Health promotion for a multiethnic population: the case of weight-gain prevention among a multiethnic population of mothers living in Amsterdam South-East

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CHAPTER 7

Does recruitment for an exercise program through ethnically specific channels and key figures contribute to its reach and receptivity in ethnic minority mothers?

A qualitative trial

Marieke A Hartman, Vera Nierkens, Stephan W Cremer, Karien Stronks, Arnoud P Verhoeff
Abstract

Background: In high-income countries, ethnic minority women from lower-income countries are more physically inactive than ethnic majority women. At the same time, they can be harder to reach with health promotion programs. Targeting channels and execution to ethnic groups is suggested to increase reach and receptivity to program participation. We explored the contribution of ethnically specific channels and key figures to reaching Ghanaian, Antillean, and Surinamese mothers with an invitation for an exercise program, and subsequently, to the mothers’ receptivity and participation.

Methods: We conducted a primarily qualitative trial in Amsterdam, the Netherlands. To recruit mothers, we employed (1) ethnically specific community organizations and (2) ethnically matched key figures as recruiters versus Dutch health educators. Reach and participation were measured using reply cards and the attendance records of the exercise programs. Observations were made of the recruitment process. We interviewed 14 key figures and 33 mothers to reflect on the recruitment channel and recruiter used. Content analysis was used to analyze qualitative data.

Results: Recruitment through ethnically specific community channels was successful among Ghanaian mothers, but less so among Antillean and Surinamese mothers. The more close-knit an ethnic community was, retaining their own culture and with poorer comprehension of the Dutch language, the better mothers were reached through ethnically specific organizations. Furthermore, we found that using ethnically matched recruiters resulted in higher receptivity to the program, and, among the Ghanaian mothers in particular, in greater participation. This was explained by the fact that the ethnically matched recruiter was a familiar, trusted person, a translator, and a motivator because of her enthusiasm and encouragement or message adaptation (targeting/tailoring). To increase the credibility and professionalism of the recruitment, key figures and mothers preferred an ethnic Dutch health expert.

Conclusions: Recruitment for an exercise program through ethnically specific organizations seems to contribute to its reach, particularly in close-knit, highly organized ethnic communities with limited fluency in the local language. Using ethnically matched recruiters as motivator, translator, and trusted person seems to contribute to receptivity to a health promotion program. An expert is also likely to be needed for effective information delivery.
Background

In high-income countries, non-Western ethnic minority groups have been found on average to be more physically inactive than the host population [1, 2]. In particular, they have been found to exercise less during leisure time [3, 4]. These countries are also becoming increasingly ethnically diverse [5]. Therefore, there is a need to promote physical activity within multiethnic populations. However, it can be challenging for health professionals to reach ethnic minority groups with health promotion programs such as exercise programs [6, 7].

To increase this reach, and thereby the accessibility of health promotion in the ethnic minority target group, the employment of community resources is considered to be a promising recruitment method. Examples of such community resources are churches, local community leaders and organizations, ethnically specific media, networks, and events [7, 8]. The high level of trust community health workers can have has been identified as a key to recruiting community members. Health providers can be seen as outsiders, and less trustworthy [9]. This might be a direct consequence of source similarity. When a person perceives a source as being similar to him- or herself – for instance, if the source is from the same ethnic group – this increases trust in and attractiveness of the source [10].

However, not all prior studies support the utility of using ethnically specific community resources during recruitment. Formative studies among different ethnic groups have shown that some ethnic minority groups seem to rely less on ethnically specific resources than other ethnic minority groups [11, 12]. Moreover, a systematic review that compared four different recruitment methods for reaching ethnic minorities – social marketing, referrals, healthcare, and community outreach – found community outreach to be the least successful in recruiting participants in terms of percentages [7].

Therefore, the utility of community resources for improving participation in health promotion programs is not yet clear, and merits further exploration [7]. First, it would seem that an exploration is needed of whether community resources can contribute to recruitment of participants, and second, if this is the case, under which conditions. Regarding the recruitment outcomes, one can distinguish between reach and participation. The use of recruitment channels is thought to affect reach – in other words, contact with the target population [13]. It has also been suggested that recruitment executers (i.e., the recruiters) and the messages used during this contact affect receptivity and the decision to participate respectively [13, 14]. Qualitative process evaluation is appropriate for unraveling underlying mechanisms of recruitment success through the resources employed [15].

This process evaluation aims to test the utility of targeting recruitment channels and recruiters to specific ethnic minority groups, with a particular focus on the conditions and mechanisms underlying its impact. We focused on mothers with young children as an example. This group is at increased risk of physical inactivity [2, 16]. The main research questions were 1) Do ethnically specific channels successfully contribute to reach among mothers
from three ethnic minority groups and if so, why? and 2) Do ethnically matched key figures contribute to these mothers’ receptivity and subsequent participation in an exercise program compared to recruitment by ethnic Dutch health educators and if so, how?

