MASTER THESIS

THE HEALTH AND WELL-BEING OF CHILDREN AND THEIR PARENTS LIVING IN POVERTY IN TWENTE

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ABSTRACT

Introduction. Poverty and health are interrelated components; poverty is a major cause of ill health, and ill health is a major cause of poverty. Within this study, it was chosen to focus on the effects of poverty on the health and well-being of children, since poverty is considered to be the most important social determinant of child health in high-income countries. In order to limit the consequences of poverty on the health and well-being of children, the 'Academische Werkplaats Jeugd in Twente' developed an intervention called 'Gezonde kinderen in krappe tijden'. The study documented in this report is part of that project. *Methods.* A two-part study was conducted. First, a measurement instrument was composed to identify the impact of poverty on the health and well-being of children and their parents. This was done using a systematic search. Second, a pilot study was conducted aimed at identifying the current state of health and well-being of children ranged from four to fourteen years old and their parents living in poverty in the region of Twente. The study population was derived from the 'Gezonde kinderen in krappe tijden' project. The results of the completed measurement instruments were described and, if possible, compared to the norm values using a One Sample T-Test. *Results.* The systematic search resulted in a selection of seven questionnaires: the Central Statistics Office health survey – overall health, EMPO Parents Version 3.1, Mental Health Continuum – Short Form, the Financial Hardship Scale, SDQ, Kiddy-KINDL or Kid-KINDL, and eleven questions concerning the child's material deprivation and social participation. The pilot study demonstrated that the current state of health and well-being of the parents included in the study is similar to the overall population in the Netherlands. The current state of health and well-being of the children included in the study population demonstrated differences with the norm values. Significant differences found were lower emotional well-being, friends, and total health-related quality of life within the study population, according to the KINDL questionnaire. Moreover, non-significant differences were identified. The KINDL questionnaire indicated that the scores on the scales concerned with the physical well-being and school scale were lower than the norm values. The scale concerning the children's self-esteem was higher within the study population than the norm values. The results of the SDQ indicated that the children included in the study population have more emotional problems, and experience more difficulties overall. *Discussion.* The results of the study are comparable with former studies: poverty affects the health and well-being of children. The main recommendation is to use the composed measurement instrument in the 'Gezonde kinderen in krappe tijden' project. Attention should be paid to increasing the size of the study population, so that additional analyses can be performed and the internal and external validity increases. *Conclusion.* A measurement instrument was composed and pilot tested, which measures the health and well-being of children and their parents participating in the 'Gezonde kinderen in krappe tijden' project. The results showed no significant differences between the health and well-being of the parents compared to the norm values. The results showed significantly lower health and well-being of the children, on the aspects of emotional well-being, friends, and total health-related quality of life.

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1. INTRODUCTION

The study described in this paper focusses on the relationship between poverty and the health and well-being of children and their parents. Poverty and health and well-being are interrelated components; poverty is a major cause of ill health, and ill health is a major cause of poverty (World Bank Group, 2014).

The introduction starts with an overview of numbers related to poverty in the Netherlands. After that, policies and interventions aimed at reducing poverty and minimizing the impact of poverty on children are outlined. Finally, the two research questions determined for this study are presented.

1.1 HEALTH AND WELL-BEING

There are different approaches towards defining health, each with different implications for policy and practice (Haverkamp, Verweij, & Stronks, 2017). Huber et al. created the concept of "health as the ability to adapt and to self-manage", which is referred to as 'positive health' (Huber, et al., 2011, p. 2). This definition takes into account the physical, mental, and social aspects of individuals. The domains included within the definition are bodily functions, mental well-being, meaningfulness, quality of life, social - societal participation, and daily functioning (Institute for Positive Health, 2017a). When referring to health and well-being within this study report, the definition of Huber et al. was in mind. The rationale for using this concept and a detailed explanation of the concept can be found in section 2.1.2.

1.2 DETERMINANTS OF HEALTH

The level of a person's health depends on multiple factors (World Health Organization, 2018). These determinants can relate to social and economic environment, the physical environment, and the person's individual characteristics and behaviours. Examples of determinants of the social and economic environment are income and social status, education, and social support networks. Higher income and social status, and a better social support network are both associated with better health outcomes. Low education is related to poorer health, more stress, and lower self-confidence. Within the physical environment, quality of air and water, employment and working conditions, and safety of the living space are important aspects. Air - and water quality of a high standard contribute to better health outcomes, as well as good employment and working conditions, and a safe living space. The accessibility of health services depends on the economic environment as well as on the physical environment. The possibility to prevent and treat diseases has a positive influence on health. The person's individual characteristics and behaviours also determine the level of health. This includes both genetics and personal behaviour. Choices for a healthy lifestyle, for example with healthy nutrition and without smoking, have a positive influence on a person's level of health (World Health Organization, 2018). Within this study, there is a focus on the determinants of health related to the economic environment.

1.2.1 GROWING UP IN POVERTY

An important aspect of the economic environment is the income level. In this study, it was chosen to focus on the effects of poverty on the health and well-being of children. Poverty is considered to be the most important social determinant of child health in high-income countries (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016). Growing up in poverty can affect social – and societal participation, mental well-being, and physical health (Kalthoff, 2018). Children living in poverty have a higher chance of being socially isolated, caused by a lack of money to participate in for example sports or cultural activities. Going to birthday parties of friends or celebrating their own birthday might also be impossible due to financial hardship. The mental well-being of children can also be affected by poverty. The feelings of fear, dependency, and being unhappy increase with the time a family lives in poverty. These feelings are mostly related to financial problems, and consequences of the financial problems. For example, the children fear to lose their house, have no food, or make more debts. In approximately one out of four children, these feelings lead to physical complaints, such as a headache, stomach ache, or tiredness (Kalthoff, 2018).

1.3 POVERTY

There are different approaches towards defining poverty, which are explained in detail in section 2.1.1. In this study, poverty is defined as "when a family's income fails to meet a federally established threshold that differs across countries" (United Nations Educational, Scientific and Cultural Organization, 2017, p. 2). To specify this, everyone living below the low-income threshold can be considered as being poor (Nederlands Jeugdinstituut, 2017). In the Netherlands, the Central Statistics Office (CBS) determined the low-income threshold to be an income up to 120 percent of the social minimum, dependent on the size of the household. In 2016, the threshold for a one-person household was 1030 euros per month (Centraal Bureau voor de Statistiek, 2018). For a couple without children, this threshold was 1410 per month. A couple with two underaged children is living under the low-income threshold if they had an income below 1940 euros per month, and for a single-parent household with two underaged children, this threshold was set at 1560 euros. A visual representation of these numbers is shown in Figure 1.

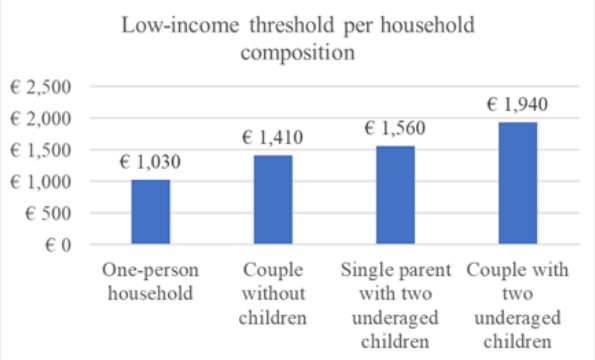

Figure 1. Low-income threshold per household composition in 2016 (Centraal Bureau voor de Statistiek, 2018)

In the Netherlands, over eight percent of all households live in poverty for a minimum time period of one year (Nederlands Jeugdinstituut, 2017). In 2016, 5.4 percent of the two-parent households, and 23.1 percent of the single-parent households with underaged children were living in poverty for over one year. This accounts for 292 thousand underaged children growing up in poverty. Moreover, 2.1 percent of the two-parent households and 8.0 percent of the one-parent

households with underaged children were living in poverty for four years or longer. This accounted for 117 thousand children in 2016. Figure 2 shows a visual representation of the percentages.

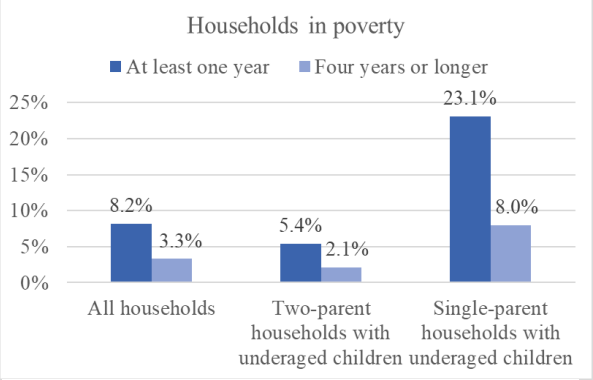

Figure 2. Visual representation of households in poverty in 2016 (Nederlands Jeugdinstituut, 2017)

Moreover, children till the age of twelve have an increased risk of living in poverty in comparison with the total population (Hoff & Wildeboer-Schut, 2016). In 2014, over twelve percent of those children lived in poverty, in contrast to 7.6 percent of the total population in the Netherlands.

1.3.1 POVERTY IN TWENTE

In Twente, 97.026 households are living with children, both one- and multiple-parent households included (provincie Overijssel, 2017). Of all households in Twente, approximately 10.4 percent is living in poverty for at least one year (Centraal Bureau voor de Statistiek, 2016). Applying this rate to the number of households results in approximately ten thousand households living in poverty in the region of Twente.

Within the ranking of poorest municipalities in the Netherlands, Enschede was ranked seventh with eleven percent of the society living in poverty in 2013 (Goderis & Vrooman, 2016). In total, four out of fourteen municipalities within the region of Twente had a poverty rate above the average rate of 7.7 percent within the Netherlands. In 2014, the average annual income per household was 23,200 euros in Twente, which was 5.9 percent lower than the average income of 24,700 euros in the Netherlands (Kennispunt Twente, 2017a). Comparing the gross regional product per capita of Twente to the gross domestic product of the Netherlands results in respectively 32,768 and 41,258 euros in 2016 (Kennispunt Twente, 2017b). The gross regional and domestic product per capita is the measure of the total output of the region or country, divided by the number of people living in that area (Investopedia, LLC, 2018).

1.4 INTERVENTIONS

1.4.1 GOVERNMENT POLICIES

Annually, the Dutch government spends approximately one hundred million euros on policies against poverty and debts, from which ninety percent is allocated to municipalities (Rijksoverheid, 2018). Municipalities have a central position in controlling and reducing poverty, since they are closest to the people, are familiar with the local circumstances, and are aware of the possibilities for cooperation with local private parties (Rijksoverheid, 2016).

The national government can support people with a low income in different ways. The disposable income can be influenced by assigning benefits and allowances, and setting a minimum wage (Vrooman, 2016). The Uitvoeringsinstituut Werknemersverzekeringen (UWV) is a government institution and provides employee insurance (UWV, 2018). The UWV can among

others offer unemployment benefits when a person loses his job or is shortened on working hours (UWV, 2018a). Another example in which the UWV can offer financial support is in a situation in which working is no longer possible due to disease (UWV, 2018b). Besides, the national tax authorities can support people with a low income by offering allowances. These benefits are for example assigned in relation to healthcare, housing, study, or children (Belastingdienst, 2018; Dienst Uitvoering Onderwijs, 2018).

Municipalities are responsible for policies aimed at preventing and minimizing the impact of poverty and providing debt management (Vrooman, 2016; Rijksoverheid, 2018). This can, among others, be done by social assistance benefits, culture and sports funds, and remission of municipal taxes (Rijksoverheid, 2018). The social assistance benefits provided by the municipalities are appropriate for people who do not have enough money to live but cannot claim any national benefit (Rijksoverheid, 2018a).

