Crossing cultures: health promotion for senior migrants in the Netherlands

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SUMMARY
A health promotion programme focusing on the meaning of everyday activities was implemented and evaluated to test its usefulness for community-dwelling seniors in the Netherlands. To evaluate how senior migrants with a Surinamese-Hindustani background and professionals received the programme, and how it could be contextualized and improved in line with their values and expectations. A responsive evaluation methodology was followed to foster reflexive learning in and among stakeholders as the basis for programme contextualization. The evaluation consisted of three phases. Outcomes of former phases served as input for subsequent phases. Methods included interviews and focus groups with seniors and professionals. Open and selective coding techniques were used to analyse the interactively derived data. A small group of women was interested and followed the programme. It was not individual concerns or daily life problems that dominated, but the wish to become well informed, to maintain functional capacities and to continue their roles in the family and community. Striking differences in perspectives between professionals and migrants related to conflict between the underlying Western values of the programme (independence, personal control and autonomy) and the values of the migrants (interdependence, predestination, rebirth and destiny). Awareness among professionals of their own cultural background and the values of the migrant seniors was enhanced, but adapting the programme to the local context and values appeared far more complicated than originally expected. Adaptation requires intensive collaboration with participants and cultural brokers in the community.

Key words: community-based intervention; cross cultural; older people; responsive evaluation

INTRODUCTION
Population ageing has led to an increased interest in preventive and health promotion strategies for older people (World Health Organization, 2002; Gezondheidsraad, 2005, 2009; European Commission, 2008). Current views on prevention and health promotion for seniors focus not only on risk detection and reduction, but also involve approaches aimed at wellbeing, quality of life and social and societal participation (Janssen et al., 2012). The European Elderly People’s Platform puts it as follows: ‘Healthy ageing is not just about prolonging life. It is about promoting the necessary means to enable elderly people to continue to participate in society and cope with daily life’ [(Borges, 2007, p. 2)]. Seniors also stress that healthy ageing does not mean an absence of limitations, but rather a level of health and adaptation to the ageing process that is optimal and acceptable to the individual (Bryant et al., 2001).
Against this background, a preventive self-management programme was developed in the USA entitled ‘Lifestyle Redesign’ (Clark et al., 1997, 2001; Jackson et al., 1998; Hay et al., 2002). A similar intervention for community living seniors can be found in the UK: ‘Lifestyle Matters’ (Mountain et al., 2006; NICE, 2008). The positive experiences and insights gained from...
studies into both programmes have contributed to the general hypothesis that meaningful everyday activities are related to health and wellbeing. More specifically, it is expected that an occupation-based intervention, delivered in a tailored programme, i.e. a highly individualized programme in a group context, focusing on behaviour change and lifestyle redesign can lead to beneficial results for seniors (Daniëls et al., 2008a).

Even though the effectiveness of the US health promotion programme for community-dwelling seniors has been demonstrated, and the UK programme has created positive expectations as to its feasibility, it was acknowledged that this is not necessarily a guarantee of success and effectiveness in different contexts, and that socio-cultural ‘translation’ will be necessary (Daniëls et al., 2008b; Kuiper, 2008; Kuiper et al., 2010).

Cross-national/cultural transfer of an intervention should bear in mind that cultural values (implicitly) embedded in the programme may not fully resonate with the country and may hinder the cultural adoption of the intervention (Voigt-Radloff et al., 2011). This implies that programmes, even if they are effective in one country or cultural setting, cannot simply be translated into another language and transferred without the context being taken into account. Between 2004 and 2008, an occupational therapy working group in the Netherlands worked on the development of a country-specific programme supported by ENOTHE (European Network of Occupational Therapy in Higher Education) (Daniëls et al., 2008b). A conceptual manual, suited to the Dutch context, was developed, and the feasibility of parts of the programme was investigated in pilot studies.

The positive findings from these pilot studies and the needs and problems as observed by care-service organizations among community-dwelling seniors resulted in the introduction of the health promotion programme entitled: ‘Healthy and Active Ageing’ in seven different contexts for seven different groups in 2009 and 2010. The introduction and evaluation were commenced in three ambulatory care settings in the city of Rotterdam, including at a meeting place for senior migrants with a Surinamese-Hindustani background. The coordinator of this meeting place reported that many visitors to the meeting place were asking health-related questions (Kuiper, 2008; Heijsmans, 2011). Including this particular group of seniors in the study enabled the research group to further explore the possibilities for transferring and contextualizing the programme to specific cultural-ethnic minority groups. It was expected that the needs of the Surinamese-Hindustani seniors would, to some extent, overlap with those of their native counterparts, but also differ.