**Methods**

In 2010 and 2011, we conducted a primarily qualitative process evaluation of culturally targeted recruitment. First, ethnically specific channels were used to reach mothers from three ethnic minority groups. Then, two conditions were compared regarding the recruiter: in the intervention condition, mothers were recruited by an ethnically matched recruiter, while in the comparison condition, mothers were recruited by ethnic Dutch health educators.

**Study context: location and target group**

The process evaluation was conducted in Amsterdam South-East, an ethnically diverse district in which Ghanaians, Afro-/Hindustani Surinamese (hereafter referred to as Surinamese), and Antilleans/Arubans (hereafter referred to as Antilleans) form the largest ethnic groups (see Figure 7.1). These ethnic groups differ in socioeconomic status, language, and migration history. The Ghanaians are known as hard-working but have relatively marginalized positions, while Surinamese women have a favorable position on the labor market. Although English is the official language in Ghana, there are 75 Ghanaian languages and dialects. Dutch is difficult for Ghanaians to learn, and their Dutch language proficiency is generally poor. Antillean

![Figure 7.1 Socio-demographic characteristics study location Amsterdam South-East](image-url)

Key figures 2011 derived from the Department of Research and Statistics, Municipality of Amsterdam [28]
and Surinamese women have less difficulties with the Dutch language. Though, the Dutch language proficiency is best among Surinamese; Antilleans use their own language more [17]. The Netherlands Antilles and Suriname have a colonial history with the Netherlands. Moreover, the Surinamese migrated longer ago (before 1976) on average, and more of them are second generation [18].

**The general recruitment method**

Mothers with young children were recruited to participate in the exercise program ‘Big Move mama’. This existing primary care program suited the shared needs of mothers from a multiethnic population derived from formative research [19]. Therefore, it provided an excellent opportunity for exploring targeted recruitment strategies to promote adoption (i.e., participation). After an intake with the Big Move mama coach, the program consisted of weekly exercise classes for a period of 6 months. More details about this exercise program can be found elsewhere [20, 21].

The general basis of the recruitment method consisted of three elements. First, to increase attention, the health educator’s visit was announced or the information was rehearsed. Then, the actual information-giving and recruitment took place. Finally, a Dutch health educator made a phone call to confirm the mother’s interest in participating and/or for final decision-making, and to schedule an intake with the Big Move mama coach with mothers who decided to participate. This proactive approach by the health educator was meant to increase accessibility.

The actual information-giving and recruitment was preferably done face-to-face, with an interactive component to promote information processing and to create positive modeling (e.g., by asking who already had exercise experience, and what the advantages of this had been). The core recruitment message was directed to mother-specific motivators and enablers shared among different ethnic groups [19, 22-24]. An example: ‘We have an exercise program especially for mothers – although mothers always tend to be busy taking caring of others, it’s also important to take care of yourself. Enjoy some time for yourself – you deserve it!’ Moreover, it was emphasized that childcare would be provided, and that the group would be made up of mothers only. After the information-giving, women received a brochure with a reply card and a pen. On the reply cards, mothers could indicate whether they would not, might, or wanted to join Big Move mama. In this way, women had time to make a decision, and could read the brochure first. In exceptional cases, women were not approached personally but through a radio broadcast, for example, and women could then contact the health promoter by phone with their questions and to enroll in the program.

**Ethnically specific recruitment channels and key figures as recruiters**

First, we evaluated the contribution of ethnically specific community channels to reach Ghanaian, Antillean, and Surinamese mothers. The recruitment via ethnically specific channels
was perceived as successful if the target number of 27 mothers per ethnic group was reached within 4 months (November–February). This target number was calculated based on the desired number of participants and an estimate of the number of mothers who would decide not to participate. To fill the two Big Move *mama* groups available, the aim of the recruitment was to attain 30 to 40 participants equally distributed among the three ethnic groups. To achieve this, we expected we would have to reach a total of 80 to 100 mothers to account for mothers who were not interested (50%), and mothers who were interested but who for practical reasons could not enroll in the end (25%). Based on earlier collaborations with community organizations by the Public Health Service of Amsterdam, we expected that four organizations per ethnic group would be sufficient to attain this goal reach of overweight/inactive mothers with young children from Amsterdam South-East. The channels employed were mainly ethnically specific churches and women’s organizations. In addition, four of these channels used ethnically specific radio broadcasts, and another one collaborated with a church and schools aimed at the ethnic target group. If the recruitment through ethnically specific channels was unsuccessful for an ethnic group (<27 mothers), we made additional efforts to reach more mothers through other channels to find reasons for this low reach and to enable testing of the use of ethnically matched recruiters.

Second, we evaluated the contribution of ethnically matched recruiters to receptivity to the recruiter’s information and subsequent participation. To do this, recruitment channels were matched according to the ethnic group targeted, type of channel (e.g., churches, women’s organizations), and characteristics of the organization (e.g., use of regular group meetings, radio programs). Then, half of the channels were exposed to the intervention condition of an ethnically matched recruiter. These matched recruiters were key figures from the community organization, mainly women’s leaders. They were asked to act as ‘community health workers’ to inform the women in their organization about the benefits of exercise and to invite them to take part in Big Move *mama*. The recruiters for mothers reached via the other half of the channels were two female ethnic Dutch health educators from the Public Health Service of Amsterdam (hereafter referred to as health educators). If leaders from the organizations did not feel confident to be responsible for the recruitment of mothers, either alternative key figures within the organization were assigned, or a health educator supported them in providing the most important information.