1.4.2 CHILD-SPECIFIC INTERVENTIONS

In order to limit the consequences of poverty on the health and well-being of children, interventions can be developed. These interventions can be aimed at parents or families, schools and child centres, or a larger 'system' (Graaf & Meij, 2011). An example of an intervention aimed at the family is the 'Armoede en Gezondheid' intervention. This intervention focusses on children who are at risk of - or suffer from a health problem related to the family's financial hardship (Graaf & Meij, 2011). This intervention offers financial support to reduce the deprivation associated with children's health. An example of an intervention provided at schools and child centres is the 'Kaleidoscoop' intervention (Nederlands Jeugdinstituut, 2018a; Graaf & Meij, 2011). This intervention focusses on children from 2.5 to 6 years old from disadvantaged backgrounds. The aim of the intervention is to minimize educational disadvantages, so that educational opportunities are increased. Interventions aimed at the larger 'system' are relevant for families with multiple and long-term problems and are focused on solving these problems. An example of an intervention within this category is the 'Praktisch Pedagogische Gezinsbegeleiding'. This intervention involves the parents, the child, the family as a whole, and the living environment of the family in solving the multiple and long-term problems.

In Twente, the 'Academische Werkplaats Jeugd in Twente' (AWJT) developed an intervention aimed at reducing the impact of poverty on the health and well-being of children and their parents. The AWJT is a collaboration in which the fourteen municipalities of Twente, GGD Twente, Saxion University, and the University of Twente are involved. The intervention is called 'Gezonde kinderen in krappe tijden', which literally means 'Healthy children in periods of financial tightness'. The intervention consists of five group meetings and focusses on parents with children attending primary school, living on or below the low-income threshold. These children are ranged from four to fourteen years old. It is estimated that the health and well-being of children can be improved by offering guidance to their parents.

Each group meeting focusses on a specific theme, all connected to at least one of the

six domains of Huber et al. (Huber, et al., 2011). In the first meeting, the theme 'here and now' is central. In this meeting, parents meet each other, the aim of the intervention is further explained, and individual goals are determined. The second meeting is called '(my) body, feelings, and thoughts'. This meeting aims at creating awareness of body, feelings, and thoughts. The third meeting is called 'participation and daily life' and includes outlining the available public services and rules to the parents. Fourth, the intervention will pay attention to 'now and later'. This meeting stimulates parents to picture their – and their child's future. Besides, the goal is to make parents aware of their impact on their children's future. The fifth and last meeting is called 'to feel good'. This meeting is aimed at outlining to parents what influences feeling good, of the parents themselves as well as their children. Besides, it offers guidance for positively influencing this feeling.

1.5 KNOWLEDGE GAP

The effects of the 'Gezonde kinderen in krappe tijden' project on the health and well-being of children and their parents is unknown. A longitudinal intervention study is being conducted within the AWJT to measure these effects. However, there is no measurement instrument measuring the health and well-being as defined by Huber et al., appropriate for the target group of the intervention (Institute for Positive Health, 2017). Therefore, the study documented in this report aimed at developing a measurement instrument focused on the health and well-being of families living in poverty.

1.6 RESEARCH QUESTIONS

To develop an instrument to assess the current state of health and well-being of children and their parents living in poverty, two research questions were determined. First, it was relevant to determine which measurement instruments could be used to identify the impact of poverty on the state of health and well-being of children and their parents. Therefore, the first research question determined was: "Which measurement instruments are appropriate for measuring the health and well-being of children from four to fourteen years old and their parents living in poverty?" The level of appropriateness was dependent on the quality of the measurement instrument and the applicability to the project specifically.

Second, an estimation was made concerning the current state of health and well-being of children from four to fourteen years old and their parents living in poverty in Twente. The second research question determined was: "What is the current state of health and well-being of children ranged from four to fourteen years old and their parents living in poverty in the region of Twente?" In order to answer this question, the results of the questionnaires completed by the study population were described and compared to the average Dutch population.

2. THEORETICAL FRAMEWORK

This chapter starts with an explanation of the most important concepts of this study, which are 'poverty' and 'health and well-being'. Following, three frameworks are discussed concerning the determinants of health: the 'Socio-Economic Determinants of Health' framework, the 'Social Determinants of Health and the Pathways to Health and Illness' framework, and 'The Total Environment Assessment Model of Early Child Development' framework. The chapter ends with an overview of the available knowledge concerning the impact of poverty on the health and well-being of children, using a mini-review as developed by Griffiths.

2.1 CONCEPTS AND DEFINITIONS

Three important concepts within this study that needed to be defined are poverty and health and well-being. Appendix 1 shows an overview of all the concept's definitions considered.

2.1.1 POVERTY

Different approaches towards defining poverty can be applied. Specifying poverty can result in the distinction of income poverty, absolute poverty, and relative poverty (United Nations Educational, Scientific and Cultural Organization, 2017). Income poverty is when a family does not meet the national established threshold. Absolute poverty measures poverty in relation to the amount of money required to meet the basic needs. Relative poverty states poverty in relation to the economic status of other members of the society. Another approach towards poverty is developed by the United Nations (United Nations, n.d.). This approach does not focus on the economic aspects of poverty alone, but includes hunger and malnutrition, limited access to education and other basic services, social discrimination and exclusion, and the lack of participation in decision-making.

In this study, it was chosen to use the definition of income poverty. This definition is concrete and specific; it is quite easy to identify eligible people. The exact definition is as follows: "Income poverty is when a family's income fails to meet a federally established threshold that differs across countries" (United Nations Educational, Scientific and Cultural Organization, 2017).

2.1.2 HEALTH AND WELL-BEING

The 'health and well-being' of children and their parents is an important concept within this study. Haverkamp, Verweij, and Stronks composed an article comparing five definitions of health, established in interaction with each other (Haverkamp, Verweij, & Stronks, 2017). The article included the definitions of Boorse, Nordenfelt, Venkatapuram, the World Health Organization (WHO), and Huber et al., all outlined in Appendix 1. The definitions were distinguished based on seven aspects. The first aspect was the naturalistic versus normative approach. The naturalistic approach considers health mainly objective and scientifically measurable, whilst the normative approach considers health as a condition relevant for the daily functioning of a person. Second, the definitions were distinguished by reductionism or holism. In the reductionistic approach, the human body is considered as a composition of organs and physical functions. In the holistic approach, the human being is studied as a whole. Third, a distinction was made between

internalism and externalism. The internalistic approach focuses on health within the person himself, whilst externalism refers to the circumstances in which the person lives as well. Fourth, health was considered to be universal or relative. Universalism refers to health as a state which should be the same for everyone, whilst in relativism health can differ per society or individual. Fifth, health could be assessed objective or subjective. A person assesses his own health subjective, a health professional is expected to assess health mainly objective. Sixth, the approach to health could be distinguished by the relationship between health and well-being according to the definition. Health and well-being can be either equivalent, or health can be a necessity for well-being. Last, the relationship between health and disease could differ among definitions. Health can be seen as the absence of disease, or disease can be seen as a factor causing deteriorated health (Haverkamp, Verweij, & Stronks, 2017).

In the nature of this study, a normative, holistic, internalistic, relative, and subjective approach was appropriate. Normative and holistic, since health was considered to be more than physical functioning alone; it is a relevant factor influencing daily functioning. Internalistic, since health should be achievable for everyone, independent of their living conditions. Relative, since people were approached as individuals within the study. Subjective, since the level of health was assessed by the people themselves, not by professionals. Furthermore, health was seen as a determinant of well-being; health and well-being were not considered equal. In addition, having a disease was considered as a factor affecting health, but health was considered as more than just the absence of disease. Comparing these requirements to the aspects of the definitions of Boorse, Nordenfelt, Venkatapuram, WHO, and Huber et al., led towards the possible appropriateness of the definition of Nordenfelt and Huber et al. (Haverkamp, Verweij, & Stronks, 2017). In the definition of Nordenfelt health was defined as the following: "A is in health if, and only if, A has the ability, given standard circumstances, to realize his vital goals, i.e. the set of goals which are necessary and together sufficient for his minimal happiness" (Venkatapuram, 2013, p. 273; Haverkamp, Verweij, & Stronks, 2017). However, the 'vital goals' were not being further specified or explained, which made measuring health according to this definition difficult (Venkatapuram, 2013).

Huber et al. created the concept of "health as the ability to adapt and to self-manage", which is referred to as 'positive health' (Huber, et al., 2011, p. 2). This definition takes into account the physical, mental, and social aspects of individuals. A scoring tool was developed in order to gain insight into the level of health according to Huber et al., which can be seen in Figure 3. This scoring tool was developed to support adults and children in consults with their physician so that they can better express how they are doing (Institute for Positive Health, 2017b). This diagram includes six domains of health: physical functioning, mental health, meaning, quality of life, social participation, and daily functioning. When referring to health and well-being in this study, the concept of Huber et al. was in mind. This definition was chosen over the definition of Nordenfelt, since the definition of Huber et al.

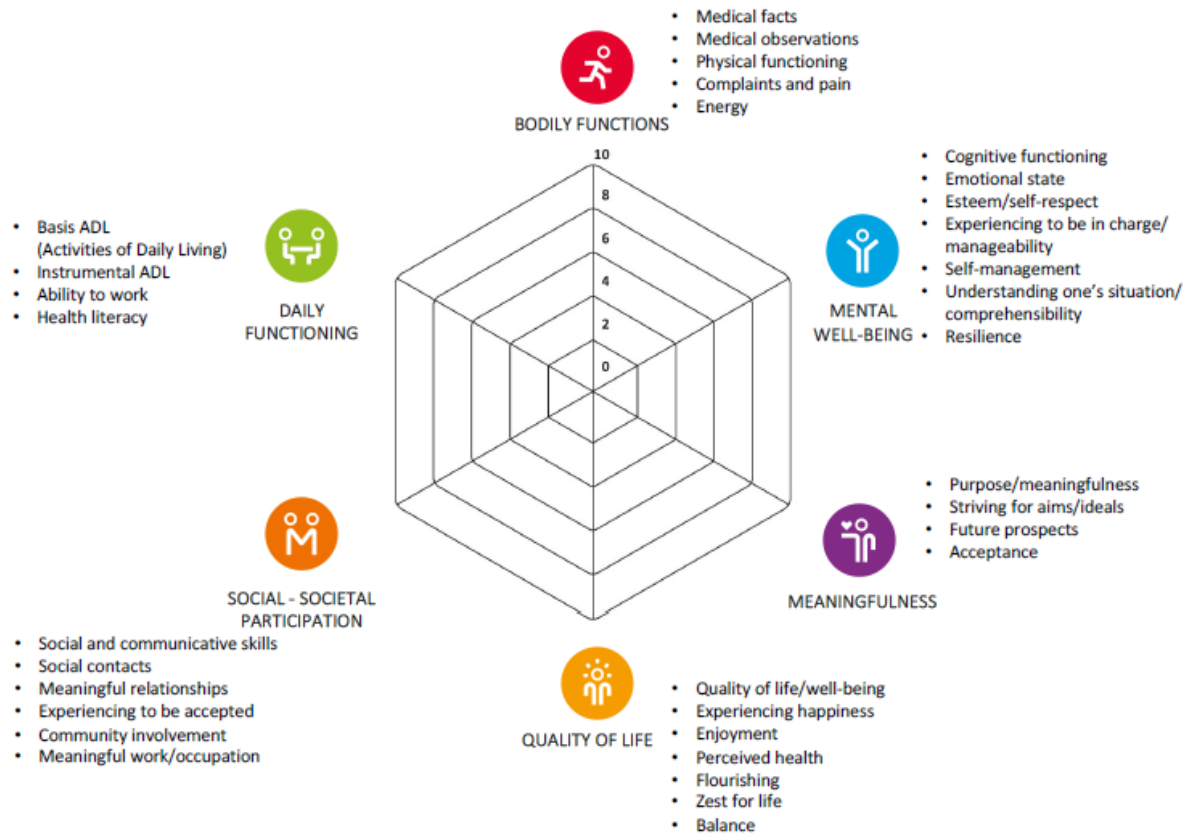

Figure 3. Pillars of positive health (Institute for Positive Health, 2017a)

explicitly states the six domains of health, which made it more appropriate for measuring the level of health and well-being.

