that they did not notice differences in clients' performances in the interventions in general.

6.6. Individuals with a migration background

Based on the results, two lifestyle coaches (3 and 5) mentioned that the CLI was not suitable for individuals with a migration background. They mentioned that the CLI was primarily based on a Dutch lifestyle. The lifestyle coaches also mentioned that the five major food groups (schijf van vijf), mainly used in Beweegkuur, were not suitable for clients with a migration background. The five major food groups are primarily based on Dutch dieting habits. Clients with culturally diverse dieting habits were also advised using the five major food groups even though their dieting habits are not based on these food groups.

> Lifestyle coach 3 (Beweegkuur)*: "I am not a major supporter of it. The dieting advice is the same for everyone and that's how it is in Beweegkuur. The diet is based on the five major food groups but not all cultures are based on the five major food groups. The basic food components are different in some cultures (...) So I wouldn't say it's suitable for everyone, no."*

A client with a second-generation non-western migration background (client 5) mentioned that she sometimes did not feel connected with the group. She mentioned that the previous group session was about the Christmas holidays and the dieting tips related to that, but she did not feel much affinity with that herself.

> Client 5 (CooL)*: "Last time they (*the group) *were talking about the upcoming Christmas holidays. They were saying: we will be eating more and more tasty. I was thinking to myself, but we (*referring to cultural background*) always eat tasty food and we eat well, not only with the holidays".*

Client 5 also stated that she found it difficult sometimes to connect with other group members if they shared a very different lifestyle. She mentioned to prefer individual sessions due to that.

Not only did she have a culturally diverse diet, she had a very different day schedule as a mother with young children as well. Most of her group members were retired or lived by themselves. This made it more difficult for her to connect with some of the group members.

> Client 5 (CooL): *"They have a different lifestyle. (...) You can't really compare things, because I will never have a lifestyle like that. (...) A family is different than living by yourselves, where you can choose independently."*

Furthermore, client 5 also talked about her experiences with a dietician who lacked knowledge about culturally diverse diets.

> Client 5 (CooL): *"My experience there was… that I was thinking that Dutch dietitians should also specialize in different cultures".*

6.7. Effectiveness and evaluation of the intervention

When asking clients about the effects of the intervention on their daily lives, clients (n=5) often mentioned that they were more aware about their dieting habits, physical activity levels and overall lifestyle. However, clients (n=3) also mentioned that they did not lose as much weight as they would have wanted. Some clients (n=3) mentioned that not only had they not lost weight themselves, they noticed other group members had not lost weight either.

> Client 2 (CooL): *"It could be stricter. What I notice around me is that the kilos aren't dropping off. (...) I can't say for sure how the others are experiencing it but from what I read on the group app, some of them, it isn't going well at all (...) They are also eating things they shouldn't."*

This was confirmed by client 4 who noticed that group members had not lost weight or only lost the weight that they had gained during the intervention.

> Client 4 (CooL): *"We are doing this for a year now, but I don't see any difference in anyone. There's no one of which I would say: oh, they lost weight."*

Client 3 who had recently quit the intervention was in particular skeptical about the effectiveness of the intervention.

> Client 3 (CooL): *"I might as well have bought a book about dieting, that would have been more affordable. If she* (lifestyle coach) *isn't going to add anything valuable. (…) To me, it's all actually one big disappointment."*

For client 2 it seemed like they were missing the point of the intervention during the sessions. She found that the sessions were not focused much on weight loss and wondered if others experienced the same. Furthermore, she was concerned that the interventions would not have the desired outcome for most clients when looking at the results so far. Client 2 also mentioned that she enjoyed the intervention and liked going to the sessions, but she doubted that the intervention was a "life changer" and worth the investment.

> Client 2 (CooL)*: "I am afraid that it won't have the desired effects long term for a big group of people I think (…) I enjoy going there. It is cozy, I like it (…) but whether this really is a life changer… I don't know. Looking at how much it costs (…) and if someone after two years only loses two kilos."*

Based on the findings, most clients (n=4) stated that they wanted to continue with the intervention even if they were skeptical about its results. Clients (n=5) also stated that they would want to continue with losing weight regardless of the interventions. Client 2 stated that she would not want to apply for this or a similar intervention again as she found the intervention to be noncommittal but since the intervention was not difficult and was insured, she did not want to drop out either. When asking if the clients would recommend the intervention to friends or family, two clients (clients 1 and 5) answered that they would recommend the intervention if their friends or family would need it. Client 2 was unsure if she would recommend the intervention and client 3 and 4 responded that they would not recommend the intervention the way it was currently performed.

> Client 4 (CooL): *"The way I experience it right now, I wouldn't recommend it. Then I would tell them that in my opinion they might as well go to the dietician once a month. You would have the same effects."*

Clients were also asked to rate the intervention. The average score for the intervention on a scale from 1 to 10 was 7,3. The lowest rating was for the intervention was a 6 and the highest rating was a 9. Most clients (n=4) admitted that they had higher expectations of the interventions. They had expected the intervention to be more in depth, diverse and proactive. However, there was also one client (5) who was less skeptical about the intervention. Client 5 had recently joined the intervention and was quite optimistic about its effects so far.

Interviewer: "*Is there anything you'd like to change about the intervention?*"
Client 5 (CooL)*: "I haven't seen much of it yet, but I like the way it is so far. I wouldn't' want to change anything about it."*

6.8. Conclusion

Contents of the CooL and Beweegkuur interventions were often based on dieting and behavioral change. Physical activity and sleep and stress management were less often mentioned during the group sessions. The interventions were often personalized based on the lifestyle coaches' preferences and use of their own materials and equipment (e.g. notebooks, sports equipment, group walks, or cooking sessions). Most clients preferred group sessions (n=3). Bonding with the group was important for most clients (n=3) as well. Two clients were hindered by the lack of group connection with other members and the lifestyle coach. Some clients (n=3) found the individual sessions to be less efficient to them. Clients could easily access the interventions. While some clients (n=2) could start immediately with the interventions, other clients (n=3) had to wait several weeks. Most lifestyle coaches (n=4) offering the interventions were experienced dieticians. Having a good network of health professionals was important to lifestyle coaches for the implementation of the interventions. Most clients (n=3) stated to have a good connection with the lifestyle coaches. All lifestyle coaches interviewed agreed to bonding well with clients. Few clients (client 3 and 4) were more skeptical about the lifestyle coach. Lifestyle coaches (n=5) did not notice differences in the performance of clients based on SES. However, lifestyle coaches (n=2) did mention that the CLI were not suitable for individuals with a migration background. This was mainly due to different dieting habits of individuals with a migration background and differences in lifestyle of clients. Most clients (n=5) mentioned that the interventions made them more aware about their lifestyle. However, some clients (n=3) did not notice weight loss. Several clients (clients 2 and 4) were very

skeptical about the interventions and doubted its efficiency. However, most clients (n=4) wanted to continue with the intervention. Clients' average rate for the intervention was a 7,3.

7. Intervention barriers

What are barriers experienced by clients and lifestyle coaches?

7.1. Lack of individuals with a migration background and low SES

Based on the findings some lifestyle coaches (n=3) found it challenging to recruit individuals with a migration background and a low SES. Most lifestyle coaches had few or no clients with a migration background (n=4) and a low SES (n=3). One lifestyle coach (5) mentioned that clients with a migration background should be recruited through different channels than clients without a migration background to reach them more efficiently.

> Lifestyle coach 5 (Beweegkuur)*: "It seems like people with native Dutch backgrounds are more easily willing to try this, and that you should reach people with different backgrounds through different channels (...) such as community welfare organizations or mosques (...) and yeah we didn't go to those places ."*

Another lifestyle coach (2) argued that the exclusion criteria based on language competences set by CooL could be a barrier to reaching individuals with a migration background who needed the intervention. The lifestyle coach did not consider language differences to be a barrier, particularly if lifestyle coaches were bilingual or multilingual themselves.

> Lifestyle coach 2 (CooL): *"I speak another language myself. If I speak the language of the target group, there shouldn't be an exclusion criterion based on language, because you need a lifestyle coach who speaks the language to also reach those people."*

Few lifestyle coaches (n=3) thought that misinterpretations about the intervention could keep individuals with a low SES away. Some individuals might think that the intervention would require them to follow a more expensive diet and gym membership, which they could not afford.