**Data collection**

We defined ‘reach’ as the extent to which the health educator came into contact with the target group, whether that contact was direct or indirect via a key figure. In this recruitment study, the intervention concerned the general recruitment method executed by an ethnically matched key figure or health educators. Proof of receipt was derived from the completed reply cards or phone calls by the target population, and assessed by counting. Every mother reached was asked to fill in a reply card, also if they did not want to participate.
‘Receptivity’ can be defined as the extent to which the target population understood, was open to, and paid attention to the information about the exercise program, expressed a positive attitude, and seemed interested. Indicators of receptivity included an open, positive atmosphere and responding to the recruiter during the interactive approach or asking questions out of interest. Receptivity was measured qualitatively by observations and interviews with key figures and the target population.

Participation was measured using the Big Move attendance records. We perceived a mother to be a participant if she passed the intake with the Big Move coach and enrolled in more than one exercise class.

Explanations for the number of mothers reached through ethnically specific organizations, and how ethnically matched recruiters may affect receptivity and participation, were measured by observations and interviews with the target population reached. The observations were made by a health educator (MH), who also conducted the semi-structured interviews with the collaborating organizational leaders (n=14, leaders of 12 organizations). The semi-structured interviews with a selection of the mothers reached during recruitment (21 participants in the exercise program and 12 non-participants) were conducted by independent interviewers (LdS, AS, MB) who were not involved with the recruitment. The characteristics of the interviewed participants were diverse (e.g., different kinds of educational level, Dutch language proficiency, and time since migration) and were similar among the non-participants (Table 7.1). An observation scheme was used for the observations. A topic list was used to guide the interviews with collaborating leaders and mothers reached. Further exploratory questions for the collaborating partners were based on the observations and previous interviews. The observation scheme and topic lists are presented in Table 7.2.

In advance of the interviews, participants consented to the taping of the interviews and participation in the study. Anonymity in the transcripts and reporting was assured. Because it complied with Dutch legislation, the study did not require review by a medical ethics board. The interviews lasted 30 to 35 minutes on average, with interviews with key figures lasting 75 minutes on average. Mothers received a small gift after the interviews (a €10 gift voucher). Key figures received a financial incentive for their organization when they helped with the recruitment and evaluation.

**Data analyses**

Numbers of mothers reached were charted by channel, and thus by ethnic group, to assess whether the recruitment was successful (reach >27 mothers per ethnic group). Receptivity (analyzed by content analysis of the observations and interviews) and participation numbers derived from the attendance records were charted by intervention versus comparison group to assess the impact of ethnically matched recruiters.

Explanations for why ethnically specific channels contributed to reach, and how ethnically matched recruiters contributed to receptivity and participation, were also analyzed using
Table 7.1  Characteristics of the interviewed key figures and mothers from the target group

<table>
<thead>
<tr>
<th></th>
<th>Ghanaian</th>
<th>Antillean</th>
<th>Surinamese</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No. of key figures</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=4</td>
<td>n=4</td>
<td>n=6</td>
<td></td>
</tr>
<tr>
<td>Organizations/ media</td>
<td>2 churches</td>
<td>1 church</td>
<td>4 women’s organizations: 3 that also use radio, 1 also via church and schools</td>
</tr>
<tr>
<td></td>
<td>2 women’s organizations</td>
<td>1 organization that uses radio</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 immigrant organization*</td>
<td>1 community project*</td>
<td></td>
</tr>
<tr>
<td><strong>No. of mothers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=20</td>
<td>n=4</td>
<td>n=8</td>
<td></td>
</tr>
<tr>
<td>Participants</td>
<td>13</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Non-participants</td>
<td>7</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Mean age</td>
<td>42 (25-50)</td>
<td>43 (33-53)</td>
<td>36 (25-50)</td>
</tr>
<tr>
<td><strong>Migration background</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generation: 1st</td>
<td>20</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mean age of migration (range)</td>
<td>24 (16-36)</td>
<td>26 (10-47)</td>
<td>12 (4-23)</td>
</tr>
<tr>
<td>Mean time since migration (range)</td>
<td>19 (11-25)</td>
<td>18 (6-23)</td>
<td>24 (17-33)</td>
</tr>
<tr>
<td>Missing age and time since migration</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Dutch language proficiency</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good/native</td>
<td>7</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Poor/average</td>
<td>13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Ethnic identity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More Dutch</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>50/50</td>
<td>15</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>More Ghanaian/ Antillean/ Surinamese</td>
<td>3</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regular church attendance (once/ week)</td>
<td>17</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Less frequent church attendance/ not religious</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary school</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Junior secondary school</td>
<td>5</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Senior secondary school</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Senior secondary vocational education</td>
<td>5</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Higher professional education /university</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Employment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