Hindustanis were originally from India or South-Asia and went to Suriname, a former Dutch colony, in the late nineteenth century. Following independence in Suriname in 1975 many people with a Surinamese-Hindustani background migrated to the Netherlands. Present senior migrants, many of whom who left Suriname as adults, feel that: ‘they are growing old in a foreign country’ (Netwerk van Organisaties van Oudere Migranten, 2009). In 2005, ~56 000 Surinamese seniors aged 55+ lived in the Netherlands (CBS, 2005). Not all are Hindus, but many (~80%) practice this religion and they are identified as ‘Surinamese-Hindustanis’. The situation of most of these senior migrants can be compared with Dutch seniors with a lower socio-economic status. In addition, there are also a number of specific problems, including their partial pension, and specific welfare and health problems such as a higher prevalence of chronic disease and functional impairment (Schellingerhout, 2004).

The full evaluation study aimed to assess how the senior participants and the professionals involved would receive the programme, and how it could be contextualized and improved in line with the particular socio-cultural group of seniors involved. This article is based on a study that forms part of the first phase of this larger evaluation project and also includes two other groups of seniors with a Dutch background, though in different settings (Heijsmans, 2011; Heijsmans et al., 2011). The article focuses on the expectations and experiences of those seniors with a Surinamese-Hindustani background. The purpose of this article is to evaluate how this particular senior migrant population and the professionals involved received the programme, and how it could be contextualized and improved in line with their particular values and needs. We expect this article will also provide lessons on the transferability and contextualization of programmes across cultures and communities.

THE HEALTH PROMOTION PROGRAMME AS INTENDED

The aim of the programme is to enable seniors to live independently at home, maintaining their health and wellbeing, whilst using relatively few
care services (Kuiper et al., 2010). The programme is informed by the concepts of self-management/self-efficacy and empowerment (Beckingham and Watt, 1995; Thompson and Thompson, 2001; Daniëls et al., 2006; Elzen et al., 2007; Elzen, 2008; Daniëls and Overbeek, 2008). People in the programme learn how to analyse their current pattern of occupations and make choices in order to improve their health and wellbeing (Danieëls et al., 2008a).

The intended target group is broadly defined as community-living seniors who are in a transitional phase. Transitions, particular in older age, may require renewed contemplation, letting go of old habits, revised skills, the need to make new contacts, the adoption of alternative coping strategies and changed time management. It is assumed that the programme will be of interest in particular to seniors who find themselves at a turning point in their lives. It is also expected that mainly people over 70 will show an interest in participation (Kuiper, 2008).

Participants are encouraged throughout the programme to reflect on and analyse their current patterns of everyday activities and to consider the changes they wish or may need to make in their life in order to preserve or improve health and wellbeing. Changing established lifestyles in this context is viewed as a dynamic process in which seniors may need information and support in order to change their existing habits (Danieëls et al., 2008a). The half-year programme is designed as a flexible cursory programme and includes 10 themes related to everyday activities, with a manual for the group leader, i.e. an occupational therapist, that sets out a number of ideas for themes of interest to those growing older (Kuiper et al., 2010). These 10 general themes are presented in Table 1: themes included.

Each theme is intended as a starting point to tailor and fine tune the content to the specific needs and wishes of the seniors involved. The manual makes various suggestions as to how thematic group sessions and individual meetings can be designed. The group leader acts as a facilitator, initiating and supporting a learning process in the group and its individual participants. The manual describes four methods of programme delivery in line with the US programme: didactic presentations; peer exchange; direct experiences and personal exploration (Jackson et al., 1998; Mandel et al., 1999). An occupational therapist is considered to be the core professional involved because of the specific professional competencies required. Other professionals, such as a physiotherapist or dietician, will be asked to take part if their expertise is needed on specific issues. A co-facilitator will assist in the group sessions. Occupational therapy students fulfilled this role in the research project, though it is preferable for a senior to act as co-facilitator in order to bring in experiential wisdom and to support the process of peer exchange.

The programme includes both group and individual sessions, assuming that a group approach alone cannot meet complex needs or deal with specific personal concerns. There are 15–20 group sessions; a minimum of 3 and a maximum of 5 individual sessions, to be held before, during and after the half-year programme. An individual needs assessment is conducted at the first individual session, preferably at a senior’s home. The results of this are then translated into personal goals to be achieved during the programme.

The cursory programme allows for weekly group meetings of ~2.5 h, including a break. The group comprises 10–14 people. The programme will be provided at neighbourhood level to strengthen social cohesion and preclude transport problems, and will be organized in close cooperation with local health and welfare organizations. This means that a variety of employees in the area of (health) care and social welfare services will assist in realizing the (starting) conditions for the programme, such as promoting it, spotting people who may be interested, informing and inviting the intended target groups (by making use of key persons working in community care, leaflets, advertisements in local papers, etc.), providing accessible accommodation and essential facilities.