Lifestyle coach 3 (Beweegkuur): *"Those with low SES, I know they have a lower budget for grocery shopping. It might be more difficult for them to eat healthy. It's sometimes more expensive, to eat more vegetables. So, yeah with low SES budget is more often an issue."*

Lifestyle coach (3) mentioned to have used different methods to recruit clients of low SES, e.g. advertising in the local newspaper, handing out flyers and putting up posters. She also mentioned to have tried to reach individuals with a low SES through local social aid workers. However, it was still challenging for her to recruit individuals with a low SES for the Beweegkuur intervention in Friesland. Some lifestyle coaches (n=3) also mentioned that reaching individuals with a low SES was not a priority in this phase of the intervention. They wanted to focus on the efficient implementation of the intervention first. This was particularly due to the lack of time and the lack of compensation for additional requirements for lifestyle coaches in the interventions. Additionally, lifestyle coach 3 thought that the lack of prioritization and referral from the GPs resulted in less clients with a low SES as most clients participating initiated referral and often had a middle or high SES.

7.2. Low quantity of sessions

Most clients interviewed (n=4) found the individual and group sessions to be too low in frequency. The group sessions occurred once every few weeks and lasted 1,5 hours per session. Individual sessions were lower in frequency (one or two sessions per phase for CooL) and lasted 30 minutes per session. Based on the findings, clients (n=4) found that more sessions were required to enable lifestyle changes and maintain a good connection with the lifestyle coach and other group members. Few clients (n=2) were also concerned about the second phase of the intervention (maintenance phase), where sessions are even less frequent. Some clients (n=3) mentioned that if the sessions were more frequent the intervention would be more efficient to them. Lifestyle coach 1 agreed with needing more sessions as well.

Client 4 (CooL): *"You meet each other once a month, and then you don't see or hear anything from each other. (...) It's such a pity."*

7.3. Lack of guidance

Findings indicate that most clients (n=4) interviewed experienced a lack of guidance throughout the interventions. Clients had to discover many things themselves, e.g. initiating the referral to the intervention, finding a lifestyle coach and looking up information on the intervention. Most clients (n=4) experienced a lack of guidance from lifestyle coaches as well. Clients (n=4) interviewed found that lifestyle coaches did not offer much personal guidance but rather made them more aware about their lifestyle and habits.

Interviewer: *"Would you have liked more guidance?"*
Client 4 (CooL): *"Yes. I am like this does not stimulate me at all. Yeah, it doesn't have to be a diet but just a little bit of rules about what you should know and what you should eat or shouldn't eat."*

Some clients (n=3) felt that they had to take the initiative and guide themselves, but this did not always go well for them. They also stated that the lifestyle coach did not pressure them to lose weight.

Client 2 (CooL): *"Every session we get exercises to do at home, but I just don't do them. I don't know why. (…) but those are the contents of the program. You aren't taken by your hand and guided. It's just a support. If you don't do anything yourself, nothing will happen of course. (…) It's noncommittal, maybe too noncommittal for me to be honest. There is no pressure from the lifestyle coach at all."*

Most clients (n=4) found the information provided by the lifestyle coaches to be too broad and noncommittal. This was a barrier for some clients (n=3). Clients found it challenging to find out what to do with the information on an individual level. This was in particular frustrating for client 3.

Client 3 (CooL): *"If I don't get personal feedback… that's just difficult for me. (…) And I might have placed too much hope on the coaches and then eventually I have to do all of it myself. (…) And then I am like look I shared this with you and now what? Yeah… I am aware, I need to lose weight and I need to do it on my own, but how do I do that?"*

7.4. Lack of physical and group activities

Most lifestyle coaches (n=4) mentioned that their clients often thought that the interventions contained physical activity. Lifestyle coaches (n=4) stated that clients were often surprised by the lack of physical activity in the interventions. Few clients (n=2) also thought to be having physical activity sessions in the intervention.

> Lifestyle coach 1 (CooL)*: "I have that a lot, that people say that I told them at the intake, and it is also mentioned on the website, but anyways people think that they will join a physical activity class while they aren't."*

Lifestyle coaches from both interventions (n=5) mentioned that clients had to integrate physical activity in their lifestyles through e.g. biking, walking or taking the stairs more frequently. However, most clients (n=4) preferred doing group walks or low threshold physical activity exercises within the group sessions. Some clients (n=3) would have liked more group activities overall. Client 1 and 4 mentioned that they would like to do more group activities to encourage the group cohesion.

> Interviewer: *"Would you like to do more with the group then?"*
> Client 4 (CooL): *"Yes. That would be very nice. To do more- to have a real group connection. (...) It sounded ideal to me to do it with a group. I thought that is the power of the group sessions, to support each other and complement each other with tips and tricks."*

To combat the lack of physical activity in the intervention, lifestyle coach 5 made an agreement with a physiotherapist and the municipality to provide accessible gym membership to clients. Lifestyle coach 3 found the lack of physical activity in the interventions to be misleading to clients. She found that clients needed more guidance in physical activity, particularly clients with a low SES needed guided physical activity sessions.

> Lifestyle coach 3 (Beweegkuur): "*People are being misled because they think: we will be actively moving, and I can go to the gym for free but that isn't the case. It's just giving information and letting them figure out what to do with it, but they are often not able to do that. Especially, in low SES you have to take their hand and guide them. (...) So, in that sense it kind of feels like an empty program."*

7.5. Repetitiveness of information

Most clients (n=4) had been struggling with weight loss most of their lives. Due to this most clients (n=4) were familiar with most dieting tips and advises during the sessions. Both clients (n=4) and one lifestyle coach (lifestyle coach 5) mentioned that contents of the intervention could be repetitive at times due to this. All clients (n=5) mentioned that they had tried different dieting methods and had consulted with dieticians before as well.

Client 1 (CooL): *"I really like all of it, but it is nothing new to me. I knew all of this. That isn't the point. I knew it before the lifestyle coach was born."*

Client 1 continued that maybe one or two things were new to her, but those were new to everyone as they were recently discovered (e.g. the influence of stress on dieting). However, the advice she had received so far was not new to her. Client 2 agreed that she was familiar with most of the contents about dieting.

Client 2 (CooL): *"It is an eye opener sometimes, but I have been dieting my whole life, I know the majority."*

7.6. Additional costs and low reimbursement rates

Lifestyle coach 3 mentioned that some dieticians or physiotherapists in the CLI offered clients additional sessions outside of the CLI. If clients wanted more information on dieting or wanted physical activity sessions, clients would have to pay additional fees for it. This was particularly the case for Beweegkuur. The lifestyle coach mentioned to have intervened just in time to prevent additional costs for the client.

Lifestyle coach 3 (Beweegkuur)*: "The physiotherapists, they're more commercially minded. They might think I have a gym and I need more people (...) but luckily we were on time and we said this is not how it works."*

Client 3 also mentioned that the lifestyle coach had informed her and her group members about the possibility of additional consultation sessions with the lifestyle coach or the lifestyle coach's

colleagues outside of the CLI for more information on dieting.

Client 3 (CooL): *"And then I am like: but you are a dietician yourself where does the money from the program go to?"*

Lifestyle coach 3 from Beweegkuur mentioned that she would have liked more funding for the intervention. In one region the lifestyle coach was not able to implement Beweegkuur due to the low reimbursement rates. Lifestyle coach 5 mentioned that she could only offer Beweegkuur to a maximum of 100 clients due to referral thresholds by the health insurance company which only provided reimbursement for 100 clients.

7.7. Time consuming and lack of compensation

Lifestyle coaches (n=5) often had to perform additional requirements for the interventions which they were not reimbursed for. Implementing the interventions was very time consuming to most lifestyle coaches (n=3). They were hindered by the extra time they invested in the interventions, particularly due to the lack of compensation for the additional requirements. Lifestyle coaches had to set up the intervention in the primary healthcare and organize the sessions themselves. Lifestyle coaches also had to build a good referral network consisting of e.g. the GP or GPA, (for Beweegkuur: physiotherapist and dietician), sports coach, local welfare organization, healthcare group, health insurance company and the municipality. Most lifestyle coaches (n=3) stated to have a good network, except for two lifestyle coaches who mentioned that they should focus more on expanding their network. However, they also mentioned that this was not a priority yet as they experienced a lack of time due to the implementation of the interventions.