2.2 DETERMINANTS OF HEALTH AND WELL-BEING

The level of a person's health and well-being is dependent on multiple factors, such as their work, educational level, income, living conditions, physical environment, and early childhood experiences (Canadian Council on Social Determinants of Health, 2015). In order to improve understanding of the determinants of health and well-being, frameworks and visual depictions can be used. The Canadian Council on Social Determinants of Health compared 36 frameworks focussed on the determinants of health. All frameworks were assessed as explanatory, interactive, action-oriented, or a combination of two or three of these. Moreover, the frameworks were grouped by their primary focus. The focusses defined were: policy development and decision-making, practice approach, issue focus, population focus, and broad focus. In the theoretical framework of the study documented in this report, it was chosen to limit to frameworks with an issue focus on living and working conditions and frameworks with a population focus on children, since these primary focusses are in line with the focus of the study. This resulted into three frameworks. The frameworks with an issue focus on living and working conditions are 'Socio-Economic Determinants of Health' by Munro and 'Social Determinants of Health and the Pathways to Health and Illness' by Brunner and Marmot (Munro, 2008; Mikkonen & Raphael, 2010). A

framework with a population focus on children is 'The Total Environment Assessment Model of Early Child Development' by Irwin, Siddiqi & Hertzman (Irwin, Siddiqi, & Hertzman, 2007). These three frameworks are briefly discussed in the following sections.

2.2.2 IMPACT OF LIVING AND WORKING CONDITIONS ON HEALTH AND WELL-BEING

Figure 4 demonstrates Munro's 'Socio-Economic Determinants of Health'-framework. This framework assumes that the health of individuals and populations is determined by social, economic, and environmental factors (Munro, 2008). The factors include income, access to healthcare, early child development, health behaviours, environment and housing, employment and working conditions, education and literacy, social support and connectedness, aboriginal status, and food security. All these determinants interact with each other, as well as with genetics and behaviour (Munro, 2008).

The second framework focussed on the impact of living and working conditions on health and well-being is the 'Social Determinants of Health and the Pathways to Health and Illness' by Brunner and Marmot (Canadian Council on Social Determinants of Health, 2015). This framework, which can be seen in Figure 5, demonstrates the impact of the organization of society on living and working conditions (Mikkonen & Raphael, 2010). In turn, the living and working conditions impact psychological and physical health and well-being. These processes takes place through material, psychological, and behavioural pathways.

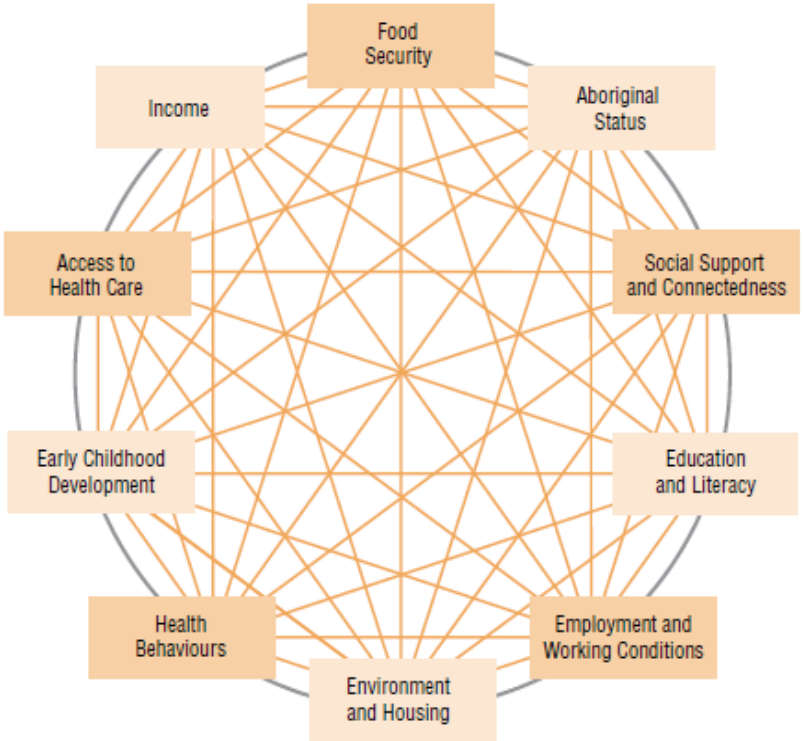

Figure 4. Socio-Economic Determinants of Health (Munro, 2008)

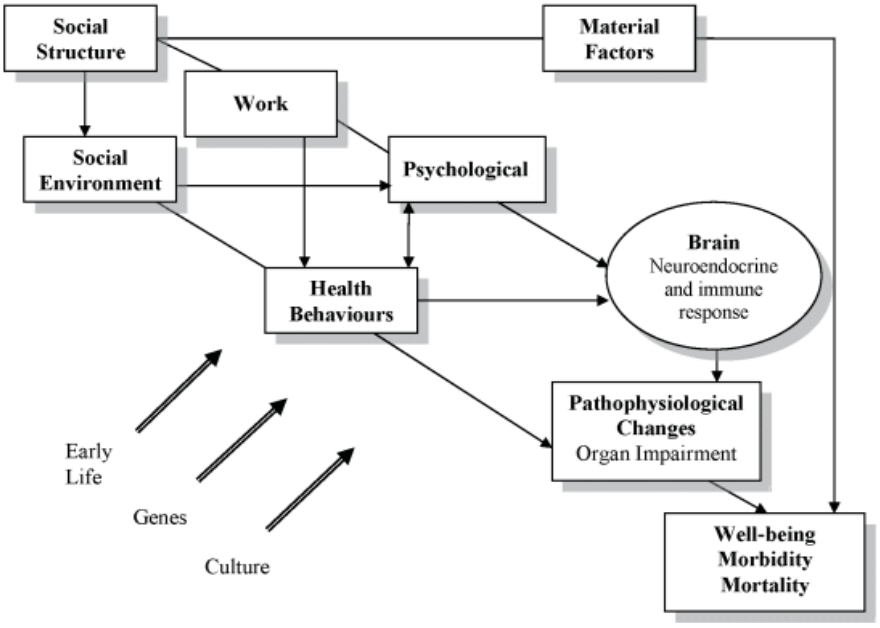

Figure 5. Social Determinants of Health and the Pathways to Health and Illness (Mikkonen & Raphael, 2010)

Moreover, genetics, early life, and cultural factors influence a person's health during the entire life course.

2.2.3 DETERMINANTS OF CHILDREN'S HEALTH AND WELL-BEING

The Total Environment Assessment Model of Early Child Development (TEAM-ECD) is specified on the determinants of early child development, as presented in Figure 6 (Irwin, Siddiqi, & Hertzman, 2007). The determinants included in the TEAM-ECD can be assigned to the individual child, the family, residential and relational communities, and the regional, national, and global environment. Moreover, ECD programmes and services can overlap several spheres of influence. Each sphere of influence is impacted by social, economic, cultural, and gender factors. Furthermore, the report of Irwan, Siddiqi, and Hertzman concluded that experiences during childhood are of significant influence during the entire life (Irwin, Siddiqi, & Hertzman, 2007). Physical, social, emotional, language, and cognitive domains strongly influence learning capabilities, economic participation, social participation, and health.

2.2.4 FRAMEWORK APPLICABLE TO THIS STUDY

When selecting a framework that is most applicable to the study documented in this report, the most relevant factors of each framework are identified. Within the 'Socio-Economic Determinants of Health' framework, three factors are identified as most applicable to this study and the 'Gezonde kinderen in krappe tijden' project. The project mainly focusses on the relationship between income and (early) child development.

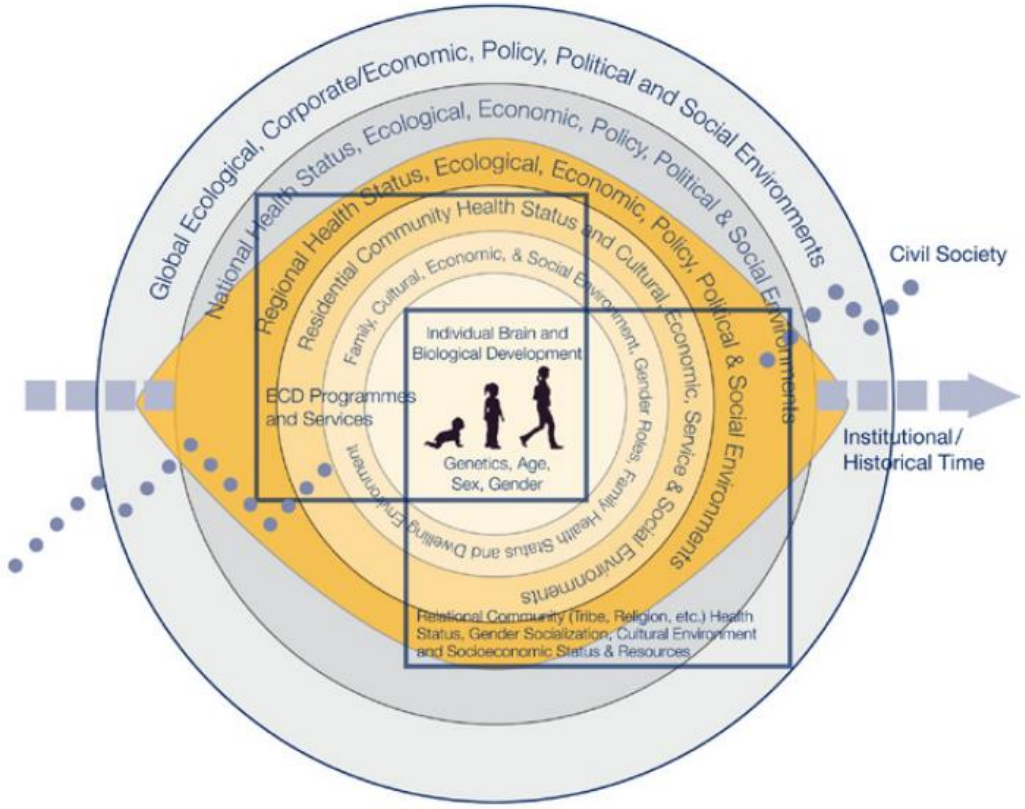

Figure 6. Total Environment Assessment Model of Early Child Development (Irwin, Siddiqi, & Hertzman, 2007)

The aim of the project is to reduce the negative impact of low income on child development, by providing social support and connectedness. Therefore, income, (early) child development, and social support and connectedness are considered to be the most applicable factors of this framework. The factor 'Aboriginal Status' is not applicable to the study and the 'Gezonde kinderen in krappe tijden' project.

Within the 'Social Determinants of Health and the Pathways to Health and Illness' framework, the 'Gezonde kinderen in krappe tijden' project mainly aligns with the social environment, and the health outcomes related to this factor. According to the framework, the social environment directly influences the psychological aspect of health and health behaviours. Moreover, the brain, pathophysiological changes, and well-being, morbidity and mortality are indirectly impacted by the social environment.

The most applicable factors of the TEAM-ECD to the 'Gezonde kinderen in krappe tijden' project are within the family and the residential and relational communities.

Altogether, the 'Socio-Economic Determinants of Health' framework is most fit to the aim of the study but without the factor 'Aboriginal Status'. This framework is chosen since it offers the clearest and most simple overview of the determinants of health and therefore is of most use to the study.

2.3 THE IMPACT OF POVERTY ON CHILDREN'S HEALTH AND WELL-BEING

The available knowledge on the relationship between poverty and the health and well-being of children from four to fourteen years old was

investigated using a mini-review as developed by Griffiths (Griffiths, 2002). A mini-review offers a quick and simple way to identify the available knowledge on a specific subject.