* These were the additional organizations employed to reach more mothers to explain differences in reach.
### Table 7.2: Observation scheme and topic lists for key figures and target population

<table>
<thead>
<tr>
<th>Topic</th>
<th>Observation scheme</th>
<th>Topic list for key figures</th>
<th>Topic list for target population</th>
</tr>
</thead>
</table>
| **Reach** | During recruitment:  
Number of attendees?  
Proportion of mothers with young children from South-East/others?  
Gender distribution?  
Proportion overweight/not overweight?  
Ethnicity?  
Estimated educational level? | What is your estimate of the number reached, and the number of mothers with young children in this group? |  |
| **Explanation for reach** | Before recruitment:  
What kind of organization?  
Size of the organization?  
Fixed group?  
Fixed meeting(s)?  
Target group: women/mothers?  
Target group: South-East?  
Health focus?  
Additional characteristics? | Did you expect this reach/number of attendees?  
- Yes/higher/lower  
- Why do you think so many mothers were reached?  
  - Own role and approach  
  - Organizational approach  
  - Information/topic  
  - Strategy used  
  - Mothers’ general motivation to attend/reactions  
  - Contextual factors (e.g., organizational structure of community) | How did you first hear about Big Move mama? (through which organization/radio station/person?)  
- How do you feel about hearing more about Big Move mama through …?  
- What is your relationship with that organization/person?  
  - Aim of going to this organization?  
  - Activities?  |
| **Alternatives to increase reach** | Side effects/tips for other channels? | How could the reach among [Surinamese/Ghanaians/Antilleans] have been improved?  
Do you have tips about other channels? | How do you normally hear about news and activities in the neighborhood? / How do you find out? |
| **Receptivity** | What is the effect of the key figure role?  
How does the group respond to this?  
How does the group react to the Dutch health educator?  
(e.g., understanding, open, attention, appreciation, acceptance)  
Which questions are asked?  
Which responses are given? | What do you remember about the information given?  
What do you remember about the recruiter? | What did you think about Big move mama when you heard more about it?  
- Did you immediately decide whether you wanted to join Big Move mama? Or did you think about it first? |
| **Explanation for receptivity** | Which role does the key figure play?  
What degree of respect does the key figure command?  
How does the message come across?  
- About exercising  
- About Big Move mama  
How is the message communicated?  
(e.g., only by providing information, with an interactive approach, etcetera)  
Context factors?  
- Duration of information-giving | Did you expect so many mothers to sign up for Big Move mama?  
- Yes/more/less  
- Why did you think so many mothers signed up?  
  - Own role and approach  
  - Role and approach of Dutch health educator  
  - Information  
  - The program Big Move mama  
  - Strategies used  
  - Mothers’ expectations, reactions, and own motivations/barriers  
  - Contextual factors  
What motivated you to collaborate and invest in spreading the word about Big Move mama?  
Were there also factors that demotivated you?  
Did you feel you were able to meet the expectations of the Public Health Service?  
- Why did/didn’t you? | Who told you more about Big Move mama? (PHS health educator/intermediary from the organization)  
- Can you tell me more about the woman who gave the information?  
- What did you think about the person who gave the information? (ask follow-up questions if only answered with good, nice, etc.)  
- Who do you think is the best person to tell more about Big Move mama?  
  - From which organization?  
  - Why?  
What did you think about the information you received about Big Move mama?  
How do you prefer to receive information?  
- In which language?  
- In which form: spoken, written, as visuals, etc. |
content analysis from the three available qualitative sources. To increase validity, two coders – a health educator (MH) and an independent coder (CV) not involved in the study – coded the first interviews independently, compared outcomes, and discussed differences. This was an iterative process until inter-coder consensus was reached (i.e., the same excerpts were extracted and assigned to the same key codes regarding reach, receptivity, or participation and to similar sub-codes describing kinds of explanation). Then, the health educator coded the final interviews and charted the outcomes in the reach and receptivity/participation table respectively. This enabled explanation of the successfulness of ethnically specific channels, and the contributory role of ethnically matched recruiters during recruitment.

**Results**

**Reach – the contribution of ethnically specific channels**

Collaboration with ten ethnically specific organizations reached 47 mothers in total. The successfulness of the use of ethnically specific channels varied between the targeted ethnic communities: 37 Ghanaians, 6 Antilleans, and 4 Surinamese mothers were reached (see Table 7.3). Additionally, 5 Surinamese women were reached for an interview through general channels.