Lifestyle coach 1 (CooL): *"You're very busy at the start with setting everything up, preparing for each session, the declarations and the program, how all of it works. A lot of energy goes into that."*

Lifestyle coaches (n=5) also had to look for their own office space and pay additional renting and material costs which they were not compensated for. Two lifestyle coaches mentioned that the intervention contained a lot of administration and paperwork which were

very time consuming. Lifestyle coach 3 and 5 were demotivated by the lack of time and compensation for the additional requirements. Lifestyle coach 3 mentioned that health insurance companies and healthcare groups required lifestyle coaches to monitor the progress of clients. However, this was also a time-consuming process which lifestyle coaches did not receive a compensation for.

> Lifestyle coach 3 (Beweegkuur)*: "It's all in your free time. Well I am not looking forward to it. And they want us to monitor the weight loss of clients, but we are not getting compensated for that. Sometimes I am just done with it, then I am like find someone else who'll do that for that money."*

7.8. Beweegkuur: insufficient content and materials

Lifestyle coach 3 and 5 from Beweegkuur stated that the materials from the Beweegkuur intervention were complex and difficult to implement in practice. The lifestyle coaches mentioned that they had received different intervention materials from Beweegkuur and it was often unclear which material was for the lifestyle coach and which for the dietician. Lifestyle coach 5 argued that materials for physical activity sessions from Beweegkuur were also too expensive. She bought the materials for a lower price elsewhere. Lifestyle coach 3 mentioned that Beweegkuur used extensive questionnaires which some clients, particularly with a low SES, found challenging to fill in. Additionally, lifestyle coach 3 argued that the five major food groups used by Beweegkuur were in fact not suitable for overweight individuals. The five major food groups are based on a healthy diet for individuals who are not overweight. Overweight individuals should consider avoiding certain foods from the five major food groups which are high on carbohydrates. She mentioned that she did not recommend the five major food groups to her clients. Another barrier mentioned by both lifestyle coaches was that the current Beweegkuur was a "dressed down" version of the original Beweegkuur. The lifestyle coaches mentioned that they had to "dress up" the intervention themselves. They stated that the original Beweegkuur was more comprehensive and contained more sessions with clients. Lifestyle coach 3 mentioned that the current Beweegkuur intervention was very limited but aimed to achieve the same results as the previous intervention. However, she thought this to be unlikely.

Lifestyle coach 3 (Beweegkuur)*: "Well I am actually surprised how the CLI got in the basic insurance package. They're supposedly effective programs but they looked at results of a more extensive program than what's in the basic health insurance. (...) It contained more physical activity. And I am actually amazed, because they say that the health insurers were satisfied with the program because people lost 1,9 kg in two years. (...) If clients would lose 1,9 kg in one month, I'd be happy but not in two years."*

7.9. Conclusion

Several barriers were experienced by clients and lifestyle coaches. Several lifestyle coaches (n=3) found it challenging to recruit individuals with a migration background and a low SES. Most lifestyle coaches had few or no clients with a migration background (n=4) and a low SES (n=3). Lifestyle coaches had different explanations for the lack of individuals with a migration background and a low SES. One lifestyle coach thought that individuals with a migration background should be reached through different channels (e.g. community welfare organizations). Another lifestyle coach thought that the exclusion criteria based on language competences could be a barrier for individuals with a migration background. Lifestyle coaches (n=3) also thought that individuals with a low SES were often not participating in the interventions as they might think that they would have to pay for additional costs. For some lifestyle coaches (n=3) the implementation of the interventions was more important than reaching individuals of target groups such as individuals with a migration background and a low SES. Some clients (n=4) would have liked more individual and group sessions. Clients (n=4) also experienced a lack of guidance during the intervention and a lack of guidance from the lifestyle coaches. Most clients (n=4) found the interventions to be noncommittal and would have liked more personal guidance from the lifestyle coaches. Most clients (n=4) also would have liked more group activities and physical activity sessions with the group members. Lifestyle coaches (n=4) mentioned that their clients often thought that the interventions contained physical activity sessions. Two clients also thought that they would do physical activity within the group sessions. Most clients (n=4) found the contents of the interventions repetitive, particularly the contents about dieting. Most clients (n=4) were familiar with most contents about dieting. All clients had tried different methods to lose weight before starting with the interventions. Lifestyle coach 3 mentioned that some CLI providers offered clients additional sessions outside the CLI. Clients would have to pay extra fees for these sessions. Client 3 confirmed that this happened in her group. Lifestyle coaches (n=5) often had to perform

additional requirements for the interventions. These interventions were often time consuming and lifestyle coaches were often not compensated for it. Additional requirements consisted of e.g. setting up a network, renting office space and administrational work. Lifestyle coaches from the Beweegkuur intervention mentioned that the intervention materials were insufficient, and the intervention was “dressed down”. They mentioned that the intervention used to be more comprehensive and contained more sessions.

8. Recommendations

What are recommendations of clients and lifestyle coaches to improve the CLI?

8.1. Recommendations by lifestyle coaches

Lifestyle coaches were asked to provide recommendations on different areas where they experienced barriers. Table 4 shows a summary of the recommendations provided by lifestyle coaches. Lifestyle coaches (n=3) mentioned that they found it challenging to reach individuals with a migration background or lower SES. Most lifestyle coaches (n=4) would prefer additional referral points alongside the GP to reach these target groups. Additional referrers could be (hospital) specialists, social aid workers and local welfare organizations. Social aid workers and local welfare organizations are often in close contact with the target groups and could identify individuals in need of the intervention more quickly. Specialist working at hospitals often receive patients with lifestyle related health problems and could refer these patients to the lifestyle coach. Lifestyle coaches (n=3) also stated that for some individuals, particularly individuals of lower SES, having to go to the GP could be a barrier to the intervention which they might be unwilling to take.

> Lifestyle coach 1 (CooL): *"It would be nice to have additional referrers. I sometimes hear for example that people ask the cardiologist advice and they tell them to go to their GP for a referral. And well yes, that can be a barrier for these people* (about low SES)*."*

Lifestyle coaches (n=2) mentioned that healthcare groups and health insurance companies usually focus on weight reduction of clients as an outcome of the intervention. The improved quality of life of clients is often overlooked. However, lifestyle coaches also recommended improved quality of life of clients as an important outcome of the intervention. To involve GPs and GPAs more in the CLI, one lifestyle coach (3) recommended that the CLI should be promoted at the annual congress of the Dutch GPs Association (NHG). Lifestyle coach 1 recommended to use the CLI as a prevention method for individuals not yet diagnosed with overweight, obesity or comorbidities. She mentioned that lifestyle change at an earlier phase could prove more effective.

All lifestyle coaches (n=5) confirmed the importance of a good network with other health professional. Lifestyle coaches (n=3) recommended the improvement of the network around the CLI to reach more clients from target groups. To combat the lack of physical activity and group activities, lifestyle coach 3 recommended employing volunteers, low threshold social aid workers or community service workers who could offer group activities, group walks and low threshold physical activity exercises. The volunteers, low threshold social aid workers or community service workers could be trained and guided by health professionals (lifestyle coach, physiotherapist or dietician). By doing this accessible group activities can be integrated into the interventions.

Lifestyle coach 3 and 5 recommend the improvement of the materials from Beweegkuur. Lifestyle coach 3 recommends the use of less complex questionnaires for clients. Lifestyle coach 5 recommends a depot where materials (e.g. sports equipment) can be picked up for a low fee. Lifestyle coach 5 also recommends the digitalization of Beweegkuur. She mentioned that Beweegkuur made use of a lot of paperwork.

> Lifestyle coach 5 (Beweegkuur): *"It's all on paper. You can't do it digitally, but that would be really motivating, to be able to do it more easily. (...) Now I have to do everything manually."*

Recommendations of lifestyle coaches
• Enable additional referrer points
• Include improved quality of life in outcomes
• Promotion of the CLI amongst GPs
• The CLI as a prevention method
• Improvement of network
• Use of budget low professionals
• Improvement of the contents of the intervention (Beweegkuur)

Table 4. Recommendations of lifestyle coaches

8.2. Recommendations by clients

Clients were asked to provide recommendations on areas they experienced barriers as well. Table 5 provides a summary of the recommendations by clients. Based on the results, most clients (n=4) would have liked more guidance during the sessions. Clients would have preferred the intervention to be more in depth and committal. Client 4 also mentioned she would have liked to be assisted by the GP when finding a lifestyle coach. Clients (n=4) also would like to do more group activities and more physical activities within the group sessions. The physical activity sessions did not have to be extensive (e.g. group walks). Most clients (n=4) also recommended more and more frequent sessions, in particular more group sessions. Client 5 would have liked to have more (culturally) diverse diets within the intervention. Client 3 recommended that clients should have no additional costs when participating in the interventions.