A literature search was performed in Cochrane Library, PubMed, Scopus, Web of Science, and Google Scholar using a combination of words equal or similar to 'health and well-being', 'poverty', and 'children'. Detailed information on search words used is presented in Appendix 2. Because of the extensive available knowledge on this subject, it was chosen to limit the mini-review to studies in which a systematic or narrative review was conducted.

The eligibility of the reviews was assessed in three rounds, according to the inclusion and exclusion criteria. The inclusion and exclusion criteria are based on the PICOTS categories (Population, Intervention, Comparators, Outcomes, Timing, and Setting), and are presented in Table 1 (Van der Zee-van den Berg, Boere-Boonekamp, IJzerman, Haasnoot-Smallegange, & Reijneveld, 2017).

Table 1

Inclusion and exclusion criteria of the mini-review

Study characteristics	Inclusion criteria	Exclusion criteria
Population	Children from four to fourteen years old	Children younger than four or older than fourteen years old
	Children in general (age not specified)	Children with specific diseases
Intervention	Poverty	
Comparators	Children not growing up/living in poverty	
Outcomes	At least one aspects of health and well-being according to the definition of Huber, et al. (Huber, et al., 2011)	Studies with a focus on a specific disease.
Timing	Published in or after 2013	
Setting	Study conducted in a high-income economic country as defined by the World Bank	Study conducted in a country other than the high-income economic countries as defined by the World Bank
		Clinical setting
Study design	Systematic or narrative review	Study designs other than systematic or narrative review

Report criteria	Article in English or Dutch	Article in a language other than English or Dutch
		Abstract/full-text not found

First, all reviews found were screened based on the title. Second, the remaining reviews were screened on the abstract. Third, the full-text of the remaining reviews were scanned. In total, five reviews were included that met the inclusion criteria, as can be seen in the flow diagram presented in Figure 7.

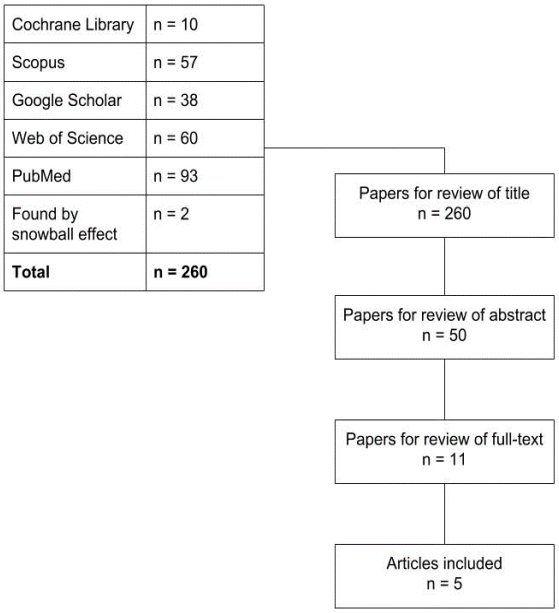

Figure 7. Flowchart mini-review

Of each included review, the study design, aim of the study, and the stated effects of poverty on the health and well-being of children are outlined in Table 2. When applying the results of the reviews to the domains of health and well-being, it can be concluded that all domains are affected by poverty. First, four out of the five included reviews reported a negative impact of childhood poverty on the domain of bodily functions (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016; Benzeval, et al., 2014; Cooper & Stewart, 2013; Dreyer, Chung, Szilagyi, & Wong, 2016). For example, children living in poverty are more likely to become overweight or suffer from asthma (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016). Second, all included reviews reported mental well-being to be affected by poverty during childhood (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016; Benzeval, et al., 2014; Cooper & Stewart, 2013; Dreyer, Chung, Szilagyi, & Wong, 2016; Reiss, 2013). Socioeconomically disadvantaged children are two to three times more likely to develop mental health problems (Reiss, 2013). Moreover, poverty affects children's cognitive outcomes (Cooper & Stewart, 2013; Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016). Third, four out of the five included reviews reported the effects of poverty related to the domain of meaningfulness (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016; Benzeval, et al., 2014; Cooper & Stewart, 2013; Dreyer, Chung, Szilagyi, & Wong, 2016). These effects are mostly concerned with future prospects. For example, poverty has long-term consequences of the children's future social economic and health circumstances (Benzeval, et al., 2014). Moreover, the impact of poverty on children's health and well-being are often lifelong, ultimately leading to intergenerational cycles of poverty (Dreyer, Chung, Szilagyi, & Wong, 2016). Fourth, the domain of quality of life partly overlaps with the domain of mental well-being, since well-being is a determinant of quality of life.

None of the reviews explicitly reported the impact of poverty on quality of life. However, because of this overlap it can be concluded that quality of life is affected by poverty as well. Fifth, three out of the five included reviews reported the impact of poverty on the social – and societal participation of children. Two reviews explicitly stated that poverty affects social outcomes (Cooper & Stewart, 2013; Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016). Furthermore, one review reported that childhood poverty leads to increased criminal behaviour (Dreyer, Chung, Szilagyi, & Wong, 2016). One aspect of the social – societal participation domain is meaningful work/occupation, which criminal behaviour conflicts with. Sixth, three reviews reported the impact of poverty on the domain of daily functioning (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016; Cooper & Stewart, 2013; Dreyer, Chung, Szilagyi, & Wong, 2016). The impacts stated in the reviews are related to the cognitive, developmental, and educational outcomes. These outcomes influence the ability to work and health literacy, which are determinants of the domain daily functioning (van der Heide, et al., 2013).

Altogether, it can be concluded that all domains of children's health and well-being are affected by poverty, either direct or indirect. These effects not only occur only during childhood, but are often long-term and persist during the entire life course.

Table 2

Study design, study aim and conclusion of included reviews in the mini-review concerning the impact of poverty on the health and well-being of children

	Title	Study design	Aim of the study	Stated effects of poverty on health
1	Poverty and child health in the UK: using evidence for action (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016).	Narrative review	To outline some key definitions with regard to child poverty, review the links between child poverty and a range of health, developmental, behavioural and social outcomes for children, describe gaps in the evidence base and provide an overview of current policies relevant to child poverty in the UK (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016).	"Child poverty is associated with a wide range of health-damaging impacts, negative educational outcomes and adverse long-term social and psychological outcomes. The poor health associated with child poverty limits children's potential and development, leading to poor health and life chances in adulthood" (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016, p. 1).
2	Socioeconomic inequalities and mental health problems in children and adolescents: a systematic review (Reiss, 2013).	Systematic review	To systematically review publications on the relationships between various commonly used indicators of socioeconomic status (SES) and mental health outcomes for children and adolescents aged four to eighteen years (Reiss, 2013).	"Socioeconomically disadvantaged children and adolescents were two to three times more likely to develop mental health problems. Low socioeconomic status that persisted over time was strongly related to higher rates of mental health problems. A decrease in socioeconomic status was associated with increasing mental health problems" (Reiss, 2013, p. 1).
3	How does money influence health? (Benzeval, et al., 2014)	Narrative review	To explore the association between income and health throughout the life course and within families (Benzeval, et al., 2014).	The relationship between income and health is complex. "For every incremental increase in income, there is an associated higher level of good health. Moreover, it is clear that there are complex chains of exposures and pathways between income and health across the life course" (Benzeval, et al., 2014, p. 4).

				"There is, however, a particular emphasis on the importance of parental income for both their children's health during childhood and also the long-term consequences of their future social economic and health circumstances" (Benzeval, et al., 2014, p. 6).
4	Does money affect children's outcomes? A systematic review (Cooper & Stewart, 2013)	Narrative review	To examine whether money has a causal impact on children's outcomes (Cooper & Stewart, 2013).	"Poorer children have worse cognitive, social-behavioural and health outcomes in part because they are poorer, and not just because poverty is correlated with other household and parental characteristics. The evidence relating to cognitive development and school achievement is the clearest and there is the most of it, followed by that on social and behavioural development" (Cooper & Stewart, 2013, p. 5).
5	Child Poverty in the United States Today: Introduction and Executive Summary (Dreyer, Chung, Szilagyi, & Wong, 2016)	Narrative review	To summarize the thoughtful articles from four categories (the impact of poverty on human capital and children, the definitions and measurement of poverty, a comparison of the United States to other developed countries, and interventions in the United States to decrease child poverty) and provide some conclusions (Dreyer, Chung, Szilagyi, & Wong, 2016).	"The negative consequences of poverty on child health and well-being are often lifelong, leading to worse health, lower developmental and educational outcomes, increased criminal behaviour as adolescents and adults, and ultimately intergenerational cycles of poverty" (Dreyer, Chung, Szilagyi, & Wong, 2016, p. 1). "Poor children experience greater trauma and have substantially worse behavioural and mental health outcomes" (Dreyer, Chung, Szilagyi, & Wong, 2016, p. 1).

3. METHODOLOGY

The study was conducted from February till July 2018, in the region of Twente. It consisted of two parts, in which each part answered one of the research questions.

The study presented in this report is part of a larger project called 'Gezonde kinderen in krappe tijden'. This chapter will start with a short explanation of that project. Consequently, a description of the methodology determined for each research question separately will be discussed. The first research question focussed on composing an appropriate questionnaire for measuring the health and well-being of participants of the 'Gezonde kinderen in krappe tijden' project. The second research question focussed on describing and analysing the results of the questionnaire completed by the participants of the 'Gezonde kinderen in krappe tijden' project.

3.1 STUDY SETTING

As mentioned in section 1.4.2, the AWJT is a collaboration between the fourteen municipalities in Twente, the GGD Twente, Saxion University, and University of Twente. One of the projects of the AWJT is aimed at reducing the impact of poverty on the health and well-being of children from four to fourteen years old and their parents. Therefore, a longitudinal intervention study is being conducted, in which an intervention is developed and evaluated. The project is aimed at reducing the impact of poverty on the health and well-being of children and parents. The intervention was developed in cooperation with people living in poverty themselves and social work professionals. Within the intervention, all six domains of Huber's concept of health and well-being are included. In section 1.4.2, the project is explained in detail. The effects of the project are measured within an evaluation study. The study documented in this report contributed to the preparation and start-up phase of the evaluation, by composing and pilot testing the measurement instrument.

3.2 MEASUREMENT INSTRUMENTS

3.2.1 STUDY DESIGN

The first research question was: "Which measurement instruments are appropriate for measuring the health and well-being of children from four to fourteen years old and their parents living in poverty?" Since the definition of Huber et al. is used in this study, the outcome measures regarding health and well-being to be covered in the final measurement instrument were bodily functions, mental well-being, meaningfulness, quality of life, social – societal participation, and daily functioning (Institute for Positive Health, 2017a). In addition, the impact of the financial situation was determined to be an outcome measure. All outcome measures needed to be measured of both the parents and the children participating in the 'Gezonde kinderen in krappe tijden' project. In order to collect the answer to this research question, a systematic search was performed.

3.2.2 DATA COLLECTION

A systematic search was conducted to collect potentially appropriate questionnaires. Questionnaires measuring the health and well-being of the parents and the children were

searched separately. Searches were performed in Scopus, PubMed, Google Scholar, and Google. Within Google and Google Scholar, searches were conducted in both English and Dutch. A questionnaire was included if it measured one or more of the outcome measures, which were bodily functions, mental well-being, meaningfulness, quality of life, social – societal participation, daily functioning, and financial impact (Institute for Positive Health, 2017a). To find questionnaires aimed at a broad perspective of health, search words used were 'questionnaire', 'measurement instrument', or 'survey', in combination with 'health' and/or 'well-being'. To find questionnaires aimed at specific outcome measures, 'health' and/or 'well-being' was replaced by this outcome measure within the search. Moreover, to find questionnaires specifically aimed at children, the word 'children' was added in the search. The search was an iterative process, which continued until all the outcome measures were covered sufficiently at both parent and child level. After completing the systematic search, the overview was supplemented with measurement instruments the members of the AWJT were familiar with.