The differences between ethnic groups seem to be related to the organizational structure within the ethnic communities. If there were more organizations available that had fixed groups that met at fixed times and places and also included young adult women (≈25-50 years of age), then more mothers with young children were reached with information about Big Move Mama. We mapped many Ghanaian organizations, especially churches (n > 5); they met regularly in the form of women’s groups that also included younger women. Collaboration with four of these organizations resulted in the 37 women reached. The four Surinamese organizations available had no fixed groups that met regularly, or included older women only (50 years of age and above), which resulted in the four mothers reached. There were

<table>
<thead>
<tr>
<th>Ethnically specific channel</th>
<th>Ghanaian</th>
<th>Antillean</th>
<th>Surinamese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Churches</td>
<td>13</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Women’s organizations</td>
<td>24</td>
<td>n.a.</td>
<td>3</td>
</tr>
<tr>
<td>Surinamese schools</td>
<td>n.a.</td>
<td>n.a.</td>
<td>0</td>
</tr>
<tr>
<td>Radio</td>
<td>n.a.</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total reach</td>
<td>37</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

n.a. = not applied or applicable
Utility of ethnically specific recruitment channels and key figures

four Antillean organizations available, of which two collaborated. Only a church had regular meetings with fixed groups, which accounted for five of the six Antillean women reached.

This explanation was supported by the interviews with the target population and key figures. Ghanaian key figures explained that the many regular gatherings of Ghanaian women – which resulted in the successful reach – stem from their community’s close-knit nature and because they hold onto their own culture and find the Dutch language relatively difficult:

I: ‘The Ghanaian women get together quite often, in fixed groups. Why do you think this is? In your group, in churches…’
R: ‘In churches, yes… we love getting together, and our own things.’ (Ghanaian key figure)

R: ‘It’s very nice, getting the women together and then giving them some information about… Dutch society. A lot of women have been here for 25, 30 years, but because they can’t read or write, they miss out on certain things.’ (Ghanaian key figure)

Accordingly, the answers of the Ghanaian mothers indicated that they continue to use their own channels. They mentioned almost exclusively Ghanaian-specific channels for obtaining information about neighborhood activities (e.g., other churches, another organization, television, radio, and word of mouth within their own community). Information obtained through these organizations was described as being better received than information obtained through things like brochures sent in the mail, and more easily accessible than information obtained through someone like the family doctor (i.e., a general channel). Mothers explained that information given through these organizations gives them more clarity, because communication is in their own language or in English and their questions can be answered if they do not understand. They mentioned that this clarity resulted in trust and a good feeling, and made it easier to enroll in activities (‘Then you know what to do’).

I: Was it good that someone came [to your organization] to talk about [Big Move mama]?’
R: ‘Yes, then you can hear it, because sometimes… although you might want to read [it], you can’t… or you are able to read [it] but you don’t understand it very well. (…) It’s very important to me. It gives you a good feeling, you can trust it.’ (Ghanaian mother)

In contrast, for the Antillean and Surinamese women, the Dutch language posed no problems. Furthermore, key figures described the Surinamese and Antillean women as not wanting to have obligations and not very close (only with their families). The latter was directly linked by these key figures to fewer regular gatherings within the ethnic community, and so reach was seen as more difficult.
I: ‘We saw how the Ghanaian women got together a lot, they really got together in groups that met every two weeks. Isn’t there somewhere like that where we could reach the Antillean group all at once?’
R: ‘No, Antillean mothers are very different from Ghanaian mothers. You can’t compare them.’
I: ‘Why not?’
R: ‘Because the sense of solidarity among the Ghanaians is different from among the Antilleans. We’re also very close, but just with family. [With the Ghanaians,] they’re all brothers and sisters. [With us,] your immediate family is what counts, and the rest are just acquaintances.’
(Antillean key figure)

Excerpts from the Antillean and Surinamese mothers followed on logically from the explanations given by the key figures. They more frequently mentioned the individual-oriented channels through which they are normally reached, most of which were not ethnically specific. As examples of alternatives for reaching them they mentioned word-of-mouth communication with friends and colleagues, via health care, brochures by mail, or possibly Surinamese radio and television. In addition, Surinamese mothers mentioned social media and email as channels. Moreover, the mothers reached via ‘an Antillean radio broadcast’ and ‘Surinamese women’s organizations’ were in fact reached by an immediate family member who was also an Antillean radio producer, and a leader and an elderly mother (i.e., a grandmother) from Surinamese women’s organizations.

The interviewees linked the role of the available organizations to these ethnic communities’ characteristics, and mentioned this as a final explanation for the reach. Excerpts from the Ghanaian interviewees showed that they see the ethnically specific community organizations as having the role of ‘bridge to Dutch society’. These Ghanaian gatherings provided support, help, and advice, also about how to deal with specifically Dutch situations. Leaders of Ghanaian women’s organizations were described as being in touch with Dutch municipal organizations such as the Public Health Service and the local government district. They invited experts to provide information to their group, and translated the information received from these experts and also important materials written in Dutch. The organizations were the usual channels their members used to get information about parenting and health. The Ghanaian key figures used these roles to explain the high attendance at their meetings.