Recommendations of clients
• More guidance
• More group activities
• Include physical activity within sessions
• Increase quantity of sessions
• Include diverse diets
• No additional costs

Table 5. Recommendations by clients

8.3. Conclusion

Both clients and lifestyle coaches had several recommendations to improve the intervention. Recommendations by lifestyle coaches contained the implementation of additional referrer points, the inclusion of improved quality of life as an outcome, the promotion of the CLI amongst GPs and GPAs, the introduction of the CLI as a preventive method at an earlier stage, the improvement of the network of the lifestyle coach, the use of low budget professionals for e.g. group activities, and the improvement of the contents of the CLI (Beweegkuur).

Recommendations by the clients consisted of more guidance during the sessions, more group activities and physical activities during the sessions, more and more frequent sessions, the inclusion of diverse diets, and no additional costs for clients.

9. Discussion

This study investigated different areas of assessment of the CLI CooL and Beweegkuur to assess its suitability and inclusiveness for both clients and lifestyle coaches. The different phases investigated in the interventions were selection of clients, referral of clients, and suitability of the interventions. Additionally, barriers were identified, and clients and lifestyle coaches were asked to provide recommendations for the improvement of the interventions. In this study inclusiveness implied that all individuals eligible for the interventions should be reached and included and have equal access to the interventions, but also in that the contents and materials of the interventions should be inclusive and appropriate for all individuals participating, particularly for individuals with a migration background and low SES. Individual in-depth semi-structured interviews with clients and lifestyle coaches were conducted to evaluate the interventions.

9.1. Discussion of results

Based on the experiences of clients and lifestyle coaches the current CooL and Beweegkuur interventions contained several obstacles for clients and lifestyle coaches. Based on the results some areas of the interventions were not suitable for the clients in general and not inclusive for individuals with a migration background and a low SES. Both clients and lifestyle coaches experienced several barriers which hindered their participation.

Clients experienced varying (health) complications due to overweight. Overweight was also the main incentive for clients to participate in the interventions. Most clients participating in the interventions were middle aged females. The average age of the clients interviewed was 59. This was confirmed by a report of the RIVM by Blokhuis (2019). Of all participants, 69% were female with an average age of 52 (Blokhuis, 2019). Dropouts were relatively low in both interventions. However, the CooL intervention appeared to be more popular amongst clients based on the report of the RIVM. The CooL intervention had more registered clients for the CLI (613) compared to Beweegkuur (278) (Blokhuis, 2019). Based on the demographic questionnaire, most clients interviewed had a middle SES. Two clients had a second-generation migration background, of which one client had a western and one client a non-western migration background.

Clients were able to participate in the interventions after referral from the GP. However, most GPs were not involved in the referral process. GPAs often took over the role of the GP as the referrer of clients. Additionally, clients sometimes initiated referral themselves. Some clients also stated that they received no or little assistance from the GP or GPA in looking for a lifestyle coach. Clients also mentioned that they looked for information about the interventions themselves online after e.g. hearing about the intervention from friends or family. Clients were not monitored on their progress by GPs or GPAs either. Several studies and reports confirm that there is a lack of participation and a lack of knowledge from the GPs regarding the CLI (RIVM, 2019a; Nederlandse Zorgautoriteit, 2019; RIVM, 2019b). Some lifestyle coaches also experienced a lack of motivation from the GPs. They stated that the CLI was often not a priority for GPs and that GPs were often too busy to be focused on prevention and lifestyle interventions. To address the lack of referral, several lifestyle coaches recommended additional referral channels. Referral from e.g. medical specialists or local social aid workers could increase the inclusiveness of different clients in the interventions as well. Particularly for individuals with a migration background or with a low SES additional referrer could be beneficial.

The inclusion criteria of both interventions were mostly similar, but the interventions differed in their intake assessment. The Beweegkuur intervention made use of extensive intake questionnaires which clients sometimes found difficult to fill in. Candidates could be excluded based on several factors. The CooL intervention had several additional exclusion criteria such as exclusion based on language competences. This was in particular a barrier for inclusiveness of individuals with a migration background. The Beweegkuur intervention had additional exclusion criteria as well. If candidates scored low or high on e.g. physical activity they could be excluded from participation. Scoring low indicated a lack of motivation while scoring high indicated that the candidate's lifestyle was already sufficient. Clients' motivation was an important requirement for participation in both interventions as well.

Both clients and lifestyle coaches liked that there were individual and group sessions in the interventions. The individual sessions were open for clients to organize themselves. However, expecting clients to do a lot themselves during the sessions could be contradicting to the purpose of the interventions as most clients required a lot of guidance. Clients also expected more guidance from the lifestyle coach as they had already tried different methods to lose weight by themselves. Most clients experienced a lack of guidance due to the low frequency of sessions and noncommittal nature of the interventions. Additionally, clients required more activities within the groups but also more physical activity sessions with group members. The

group sessions were an important incentive for some clients to stay motivated. Clients who did not feel a group connection felt more hindered in participating in the intervention. Clients who had a different lifestyle or dieting habit from most of the group members felt less connected.

Some clients mentioned to find the lifestyle coach not experienced enough. They mentioned to feel no pressure to lose weight and would have liked a more experienced lifestyle coach. This was confirmed by Gutter and Stuij (2019) who discussed the competencies of lifestyle coaches. Lifestyle coaches with more competencies, e.g. medical background, could be more effective for the target group of the CLI.

Most clients did not experience desired weight loss in themselves or in group members after having participated for several months. Clients often based the effectivity of the intervention primarily on weight reduction and not on lifestyle improvements or improved quality of life. Lifestyle coaches mentioned that improved quality of life was not considered a considerable outcome by health insurance companies either and would like to include improved quality of life as an outcome of the interventions. A study by Berendsen et al. (2015) about the Beweegkuur intervention showed similar results. Clients in the study also expected immediate weight loss as an outcome to assess the effectivity of the intervention. However, clients were less focused on the improvements in their lifestyle in terms of dieting and physical activity (Berendsen et al. 2015).

The interventions had a relatively low intake of individuals with a migration background. Literature confirms that individuals with a migration background participate less in lifestyle interventions (Bukman, 2016). In most groups there was a lack of cultural diversity. Most groups had few or no individuals with a migration background. Of the groups with more individuals with a migration background, the lifestyle coaches had a migration background as well. The contents of the interventions were not always inclusive and suitable for clients with a migration background either. This was also confirmed by lifestyle coaches. Lifestyle coaches from Beweegkuur admitted that the interventions might not be suitable for clients with a migration background. The Beweegkuur intervention used the five major food group which were primarily based on Dutch dieting habits.

Clients' SES were assessed with demographic questions based on their current occupation, income, and highest obtained degree. Most clients had a middle SES based on the questionnaire. Lifestyle coaches mentioned to have few or no clients with a low SES. However, lifestyle coaches also mentioned to find it challenging to recognize intervention performance of clients based on their SES. There was no difference in intervention performance and understandability based on the SES of clients. Lifestyle coaches also mention edthat they found

it challenging to reach clients with a low SES. However, reaching target groups such as low SES was not a priority for some lifestyle coaches as they were often too busy with the implementation of the interventions. Literature confirms that individuals with low SES often participate less in lifestyle interventions and are more difficult to reach (RIVM, 2019d). Nevertheless, a recent report also indicated that of the 1337 clients who are registered in the CLI, 37% had a low SES (Blokhuis, 2019). However, the report did not describe how the SES of the clients were assessed and did not consider dropouts.