### Table 1: Ten general themes

| (1) | Life stories and occupation in daily life |
| (2) | Physically fit |
| (3) | Mentally fit |
| (4) | Modern technology and home automation |
| (5) | Social contacts |
| (6) | Special events (rituals and outings) |
| (7) | Leisure time and voluntary work |
| (8) | Using resources in the environment |
| (9) | Safety inside and outside the home |
| (10) | Mobility and transport |

**RESPONSIVE EVALUATION**

Responsive evaluation was the method selected for the research. This is an approach that aims to
enhance mutual understanding among stakeholders as a vehicle for programme improvement (Guba and Lincoln, 1989; Abma, 2005). Reflexive dialogues are applied as a means to foster learning (Abma, 2001). Responsive evaluation appeared particularly suitable for our purpose as it is an approach that not only interactively engages stakeholders in the evaluation process, but also takes meaning and context fully into account. It is believed that the worth of a programme is inevitably related to its usefulness in a certain context, and its meaningfulness for participants (Stake, 1975, 2004; Guba and Lincoln, 1981). Before the worth of a programme in a particular context can be inferred, a large amount of descriptive information is required, often referred to as ‘thick descriptions’ (Abma and Stake, 2001). To this end, the historical, social, cultural and political contexts of a programme are thoroughly investigated. An important characteristic of the local setting where the programme is adopted is the set of values held by the stakeholders in that particular setting. Responsive evaluation assumes that a plurality of values will lead to different evaluations by different stakeholders (Stake, 1975, 2004). From a methodology point of view, this implies that evaluations of worth must be grounded in field studies through close interaction with the stakeholders in that context.

Responsive evaluation focuses on various stakeholder issues and engages stakeholder groups in dialogue about the quality of the programme with the particular aim of heightening the personal and mutual understanding as a vehicle for improvement (Guba and Lincoln, 1989; Abma, 2005). Criteria for evaluation will be derived from the issues found among the various stakeholders and will gradually emerge in conversation with the stakeholders. Communication and evaluation are inevitably linked; a practice cannot be improved without entering into dialogue with the parties concerned (Widdershoven, 2001). Consequently, the kind of communication in responsive evaluation is to be characterized by openness, respect, inclusion and engagement. The conditions for dialogue are the willingness of stakeholders to participate, to share power and to change in the process. However, consensus is not the ultimate goal. Dialogue is also considered successful if personal and mutual understanding has increased or if the understanding of differences is enhanced.

The intention of the subproject was to evaluate the process and outcomes of the programme and to adopt a proactive role as researchers by fostering dialogue between stakeholder groups, including the participating seniors and the professionals. The study sought to describe and assess the worth of the programme for a particular group of seniors in a particular context and to enhance the fit between the programme and the local context. This intention to adapt the programme locally and to actively encourage learning and bring about a process of change is grounded in a transformative research paradigm (Mertens, 2009). Participatory methods were chosen in order to foster the inclusion and equal participation of representatives of all groups involved in the programme. An emergent design was followed to match action learning with the context and participating seniors. This iterative and developmental process is crucial for generating ownership and inclusion (Abma et al., 2009).

The second author and a junior researcher formed the local research team. Both were part of a larger research group. The first author supervised the responsive evaluation, which was completed between May 2009 and February 2010 and resulted in a Master’s thesis (Heijsman, 2011) and a report on the full evaluation project (Heijsman et al., 2011).

Setting and recruitment
‘Vijf Havens’ is a large care centre for seniors that provides various residential and community services in the city of Rotterdam, the Netherlands. The ‘Inloop’ (walk-in) is a meeting place where senior migrants with a Surinamese-Hindustani background can participate in various social, recreational and educational activities either voluntarily or with a referral for day care. Visitors will be given the information they require if there are questions or problems surrounding personal and/or social functioning. Since staff were aware that a number of visitors were having serious problems with health issues, it was expected that many of them would be interested in what the course had to offer. Visitors were informed about the programme in a leaflet, the monthly activity calendar, or in person by the ‘Inloop’ coordinator. Participation was based on motivation and self-selection. There were no exclusion criteria. In the end some 12 seniors, all women, from a group of ~60 potentially interested visitors, showed serious interest in continuing. The 12 seniors who had signed up for the programme were further informed by the group facilitator about the evaluation project. Informed consent procedures were accordingly completed.
Design and procedures

The evaluation project consisted of three phases: exploration, deepening and integration. The outcomes of previous phases served as input for subsequent phases. Table 2 gives an overview of the research activities in the various phases.

Data collection involved semi-structured individual interviews with a (natural) selection from the group of senior migrants involved (n = 7), the group facilitator at the ‘Inloop’ (n = 1), five focus groups with representatives of the three contexts and groups involved in the first phase of the full evaluation project and a dialogue group.