I: ‘How do you learn more about activities that take place in the neighborhood?’
R: ‘Umm, [our Ghanaian women’s organization] has a secretary, and she looks all over to see where we can go.’
I: ‘But is there also another way for you to get information?’
R: ‘No, she gives us all of the information, and sometimes she just puts it on the table.’
Utility of ethnically specific recruitment channels and key figures

Should we do this? Do we want to do this?’
I: ‘But don’t you get a newsletter from your local government district, for example?’
R: ‘Sure, a newsletter, all kinds of things. [The key figure] also reads them to us and explains it to those who don’t understand Dutch. (…) She [also] usually works together with the district.’ (Ghanaian mother)

I: ‘What struck me was that quite a few young Ghanaian women get together at [names of women’s organizations] and in churches. Why do you think this is?’
R: ‘The reason for this is [for example], for most women (…), the communication between them and their partner isn’t like in Ghana. One of them works in the evening and the other one in the afternoon, so then you don’t see each other. So with a group like this they have more of a chance to talk about problems and give each other advice. Or [for] certain subjects.’ (Ghanaian key figure)

The one Antillean church had the same kind of role, providing information every week about upcoming activities. In contrast, at the informational meetings organized by Surinamese organizations, no mothers with young children were present. A key figure mentioned that daughters of their elderly members said they were ‘glad their mothers have Surinamese organizations to empower them’ but they did not seem to be interested in these organizations themselves. Furthermore, Surinamese mothers were not used to receiving information about activities like these through their churches.

Receptivity and participation – the contribution of an ethnically matched recruiter versus an ethnic Dutch health educator

If we compare expressions of receptivity and participation numbers between mothers exposed to ethnically matched recruiters with those exposed to ethnic Dutch recruiters, overall, the former showed more receptivity and a larger proportion enrolled in the exercise classes. In the intervention condition, a more positive atmosphere was observed than in the comparison condition. Mothers seemed more open to and to pay more attention to the recruiter and recruitment message. The interviews with mothers supported this: they remembered the ethnically matched key figures and what they said better than the health educators and the information they provided. There was more positive interaction, and women asked more questions. After the information-giving and invitation for Big Move mama, several mothers in the intervention group actively approached the key figure for additional information and advice. In the comparison group, however, women left early or the health educator had to approach the mothers herself. Moreover, if an ethnically matched key figure was involved in the recruitment strategy, the health educator received more positive reactions afterwards – such as ‘A really good initiative’ and ‘It was a very nice evening’ – and two women asked whether the information could also be given in their churches.
Regarding the decision to participate (Table 7.4), we see that almost all of the mothers who indicated they did not want to join the exercise program (or who indicated they might want to join) had been recruited in the comparison group by a health educator (9 out of 10 mothers). There were a few more mothers in the intervention group than in the comparison group who indicated they wanted to join the exercise classes, but did not do so in the end (34% versus 28%). However, there was also a majority of mothers in the intervention group versus a minority of mothers in the comparison group who actually started taking part in the exercise classes (63% versus 36%).

The interviewees described several roles played by the ethnically matched recruiter that might explain the higher receptivity and participation in the intervention condition. First, the

<table>
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<th>Table 7.4 - Participation according to intervention versus comparison condition regarding recruiter</th>
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<tr>
<td><strong>Total reach</strong></td>
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<td>Comparison group (C) total:</td>
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<td>(C) Surinamese radio (interview), elderly 1</td>
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<td>(I) Surinamese radio (spot), elderly 2</td>
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<td>(C) Surinamese radio (interview) 3</td>
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<tr>
<td>(I) Antillean radio (interview)</td>
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<td>(C) Community project</td>
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<td>(I) Antillean church</td>
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<td>(C) School (via immigrant organization)</td>
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recruiter was familiar to the target population, which seemed to create openness, attention, accessibility, trust, and persuasion regardless of ethnic group. Mothers approached by an ethnically matched key figure could more easily recall who the recruiter was and the information she gave. Explanations given for this better recall had to do with the recruiter’s ethnicity, and whether she was known for her expertise or activities in this area. Subsequently, mothers actively accessed information and advice from these key figures. If the recruiter was described as a close, familiar person, this was described as contributing to trust and persuasion.

R: ’I thought the radio spot was good, too. Because everyone called me, saying, [name of key figure], are you going to take part in a project?’ Because they heard my name (…).’
I: ’Ooh, okay, that’s funny, because I actually didn’t have a single response to what was on the radio. But you did, huh?’
R: ’Yees, I did, I heard it, yes. But then, you’re not so well-known in the Surinamese community. So I’m not too surprised. But the moment you mentioned my name. Then they say, Hey [name of key figure], I heard your name on the radio. Are you taking part?’ I say, Yes I am, together with Ms. [name of the health educator], we’re doing a project called Big Move mama.” (Surinamese key figure, intervention condition)

I: ’And who was the person who told you about Big Move mama? Who was that?’
R: ’Er, er, [name of key figure], yeah, and also a lady, a white lady, but I forgot her name. Because [name of key figure] is… (runs her hand over her skin), so then I won’t forget, ha-ha-ha. So the other lady, she’s also white but, I forgot her name.’
I: ’Well, it was also a while back. And [name of key figure], is she from the church?’
R: ’Yes! The church, we have two services, one in the morning and one in the afternoon. But she goes to the morning service and I go to the afternoon service. But sometimes she comes to give us information.’ (Ghanaian mother, intervention condition)