Lifestyle coaches experienced several barriers which made offering he interventions more difficult for them. Most lifestyle coaches found the contents and materials used for the interventions to be insufficient and complex, particularly for Beweegkuur. The contents of the intervention were complex, and materials used were expensive as well. Lifestyle coaches used their own additional materials from e.g. the dietician practice or bought inexpensive material elsewhere. Most lifestyle coaches were experienced dieticians. Lifestyle coaches also mentioned the interventions to be very time consuming. The interventions required many additional requirements from lifestyle coaches. Lifestyle mentioned to have an administrative burden, particularly due to the complex content and materials, but also due to the additional paperwork and organization of the interventions. This was also confirmed by recent reports of the RIVM (RIVM, 2019d). Lifestyle coaches had to discover many things themselves in trial and error. Setting up a network was experienced to be time consuming as well. However, lifestyle coaches did not receive a compensation for the additional requirements of the intervention. Gutter and Stuij (2019) confirm the barriers in the implementation of the interventions by health professionals. The interventions were implemented too quickly while some aspects of the CLI were not finished in practice (Gutter and Stuij, 2019).

9.2. Methodological reflection

This study used the qualitative description research approach to explore the suitability and inclusiveness of the CLI CooL and Beweegkuur in different phases of the interventions. Data was collected through in-depth semi-structured interviews with clients and lifestyle coaches through purposeful and snowball sampling. Five clients (CooL n= 5) and five lifestyle coaches (CooL n= 3, Beweegkuur n= 2) were interviewed for this study.

This study had several strengths. Qualitative studies are essential as they can describe in-depth experiences of the study population. Qualitative interviews can provide more insight into

the barriers experienced by both clients and lifestyle coaches and leaves more room for recommendations. Additionally, there are not many studies that represent the views and experiences of clients and lifestyle coaches on this topic in a qualitative in-depth manner. To gain more insight into what clients and lifestyle coaches experienced, two different sets of questionnaires were developed. Lifestyle coaches from both CooL and Beweegkuur were selected from different regions to increase variety of outcomes. Systematic text condensation was used to systematically analyze the data based on the stepwise descriptions of Malterud (2012). Additionally, purposeful sampling is a strength if time and study population are restricted. However, it can also become a limitation as it can increase researcher bias due to its vulnerability to judgment errors (Research-Methodology, 2019a).

Another limitation of this study was that there were no clients interviewed from Beweegkuur due to nonresponse. Clients and lifestyle coaches from SLIMMER were not included either due to nonresponse as a result of a short recruitment period for this study. An additional limitation of this study was that it was challenging to include clients with a migration background and low SES. Lifestyle coaches were selected based on a map of the SES per postal region in the Netherlands by Volksgezondheidenzorg (2020b). However, this did not ensure the inclusion of many clients with a low SES. Furthermore, SES is a complex concept which is challenging to assess, and lifestyle coaches found it challenging as well to indicate the SES of clients or answer questions related to the SES of clients. Qualitative in-depth interviews are a strength but also a limitation of this study. As there were only ten study participants, this study represents a limited view of the experiences of clients and lifestyle coaches. However, even though the number of study participants were low, there were similarities in the experiences of study participants from different regions. Additionally, several results of this study were confirmed with recent reports about the CLI (Gutter and Stuij, 2019; RIVM, 2019a; Nederlandse Zorgautoriteit, 2019; RIVM, 2019b).

9.3. Implications for further research

The findings of this study show that there are many similarities between clients and lifestyle coaches from different regions. This indicates that the similarities which are found between the clients and lifestyle coaches interviewed might be widespread. To confirm this, further research in different regions is needed. Particularly due to the confirmation of several findings of this study by literature as well. Further research is also needed into the relationship of lifestyle coaches who have a migration background and the inclusion of more clients with a migration

background in their intervention. As this was an extensive study with several sub questions and areas of assessment, more in-depth research should be conducted into the separate sub questions and the different areas of assessment (selection of clients, referral of clients, suitability of the interventions and the barriers experienced) to gain more insight into the different areas of the CLI. Additionally, research can be conducted on the low SES of clients in the interventions and the challenges lifestyle coaches face to indicate low SES of clients but also on the challenge to reach individuals with a low SES. As this study could not include experiences from lifestyle coaches from SLIMMER and experiences of GPs and GPAs, further research into the experiences of both health professionals should be conducted to gain more insight into the CLI.

9.4. Implications for practice

This study provides several implications for practice to improve the suitability and inclusiveness of the CLI CooL and Beweegkuur.

9.4.1. Referral

To increase referral and commitment from the GPs and GPAs, the CLI should be brought under the attention of the GPs more often, e.g. inclusion of the CLI in annual meetings of the GPs, (the congress of the Dutch GPs Association NHG). Additional referrers alongside the GPs and GPAs should be implemented as well (e.g. social aid workers and medical specialists) to increase the inclusiveness of individuals with a migration background and a low SES and additionally reduce the burden of referral from GPs and GPAs.

9.4.2. Inclusiveness of individuals with a migration background and low SES

The interventions should include different (culturally diverse) diets. There should be more awareness from lifestyle coaches on how to offer the interventions to individuals with a different lifestyle e.g. individuals with a migration background or lower SES. Additional training should be provided for lifestyle coaches about the inclusiveness of clients and how to offer the CLI to clients with a migration background and clients with a low SES. A CLI should be implemented specifically for women (of ethnic minorities) who would not want to participate in the CLI if groups are mixed due to religious reasons. Lifestyle coaches with a culturally diverse background who are multilingual, or interpreters and translators could assist in providing the CLI to individuals with a language barrier. Additionally, the implementation of

an intervention developed for individuals with a low SES could be useful in reaching more individuals with a low SES as well.

9.4.3. Contents and materials

To reduce the administrational burden, all contents and materials should be digitalized and stored in one location per intervention (e.g. online database). Lifestyle coaches should have easy access to the contents and materials. Contents and materials should be concise and understandable (Beweegkuur). The current interventions leave too much room for interpretation for lifestyle coaches. Organizing and implementing the interventions are very time consuming for lifestyle coaches as well. An implementation framework should be developed which includes an outline of the sessions and can assist the lifestyle coaches in implementing and organizing the interventions more efficiently.

9.4.4. Individual and group sessions

The frequency and quantity of individual and group sessions should be increased. Group sessions should include more group activities (e.g. cooking sessions) and physical activity sessions (e.g. group walks). There should be more extensive guidance and coaching from lifestyle coaches where clients receive personal feedback on their process and lifestyle coaches closely monitor the progress of clients. Low budget volunteers or local social aid workers could offer the group activities and low threshold physical activity sessions in the groups.

9.4.5. Lifestyle coaches

Lifestyle coaches should establish a good network to improve the coordination between the different parties involved (e.g. dieticians, physiotherapists, sports coach, local social aid workers, welfare organizations, the municipality, health care groups, and health insurance companies). The coordination of the different parties involves the provision of a clear standard reimbursement tariff to minimize additional costs which are not accounted for. Additionally, improved quality of life should be included as an outcome of the intervention. Lifestyle coaches should also be compensated for the additional requirements of the interventions (e.g. setting up the intervention, networking and monitoring clients).

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Appendix I. Flyers for participation clients

CooL, SLIMMER & Beweegkuur

UITNODIGING MEE TE DOEN AAN EEN ONDERZOEK NAAR DE GECOMBINEERDE LEEFSTIJLINTERVENTIES (GLI)

Voor wie:

Iedereen die meedoet aan een van de volgende interventies: CooL, SLIMMER, Beweegkuur en over zijn/ haar ervaringen wil vertellen.

Wat vindt u van de hulp die u krijgt bij het aanpassen van uw leefstijl?

Wij gaan graag met u in gesprek om te horen wat er goed gaat en wat er beter kan.

Waar:

In de praktijk zelf waar u de interventie volgt.

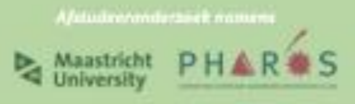
Heeft u interesse?

Neem dan contact op met uw leefstijlcoach of neem contact op met:

Fattana Mohammad
Tel.: 06 85 307256
f.mohammad@pharos.nl

Als dank voor deelname krijgt u een VVV-bon ☺☺☺

Afstudeeronderzoek namens



Appendix II. Questionnaire lifestyle coaches

Kenmerken leefstijlcoach

U bent: fysiotherapeut/ diëtist/ leefstijlcoach/ of iets anders bij CooL/ SLIMMER/ Beweegkuur.