Topic lists for the interviews with the participants and group facilitator were developed based on a literature search, and included (i) expectations of the programme (e.g. perception of becoming older; coping strategies; personal goals; motivation; perception of the programme; recruitment; bottlenecks in steering the programme); (ii) experiences with the programme (e.g. interaction, communication, goals, subjects, learning and changing process) and (iii) programme evaluation (value judgements, improvements). The interviews were completed by the second author, a non-migrant female. The interview was guided by the respondent (Kvale, 1983). Open-ended questions were used to create an open, unprejudiced atmosphere. The topic list was used as a checklist to ascertain that all topics were covered. If this was not the case, various subjects were introduced as the conversation went on. The interview setting was chosen by the respondent and most interviews were held at home. The interviews lasted between 1 and 1.5 h.

Five focus groups were organized during the first phase of the full evaluation project, involving the three starting contexts in the city of Rotterdam. One focus group with (representative) seniors from these first three starting groups (n = 5) was organized. Six seniors, two per group, were invited; one participant from the ‘Inloop’ was present, the other one was unable to attend due to illness. In addition, four focus groups with the group facilitators (3–5) were present at each meeting, including those who led the other groups.

Focus groups are suitable for establishing a broad, rich spectrum of meanings in a relatively short time frame. The moderator’s role is to keep the discussion focused on the topic while encouraging the group to interact freely and to maximize interaction among participants (Morgan, 2001). A protocol was developed in advance. This protocol gave an accurate description of the topics, timing, instructions and working methods. Themes that were discussed included recruitment, length and name of the programme, target population, aims, working methods, self-management, content, structure and information. The focus groups were moderated by the second author. The focus groups were held in public meeting centres and lasted ~2 h.

At the end of the evaluation of the first phase of the full project, an evaluative, integrative dialogue group, including a mix of participating seniors in the first three groups (2 per group), the professionals involved, and managers of the care organizations was held (15 participants in total). This dialogue meeting concentrated in particular on learning experiences and improvements for the programme by fostering reflection on the different perspectives, expectations of, and experiences with the programme. Consensus, as explained above, was not the ultimate goal of this meeting, but increased personal and mutual

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<tr>
<th>Period</th>
<th>Phase and focus</th>
<th>Activity</th>
<th>Details</th>
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<tr>
<td>May–October 2009</td>
<td>Exploration: consultations on</td>
<td>Interviews</td>
<td>Interviews with seniors before or at start of the programme (n = 2).</td>
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<td></td>
<td>expectations</td>
<td>Focus groups</td>
<td>Peer group meetings with group facilitators (total meetings 2; 5 persons were present per meeting)</td>
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<td>October 2009–</td>
<td>Deepening: consultations on</td>
<td>Interviews</td>
<td>Interviews with seniors half way the programme (n = 2).</td>
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<td>January 2010</td>
<td>experiences</td>
<td>Focus groups</td>
<td>Interviews with seniors 2 month after the programme (n = 3).</td>
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<td>Interviews with group facilitator (n = 1)</td>
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<td>Focus group with seniors (5 persons were present)</td>
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<td>February 2010</td>
<td>Integration: evaluation of</td>
<td>Dialogue</td>
<td>Meeting with the seniors, group facilitators, managers,</td>
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<td>expectations and experiences</td>
<td>group</td>
<td>policy-makers and other stakeholders of providers (n = 15 persons were present)</td>
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understanding or enhanced understanding of differences. This group was prepared by the second author and moderated by a member of the research group.

In addition to these research activities, the second author organized frequent reflexive dialogue groups—once every 5–6 weeks—with all parties involved in organizing and running the programme locally to evaluate and monitor the process per setting.

All interviews, the focus groups and dialogue group were audio taped with consent. These tapes were transcribed into full scripts. Audio tapes of the focus groups and dialogue meeting were partly transcribed and used to make reports. Transcripts and reports of the meetings were returned to the respondents and group members were asked whether they recognized themselves in them (member check). Saturation was discussed in the research team to assess when the data collection could be finalized. The team made sure enough data and repetition was obtained for each stakeholder group. It was felt that all perspectives (seniors, staff) were well covered to give an accurate portrayal of the local setting at the ‘Inloop’. The transcripts were analysed with colleagues from the research team to enhance reliability.

Open coding techniques were applied to discover themes within the main categories of ‘expectations’ and ‘experiences’, both from the perspective of the seniors and from the professionals. The entire interview was first read to identify emerging themes and subthemes. Labels were attached to those parts of the text that was related to a specific (sub)theme. Each interview was first analysed separately. Any new themes that emerged were added to the process of labelling and analysis and also adopted to the interviews analysed previously. The data from the different interviews were then grouped into clusters based on the main (sub)themes emerging from the interviews. Quotations from different interviewees were compared and example citations were identified per cluster and theme.

