An exploration of beliefs and attitudes regarding healthy lifestyle behaviour in an urban population in the Netherlands: Results from a focus group study in a community-based prevention project

Sanne M. Kloosterboer¹, Karolien van den Brekel², Antonia H. Rengers², Niels Peek³, Niek J. de Wit¹,²

¹ Julius Centre for Health Sciences and Primary Care, University Medical Centre, Utrecht, the Netherlands
² Julius Health Centres Leidsche Rijn, Utrecht, the Netherlands
³ Department of Medical Informatics, Academic Medical Centre, Amsterdam, the Netherlands

Correspondence: Sanne M. Kloosterboer, Tel: +31 6 27 414 656, Fax:+31 4 13 478 611, e-mail: kloosterboer.sanne@gmail.com

Background: The positive effects of lifestyle intervention programmes might be enhanced when targeted to the health-related behaviour of the users. This study explores the beliefs and attitudes regarding a healthy lifestyle, the influences on lifestyle behavioural change and the needs to support a healthy lifestyle in the local community, during an integrated community-based prevention project in newly developed urban area in the Netherlands.

Methods: Three focus groups were conducted with urban residents aged 45–70 (n = 28). Thematic qualitative analysis was applied to verbatim transcripts to identify emerging themes.

Results: The following themes were identified: beliefs to healthy behaviour, responsibility for health, perceived behavioural control, external influences on health behaviour and needs in the local community. Within these themes, personal responsibility for health and the influence of the social and physical environment emerged to be important for health and lifestyle. The participants expressed the need for clearly organized health and lifestyle facilities, a personalized approach and an easily accessible health risk assessment to support lifestyle behavioural change in the community.

Conclusion: In our study, urban residents experienced a strong influence of the social and physical environment to their lifestyle behaviour. This finding supports an integrated approach for preventive health services in this population.

Introduction

Early detection and altering of specific behavioural risk factors may lead to reduced morbidity and mortality. Lifestyle intervention programmes can effectuate individuals’ behavioural change and potentially have positive effects on health, quality of life and costs. However, the effects of lifestyle intervention programmes are generally small, especially when not targeted to high-risk patients.

An integrated approach—when incorporated—might enhance the effectiveness of lifestyle interventions. This approach, also known as health in all policies, acknowledges the influences of the social and physical environment and is characterized by intersectoral cooperation elaborated on the community level. The first results of community-based integrated prevention seem promising.

Integrated prevention programmes are characterized by adaptation to the local context, as effectiveness might be enhanced when targeted to the health-related behaviour of the users. By investigating the perceptions and beliefs of the target population, health behaviour could be understood and prevention programmes could be better adjusted to users’ needs.

This study aims to get an understanding of current thoughts and attitudes regarding health behaviour in an integrated, community-based prevention project in an urban population. By a qualitative method using focus groups, we investigate beliefs, attitudes and needs regarding a healthy lifestyle focusing on the following key issues: beliefs of a healthy lifestyle, influences on lifestyle change and needs in the local community to create and maintain lifestyle behavioural change.

Methods

Design

Focus group discussion sessions were used for data collection. Such sessions can lead to richer data than one-to-one interviews or questionnaires because group interaction is facilitated.

Sample and recruitment

The focus group sessions were part of the integrated community-based prevention programme ‘Personalized Prevention in the Local Community’ (PPLC) that was implemented by the ‘Julius Health Centres’ (JHC). The JHCs provide integrated community-based primary healthcare to 34 000 patients from four multidisciplinary health centres in Leidsche Rijn, a newly developed urban area in Utrecht, the Netherlands. The largest population area is rapidly developing as a housing and industrial development site in the Netherlands.

During PPLC, three focus groups were conducted. The participants of the first focus group were randomly recruited by healthcare professionals (practice nurse and general practitioners [GPs]) of JHC using word of mouth during consultations. For the second and third focus group, patients who had previously been invited for a pilot on cardiovascular risk assessment were approached by a follow-up questionnaire, telephone and email. The latter group consisted of 800 patients of the JHCs, aged 45–70.

More eligibility criteria were not established to allow for a variety of experiences and backgrounds. The researchers did not expect the
differences in sex, age and background to influence the participants’ feeling of comfort. A €25 gift card was given to each participant as incentive for participation.