1. Kunt u mij kort iets vertellen over het programma dat u aanbiedt, bijvoorbeeld welke onderdelen aan bod komen?
    a. Wat voor materialen gebruikt u tijdens het programma, worden er boekjes gebruikt of apps?
    b. Wat maakt uw programma anders dan andere leefstijlinterventie programma's Gebruikt u bijvoorbeeld andere methodes, bijvoorbeeld een kookles of lichamelijke beweging les?
2. Hoe is de samenwerking in de wijk? Met wie werkt u samen (bijvoorbeeld buurtsportcoach)?
    a. Werkt u samen met de sociale wijkteams?
    b. Heeft u een goed netwerk om cliënten voldoende te kunnen bereiken?
3. Heeft u al veel ervaring op kunnen doen bij het programma dat u aanbiedt?

Verwijzing

Nu volgen er een aantal vragen over de verwijzing van cliënten door de huisarts.

4. Wat vindt u van de huisarts als aanmeldpunt voor de gecombineerde leefstijlinterventie?
    a. Zou u de rol van de huisarts als aanmeldpunt willen veranderen?
    b. Vindt u dat u voldoende cliënten bereikt via de huisarts?
5. Hoe zou u nog meer cliënten kunnen bereiken voor uw leefstijl programma?

Het kan ook zijn dat sommige huisartsen meer patiënten verwijzen dan anderen. Uit onderzoek blijkt dat veel huisartsen patiënten niet verwijzen om verschillende redenen.

6. Zijn er huisartsen die vaker hun patiënten naar u verwijzen dan andere huisartsen?
    a. Waaraan zou het kunnen liggen dat sommige huisartsen meer patiënten verwijzen dan anderen?
        i. Zijn de huisartsen goed op de hoogte van uw programma?
    b. Welke patiënten worden er door de huisarts verwezen naar u?
        i. Komt het voor dat patiënten wel aan de voorwaardes voldoen maar niet worden verwezen door de huisarts? Waarom niet/ waarom wel?
        ii. Of andersom dat patiënten wel verwezen worden maar niet besluiten om naar een leefstijlcoach te gaan? Weet u waarom dat is?
    c. Zijn het vaker de patiënten die naar de huisarts stappen voor een verwijzing of de huisarts het initiatief neemt en patiënten verwijst?
7. Onderzoek geeft aan dat mensen uit kwetsbare groepen niet altijd voldoende worden bereikt voor leefstijl interventies, maar de interventies wel het meest nodig hebben. Vindt u dat die mensen ook voldoende naar u verwezen worden door de huisarts? En met kwetsbare groepen bedoel ik bijvoorbeeld mensen met minder gezondheidsvaardigheden of met een lagere opleiding.
8. Is het voorgekomen dat u cliënten heeft afgewezen na een verwijzing van de huisarts?
    a. Op basis waarvan zou u een cliënt afraden om aan het programma mee te doen?
9. Heeft u ook cliënten in uw programma die niet door de huisarts zijn verwezen? Bijvoorbeeld via de POH?

Cliënten

Nu volgen er een paar vragen over uw ervaring met de cliënten aan het programma.

10. Aan hoeveel cliënten geeft u het programma op dit moment?
11. Krijgt u voornamelijk cliënten uit deze wijk/ de wijk waar uw praktijk is gevestigd of ook uit andere wijken?
    a. (Doorvragen: Heeft u een beeld van wat voor mensen er wonen in deze wijk)?
12. Waaruit bestaat uw deelnemersgroep voornamelijk. Bijvoorbeeld qua leeftijd, beroep, migratie achtergrond of geslacht?
    a. Wat hebben de cliënten die aan het programma meedoen met elkaar gemeen?
    b. Zijn er ook opmerkelijke verschillen tussen de cliënten die meedoen?
    c. Heeft u ook veel cliënten uit kwetsbare groepen? Bijvoorbeeld cliënten die lagere gezondheidsvaardigheden hebben, of lager opgeleid zijn?

De leefstijlinterventie programma's zijn er voor iedereen die ervoor in aanmerking komt.

13. Vindt u dat het programma ook geschikt is voor iedereen die ervoor in aanmerking komt?
    a. Voor wie zou de leefstijlinterventie niet of minder geschikt zijn?

Sommige mensen hebben minder toegang tot een gezonder leefstijl door bijvoorbeeld de wijk waarin ze leven of de financiële middelen die ze hebben.

14. Vindt u dat het programma ook net zo geschikt is voor die mensen?
    a. Nederland heeft een multiculturele samenleving. Sluit het programma ook aan bij cliënten met een ander culturele achtergrond of met een andere leefwijze?
    b. Friesland: Bent u bekend met de 8 Turkse vrouwen die gestopt zijn met de GLI omdat het niet aansloot?

Nu ga ik een paar vragen stellen over wat de cliënten van het programma vinden.

15. Zijn er cliënten die meer moeite hebben met het volgen van het programma dan anderen?
    a. Welke cliënten zijn dat? Heeft u daar voorbeelden van?
        i. Merkt u verschillen tussen cliënten uit kwetsbare en niet kwetsbare groepen? Bijvoorbeeld tussen cliënten die hoger op lager opgeleid zijn en of meer of minder gezondheidsvaardigheden hebben?
    b. Welke onderdelen van het programma vinden cliënten het moeilijkst?
16. Heeft u al cliënten gehad die zijn gestopt met het programma?
    a. Wat voor cliënten waren dat? Heeft u voorbeelden?
        i. Merkt u verschillen tussen kwetsbare en niet kwetsbare groepen in de uitvallers bij het programma? Heeft u voorbeelden?
    b. Waarom denkt u dat die cliënten sneller stoppen?
        i. Besteed u ook meer aandacht aan deelnemers die minder gemotiveerd zijn, bijvoorbeeld door cliënten meer te motiveren? Heeft u voorbeelden?
    c. Wat kan er gedaan worden om cliënten minder snel te laten stoppen?

Cliënten en hun leefstijl staan centraal bij de leefstijl interventie. Het is daarbij belangrijk om een goede band met de cliënten op te bouwen.

17. Heeft u het gevoel dat u een goede band heeft met de cliënten?
    a. Begrijpen de cliënten u ook goed en begrijpt u de cliënten goed? Voorbeeld?
    b. Hebben de cliënten ook een goede band met elkaar?

18. Praat u ook met cliënten over problemen in hun dagelijkse leven? Bijvoorbeeld over armoede, schulden, werkeloosheid, laag geletterdheid? Kunt u een voorbeeld noemen?
    a. Wat gebeurt er als cliënten geen toegang hebben tot gezonder eten en meer bewegen, gezond eten is bijvoorbeeld duurder. Kunt u een voorbeeld noemen?
        i. Merkt u verschillen daarin tussen kwetsbare en niet kwetsbare groepen in uw sessies?
    b. Wat doet u als er complexe problemen zijn die u bijvoorbeeld niet zelf kunt oplossen?

Uitvoering

Ik ga nu een paar vragen stellen over de uitvoering van het programma.

19. Wat zijn obstakels waar u tegen aan loopt bij het goed uit kunnen voeren van uw programma?
    a. Wat vindt u zelf van de verschillende onderdelen: voeding, beweging en stress en slaap management?
    b. Vindt u de materialen die u daarvoor gebruikt geschikt?
    c. Begrijpen de cliënten de materialen ook goed?
    d. Bij wie sluit het minder goed aan?
    e. Heeft u toegang tot alle kennis en materialen die u nodig hebt om het programma goed uit te voeren?

Er zijn groeps- en individuele sessies.

20. Merkt u dat de cliënt meer heeft aan de groeps- of de individuele sessies?
    a. Zou u iets willen veranderen aan de groep sessies en individuele sessies?
21. Past u de groep en individuele sessies ook regelmatig aan op basis van wat beter werkt? Of is er een standaardbehandeling?
    a. Hoe past u de sessies aan? Kunt u voorbeelden geven? (Bijvoorbeeld als een cliënt minder geld heeft om gezond eten dan een ander)?
    b. Hoe gaat u om met de verschillen tussen cliënten?
        i. Merkt u verschillen tussen kwetsbare en niet kwetsbare groepen?

Het doel van de gecombineerde leefstijlinterventie is dus het kunnen veranderen van ongezonde leefstijlen.

22. Vindt u dat uw leefstijl programma effectief is tot nu toe in het veranderen van ongezonde leefstijlen?
    a. Wat vindt u minder effectief aan het programma?
    b. Welke factoren spelen mee bij de verhindering van leefstijlveranderingen in cliënten?
    c. Volgen cliënten altijd uw adviezen op?