RESULTS

Seniors at the ‘Inloop’

The 12 seniors, who had expressed serious interest in the programme after attending the general information meeting, were contacted individually by the group facilitator, and they were invited to attend the first group meeting. However, seven seniors, who had immediately expressed an interest or who had participated in the first individual meeting and/or after first group meeting, decided not to continue the course. The main reasons for this were conflicting expectations, unwanted interference in privacy, illness (self or family members) and sudden long-term departure to Suriname because of the availability of cheap tickets. Only a small core group of three seniors (out of five) attended all group meetings (finally, only four in total) and individual contacts (three moments in time).

The average age of the 12 starting seniors was 68.8 years, ranging from 59 to 79. Most of them were sprightly individuals, i.e. they were all able to live independently at home, take care of themselves and their family, perform household activities and travel by car or public transport to the ‘Inloop’. Those with a referral for day care due to physical, cognitive, social and/or emotional problems can be characterized as frail.

Most of the ‘Inloop’ visitors who were initially interested were Hindustanis and a few were Muslims. Nearly all the senior migrants who visited the ‘Inloop’ had left Suriname in the 1980s later in life, after having raised their own family. Consequently, families and relatives are spread widely throughout the Netherlands and Suriname. This meant that giving or receiving informal care was not always possible in the way that these seniors either expected or were used to. Most of the seniors visiting the ‘Inloop’ practiced a Surinamese-Hindustani culture, and this was expressed in traditional music, dance, movies (Bollywood), festivals (Holy-Phagwa, Divali), clothing (sari), food (vegetarian) and by participating in and performing religious ceremonies (prayer, song, meditation). Hindustani was the common language at the ‘Inloop’ and with their families. The member of staff who coordinated the ‘Inloop’ also had a Surinamese-Hindustani background and could speak both Dutch and Hindustani. The group facilitator and the two students who were involved as co-facilitators were Dutch, and initially unfamiliar with the sociocultural background of the seniors. However, the group facilitator and students studied the history, traditions, culture and actual way of living of the specific migrant population attending the ‘Inloop’ through visits to the ‘Inloop’, informative talks with visitors and the coordinator, and by consulting brochures and
websites. The expectations and experiences of the seniors and professionals are presented below.

**Expectations of seniors**

The seniors who signed up for the course appreciated the personal invitation and were curious and eager to learn more about ageing and health-related issues such as physical activity, nutrition, social contacts and recreation. Most expected that the course would be some kind of training, as one of the participants put it: ‘We’re going to school’. They had high hopes, particularly because they had only attended primary school and had had very little education: ‘I like to learn new things and to use my head, do something active’. An important social motive was to contribute to the research part of the project and to the education of the young students who were involved. In addition, it was also expected that learning from others and sharing experiences would be worthwhile. However, although the seniors attended the introductory meeting, they did not really get a clear idea about the programme content or its objectives.

**Expectations of the group facilitator**

Leaflets for seniors were made and distributed by the group facilitator in close cooperation with the coordinator to give the group visiting the ‘Inloop’ the programme details. In addition, informative talks were held with the coordinator to explain the purpose, content and programme methods, and supportive activities for recruitment were carried out, such as delivering registration forms prior to the planned introductory meeting to be held by the coordinator as, in her words, she ‘knew the visitors best’.

On the basis of these preparations the group facilitator expected that the coordinator would be able to form a well-informed and motivated group to start the programme. However, this was not the case due to miscommunication and unforeseen reasons for delay. It turned out, for instance, that the required half-year commitment and weekly attendance had not been properly understood, either by the coordinator or by those seniors who had initially expressed their interest. The result was that many seniors withdrew. The summer break at the ‘Inloop’ in August caused further delay. Yet another setback that had an impact on seniors’ commitment was Ramadan, which started on 18 August. When the course could actually start in early September, seniors with a Muslim background could not take part because they were too tired. In the end the course started much later, with a much smaller group than expected, and a group that was not very well informed. Moreover, much to the group facilitator’s surprise, the small remaining group of seniors was not able to give their personal motives for participation. The group facilitator in particular was worried about the ‘service-minded’ attitude, the failure to clarify individual needs and people not speaking for themselves, and the participants’ emphasis on secondary motives (i.e. research and student education), as this might hamper their personal engagement and goal attainment. The group facilitator felt unsuccessful in communicating the programme’s aim:

‘I have told them many times that they are not participating in the course for research purposes, but simply for themselves. I don’t know if they really understood this. I think it’s a feature of the target group – servitude’.