**Procedure**

Three separate focus group sessions were held with, on average, nine participants per group. There was no overlap in the participants of different sessions. The three sessions were guided by the same moderator (AHR) using recommended focus group techniques.20 The role of the moderator was to ask questions, steer the discussion when needed and encourage participation by all group members. A second moderator (KvdB, SMK) was present to observe the group process and asked for further explanation when needed.

A semi-structured format with a set of mostly open-ended questions was used to guide the discussion. The facilitator emphasized that both positive and negative responses were appreciated during the discussions. Three topics concerning lifestyle were discussed (Table 1). Focus group discussions lasted approximately two hours and were digitally audiotaped. All participants agreed on the use of the data for scientific purpose and privacy was ensured.

**Analysis**

Qualitative content analysis was conducted on verbatim transcripts of the focus group discussions with quotations being listed anonymously. Our thematic analysis was based on the steps described by Boeije and performed in a bottom-up manner.21 In the first step, two researchers (SMK and AHR) reviewed the transcripts to identify the key themes. In step two, the transcripts were entered into the QSR NVivo programme and one researcher (SMK) conducted line-by-line open coding.22 The next step was axial coding, during which the data were put in (sub-) categories, and relationships were generated and modified.23 During the axial coding, the behavioural concepts described by the Theory of Planned Behaviour were used to guide the analysis, while allowing for other concepts to cover topics outside the scope of this theory.24 After this step, the data were recoded (SMK) to progress the descriptive codes to more abstract ones. To ensure interrater reliability, one-third of the transcripts were independently coded by a second researcher (AHR), and differences in coding were discussed. By clustering the categories, the emerging themes and subthemes were identified.

**Results**

**Participant demographics**

A total of 28 eligible patients agreed to participate. Table 2 presents a summary of the demographics of all participants.

**Focus groups results**

The participants freely discussed the provided topics. The results of the focus groups are listed using representative quotes to illustrate the way in which individuals responded to the issues in the discussions. These quotes are numbered, where the first number represents the focus group session and the second number indicates the participant. Divergent opinions are noted when present.

**Beliefs to healthy lifestyle**

When asked to define a healthy lifestyle, participants began to express topics in accordance with the leading cultural norm of healthy behaviour. Some participants expressed that common sense informs most people’s knowledge of what they should do to live a healthy lifestyle:

2-9: ‘General factors, alcohol -or little alcohol-, not smoking, I think those are very clear to everyone.’

1-1: ‘Actually, people know what they’re doing wrong’

When reasons for lifestyle change were discussed, many participants expressed that they ‘feel good’ when performing healthy lifestyle activities.

1-4: ‘But actually, if you eat healthy, you feel wonderful. Your head is doing well, your mind is working better’

**Responsibility for health**

**Personal responsibility** In general, the participants reported a strong normative belief of personal responsibility regarding health issues. The majority of participants stated that starting to change behaviour is primarily a person’s own concern. The opinion was shared that

<table>
<thead>
<tr>
<th>Topic or domain</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs in the local community</td>
<td>What do you need to live healthy in this neighbourhood? How do you find out where you can find the lifestyle provider that fits you? Which factors determine your choice for a lifestyle provider? Who should play an active role in improving your lifestyle?</td>
</tr>
<tr>
<td>Influences on behavioural change</td>
<td>What is in your opinion a healthy lifestyle? How do you feel about your health? Why would you change your lifestyle? Do you think it is necessary to change your lifestyle? What do you do to improve your lifestyle? What made you start? What helps you to maintain? What makes it difficult to improve your lifestyle? Do you feel supported by your social environment?</td>
</tr>
</tbody>
</table>

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**Table 1 Interview format**

<table>
<thead>
<tr>
<th>Topic or domain</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beliefs to a healthy lifestyle</td>
<td>What is in your opinion a healthy lifestyle? How do you feel about your health? Why would you change your lifestyle? Do you think it is necessary to change your lifestyle? What do you do to improve your lifestyle? What made you start? What helps you to maintain? What makes it difficult to improve your lifestyle? Do you feel supported by your social environment?</td>
</tr>
</tbody>
</table>