CooL werkt voornamelijk met een leefstijlcoach, maar SLIMMER en Beweegkuur werken met een team bestaande uit bijvoorbeeld een diëtist, fysiotherapeut of leefstijlcoach.

    a. Wat is uw mening daarover? Waar gaat uw voorkeur naar uit?

Een ander belangrijk aspect van de leefstijlinterventie is duurzame gedragsverandering.

23. Hebben cliënten blijvend gedragsverandering tot nu toe?
    a. Hoe zou u het programma meer duurzaam willen maken?
24. Heeft u vaak te maken met cliënten die terugvallen op oude leefstijl patronen? Of gaan cliënten ook zelfstandig door?

a. Wat belemmert cliënten om zelfstandig door te gaan (bijvoorbeeld door minder financiële toegang tot sportcentrum en gezonder voeding)?

Tot slot.

25. Wat zou u willen veranderen aan: CooL, Beweegkuur, SLIMMER? (Bijvoorbeeld andere verwijzing methode of criteria voor deelname, of meer sessies)?
    a. Heeft u ook de ruimte om die veranderingen aan te brengen?
    b. Wat zou er veranderd moeten worden om kwetsbare groepen nog beter te kunnen bereiken?
26. Hoe zou de gemeente en zorgverzekeraars kunnen bijdragen aan een betere leefstijl programma? Wat heeft u als leefstijlcoach (of diëtist/ fysiotherapeut) bijvoorbeeld nodig van de gemeente?
    a. Hoe kan de gemeente bijdragen aan een meer geschikte leefstijlinterventie programma voor kwetsbare groepen?
27. Zijn er nog andere dingen die u zou willen zeggen waar we het niet over hebben gehad?

Appendix III. Questionnaire clients

Demografische vragen deelnemer

1. Wat is uw geslacht?
   - Vrouw
   - Man
   - Niet-binair/ derde gender
   - Wilt zelf uitleggen
   - Wilt openlaten
2. Wat is uw leeftijd? ___________________________________

(Indien leeftijd niet wordt genoemd.)

3. Tot welke van de volgende leeftijdscategorieën behoort u?
   - 18-24
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65-74
   - 75+
4. Waar bent u geboren?
   - In Nederland
   - Ergens anders: ___________________________________
5. Wat is de achtergrond van uw ouders?
   - Nederlands
   - Surinaams
   - Turks
   - Marokkaans
   - Indonesisch
   - Chinees
   - Anders: ___________________________________
6. Wat is uw burgerlijke staat?
   - Ongehuwd
   - Samenwonend
   - Gehuwd/ geregistreerd partnerschap
   - Gescheiden
   - Weduwe/ weduwnaar
7. Wat is uw hoogst behaalde diploma?
   - Geen opleiding/ onvolledige basisonderwijs
   - Basisschool
   - Middelbaar geen opleiding (vmbo/mavo/ havo/ vwo)
   - Middelbaar met diploma (vmbo/mavo/ havo/ vwo)
   - Middelbaar beroepsonderwijs (mbo)
   - Hoger beroepsonderwijs (hbo) of technische hbo-opleiding
   - Universiteit bachelorsdiploma
   - Universiteit Masters diploma
   - Universitair gespecialiseerd diploma (Doctoraal, Juridisch)
   - Anders: ___________________________________

(Indien deelnemer opleidingsniveau niet weet)

8. Hoeveel jaar bent u naar school geweest? ________________________________
9. Heeft u werk op dit moment? / Wat voor werk deed u?
    - Werkeloos
    - Vrijwilligerswerk
    - Parttime werkzaam
    - Fulltime werkzaam
    - Gepensioneerd
    - Arbeidsongeschikt
10. Waar komt het grootste deel van uw inkomen vandaan?
    - Een betaalde baan
    - Een uitkering
    - Niet-geregistreerd werk (zwart werken)
    - Anders: ________________________________
11. Weet u wat uw (gezamenlijke) maandelijkse inkomen is?
    - 770 euro per maand of minder
    - Tussen de 770 euro en – 2000 euro per maand.
    - Meer dan 2000 euro per maand
12. Met wie woont u samen:
    - Met mijn partner/echtgenoot of echtgenote
    - Met kind(eren) jonger dan 18 jaar
    - Met kind(eren) van 18 jaar of ouder
    - Met mijn ouder(s) of ander familielid
    - Met een andere volwassene/ andere volwassenen
    - Dakloos

Inhoudelijke vragen over GLI

We gaan het nu hebben over het programma waar u aan meedoet. Ik stel u vragen over uw ervaring met het programma. Het is belangrijk voor ons om te weten wat u echt van het programma vindt. U mag het ook hebben over dingen die u minder leuk vindt aan het programma. Er is geen juist antwoord. U mag alles zeggen wat u wilt. Het is geheel vertrouwelijk.

Verwijzing

We gaan het eerst hebben over de verwijzing naar het programma. U doet mee aan de gecombineerde leefstijlinterventie programma's. Er zijn drie verschillende programma's, CooL, Beweegkuur en SLIMMER.

1. Aan welke programma doet u mee (CooL, Beweegkuur, SLIMMER)?
2. Hoe bent u bij deze programma (CooL, Beweegkuur, SLIMMER) terecht gekomen?
3. Begrijpt u waarom u bent verwezen naar GLI?
4. Wat heeft volgens u een rol gespeeld bij uw verwijzing?
    a. Wat waren uw klachten?
5. Wat wist u van de GLI/ het programma waar u aan meedoet af?

Toegankelijkheid

Ik ga nu een paar vragen stellen over de toegankelijkheid. Het is belangrijk dat u makkelijk aan het programma mee kan doen en u het makkelijk kan bereiken.

6. Volgt u het programma omdat de huisarts dat heeft gezegd of wilt u zelf ook graag mee doen?
7. Heeft uw huisarts u geholpen met het vinden van de leefstijlcoach of heeft u zelf een leefstijlcoach moeten zoeken?
    a. Hoe heeft uw huisarts u ermee geholpen?
    b. Heeft uw huisarts aan u uitgelegd waar het programma over gaat?
    c. Gaat u tussentijds naar de huisarts of POH voor check ups?
8. Was het makkelijk voor u om aan het programma te beginnen?
    a. Was er een wachttijd of kon u meteen beginnen met het programma?
9. Is het makkelijker voor u om de praktijk van de leefstijlcoach te bereiken?

Ervaringen programma

Het is belangrijk voor ons om te weten hoe u het programma ervaart. U kunt zo eerlijk mogelijk zijn over uw ervaringen. Ik ga nu een aantal vragen stellen over de programma zelf en wat u ervan vindt.

10. Hoe lang doet/ deed u mee aan het programma (CooL, Beweegkuur, SLIMMER)?

(Indien deelnemer is gestopt met GLI.)
    a. Waarom bent u gestopt met het volgen van GLI?
11. Wat vindt u van het programma waar u aan meedoet (of mee hebt gedaan)?
    a. Wat vindt u van de lichamelijke beweging en sporten in het programma?
    b. Wat vindt u van het gedeelte over voeding en dieet?
    c. Is er ook aandacht voor stress tijdens de sessies?
    d. Hebben jullie het ook over slaap ritme en slaap kwaliteit in het programma?
    e. Zijn er nog andere onderdelen waar jullie het over hebben tijdens de sessies in het programma?
12. Is het programma wat u ervan had verwacht?
13. Hoe helpen de sessies u?
14. Ziet u veranderingen in uw gezondheid?
    a. Zijn de adviezen goed uit te voeren in uw dagelijks leven?
        i. Waarom wel of waarom niet?
    b. Heeft u het gevoel dat u iets aan het programma heeft?
15. Ziet u veranderingen in uw leefstijl?
    a. Zijn er bijvoorbeeld veranderingen in wat u eet, in hoe vaak u beweegt, in uw slaap ritme en slaap kwaliteit, in de stress levels?
    b. Zijn er andere veranderingen in uw leefstijl sinds u meedoet aan dit programma?
16. Als er niks verandert/het niet helpt: waardoor heeft u het gevoel dat het niet helpt (bijvoorbeeld door adviezen die moeilijk zijn uit te voeren in het dagelijks leven)?

Begrijpelijkheid

U moet natuurlijk ook snappen waar het programma waar u aan meedoet nou precies over gaat. We willen graag weten of het programma begrijpelijk is voor de deelnemers. Daar gaan de volgende vragen over.