**Experiences of the seniors**

Much to the participants’ surprise the course did not provide information, but focused on themselves and on their performance of daily life activities. Many seniors felt this was an intrusion into their private lives and became uncomfortable: ‘What do they want with our private stuff, like how we live in our houses, at what time we wake up, how we manage and save money’. They expressed reservations, particularly because they were afraid they would be gossiped about in the community: ‘There’s too much talk, and then they might say it to someone else, and they’ll laugh at you’. Assignments focusing on self-reflection and on reconsidering habits led to misunderstandings, they believed, for example, that making an activity schedule for a day and a week was simply to inform the group leader, and the task even met with resistance. Participants’ belief in destiny and reincarnation prevented them from reflecting critically on their everyday activities with a view to considering change or an alternative way of conducting their everyday activities, if necessary. They believed the progress of their life course was predetermined and that their main task was to accept the challenges life might bring (karma) and to live a ‘good life’. Thinking about changing daily routine or behaviour was considered to be impossible—even
though continuing in the present situation was difficult—as this kind of interference might burden the soul:

‘It wasn’t my intention to live with such an old man. But it is my destiny. I believe in destiny and this is my destiny. Sometimes I’m sad and angry. But I can do nothing. I cannot fight with others or myself’.

In particular, activities related to religious, spiritual or cultural rituals and habits were not allowed to change. These daily rituals were almost holy in nature, sequence and performance, and discussing them was not possible even if performing these rituals was difficult, for example, due to physical impairment. Participants tended to complain about the challenges they faced rather than reflect on their habits and eventually adjust them.

Participants were worried about the future, though not so much about their own health or wellbeing, but about possible limitations to fulfilling their religious and spiritual duties in the way they should be performed, and about meeting their family obligations and expectations within their own community. There was a fear of failing in one’s duty and therefore a fear of being punished by God:

‘If you are not good for people, your soul is not clean and you will not go to God. You go to hell and burn for your actions. For that reason I don’t want to harm people. I know what I must do: be kind, live well, eat and drink well, don’t quarrel. That’s why I pray every day. God bless me, let me live well for others, myself, my children, everybody. So I will not do naughty things and God will take me’.

The seniors enjoyed the social element of the course, sharing experiences and recalling memories:

‘To think about the past, what you have experienced, your parents, brothers and sisters, how you grew up. I felt happy, laughed, thinking about the past, a bit of happiness in myself’.

Experiences of the group facilitator
The group facilitator encountered numerous difficulties. The most significant and disappointing experience was the premature termination of the programme—only four group meetings were held. The poor turnout was partly caused by individual, practical reasons, such as sickness, medical appointments or family bereavement. Furthermore, the informal atmosphere that the seniors and staff were used to at the ‘Inloop’ was not compatible with the required weekly attendance for half a year. On top of that, this regular attendance did not seem to fit into the participants’ busy family lives. Seniors and staff saw the programme as one of the optional activities at the ‘Inloop’. It was therefore often necessary to bring group meetings to an end earlier than intended, or even to cancel them because other activities had been arranged for the same time, or there were special outings or celebrations. Moreover, language—in the literal and the figurative sense—appeared to be a source of misunderstanding between the group facilitator and the seniors. Problems related to the fact that the seniors felt that Dutch was not their native language: the Dutch language they had learned at school and spoke in Suriname was different from the Dutch spoken in the Netherlands, and difficult words were not always understood.

The group facilitator felt that thematic group activities, as suggested in the manual, could not be easily tailored to the target group and they demanded a lot of time, energy, creativity and inventiveness. Many adaptations were required because of the participants’ specific sociocultural and historical characteristics, such as the country they had grown up in, their educational background, and their traditional way of living, family relationships and roles, immigration in later life and language barriers. Because there was a serious discrepancy between the effort put in and the results, there was serious concern about the feasibility of the programme for the particular target group. It was felt that the target group was not receptive to the notion of (self)management, and to the idea that it was possible to choose, if necessary, to change one’s daily life activities—which was an important aim of the programme:

‘You see these people sticking to their habits. All of them are housewives, do the housekeeping, a few of them take care of their husband. Yes, these are the things they must do. That’s how they say it, it is a duty. It must be that way. It’s as if they have no choice’.

Over time the group facilitator learned that independence and keeping one’s personal life under control is actually part of her own Dutch culture: ‘We found it a pity [not being open to change, to guide one’s life] but maybe that’s more our own way of looking at things. Perhaps you shouldn’t expect it’. The group facilitator also became more aware of how a person’s outlook on life has
a significant impact on the meaning and perception of daily activities.

**Evaluation by seniors and group facilitator**

Only the group facilitator understood that the activities were intended as a means (and not as an end in itself) to initiate and facilitate reflective learning and to support, if needed or desired, behavioural change in performing daily life activities. It turned out to be very difficult, if not impossible, to overcome these perception differences. Perceptions were grounded in underlying values, and the conditions to really get to know one another and to understand each other’s perspective were far from optimum. In particular, the programme’s focus on raising awareness through storytelling, self-reflection, self-insight and self-efficacy, in order to accomplish (enhanced) self-management abilities, was apparently very difficult to understand and did not readily correspond with the participants’ belief in predestination, destiny and the ongoing cycle of life.