Of all measurement instruments the length of the questionnaire in items and time, whether they were validated, where and in which language they were validated, the availability of reference values, the availability of a Dutch version, the target group of the questionnaire, the costs, and the outcome measures were documented. For each questionnaire, it was assessed which domain(s) of health and well-being according to Huber et al. could be measured with that questionnaire.

3.2.3 DATA ANALYSIS

After creating an overview of available measurement instruments aimed at one or more of the outcome measures, it was decided which measurement instruments were most appropriate for use. The level of appropriateness was assessed based on the quality of the measurement instrument and the applicability to the project specifically. The quality was assessed based on the reliability, validity, and responsiveness of the instrument (VU Medisch Centrum, n.d.). The applicability of the measurement instrument was assessed based on six criteria for the project specifically. First, the final measurement instrument must cover all six outcome measures according to the definition of health and well-being of Huber et al. and the outcome measure concerned with financial impact, on both parent and child level (Institute for Positive Health, 2017a). Second, it was desired that the questionnaires were valid or widely used, and norm values were available. These norm values could be used to compare the study population with the average Dutch population. Third, the measurement instrument was required to be available in Dutch, since the 'Gezonde kinderen in krappe tijden' project is provided in Dutch. Fourth, since the AWJT project budget is limited, the questionnaires needed to be available for free or at low costs. Fifth, respondents must be able to complete the total composed questionnaire in a maximum of thirty minutes. The longer a questionnaire, the higher the data collection costs, and the greater the respondent burden (Lavrakas, 2008). The respondent burden leads to lower response rates and diminished quality of response. Sixth, questionnaire was required to be applicable

to the study population according to the level of language used. Since a minimum level of B2 in Dutch is required to be included in the study population, the questionnaire used needed to meet this criterion as well.

It was decided which measurement instruments were most appropriate for use according to the criteria during a meeting in which six members of the AWJT were present. One the members who attended this meeting is a researcher at the University of Twente. Three of the members present are researchers at the University of Applied Sciences, Saxion. One of the researchers from Saxion is a social worker as well. Moreover, one member who attended the meeting is living in poverty herself and involved in the 'Gezonde kinderen in krappe tijden' project to share her experiences with poverty. The sixth member is a master student Health Sciences at the University of Twente.

Once the measurement instrument was composed, it was tested by five members of the AWJT, among whom three researchers from Saxion, one student at the University of Twente, and one person living in poverty herself. It was assumed that the person living in poverty herself was most similar to the target group of the 'Gezonde kinderen in krappe tijden' project. The researchers, student, and the person living in poverty indicated some points of improvement in the introduction, instruction, and structure, which were improved afterwards. Moreover, it was important to estimate the required time to complete the questionnaire. They all needed up to fifteen minutes to complete the full questionnaire. This information was useful for the invitation letter and introduction of the questionnaire.

In addition to the selected questionnaires to measure the six domains of health and well-being and the financial impact, background characteristics of both parent and child were asked.

3.3 HEALTH AND WELL-BEING OF CHILDREN IN POVERTY

3.3.1 STUDY DESIGN

The current state of health and well-being of children and their parents participating in the 'Gezonde kinderen in krappe tijden' project was examined using the questionnaire developed in the first part of the study. The research question in line with the second part of the study is: "What is the current state of health and well-being of children ranged from four to fourteen years old and their parents living in poverty in the region of Twente?" This part of the study is observational and cross-sectional. Observational, since no intervention was involved yet when the survey took place. Cross-sectional, since this type of study design is suitable for population-based surveys in which one measurement moment takes place (Setia, 2016).

A pilot study was conducted in which the questionnaire was completed by the first group of participants of the AWJT intervention study. The aim of this pilot study was to identify the health and well-being of the study population included in the 'Gezonde kinderen in krappe tijden' project. Furthermore, the data was used as the baseline measurement of the total project.

3.3.1.1 ETHICAL APPROVAL

Since the study involved humans in a direct way, the study design had to be approved by the ethical committee (University of Twente, 2018). The

study was approved by the ethical committee affiliated with the faculty of Behavioural, Management and Social Sciences (BMS) of the University of Twente. The request form can be found in Appendix 3. The application number related to the approval was 18127. Besides that, informed consent was signed by the participants of the study, which can be found in Appendix 4.

3.3.2 STUDY POPULATION

According to the "rule of 12", at least twelve participants are needed for pilot studies with a primary focus on estimating average values and variability for planning larger subsequent studies (Moore, Carter, Nietert, & Stewart, 2011). Moreover, this number of participants is feasible for early-stage studies while still providing valuable information. A family was fit for inclusion if the parent was eighteen years or older, at least one of the children was in primary school and between four and fourteen years old, and the family was living on or below the low-income threshold. An exclusion criterion determined was not mastering the Dutch language.

The respondents were selected by the municipality of Almelo, which was the first municipality to start with the 'Gezonde kinderen in krappe tijden' intervention. A total of sixteen participants completed the questionnaire. The parents were asked to complete the questionnaire regarding their oldest child that was still in primary school.

3.3.3 DATA COLLECTION

All participants were divided in an intervention (n=10) or control group (n=6), which was relevant for the 'Gezonde kinderen in krappe tijden' project. At the start of the first session of the 'Gezonde kinderen in krappe tijden' project, the questionnaire was filled in by the participants of the intervention group. The participants in the control group of the 'Gezonde kinderen in krappe tijden' project could choose to receive their questionnaire on paper or online.

The independent variable involved is poverty, which is defined as living on or below the low-income threshold. This was measured by a question in which was asked what the disposable income of the family was after paying for the mandatory payments. The dependent variables in this study are financial impact and the six domains of health and well-being of children ranged from four to fourteen years old and their parents. These domains are bodily functions, mental well-being, meaningfulness, quality of life, social – societal participation, and daily functioning (Institute for Positive Health, 2017a). The questionnaires used to measure the outcome measures were identified in the first research question. A detailed explanation of how the outcome measures were measured can be found in section 4.1. The questionnaire can be found in Appendix 6.

In addition to the questionnaires, possible foreseen covariates associated with the parents and children were collected. These possible covariates were asked as background characteristics and are explained in detail in section 4.1.

The questionnaires were completed in May and June 2018, in the region of Twente.

3.3.4 DATA ANALYSIS

The data collected was used to describe the characteristics of the study population. To be able to compare the values of the study population to

the average population, norm values were presented. Data gathered through the questionnaires were analysed using SPSS (Statistics 25). The characteristics of the study population were explored using descriptive statistics. The continuous variables were checked on normality using the Shapiro Wilk test (Ghasemi & Zahediasl, 2012). In all data analyses a significance level of five percent was used.

The EMPO questionnaire consists of three subscales, being Intrapersonal, Interactional, and Behavioural control. A score could be calculated for each subscale separately. In addition, a total score could be calculated, in which the subscales were combined. The answers given were transformed to a scale from one to five, with respect to the manual (Praktikon B.V., 2017). A higher score represents a stronger feeling of empowerment. The norm values used were retrieved from a reliability and validity study conducted among a non-clinical group of 673 people in the Netherlands (Damen, et al., Parental Empowerment: Construct Validity and Reliability of a Dutch Empowerment Questionnaire (EMPO), 2017).

The Mental Health Continuum – Short Form (MHC-SF) questionnaire consisted of three subscales and a total score in which the subscales were combined. The subscales were emotional, social, and psychological well-being. The answers given were transformed to a scale from zero to five, with respect to the manual, in which five represents the highest positive mental health (Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2010). The norm values presented were retrieved from a study in which 1,662 Dutch participants completed the MHC-SF (Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2010).

There are five versions of the KINDL questionnaires available. Three versions are available as self-report measures for different age groups. Two versions are available as parent-report measures for children in different age groups. Within the measurement instrument used in this study, the Kiddy-KINDL and the Kid-KINDL were used. The parents of whom the oldest child in primary school was younger than seven years old completed the Kiddy-KINDL. The parents of whom the oldest child in primary school was seven years or older completed the Kid-KINDL was completed. The answers given were transformed to a scale from zero to one hundred, with respect to the manual, in which one hundred represents the best health-related quality of life (Ravens-Sieberer, Ellert, & Erhart, 2007). The norm values used were retrieved from a study conducted in Germany (Ravens-Sieberer, Ellert, & Erhart, 2007). Dependent on the mean/median age of the study population, the norm values of a sample from three to six (n=3875), seven to ten (n=4148), or eleven to thirteen (n=3076) years old are presented.

Each answer of the Strengths and Difficulties Questionnaire (SDQ) was transformed to a scale from zero to two. The SDQ consists of five subscales: Emotional symptoms, Conduct problems, Hyperactivity, Peer problems and Prosocial behaviour. To calculate the score per subscale, the scores of each individual question corresponding with that subscale are summed up. Each subscale consists of five questions, which means the scores are ranged from zero to ten. A higher score indicates more difficulties within that

subscale, except the Prosocial behaviour scale. In the Prosocial behaviour scale, a higher score indicates better prosocial behaviour. In addition, a total difficulties score could be calculated by summing up the values of the scales Emotional symptoms, Conduct problems, Hyperactivity, and Peer problems. The scale of Prosocial behaviour is not included in calculating the total score. The norm values used were retrieved from a study conducted in the Netherlands, in which 1174 parents completed the SDQ (Maurice-Stam, et al., 2018). The norm values are separately presented for different age groups. The norm values used in this study are corresponding with the age group from six to eleven years old, since this matches with most of the children included in the study.

3.3.4.1 COMPARISON STUDY POPULATION AND NORM VALUES

To examine whether poverty is associated with a deviating state of health and well-being, the values of the study population were compared to the norm values presented in publications. Prior to conducting the One Sample T-Test, all subscales and total scores were tested on normality, using the Shapiro Wilk test. Only if the Shapiro Wilk test showed that the data were normally distributed, a One Sample T-Test could be performed. The eligible questionnaires were the EMPO, MHC-SF, KINDL, and SDQ. If the (sub)scales were normally distributed, the values of the study population were compared to the norm values. The null hypothesis (H_0) tested in the analyses was: "The health and well-being of the study population do not differ significantly from the reference values".

4. RESULTS

4.1 MEASUREMENT INSTRUMENTS

Collecting questionnaires from the systematic search and the members of the AWJT resulted in an overview of 68 questionnaires. This overview can be found in Appendix 5. For each questionnaire, the length of the questionnaire in items and time, validity, where and in which language they were validated, the availability of reference values, the availability of a Dutch version, the target group of the questionnaire, the costs, and the outcome measures were documented, if available. According to these characteristics, an initial estimation of the appropriateness was made. This resulted in 38 questionnaires which were estimated to be appropriate. During a meeting with six members of the AWJT, these questionnaires were discussed in detail with respect to the criteria determined in section 3.2.3. Among the attending members were four researchers, one person living in poverty, and one master student. The discussion resulted in a selection of seven questionnaires; four focussed on the parent, three focussed on the child. The four questionnaires selected focussed on the parent are the general health questions of the CBS health survey, the EMPO Parents version 3.1, the Mental Health Continuum – Short Form, and the Financial Hardship Scale (Damen, et al., 2017a; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2010; Van der Werf, van Dijk, & Van Dillen, 2018). The three questionnaires selected focussed on the child were the One-sided Strengths and Difficulties Questionnaire for parents of 4-17-year-olds, KINDL, and Material Deprivation and Social Participation(Goodman, 2005; Roest, Lokhorst, & Vrooman, 2010; Ravens-Sieberer & Bullinger, 2017). The Kiddy-KINDL was selected for children up to seven years old, and the Kid- & Kiddo-KINDL was selected for children aged seven years and older. Table 3 illustrates an overview of which questionnaires were used to measure the outcome measures.