**Table 2 Characteristics of study participants**

<table>
<thead>
<tr>
<th>Patient characteristics</th>
<th>mean ± SD or n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age mean ± SD</td>
<td>55.4 ± 6.7</td>
</tr>
<tr>
<td>Gender, n (%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>10 (36%)</td>
</tr>
<tr>
<td>Female</td>
<td>18 (64%)</td>
</tr>
<tr>
<td>Country of birth, n (%)</td>
<td></td>
</tr>
<tr>
<td>The Netherlands</td>
<td>28 (100%)</td>
</tr>
<tr>
<td>Other</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Education, n (%)</td>
<td></td>
</tr>
<tr>
<td>Low (elementary and lower secondary education)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Middle (upper/post-secondary education)</td>
<td>12 (48%)</td>
</tr>
<tr>
<td>High (tertiary education)</td>
<td>13 (52%)</td>
</tr>
<tr>
<td>Marital status, n (%)</td>
<td></td>
</tr>
<tr>
<td>Married or living together</td>
<td>22 (79%)</td>
</tr>
<tr>
<td>Single</td>
<td>6 (21%)</td>
</tr>
<tr>
<td>Work Status, n (%)</td>
<td></td>
</tr>
<tr>
<td>Paid</td>
<td>18 (64%)</td>
</tr>
<tr>
<td>Voluntary</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Retired/no work</td>
<td>9 (32%)</td>
</tr>
</tbody>
</table>

SD: Standard deviation; n: number.

a Three participants did not provide information.

Initially nine key themes were identified. Of these, responsibility for health, beliefs to a healthy lifestyle and responsibility for health corresponded to the themes subsequently identified during the coding process. There were a small number of coding differences. After discussing the interpretation of codes in question, consensus was reached on their meaning within the context of this study, and all the concerning quotes were recoded.

The thematic analysis process eventually yielded five emerging themes and seven subthemes (Table 3).

**Beliefs to healthy behaviour**

When asked to define a healthy lifestyle, participants began to express topics in accordance with the leading cultural norm of healthy behaviour. Some participants expressed that common sense informs most people’s knowledge of what they should do to live a healthy lifestyle:

2-9: ‘General factors, alcohol -or little alcohol-, not smoking, I think those are very clear to everyone.’

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**Responsibility for health**

**Personal responsibility** In general, the participants reported a strong normative belief of personal responsibility regarding health issues. The majority of participants stated that starting to change behaviour is primarily a person’s own concern. The opinion was shared that
individuals should first make serious effort before seeking (professional) support; however, support was perceived as being acceptable.

1-4: ‘But you really have to do it for yourself, you have to take care of yourself. No one else can tell you, “This is how you should live,” that sort of thing. You have to figure it out for yourself.’

Some participants identified that as long as they feel good, they do not feel the urge to change behaviour.

2-10: ‘I think that’s pretty typical. As long as you feel good about it yourself, then no, you don’t feel the need.’

The role of the GP When discussing responsibility, some participants stated that they will only visit a GP when they suspect personal health problems. As long as they felt healthy, they considered the GP to have a minimal role in preventive activities.

2-7: ‘But if it’s my idea, then I think it’s up to me to take the initiative – I do not think there is a role for the general practitioner.’

Some participants articulated that whether or not they consult their GP for lifestyle issues is dependent on the personal bond that they feel with their GP:

3-2: ‘Yes, then you expect the general practitioner to know you well enough to be able to tell whether it’s a good fit.’

Other participants state that they consult their GP for referrals to suitable lifestyle professionals, such as a dietician.

Perceived behavioural control

A strong belief in internal motivation to achieve behavioural change was expressed in all three focus groups. Most participants said an ‘inner drive’ and positive attitude makes it possible to initiate behaviour change.

2-6: ‘But isn’t it true that if I say, “I can’t do it,” then I can’t do it? The moment you say, “I’m going to work on this,” “I want to take a positive approach” and say, “I have to achieve that,” “I’m determined to do that,” then it’s possible, but it is a matter of thinking about things in a different way.’

3-8: ‘In any case, I think that if you don’t really want it, you won’t succeed. No matter how supportive the general practitioner is.’