I: ’And so is it also important that it’s your father [an Antillean radio producer] who’s saying this? Do you immediately take it on board then?’
R: ’No (laughs), no, I don’t, but still… I have a really good relationship with my father, so as far as that goes, if he suggests something he thinks would be good for me, I’ll take it on board. That’s what I mean.’ (Antillean mother, intervention condition)

Second, ethnically matched recruiters used the mother tongue, and could translate and explain things in a way that was relevant to the target population, which might have increased attractiveness, attention, and accessibility. This did not seem just a matter of understanding, but rather attraction to something that is ‘familiar’ and not a barrier to asking questions and interacting. In fact, mothers and key figures mentioned that most Ghanaian and Antillean women could understand both English and Dutch, the languages used by the health edu-
cators. Still, more positive interaction was observed when an ethnically matched recruiter used the mother tongue during recruitment, and if women approached these key figures afterwards with additional questions and for advice, they used their own language then as well. Although all women said their leader was able to translate if necessary, questions were asked only in their native language if the information had also been given in this language:

I: ‘And I also noticed you were quick to translate it into Papiamento.’
R: ‘I translated it myself – it carries more feeling, the Antillean feeling. It has nothing to do with people not being able to understand Dutch or anything like that. It’s all about feeling – you feel more.’ (Antillean key figure, intervention condition)

Third, mothers and key figures particularly highlighted the role of the ethnically matched recruiter as ‘motivator’ as being contributory. The kind of motivational approach most frequently applied was that of role model: expressing a positive attitude towards exercising and the exercise program, positive initiation of interaction with the health educator, encouraging participation (‘Let’s go with the group;’ ‘Take this opportunity’), and ultimately, their own participation in the program. Ghanaian women responded mainly with a wait-and-see attitude to the interactive approach of the health educators. Positive initiation of interactivity by the ethnically matched key figures with the health educator resulted in positive interactions with the whole group, and in questions being asked. Moreover, the matched recruiter’s enthusiastic approach and reinforcing of the benefits mentioned seemed to lead to a more positive group process, and also to more positive reactions to the health educator afterwards. The availability of a role model who participated in the exercise classes herself and who could be a contact person if constraints emerged during enrollment in the exercise program also seemed to contribute to actual participation after indicating interest.

R: ‘Yes, I think the information provided is good, I introduced you to the parents, you told the parents the reason, everything, and, er, you also did a good job, you talked about everything, so, er, people [responded] very enthusiastically and just signed up, and I wanted to take part too, so we had a good response (…).’
I: ‘What was it that made everyone want to take part?’
R: ‘Because I told them it’s for our health and that it would be once a week and that we’d do it with the group. Like that, which was good. [But then later on] the time is changed. So now you come from half past seven to half past eight’, I think it’s a little on the late side, but in fact I said no, I can’t complain. Because if I complain then the women will complain too. Because everyone looks over at me (laughs)!’ (Ghanaian key figure, intervention condition)

Another kind of motivational approach applied was adaptation of the message by the matched recruiter – unconsciously towards cultural factors, and more consciously towards
mothers’ characteristics and the social network. For example, an Antillean recruiter emphasized that she exercises so she can eat, and also stressed the social benefits of exercising together. Moreover, there were Antillean and Surinamese recruiters who highlighted the benefits for a particular mother’s needs, such as less back pain, exercising, and some time for herself. Or they linked people within social networks to each other, and asked whether one could support the other. This seemed to result in greater participation by the mothers reached, especially those mothers who were skeptical about the benefits of exercising at first.

Nevertheless, providing information was not always the best role for an ethnically matched recruiter. There were several examples where incomplete or even inaccurate information was given. This resulted in no additional benefits for participation, or counterproductive effects on receptivity. For example, if mothers were not told about the day or price of the exercise program, although they might have been interested, they did not participate. Furthermore, in one comparison church, an inaccurate introduction was given about the theme of presentation, namely, that it would concern health and a healthy diet instead of the health benefits of exercising and an invitation for Big Move mama. This resulted in very negative atmosphere. People listened, but were not really open to the information, and had negative attitudes and reactions afterwards (‘This wasn’t what we expected’).

Because of this, key figures generally preferred to have a health educator give the most important information about exercising and Big Move mama, and this was also appreciated by mothers. Only if the recruiter was a health expert herself or known for her sport activities, she felt to be capable of informing and recruiting mothers. Otherwise, several key figures from the intervention condition asked the health educator to provide the information herself, since she was the expert. The Public Health Service of Amsterdam was perceived as a credible source – also because of collaborations with community organizations in the past – thereby creating trust in the exercise program offered. Mothers perceived the health educator as a suitable messenger, especially because she had the knowledge required and was able to answer questions in detail. Other characteristics appreciated about the health educator were her involvement with the subject matter and the target group, her friendliness, and her patience in explaining things in detail. It was explained that if an expert comes herself, the women can assess for themselves whether they have a good feeling about it.