Table 3

Coverage of the outcome measures on parent and child level

Outcome measures	**Parent**	**Child**
Bodily functions	CBS health survey - overall health	KINDL
Mental well-being	MHC-SF, EMPO	KINDL, SDQ
Meaningfulness	EMPO, MHC-SF	KINDL
Quality of life	CBS health survey - overall health, MHC-SF	KINDL
Social – societal participation	MHC-SF	KINDL, SDQ
Daily functioning	CBS health survey - overall health	KINDL, SDQ
Financial impact	Financial Hardship Scale	Material deprivation and social participation

In addition to the selected questionnaires to measure the six domains of health and well-being and the financial impact, background characteristics were determined. First, it was asked who filled in the questionnaire, at which the parent could choose between 'Mother', 'Mather', or 'Other, namely…' (Raat, et al., 2013). By this, the gender of the parent could be identified as well. Second, the parent's country of origin was asked, at which they could choose between 'the Netherlands', 'Suriname', 'the Netherlands Antilles/Aruba', 'Morocco', 'Turkey', or 'Other, namely…' (Raat, et al., 2013). Third, the living situation of the parent was asked, at which they could choose between 'alone', 'With a partner', 'With children', 'With a partner and children', or 'Other, namely…'. Fourth, the marital status of the parent was asked as well, at which they could choose between 'Unmarried', 'Married', 'Divorced', 'Cohabiting', or 'Other, namely…'. Fifth, the level of education was identified, at which the answer possibilities are 'No education', 'Primary school', 'VMBO/LBO/MAVO', 'HAVO/VWO/MBO', 'HBO/University', and 'Other, namely…' (Raat, et al., 2013). LBO, VMBO, MAVO, HAVO, and VWO are different levels of secondary education in the Netherlands. MBO is the Dutch version of secondary vocational education. HBO is the level addressed to universities of applied sciences. Sixth, information about the current working situation was asked, at which the parents could choose between 'I am working full-time', 'I am working part-time, namely … hours per week', 'I do not have a paid job', and 'Other, namely…' (Raat, et al., 2013). In addition to this question, the parents were asked what their profession is, if they had a job (Raat, et al., 2013). Seventh, the parents were asked about the family's source of income, at which the answer possibilities were 'Through a paid job', 'Through benefits and allowances for less than three years', 'Through benefits and allowances for more than three years', and 'Other, namely…' (GGD West-Brabant, 2017). It was possible to give more than one answer at this question. Eighth, the parents were asked if they knew what their disposable income is, at which they could answer 'Yes, namely … euros per week', 'Yes, namely … euros per month', or 'No'. Ninth, the parents were asked how many children are living with them full-time, and how many are living part-time with them. Last, the parents were asked to fill in the age of all their children.

The questionnaire continued with four questions concerning the background characteristics of the parent's oldest child in primary school. First, it was asked what the gender of their child is, at which they could choose between 'Boy' or 'Girl'. Second, the birth date of the child was asked. Third, the current class in school was asked, at which check boxes were created for each class separately. In the Netherlands, primary school consists of eight classes. In addition, the parents could choose for 'other, namely…'. Fourth, the parents were asked to indicate their child's living situation, at which they could choose between 'With father and mother', 'Only with mother (possibly with new partner)', 'Only with father (possibly with new partner)', 'Alternately with mother and father (possible with new partner)', and 'Other, namely …' (Raat, et al., 2013). The exact questions and answer possibilities can be found in Appendix 6.

4.2 HEALTH AND WELL-BEING OF CHILDREN IN POVERTY

4.2.1 CHARACTERISTICS OF THE STUDY POPULATION

The total research population contained sixteen parents participating in the 'Gezonde kinderen in krappe tijden' project. The characteristics of these respondents are summarized in Table 4.

All questionnaires were completed by the parent regarding their oldest child in primary school. Twelve questionnaires were completed by the mother, three were completed by the father, and one was completed by an older sister, together with the mother. The mean age of the parents was 41 years old. Of all parents, twelve were born in the Netherlands, one was from the Netherlands Antilles/Aruba, two were from Iraq, and one was from Nepal. Three parents indicated that they did not finish any education, not even primary school. Moreover, one parent only finished primary school. The other twelve parents did finish at least secondary school. Fourteen parents who completed the questionnaire did not have a paid job themselves. However, in five families the main income comes from a paid job. Two families indicated a second source of income, which was in one family through benefits or allowances longer than three years in combination with not having a paid job. In the other family, the first source of income was through a paid job, and the second source of income was indicated as 'Other'. It was explained that they are using WNSB (Debt Rescheduling Natural Persons Act). Most parents had two children living with them full-time, and zero children living with them part-time. The median age of all their children was ten years old.

The children about whom the questionnaire was completed had a mean age of nine years old. Among them were nine boys and six girls. In one questionnaire, the gender of the child was missing. The children's classes are very scattered; in almost all classes is at least one child, except from class four. Moreover, fifty percent of the children lives with both parents, and 44 percent lives with only their mother.

An assessment of normality was executed on the continuous variables, using the Shapiro-Wilk test (Ghasemi & Zahediasl, 2012). The variables assessed were the age of the parent, the number of children living in the parent's house, the age of all children, the age of the oldest child in primary school, and the disposable income per month. The age of the parent and their oldest child in primary school were both normally distributed. The number of children living in the parent's house, the age of all children, and the disposable income per month were not. Therefore, the mean and standard deviation were presented of the age of the parents and children, and the median and interquartile range were presented of the number of children, age of the children, and disposable income.

Table 4

Characteristics of the pilot study population of the 'Gezonde kinderen in krappe tijden' project

Variable	**n (%)[1]/Mean (SD)[2]/ Median (IQR)[3]**
Study population	16 (100)[1]
Baseline characteristics parent	
Age	41 (8.8)[2]
Country of origin	
The Netherlands	12 (75)[1]
Netherlands Antilles/Aruba	1 (6)[1]
Iraq	2 (13)[1]
Nepal	1 (6)[1]
Living situation	
With partner and children	10 (63)[1]
With children	6 (38)[1]
Marital status	
Unmarried	3 (19)[1]
Married/cohabiting	10 (63)[1]
Divorced	1 (6)[1]
Other	2 (13)[1]
Education	
No education	3 (19)[1]
Primary school	1 (6)[1]
VMBO/LBO/MAVO	6 (38)[1]
HAVO/VWO/MBO	6 (38)[1]
Working situation	
No paid job	14 (88)[1]
Paid job	2 (13)[1]

Income status	
Through a paid job	5 (31)[1]
Through benefits and allowances for less than three years	5 (31)[1]
Through benefits and allowances for more than three years	4 (25)[1]
Other	1 (6)[1]
Missing	1 (6)[1]
Income status 2	
Other	1 (6)[1]
Through benefits and allowances for more than three years	1 (6)[1]
No second income status	14 (88)[1]
Disposable income per month	303 (217 – 347)[3]
Children living in house	
Full-time	2 (1 – 2)[3]
Part-time	0 (0 – 2)[3]
Age of all children	10 (7 – 13)[3]
Baseline characteristics child	
Gender	
Boy	9 (56)[1]
Girl	6 (38)[1]
Missing	1 (6)[1]
Age	9 (3.4)[2]
Class in school	
1	1 (6)[1]
2	3 (19)[1]
3	2 (13)[1]
4	0 (0)[1]
5	2 (13)[1]
6	1 (6)[1]

7	3 (19)[1]
8	3 (19)[1]
Living with	
Father and mother	8 (50)[1]
Mother	7 (44)[1]
Other	1 (6)[1]

[1] Number and percentage

[2] Mean and standard deviation

[3] Median and interquartile range

In addition to the baseline characteristics, the parents were asked to fill in three questions concerning their overall health. One parent reported his/her health as bad, six reported that their health is okay, and nine reported their health as good. Eight parents are suffering from a long-term illness or disorder, in which long-term is defined as longer than six months. Moreover, nine parents reported being moderately restricted due to health problems. However, none of the parents were severely restricted due to their health problems. A visual representation of the overall health of the parents is demonstrated in Figure 8.

4.2.2 OUTCOMES QUESTIONNAIRES STUDY POPULATION

The composed measurement instrument consisted of six questionnaires. For each questionnaire, an overview of mean and median scores in combination with the norm values, or an overview

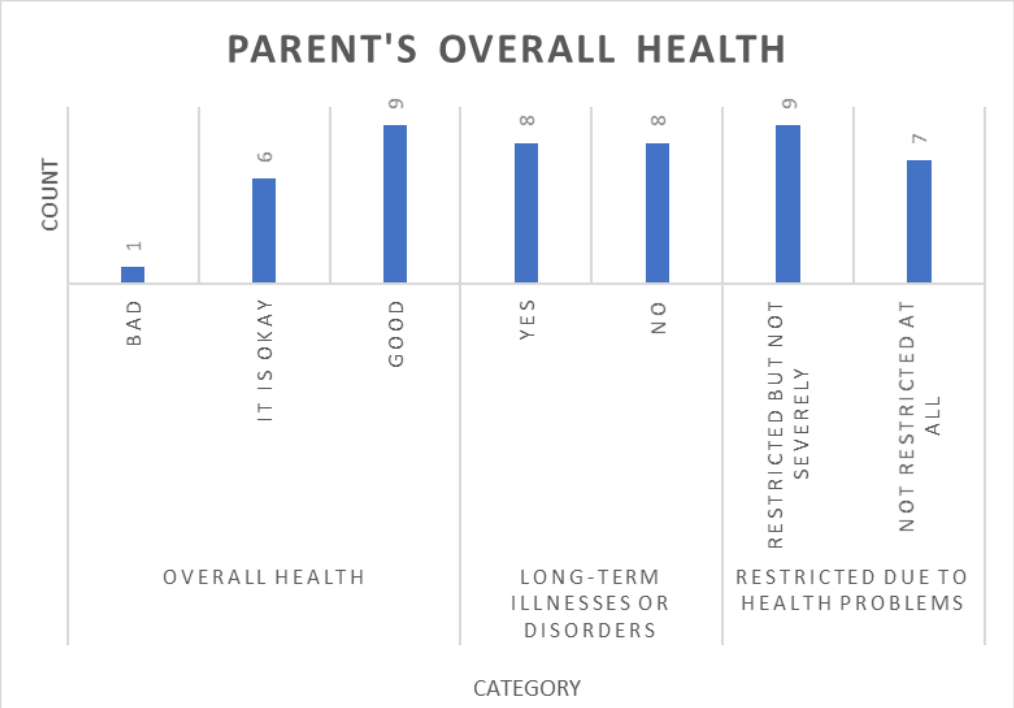

Figure 8. Parent's overall health and limitations

of given answers is provided. It was chosen to provide both mean and median values for each questionnaire, due to the small study population of sixteen participants.

First, the EMPO questionnaire was completed by the parents. As can be seen in Table 5, there are no substantial differences between the study population values and the norm values. The answers given scaled from one to five, in which a higher score represents a stronger feeling of empowerment.

Second, the short form of the Mental Health Continuum was completed by the parents. The answers given were transformed to a scale from zero to five, in which five represents the highest positive mental health. As can be seen in Table 5, there are no substantial differences between the study population values and the norm values.

Third, the KINDL questionnaires were completed by the parents. The answers given were transformed to a scale from zero to one hundred, in which one hundred represents the best health-related quality of life. Within the study population, the Kiddy-KINDL was completed six times and the Kid-KINDL was completed ten times. The norm values and 95 percent confidence interval presented in Table 5 correspond with the values of a study sample ranged from seven to ten years old, since the mean age of the children included in the study population is 8.5 years old. As can be seen in Table 5, the values of the Physical well-being, Emotional well-being, Friends, and School scales and the Total health-related quality of life are lower than the norm values. On the contrary, the values of the Self-esteem scale are higher within the study population.

Fourth, the Strengths and Difficulties Questionnaire (SDQ) was completed by the parents. The scores within the subscales are ranged on a scale from zero to ten, in which a higher score indicates more difficulties, except the Prosocial behaviour scale. Within the Prosocial behaviour scale, a higher score indicates better prosocial behaviour. The total difficulties score is scaled from zero to forty. As can be seen in Table 5, the values of the Emotional symptoms scale and the Total difficulties score are higher within the study population compared to the norm values.