The group facilitator made the following suggestions for adapting the programme: use examples that stem from the Surinamese-Hindustani culture, Hindustani religion and habits; use easy written and spoken language; pay more attention to family values and the sociocultural system. In addition, the group facilitator suggested splitting the programme into two parts with a view to explaining and sharing expectations beforehand. Additional depth can then be achieved in close agreement with those group members who want to go into things in more detail. Improved teamwork with the staff at the care centre was also found necessary in order to create a better understanding of the intentions of the programme and its organizational and conditional requirements.

For the seniors, attention to practical issues and doing exercises was worthwhile, e.g. being given information about health-related issues (e.g. diet), safety at home, home-care services, practicing scholastic skills (e.g. writing and reading in Dutch), memory training and mental exercises.

**DISCUSSION**

Evidence-based medicine and practice has fuelled the development and evaluation of health promotion programmes based on randomized controlled trials to demonstrate their effectiveness. However, effective programmes—which may have intrinsic merit, a quality in itself—do not necessarily lead to local uptake and usefulness. Fundamentally, this indicates that the benefits of a programme depend on its fit with the local context and values. This also implies that programmes developed and tested in one country or locality cannot simply be generalized to another country and locality. Cultural and contextual adaptation was the underlying idea behind transferring a programme developed in the USA to the Netherlands, and to a specific cultural minority, in this case senior migrants. The aim of the present study was not just to describe how to make a fit between programme and context, but was also intended to foster such local contextualization through reflexive dialogues among the stakeholders involved.

As our case study demonstrates, this contextual adaptation is much more complex than might initially be expected. Despite the fact that the senior migrants were willing to invest in their health and wellbeing, and despite the fact that the professionals were willing to adapt the programme to the seniors, it turned out that it was very difficult to achieve the goals of the health promotion programme. The reason for this is a clash of expectations between the seniors and the professionals. The seniors expected to be given information, yet the aim of the programme and of the professionals was for the seniors to formulate personal goals, to reflect on daily habits and to work systematically toward lifestyle changes. The clash of expectations between the migrants and professionals can also be found in the literature on cultural-competent care and ethnicity-sensitive care (Kleinman et al., 1978; Resnicow et al., 1999; Suurmond et al., 2010).

At a more fundamental level, the clash of expectations was grounded in different value commitments, and the absence of conditions to arrive at mutual understanding between stakeholders. The religious, spiritual and sociocultural background of the Surinamese-Hindustani seniors in the programme led to questions about the meaning of a self-management programme for people who grew up in collectivism, who are convinced that their life is predetermined and who believe in a life after death and in reincarnation. Even though the programme focused on group activities, something the participants enjoyed, they were not keen to share private feelings which may possibly lead to gossip in their own community.
Within the collectivist culture some reservations were kept to relate about personal matters. The programme appeared to reflect many, often implicit, Western views about individualism, independence, autonomy and self-steering options, ranging from the presumed values of planning, managing and controlling one’s life and living conditions, to the supposed value of proactive behaviour, the presumed importance of freedom of choice and personal responsibility. The strong influence of sociocultural and historical backgrounds on views and meaning of ageing and health are consistent with the literature on ageing and diversity, as well as with studies that have investigated the impact of culture and life contexts on perceptions of health, wellbeing and quality of life in old age (Bryant et al., 2001; Westerhof et al., 2001; Gabriel and Bowling, 2004; Eyetsemitan, 2007).

Consequently, tailored professional competences should be based on appropriate knowledge of the population and its background, cultural information, cultural sensitiveness, awareness, skills and attitudes that respect and appreciate people’s diverse standards, values and beliefs (Seeleman et al., 2009). Although the facilitators of the evaluated programme did invest in finding out about the particular culture of the Surinamese-Hindustani women, it did not appear to be enough to be able to adapt the programme to the values of the seniors. Critical self-reflection and a willingness to look beyond, and if necessary renounce, personal, value-based interpretations and normative judgments are prerequisites. This may then lead to a greater appreciation of ‘otherness’ as Ruth Watson, cited by Kinébanian and Stomph (Kinébanian and Stomph, 2009), p. 15 aptly says: ‘If and when we are able to recognize and are willing to try and deal with the barriers to the perceived otherness in the people we meet and treat, we will begin to appreciate what it is to respect and celebrate them for who and what we are, and not what we would like them to become’. Although appreciation is a starting point, it alone is not enough. Professionals also need to learn competencies to deal with barriers to the perceived otherness and to deal with diversity in practice. Such intercultural competences include how to contact and approach people, how to create commitment and a shared vision grounded in finely tuned expectations, how to understand and communicate with each other.