External influences on behavioural change

Direct social environment In general, spouses were reported to play an important role in behaviour change. Altering lifestyle together with a partner or friend was generally seen as an important motivator in maintaining behavioural change: ‘It’s always easier to do things together, of course – you motivate each other, it’s like that with everything.’ (2–10). Participants explained the stimulating function of changing behaviour together in two ways. First, most participants experienced the aspect of sociability as pleasant. Second, having someone who reminds you of the agreements one has made was experienced as helpful by many participants: ‘After all, it’s a commitment when you arrange to meet up with someone.’ (2–11). Some participants experienced more difficulty changing their behaviour when their partner was not joining their efforts, but in general, the participants felt well-supported in their behavioural change.

Living environment The local environment emerged as an important theme when discussing health issues in the various focus groups. The ethnic composition of the neighbourhood was often reported. Some participants experienced serious stress as a result of conflicts with culturally different residents in their living area. Some participants reported to feel lonely.

1-3: ‘Because if people don’t feel good for whatever reason, neighbours or what’s happening on the streets in the neighbourhood … (…) Griping at each other, and then you get stressed. And stress makes you sick.’

2-9: ‘Well, I don’t like it. Too many people settled here all at the same time. So in the end there’s no integration, either.’

Other participants responded not to experience a negative influence of other ethnicities in the street. Peace and quietness were predominantly indicated as important factors for well-being, and the majority of participants perceived these as unsatisfactory. When discussing the local landscaping, this appeared to strongly influence the threshold to exercise. Many participants expressed the preference to exercise outdoors and perceived the environment suitable to work out.

Needs in the local community

The needs mentioned in the focus groups to attain a healthy lifestyle in the local community were personalized care, an easily accessible health risk assessment and a structured overview of facilities and services.

Personalized care Many participants underlined the need for personalized care. They believed care should fit personal preferences and circumstances.

2-9: ‘I don’t think you can ever say, “This is healthy, so that means you will stay healthy” – it’s different for everyone. I think that what works really well for one person won’t work for someone else. It’s impossible to take a single approach, and say, “This is healthy.”’

Some participants expressed the preference for a personal talk when visiting a health professional: ‘To be able to say what I have to say.’ (2–2).

Structured facilities and health services All participants stated to have enough possibilities to change behaviour in the local community. However, a lot of participants experienced a non-structured overview of the different facilities and services:

1-4: ‘Where are you supposed to go if you need something? It drives me crazy – you have to look so hard for “the best place to find something.”’

Some participants received conflicting advice concerning health from different lifestyle providers: ‘And one person says this, and another person says that, and sometimes I get a little tired of it.’ (1–2). Some participants advocated for the collaboration of various health professionals in one centre. One of the participants referred to JHC, where a multidisciplinary lifestyle programme is offered:

3-8: ‘And that’s really nice, because, to start with, they know what the others are doing. And they can easily communicate this to each other.’
Health risk assessment The participants who took part in the online health check of PPLC expressed the need for measurable outcomes of their health behaviour, suggesting that a general health check be incorporated in primary care services.

2-14: ‘(…) because if you come to me and say, for example, “A body mass index of 25 is good” and mine is 26, then I think, well… I’m not going to worry about it. What you’re giving me is just a score on paper. So you’ll have to present some good arguments. For instance, based on urinalysis, blood tests, things like that.’

Most of these participants believed prevention of diseases could work by an early diagnostics: ‘I think that… if the diagnostic procedures were more easily available to patients, it would make a big difference.’ (3–6). They expressed the requirement for such a health check to be easily accessible in terms of being free of charge and open at any time.

2-9: ‘I wish that were possible. That you could just walk in and make an appointment at short notice, and ask them to do a number of tests.’

Participants said this ‘check-up’ should be free of obligatory consequences. One participant indicated the false certainty that a test can entail.

Discussion

In this study we explored the perspectives of a healthy lifestyle and perceived influences on lifestyle behavioural change in a new urban population. Using a qualitative analysis of focus group interviews, an emerging influence of the social and physical environment on health experience and lifestyle behaviour was identified. The participants expressed the importance of personal responsibility for healthy behaviour. Several practical implications for community-based prevention originated in our sample. These were personalization of care, a structured and centralized overview of health services and an easily accessible health risk assessment.