Table 5

'Gezonde kinderen in krappe tijden' study population values and norm values questionnaires

Questionnaire (sub)scale	**Study population values**				**Norm values**	
EMPO	*Mean*	*SD*[1]	*Median*	*IQR*[2]	*Mean*	*SD*[1]
Intrapersonal	3.6	0.44	3.8	3.3 - 4.0	3.8	0.55
Interactional	4.0	0.39	4.0	4.0 - 4.4	4.0	0.48
Behavioural control	3.8	0.49	3.7	3.7 - 4.0	3.5	0.59
Total empowerment	3.8	0.27	3.7	3.7 - 4.0	3.8	0.43
Mental Health Continuum	*Mean*	*SD*[1]	*Median*	*IQR*[2]	*Mean*	*SD*[1]

	Emotional well-being	3.5	0.97	3.8	2.5 - 4.0	3.7	0.94
	Social well-being	2.5	1.01	2.5	1.6 - 3.2	2.3	1.01
	Psychological well-being	3.3	1.07	3.3	2.7 - 4.0	3.2	0.99
	Overall positive mental health	3.0	0.90	3.2	2.1 - 3.8	3.0	0.85
KINDL		*Mean*	*SD*[1]	*Median*	*IQR*[2]	*Mean*	*95%-CI*[3]
	Physical well-being	67.6	14.3	75.0	56.3 - 79.7	80.5	79.9 - 81.2
	Emotional well-being	70.7	14.4	75.0	62.5 - 81.3	82.3	81.9 - 82.7
	Self-esteem	75.4	16.1	81.3	62.5 - 85.9	70.8	70.3 - 71.2
	Family	80.2	8.3	81.3	75.0 - 87.5	79.8	79.4 - 80.3
	Friends	64.8	14.6	68.8	51.6 - 75.0	78.3	77.8 - 78.8
	School	77.3	13.3	78.1	64.1 - 92.2	82.6	82.1 - 83.0
	Total health-related quality of life	72.6	9.0	74.5	65.6 - 79.9	79.0	78.7 - 79.3
Strengths and Difficulties Questionnaire		*Mean*	*SD*[1]	*Median*	*IQR*[2]	*Mean*	*SD*[1]
	Emotional symptoms	3.3	2.57	3.0	1.0 - 4.8	2.1	2.2
	Conduct problems	1.3	1.66	1.0	0.0 - 2.0	1.2	1.4
	Hyperactivity	3.4	2.70	3.0	1.3 - 5.0	3.6	2.8
	Peer problems	2.0	1.97	1.5	0.3 - 3.0	1.3	1.8
	Prosocial behaviour	8.8	1.22	9.0	8.0 - 10.0	8.3	1.9
	Total difficulties score	10.0	6.16	10.5	5.0 - 13.0	8.2	6.2

[1] Standard deviation

[2] Interquartile range

[3] Confidence interval

In order to measure the financial impact, the Financial Hardship Scale and the Material deprivation and social participation questions were asked to be completed by the parents. For these questionnaires, it was not possible to calculate scores and therefore no norm values were available. The Financial Hardship Scale consists of five questions regarding the extent people are suffering from financial hardship. Of each category, the count per answer was provided. The answer possibilities ranged from totally disagree to totally agree, using a Likert five-point scale. One parent did not complete the questionnaire at all, and one parent did not complete the last

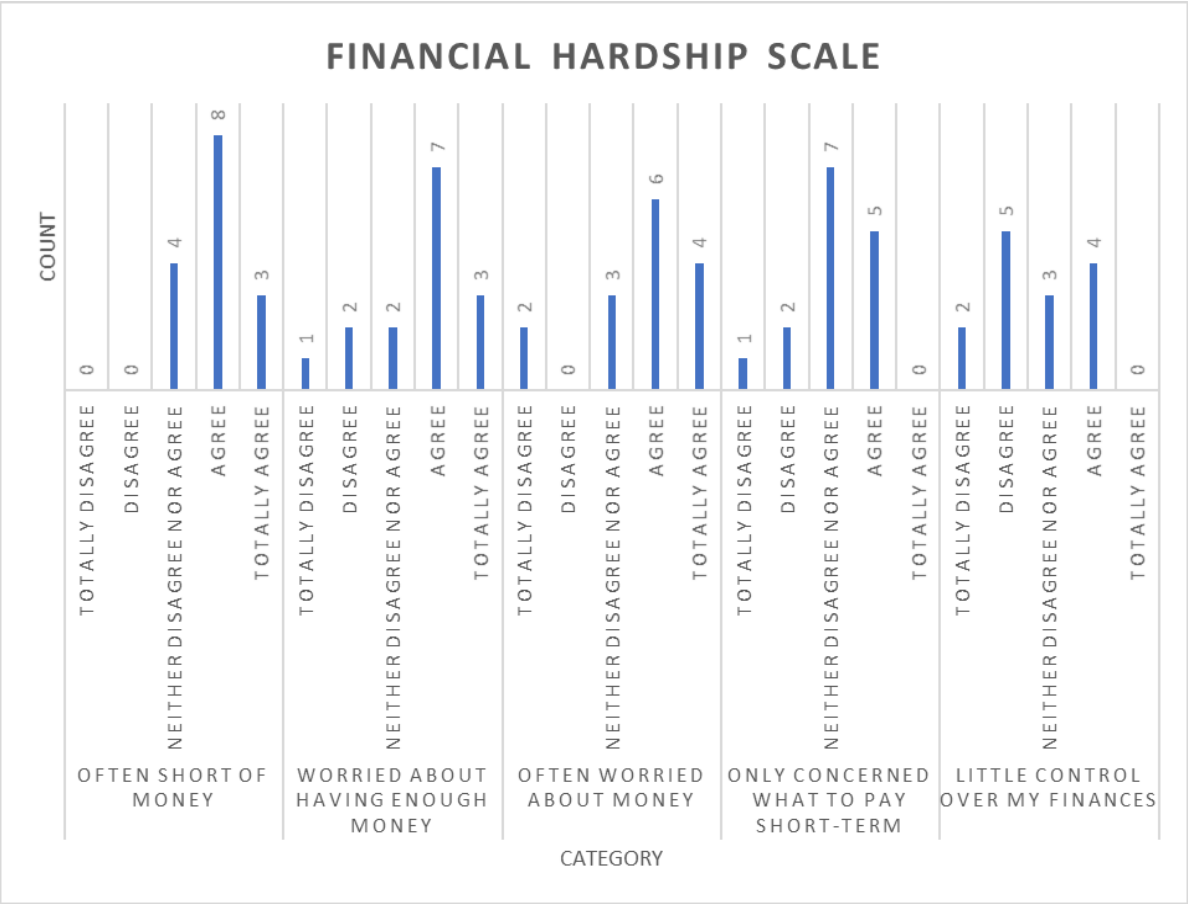

Figure 9. Count of answers given by the parents participating in the 'Gezonde kinderen in krappe tijden' project on the Financial Hardship Scale

question. As can be seen in Figure 9, eleven parents stated to be often short on money, and ten are often worried about (having enough) money. Moreover, five parents are only concerned with what to pay short-term and are not four feel like having little control over their finances.

The second questionnaire of which no scores could be calculated was concerned with the level of material deprivation and social participation of children. The results of this questionnaire are presented in Table 6. One parent stated that his/her child is sometimes invited to birthday parties but never goes to birthday parties. The reason for this could be the lack of money to buy a gift for the child organizing the birthday party since four parents mentioned that they can never afford birthday gifts for other children. Fourteen children invites friends at home, and ten children invited friends for their last birthday. Only six parents stated that they can afford a birthday party for their child(ren). Moreover, most children have not been on vacation and/or camp last summer, which is possibly also due to financial hardship. Five parents stated that they can never afford new clothes and shoes for their child(ren), and four parents cannot afford school(activities) of their child(ren).

Table 6

Answers of the parents participating in the 'Gezonde kinderen in krappe tijden' project concerning material deprivation and social participation

Statement	**n (%)**
My child makes trips (e.g. cinema, zoo, theme park, etc.)	
Never	3 (19)
Sometimes	13 (81)
My child is invited to birthday parties	
Sometimes	12 (75)
Often	4 (25)
My child goes to birthday parties	
Never	1 (6)
Sometimes	10 (63)
Often	5 (31)
My child invites friends at home	
Sometimes	14 (88)
Often	2 (13)
My child invited friends for his/her last birthday	
Yes	10 (63)
No	6 (38)
My child attends sports/music/culture/etc. activities	
Yes	13 (81)
No	3 (19)
My child went on vacation/camp last summer	
Yes	6 (38)
No	10 (63)
I can afford birthday gifts for other children	
Never	4 (25)

Sometimes	12 (75)
I can afford new clothes/shoes for my child	
Never	5 (31)
Sometimes	10 (63)
Often	1 (6)
I can afford my child's school(activities)	
Never	4 (25)
Sometimes	10 (63)
Often	2 (13)
I can afford birthday parties for my children	
Yes	6 (38)
No	10 (63)

4.2.3 COMPARISON STUDY POPULATION AND NORM VALUES

To examine whether poverty is associated with a deviating state of health and well-being, the values of the study population were compared to the norm values of the questionnaires. One Sample T-Tests were executed on the normally distributed subscales and total scores. The results of the One Sample T-Tests are shown in Table 7. The null-hypothesis tested in the analyses is: "The health and well-being of the study population do not differ significantly from the reference values".

The subscales of the EMPO questionnaire were not normally distributed. Therefore, the One Sample T-Test could not be conducted on the subscales. The total score was normally distributed, thus the One Sample T-Test was conducted on the total score. This resulted in a p-value of 0.653, which means the study population does not significantly deviate from the norm values. Therefore, the hypothesis could not be rejected.

The Mental Health Continuum – Short Form (MHC-SF) questionnaire consisted of three subscales and a total score in which the subscales were combined. All four values were tested on normality, which showed that all variables were normally distributed. Therefore, a One Sample T-Test could be conducted on all variables. This resulted in a p-value of 0.40 on the subscale of emotional well-being, 0.57 on social well-being, 0.71 on psychological well-being, and 0.82 on the total score. This means no significant differences were found compared to the reference values. Therefore, the null-hypothesis could not be rejected.

The KINDL questionnaire consisted of six subscales and a total score. Except for the physical well-being scale, all (sub)scores were normally distributed. Therefore, One-Sample T-

Tests were performed on five subscales and the total health-related quality of life score. The analyses demonstrated significant differences in emotional well-being (p-value=0.01), friends (p-value=0.00), and the total health-related quality of life (p-value=0.01). In all three (sub)scales, the study population of this study scored below the norm values. Therefore, the null-hypothesis could be rejected based on the emotional well-being, friends, and total health-related quality of life. The null-hypothesis could not be rejected concerning the self-esteem (p-value=0.27), family (p-value=0.85), and school (p-value=0.13).

The Strengths and Difficulties Questionnaire consists of five subscales and a total difficulties score. The emotional and hyperactivity subscales and the total difficulties score were normally distributed. The p-value related to the emotional subscale was 0.08, the p-value related to the hyperactivity subscale was 0.80, and the p-value related to the Total difficulties score was 0.25. Therefore, the null-hypothesis could not be rejected.