More fundamentally, one might question whether this programme was not too professional driven. Although the group work was based on peer-to-peer support, group facilitation was moderated by professionals. Involving a senior with experiential expertise as a facilitator might lead to a better alignment with the values and needs of the seniors. More intensive collaboration with the local coordinator, who knew the seniors, who had a similar cultural background and spoke their language might also help contextualize the programme to the cultural values of the community. The literature refers to these people as ‘cultural brokers’ (Burlew, 2003); those who are both part of and familiar with a local community and culture, and who have trust both in that community, and in the dominant culture. Given their multiple partiality these cultural brokers are able to explain and help create mutual understanding between local participants and external parties. Cultural brokers are also more knowledgeable about and sensitive to the diversity within a cultural group than external parties. Another fundamental issue is whether the group of Surinamese-Hindustani participants should actually be approached as one group. With regard to the diversity in our case, we noticed, for example, that there were differences in health, age, religion (some participants were Muslim or Catholic), the number of years in the Netherlands, reason for migration and Dutch language proficiency. Notable differences within the group played a significant role, both stimulating and impeding the group’s dynamic processes. On the one hand, the emerging differences between individual seniors in the group caused commotion, conflict and even to participants dropping out. On the other hand, the heterogeneity within the group, albeit on a more delicate level, contributed to a wealth of views, opinions and beliefs.

It can be argued that due to the considerable diversity among individual seniors, contextual, person and group-centred adaptations will always be necessary when applying the programme to a specific target group. A universal approach is neither possible nor desirable, since each group will have its own particular features and each senior will have to be approached as a unique person, with a unique life course, living in a unique context. Diversity in this context is understood as the pluriformity in which humankind presents itself and the multi-layered components and dynamic interplay between these components (cultural, social, psychological, biological, financial, political, religious and spiritual) through which the complex construct manifests itself.
This cultural dynamic view on diversity prevents us from thinking in static cultural categories. People are always more than their culture and not determined by it for the rest of their life, and we need to ensure that we do not reduce a person to his or her ethnic and cultural background. Transferring or contextualizing a programme to a local context and group should therefore not lead to culturally specific programmes for certain minority groups, but rather to individually tailored plans.

Another way to prevent ‘over-culturalization’ is to observe the commonalities between the minority and the dominant group, in this case between older Dutch people and the Surinamese-Hindustani people. From a comparison between the migrant group and two other groups of seniors with a Dutch background who participated in the intervention, it became clear that most of the participants were enthusiastic about the group activities and the sharing of (life) stories and experiences (Heijsman, 2011). Remembering and reliving the past and exchanging past and present experiences were considered meaningful for a great majority of the participants. The literature does indeed acknowledge that life reviews may have therapeutic value. In elderly care ‘reminiscence work’ and ‘storytelling’ are acknowledged as ways to create a coherent self and identity (Bohlmeijer et al., 2007; Bendien, 2010).

A commonality among participants across cultural backgrounds was also found in the difficulty all groups encountered to formulate goals and reflect on daily habits. This requires a willingness to methodically work towards lifestyle changes (which was often not found among most participants), but also a certain level of abstraction and education. Together with the language barriers, the migrant group might have suffered even more from this as their socio-economic position is relatively low. Many migrant Surinamese-Hindustani people are poor and live in deprived neighbourhoods (www.netwerknoom.nl).

Contrary to what professionals might assume, hardly any of the senior migrants showed an interest in the programme because they had functional problems with everyday activities, nor could they initially indicate specific targets, needs or wishes to aim for. In fact, it was the opposite that appealed to them: they showed a specific interest in exchanging experiential wisdom on how other seniors had learned to cope with life tasks as well as the various changes, difficulties and challenges that can accompany the ageing process. Moreover, initial (general) intentions appeared not to be exclusively based on personal motives or benefits. Many of the interested seniors were emphatically motivated. The involvement of other people, including other seniors, and especially the students, professionals and researchers, inspired them to participate in order to make a difference in someone else’s life and to contribute to society in a meaningful way. However, these findings are not exclusive to the migrant group but also apply to the other research groups. The findings indicate that we should not focus on (functional) problems or impairments older people experience, but should instead focus on their capacities. This relates to the literature on strength-based, appreciative and positive approaches to ageing (Seligman, 2002; Moore and Charvat, 2007) and caring and the ‘power of giving’ as important sources of resilience in later life (Felten, 2000; Alex, 2010; Janssen et al., 2011).

CONCLUSION

The health promotion programme for community dwelling seniors was guided by Western values of independence and personal control and did not meet the expectations and values of female senior migrants with a Surinamese-Hindustani background. Instead of focusing on themselves, and on their own health and well-being, the seniors participated in order to help others, become informed and to live a ‘good life’ as far as possible. Although proven to be effective, the programme’s worth and usefulness was limited as it did not correspond with the local setting and values. Although we intended to foster contextualization of the programme to the local context and values, it actually turned out to be a complex process. The professionals’ knowledge of the seniors and awareness of their own cultural baggage improved, but conditions were not met to enhance the mutual understanding between stakeholders. Future research should focus on collaboration with participants themselves and cultural brokers, as is widespread in community-based work.

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