Firstly, the participants in all focus groups predominantly discussed their living and social environment as determinants of their health, well-being and subsequent health behaviour. Creating a social network in a newly built city district is known to be of great challenge and is recognized in our sample. Literature shows that the social and physical environment is not naturally represented in the lay perspective on determinants of health, while the influences of social cohesion and community processes, the direct social environment and the physical environment on health behaviour are repeatedly demonstrated. In our sample, the urban inhabitants recognized the importance of these factors. An integrated approach might be the key to effective prevention, as it reflects the beliefs of the users in this community.

Integrated community-based prevention can be promising, as is shown in England and Finland. However, the outcomes and impact of these programmes are still complex to describe. Multiple interventions typically interact, and programmes vary in different communities and are hard to measure and compare. Recent research therefore focuses on the impact of the neighbourhood environment rather than health as primary outcome, and demonstrated that area-based preventive interventions in the Netherlands address the social determinants of health to such an extent that future health impacts may be expected. While more results are awaited, an integrated approach could be advocated for.

Secondly, a strong norm of personal responsibility emerged in our sample. Participants perceived themselves as having choices and being responsible for making them. Today’s health promotion strategies which focus on the personal responsibility of every individual seemed to be accepted by the participants in our study. The emerging theme responsibility for health has consequences for the expectations regarding the role of the health professionals in lifestyle behaviour. The participants reported a minimal task in behavioural change for their GP. Concerning an integrated approach, the role of the GP might be more facilitative, involving referrals to suitable lifestyle providers in the community. Earlier research showed that patients hold positive attitudes towards the GP introducing topics related to their lifestyle.

Thirdly, some practical implications for community-based prevention were made in our sample. The need for personalized care emerged. Participants stressed individual preferences and circumstances should be taken into account when lifestyle advice is provided. Earlier studies demonstrated the importance of personalized, tailored care. Furthermore, participants expressed their need for an easily accessible health risk assessment consisting of biometric measurements like blood pressure, blood tests and urinalysis. Participants in our sample stated that these measurements made lifestyle advice more realistic. As this need has been recognized before, large-scale research is currently being enrolled in 40 primary care facilities in the Netherlands to evaluate the effects of regular risk analysis in primary care.

Finally, our study showed a need for a structured, organized and centralized collaboration between different lifestyle professionals. Participants reported that it is confusing to have numerous options for lifestyle services and activities; advocating for a clear overview and supply of information. This coincides with findings from a large qualitative study that was recently conducted in the Netherlands. This study found that the Dutch experience an overload on information about health, and struggle to structure and manage this. These findings support a structured collaboration between all parties involved in integrated prevention.

To our knowledge, our study is unique in so far as no other focus group research is conducted in a comparable setting and population to investigate beliefs about healthy lifestyle behaviour.

Our study has several limitations. First, the group interaction process in focus group sessions can enhance disclosure, but may also induce self-presentation and socially desirable behaviour. The responses could also be influenced by the fact that the sessions were held at a general health centre. Second, the results might be influenced by the composition of the sample. Most participants in the focus groups had actively participated in a pilot of the community-based prevention project PPLC before. Obviously the study population was relatively well-educated, employed or retired. No ethnic minorities were represented in our sample. It is expected that the participants have a relatively high health literacy, which might influence their beliefs regarding health behaviour. Health literacy might be associated with higher levels of self-management, meaning the themes responsibility for health and perceived behavioural control could be more strongly expressed. However, as the new urban area Leidsche Rijn is characterized by relatively well-educated and employed population, the sample is assumed to be representative for the local community.

Moreover, focus group methodology aims to identify new themes in guided discussions, and not to get a representative picture of these themes in the population. However, further qualitative research is recommended focussing on the themes that emerge from the immigrant population.

This study yielded insights concerning perspectives on lifestyle and behavioural change in a new city district population. The strong influence of the social and physical environment that is reported seems to advocate for an integrated approach to preventive services. When future preventive services based on lifestyle behavioural change are designed in a comparable setting, our findings should be taken into consideration to reflect the perspective of the users.

Acknowledgements

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Key points

- In our study, urban residents experienced a strong influence of the social and physical environment to their lifestyle behaviour.
- This finding supports an integrated approach for preventive health services in this population.
- The need for personalization of care, a structured and centralized overview of health services and an easy accessible health risk assessment originated in our sample of residents of a newly developed urban area.

References

23. QSR International Pty Ltd. NVivo qualitative data analysis software, 2012.