R: ‘I think it’s good that someone from the Public Health Service does it. (…) See, to me, I just see someone from the GGD, you know, they’re not specialized in one thing, but they know a little bit of everything. [Or] she can also give you information along the lines of, my colleague can help you further, that kind of thing. So I do like it that it’s someone from the GGD.’

I: ‘And what about someone from the neighborhood?’
R: ‘Yes, that’s a possibility, but then I hope that person doesn’t get stuck if someone has questions they can’t answer. That looks rather unprofessional. So... no, I was glad she was also from the GGD.’ (Surinamese mother, comparison condition)

I: ‘And why was it important to you that I explained things?’

R: ‘Well, because (...) you know more about the subject matter than I do. And the only thing I can help with is introducing you to the women. Emmm, I say a little and then, er, you can tell them about it yourself, and I always think that works the best with us, then they know that the person or the expert is getting the message across or giving the information, and then they can [ask] all of their questions (...) And the women felt much the same, they accepted it, so that was good.’ (Ghanaian key figure, intervention condition)

Discussion

The recruitment through ethnically specific community channels was successful among Ghanaian mothers, but less so among Antillean and Surinamese mothers. The more close-knit an ethnic community was, retaining their own culture and with poorer comprehension of the Dutch language, the better mothers were reached through ethnically specific organizations. They came together more often in organizations that had regular meetings with fixed groups that also included young women, and these organizations fulfilled a role as a bridge to Dutch society, such as to the Public Health Service of Amsterdam and their health promotion facilities. Furthermore, regardless of ethnic group, we found that using ethnically matched recruiters resulted in higher receptivity, and, among the Ghanaian mothers in particular, greater participation. This was explained by the fact that the ethnically matched recruiter was a familiar, trusted person, a translator, and a motivator because of her enthusiasm and encouragement or message adaptation. To increase the credibility and professionalism of the recruitment, key figures and mothers preferred the ethnic Dutch health expert.

The success of using ethnically specific organizations to reach mothers seems dependent on the target community’s characteristics. Our findings reinforce previous findings in that, in the Netherlands, Ghanaians seem to rely mainly on their own channels, while the Surinamese seemed to do this the least [25]. This can be explained by the more close-knit nature of the Ghanaian community. This is supported by a recruitment study in England, which found ethnic differences in responses to recruitment efforts via the ethnic community that were related to their social network structure, such as how close-knit a network was [26]. This characteristic might therefore be applicable to different contexts and different ethnic groups. Our study adds further insight into conditions under which application of ethnically specific channels might be likely to work. For instance, ethnic groups with more difficulties with the local language, and less integrated ones that hold on to their own culture, might be better
reached through ethnically specific community organizations. This is also because of associated organization characteristics (e.g., the availability of organizations that meet regularly and have a bridging role).

In addition, this study provided insight into which of the roles of the ethnically matched key figures might contribute to recruitment and which might not. This seemed to be a direct consequence of whether or not they felt confident with a role. These roles mainly concerned acting as familiar and trusted ‘natural helpers,’ translators, and positive role models. These findings are in line with previous study results regarding the effectiveness of community health workers [9]. However, review articles have also reported the potential contribution made by community health workers because of their ability to provide tailored and culturally relevant messages [9, 27]. We found that this role was less likely to be executed, however. Only a few key figures felt capable of being fully responsible for the recruitment. Although community health workers might contribute to the recruitment by being a trustworthy person, an expert was also needed for information-giving [10].

There were some strengths and limitations to this study, and it may be useful to consider them before drawing any final conclusions. This study was able to unravel which kinds of ethnic communities would benefit from recruitment through ethnically specific community organizations as a single channel in terms of contributing to successful reach. However, using this single approach, we were not able to test whether ethnic communities that did not conform to these characteristics could be better reached via the alternative channels they proposed, or whether several different channels might be needed to reach them successfully.

As a consequence of the higher reach among Ghanaian mothers, we have more evidence that ethnically matched recruiters can contribute to receptivity and participation among them than among Surinamese and Antillean mothers. In all three ethnic minority groups, though, qualitative data showed indications for increased receptivity when using ethnically matched recruiters. However, it could be that the lower degree of distrust towards general audience-oriented channels like health care and a good proficiency of Dutch might decrease the need for ethnically matched recruiters. More research on ethnic minority groups that are not as close-knit, less organized, and have relatively good local language proficiency might additionally contribute to grounded approaches to effectively recruiting multiethnic populations to participate in health promotion programs.

**Conclusions**

Ethnically specific organizations contributed successfully to the recruitment for an exercise program, but particularly in close-knit, highly organized ethnic communities with limited fluency in the local language. Ethnically matched recruiters were most confident in roles such as motivator, translator, and being a positive role model. At the same time, an expert was likely to be needed for effective information delivery. In particular the involvement of a trusted
familiar key figure in combination with an expert during recruitment might have contributed to the increased receptivity and participation in the exercise program.
References


similarities and differences in perceived determinants of weight-related behaviors among mothers.