17. Is het programma begrijpelijk en makkelijk te volgen voor u?
    a. Waarom is het wel of niet makkelijk te volgen voor u?
        i. Zijn alle onderdelen begrijpelijk?
18. Wat voor materialen gebruikt u tijdens het programma? Denk aan een app of vragenlijsten, PowerPoint.
    a. Vindt u de materialen makkelijk te gebruiken?

19. Wat zijn de grootste drempels voor u om mee te doen? Zijn er dingen waardoor u minder goed met het programma mee kan doen?
    a. Zijn er persoonlijke dingen die het moeilijker maken voor u om mee te doen met het programma (bereikbaarheid van sportscholen bijvoorbeeld of toegankelijkheid om gezond te eten of meer te bewegen)?
    b. Denkt u dat een aangepast programma beter zou zijn voor u?
    c. Zijn er andere dingen waar u tegen aan loopt?
20. Wat zou u willen veranderen aan het programma? Wat zou u anders hebben gewild om makkelijker met het programma mee te kunnen doen?
    a. Wie kan u daarbij helpen volgens u? Met het makkelijker te maken van het programma?
21. En wat vindt u juist goed aan het programma?

Ervaringen leefstijlcoach

Omdat u veel met de leefstijlcoach omgaat en veel met de leefstijlcoach deelt, willen we graag weten hoe dat precies in elkaar zit en of het wel allemaal goed gaat. Allereerst is het handig om te weten wie er allemaal het programma geven en wat u van ze vindt. U mag er zo eerlijk mogelijk over zijn.

22. Waar praat u over met de leefstijlcoach?
        i. Heeft u het met de leefstijlcoach ook over uw dagelijks leven (over problemen waar u mee zit of meer moeite hebben met het volgen van het programma)? Of gaat het alleen over het programma en de sessies?
    b. Waar praat u over met de diëtist?
    c. Waar gaan de gesprekken met de fysiotherapeut over?
23. Zou u liever met een of meerdere coaches willen werken?
24. Wat vindt u van de leefstijlcoach?
    a. Vindt u het prettig te werken met de leefstijlcoach?
25. Vertrouwt u de leefstijlcoach?
    a. Voelt u zich begrepen door de coach?
    b. Vindt u dat u een goede band heeft met de leefstijlcoach?
26. Vindt u dat de leefstijlcoach u goed helpt? Legt de leefstijlcoach dingen goed uit en wordt u goed begeleidt?
    a. Wat zou u willen veranderen aan de leefstijlcoach?
27. Vindt u de leefstijlcoach voldoende gekwalificeerd voor het programma?
28. Wat vindt u van de individuele sessies en de groep sessies?
    a. Zou u meer individuele of meer groep sessies willen?
    b. Heeft u een goede band met de andere deelnemers?

Vragen over verschil met diëtiste

29. Bent u al wel eens bij een diëtist geweest? Wat waren uw ervaringen daar?
    a. Zou u daar nog naartoe willen?
30. Ervaart u verschillen tussen een diëtist en een leefstijlcoach?
    a. Zo ja, wat zijn de verschillen?

Motivatie deelnemer

Het is natuurlijk ook belangrijk om te weten of het ook nog een beetje leuk is allemaal en of u graag mee doet aan het programma.

31. Vindt u het leuk om mee te doen met het programma?
    a. Heeft u zin om mee te doen? Voelt u motivatie om mee te doen?
    b. Hoe zou u beter mee kunnen doen of meer motivatie krijgen om mee te doen?
32. Denkt u dat anderen makkelijker aan het programma mee zouden kunnen doen dan u?
    a. Zou u anderen aanraden om aan GLI mee te doen?
33. U heeft tijdens het programma veel kunnen leren over een gezonde leefstijl, maar het programma duurt maximaal twee jaar. Denkt u dat u verder gaat met wat u geleerd heeft tijdens het programma nadat u ermee klaar bent?
34. Gaat u door met het programma of bent u van plan te stoppen?

Evaluatie

35. En als laatste. Wat voor cijfer zou u de GLI geven op een schaal van 0-10?
36. Zijn er nog andere dingen die u zou willen zeggen waar we het niet over hebben gehad?

Appendix IV. Informed consent form

Toestemmingsverklaring

Voor deelname aan onderzoek naar de gecombineerde leefstijlinterventies.

- Ik vind het goed om met Fattana te praten over mijn ervaringen met de gecombineerde leefstijlinterventie.
- Ik heb de informatie(brief) gelezen en begrijp het doel van dit gesprek.
- Ik weet dat mijn naam nergens genoemd zal worden, het gesprek niet naar mij kan worden herleid en niemand zal horen dat ik dit gesprek heb gehouden.
- Ik weet dat ik elk moment kan stoppen met het gesprek, zonder een reden te geven.
- Ik weet dat het gesprek wordt opgenomen op een taperecorder, maar dat alleen Fattana daarnaar zal luisteren.
- Ik weet dat de verzamelde gegevens veilig zullen worden opgeslagen en alleen de onderzoekers toegang tot de informatie hebben.
- Ik weet dat het opgenomen gesprek na gebruik voor het onderzoek wordt verwijderd als ik geen toestemming geef om mijn gegevens te gebruiken voor een vervolgonderzoek.

Ik wil meedoen aan het onderzoek en geef toestemming voor het verzamelen, bewaren en gebruiken van de informatie die ik geef.

- ☐ **Ja**
- ☐ **Nee**

Ik geef toestemming om mijn gegevens na dit onderzoek te gebruiken voor een eventueel vervolgonderzoek onder voorwaarde van de ethische normen voor wetenschappelijk onderzoek.

- ☐ **Ja**
- ☐ **Nee**

Naam deelnemer ______________________________

Datum en plaats ______________________________

Handtekening ______________________________

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

Naam onderzoeker ______________________________

Datum en plaats ______________________________

Handtekening ______________________________

Appendix V. Information on participation

Uitnodiging deelname aan onderzoek

Uitnodiging
U bent gevraagd om mee te doen aan een onderzoek naar gecombineerde leefstijlinterventies.

Waarom dit onderzoek?
Gecombineerde leefstijlinterventies helpen mensen met gezondheidsproblemen om gezonder te leven. Bijvoorbeeld door gezond te eten en meer te bewegen. Soms sluit de begeleiding niet aan bij de deelnemers. Wij willen beter begrijpen waardoor het precies komt dat sommige mensen wel en sommige mensen niet meedoen aan gecombineerde leefstijlinterventies. En wat er precies gedaan kan worden om dat te verbeteren. Met de informatie die we krijgen willen we ervoor zorgen dat de mensen die begeleiding bij hun leefstijl juist goed kunnen gebruiken ook echt mee kunnen doen.

Waarom ben ik uitgenodigd om mee te doen?
U doet mee omdat u wilt praten over uw ervaringen met de gecombineerde leefstijlinterventie. U bent (kruis aan wat van toepassing is):

- ☐ Deelnemer aan de gecombineerde leefstijlinterventie.
- ☐ Zorgverlener die patienten wel of niet heeft verwezen naar gecombineerde leefstijlinterventies.
- ☐ Leefstijlcoach die begeleiding geeft aan deelnemers van de gecombineerde leefstijlinterventie.

Wat gebeurt er als ik meedoe?
U zult 1 keer geïnterviewd worden door Fattana Mohammad. Het interview zal worden opgenomen. Als u meedoet helpt u de zorg verbeteren. Bij vragen over het interview kunt u contact opnemen met Fattana via;

- E-mail: f.mohammad@pharos.nl
- Telefoon: 06 85307256

Mijn deelname is vertrouwelijk en vrijwillig
Deelname aan dit onderzoek is vertrouwelijk. Alle informatie die wij verzamelen is anoniem. De informatie wordt beveiligd opgeslagen en zal verwijderd worden na gebruik voor dit onderzoek als u niet toestemt voor hergebruik van de informatie voor een eventuele vervolgonderzoek. Alleen de onderzoekers hebben toegang tot de opgeslagen informatie.De informatie is niet terug te leiden naar u. Uw naam zal nooit genoemd worden in de projectresultaten of publicaties hiervan. Meedoen is vrijwillig. U bepaalt zelf wat u wel en niet vertelt. U mag altijd stoppen zonder reden. Als u besluit niet meer mee te willen doen worden uw gegevens verwijderd. Alvast bedankt voor uw medewerking.