Table 7

Results One Sample T-Test - (sub)scores questionnaires compared to norm values

Questionnaire (sub)scale	**Mean**	**SD**	**Norm value**	**p-value[1]**
EMPO				
Total empowerment	3.8	0.3	3.8	0.65
Mental Health Continuum				
Emotional well-being	3.5	1.0	3.7	0.40
Social well-being	2.5	1.0	2.3	0.57
Psychological well-being	3.3	1.1	3.2	0.71
Overall positive mental health	3.0	0.9	3.0	0.82
KINDL				
Emotional well-being	70.7	14.4	82.3	0.01
Self-esteem	75.4	16.1	70.8	0.27
Family	80.2	8.3	79.8	0.85
Friends	64.8	14.6	78.3	0.00
School	77.3	13.3	82.6	0.13
Total health-related quality of life	72.6	9.0	79.0	0.01
SDQ				
Emotional	3.3	2.6	2.1	0.08

Hyperactivity	3.4	2.7	3.6	0.80
Total difficulties score	10.0	6.2	8.2	0.25

[1] p-value < 0.05 was considered to be significant

5. DISCUSSION

The study documented in this report answers two research questions. The first research question determined was: "Which measurement instruments are appropriate for measuring the health and well-being of children from four to fourteen years old and their parents living in poverty?" Seven questionnaires were selected. To measure the health and well-being of the parents, the CBS health survey – overall health, EMPO Parents Version 3.1, Mental Health Continuum – Short Form, and the Financial Hardship Scale were selected. To measure the health and well-being of children, the Strengths and Difficulties Questionnaire, Kiddy-KINDL or Kid-KINDL, dependent on the age of the child, and eleven questions concerning the child's material deprivation and social participation were selected.

The second research question determined was: "What is the current state of health and well-being of children ranged from four to fourteen years old and their parents living in poverty in the region of Twente?" Over half of the parents (9/16) reported their health as good, half of the parents (8/16) are suffering from a long-term illness or disorder, and over half of the parents (9/16) reported to be moderately restricted due to their health problems. Moreover, the results of the EMPO and MHC-SF questionnaire did not indicate any substantial differences between the study population and the norm values. Therefore, it can be assumed that the current state of health and well-being of the parents included in the study is similar to the overall population in the Netherlands. This was confirmed in the One Sample T-Test, in which no significant differences were found within these questionnaires. The results of the KINDL demonstrated that the children included in the study population have lower scores on the physical, emotional, friends, school, and total health-related quality of life scales. On the contrary, the children within the study population had higher scores on the self-esteem scale. The One Sample T-Test confirmed that the study population scored significantly lower on emotional well-being, friends, and total health-related quality of life, in comparison with the norm values. The results of the SDQ indicated that the children included in the study population have more emotional problems, and experience more difficulties overall. However, the One Sample T-Tests did not confirm significant differences between the study population and the norm values. Altogether, it can be concluded that the children included in the study population have significantly lower emotional well-being, friends, and health-related quality of life.

The results of the study can be linked to the information collected in the theoretical framework. The 'Socio-Economic Determinants of Health' framework illustrated the interconnectedness of the determinants of health. The results of the study documented in this report are in line with the factors Income, Social Support and Connectedness, and Early Child Development. Moreover, it is suspected that Education and Literacy and Employment and Working Conditions are affected as well, since the values related to these factors did deviate from the norm values as well but not significantly. The conducted mini-review indicated that all domains of children's health and well-being are affected by poverty. The conducted study did not provide

significant results to support the impact of poverty on all domains of health and well-being. However, the significant differences found can be linked to the domains of mental well-being, social – societal participation, and quality of life. Further research might support the impact of poverty on the three remaining domains as well.

5.1 LIMITATIONS

There are several limitations concerning the outcomes of this study. First, the study population contained sixteen parents, which is quite small (Hackshaw, 2008). Therefore, the results should be interpreted carefully. Having a small study population increases the chance of assuming a true or false premise (Faber & Fonseca, 2014). Moreover, small samples undermine both the internal and external validity of a study. Furthermore, normality tests have little power to reject the normality of small study samples, which causes small study samples often pass the normality tests (Ghasemi & Zahediasl, 2012). The normality of the age of the parent, age of the child, disposable income, and the scores on the (sub)scale of the questionnaires should therefore be interpreted carefully. Due to the small study population, no adjustments could be made for the possible covariates mentioned in section 3.3.3.

Second, the people included in the study population are at a higher chance of having low literacy skills, because of their level of education and origin. In the Netherlands, among the people who only finished primary school, 42.3 percent have low literacy skills (Buisman & Houtkoop, 2014). In the study population, 25 percent did not finish primary school, or only finished primary school. Moreover, 38 percent of the study population finished VMBO, LBO or MAVO. In the Netherlands, 14.0 to 24.4 percent of the people with this level of education have low literacy skills. Furthermore, 38 percent of the study population finished HAVO, VWO or MBO. It is estimated that 2.9 to 9.2 percent of these people have low literacy skills. Besides the level of education, the origin of a person affects the literacy skills as well. In the Netherlands, 37.0 percent of the first generation immigrants have low literacy skills, in contrast to 8.2 percent among the people born in the Netherlands (Buisman & Houtkoop, 2014). In the study population, 25 percent of the parents were first generation immigrants. The presence of people with low literacy skills in the study population may have affected the reliability of the completed questionnaires, and therefore the results of the second part of the study.

Third, the norm values available for the KINDL and SDQ were specified on age groups. Within this study, it was chosen to use the norm values corresponding to the mean age of the study population. The mean age of the children included in the study was 8.5. For the KINDL questionnaire, the norm values of a study sample ranged from seven to ten years old were used. This study was conducted in Germany, no norm values were available for the Dutch population. However, it was assumed that the German health-related quality of life is similar to the Dutch health-related quality of life (Numbeo, 2018). For the SDQ, the norm values corresponding with a Dutch study population ranged from six to eleven years old was used. However, it is recommended to separate the values of the study population with respect to the separation of the norm values in further research.

Due to the small study population, this could not be executed in this study.

5.2 RECOMMENDATIONS FOR FUTURE RESEARCH

The results of the study conducted are going to further explored within the 'Gezonde kinderen in krappe tijden' project. The most important recommendation for the project is to use the measurement instrument composed within this study. Moreover, it is recommended to take into account the low literacy skills of a part of the study population. Partly, this can be solved by creating a sound record of each question. This can be implemented in the online questionnaire, and can be played during the intervention meetings in which the participants complete the questionnaires. Another solution can be to exclude people from the study when not mastering a minimum level of B2 of the Dutch language. This level is suitable for people who can understand the main idea of difficult texts and can have a normal conversation with native speakers, without extra effort (Universiteit van Amsterdam, n.d.).

Furthermore, an important recommendation for further research is to increase the number of parents in the study population. This may increase the number of scales with a significant difference, and therefore, may increase the fit for use of the results. Significant differences between the study population and norm values can be used to support the necessity of the 'Gezonde kinderen in krappe tijden' project. Moreover, although no significant differences were found within the KINDL subscale of school and the SDQ emotional subscale, these subscales might deviate in further research, since the One Sample T-Test showed a p-value of 0.13 and 0.08, respectively. This can be interpreted as a suggestion of a deviation. Moreover, no analyses could be conducted on the physical and friends subscales, since these variables are not normally distributed. Nevertheless, the scores of the study population seem to deviate strongly from the norm values. Therefore, attention should be paid to the subscales physical, friends, and school of the KINDL questionnaire, and the emotional subscale of the SDQ in further research.

6. CONCLUSION

The study documented in this report consists of two parts. The first part is concerned with the research question: "Which measurement instruments are appropriate for measuring the health and well-being of children from four to fourteen years old and their parents living in poverty?" The questionnaires considered to be most appropriate were the CBS health survey – overall health, EMPO Parents Version 3.1, Mental Health Continuum – Short Form, the Financial Hardship Scale, SDQ, Kiddy-KINDL or Kid-KINDL, and eleven questions concerning the child's material deprivation and social participation.

The second part is concerned with the research question: "What is the current state of health and well-being of children ranged from four to fourteen years old and their parents living in poverty in the region of Twente?" The current state of health and well-being of the parents included in the study is similar to the overall population in the Netherlands. The children included in the study population have significantly lower emotional well-being, friends, and health-related quality of life. The remaining aspects of the children's health are similar to the Dutch population.

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APPENDIX 1: CONCEPTS AND DEFINITIONS

Concept	Definition
Poverty	*The condition of being extremely poor* (Cambridge Dictionary, n.d.)
	The state or condition of having little or no money, goods, or means of support; condition of being poor. (Online Etymology Dictionary, 2010)
	deficiency of necessary or desirable ingredients, qualities, etc. (Online Etymology Dictionary, 2010)
	scantiness; insufficiency (Online Etymology Dictionary, 2010)
	Income poverty is when a family's income fails to meet a federally established threshold that differs across countries. (United Nations Educational, Scientific and Cultural Organization, 2017)
	Absolute poverty measures poverty in relation to the amount of money necessary to meet basic needs such as food, clothing, and shelter. (United Nations Educational, Scientific and Cultural Organization, 2017)
	Relative poverty defines poverty in relation to the economic status of other members of the society: people are poor if they fall below prevailing standards of living in a given societal context. (United Nations Educational, Scientific and Cultural Organization, 2017)
	Poverty is more than the lack of income and resources to ensure a sustainable livelihood. Its manifestations include hunger and malnutrition, limited access to education and other basic services, social discrimination and exclusion as well as the lack of participation in decision-making. (United Nations, n.d.)
	Individuals, families and groups in the population can be said to be in poverty when they lack resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged and approved, in the societies in which they belong (Wickham, Anwar, Barr, Law, & Taylor-Robinson, 2016).
Health (and well-being)	Boorse: "*Health is normal species functioning, which is the statistically typical contribution of all the organism's parts and processes to the organism's overall goals of survival and reproduction"* (Kingma, 2007; Haverkamp, Verweij, & Stronks, 2017).
	Nordenfelt*: "A is in health if, and only if, A has the ability, given standard circumstances, to realize his vital goals, i.e. the set of goals which are necessary and together sufficient for his minimal happiness"* (Venkatapuram, 2013; Haverkamp, Verweij, & Stronks, 2017).
	Venkatapuram: *"the health of an individual should be understood as the ability to achieve a basic cluster of beings and doings—or having the overarching capability, a meta-*

capability, to achieve a set of central or vital inter-related capabilities and functionings" (Venkatapuram, 2013; Haverkamp, Verweij, & Stronks, 2017).

WHO: *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (Huber, et al., 2011).

Huber: *"health as the ability to adapt and to self-manage"* (Huber, et al., 2011).

APPENDIX 2: RESULTS MINI-REVIEW

SEARCH WORDS

Database	Search term	# of records	Action	Result
Scopus	children OR child OR infant AND health OR wellbeing OR "well-being" AND poverty OR "low income" AND impact OR relation OR relationship OR connection OR association OR causation OR causal OR determinant AND "high income" OR "developed country"	901	Limit to records from 2009-2018 (last 10 years)	529 records
Scopus	TITLE-ABS-KEY (children OR child OR infant AND health OR wellbeing OR "well-being" AND poverty OR "low income" AND impact OR relation OR relationship OR connection OR association OR causation OR causal OR determinant AND "high income" OR "developed country") AND PUBYEAR > 2008 AND (LIMIT-TO (AFFILCOUNTRY , "United States") OR LIMIT-TO (AFFILCOUNTRY , "United Kingdom") OR LIMIT-TO (AFFILCOUNTRY , "Canada") OR LIMIT-TO (AFFILCOUNTRY , "Australia") OR LIMIT-TO (AFFILCOUNTRY , "Sweden") OR LIMIT-TO (AFFILCOUNTRY , "Switzerland") OR LIMIT-TO (AFFILCOUNTRY , "Netherlands") OR LIMIT-TO (AFFILCOUNTRY , "France") OR LIMIT-TO (AFFILCOUNTRY , "Japan") OR LIMIT-TO (AFFILCOUNTRY , "Denmark") OR LIMIT-TO (AFFILCOUNTRY , "Germany") OR LIMIT-TO (AFFILCOUNTRY , "Norway") OR LIMIT-TO (AFFILCOUNTRY , "Spain") OR LIMIT-TO (AFFILCOUNTRY , "Belgium") OR LIMIT-TO (AFFILCOUNTRY , "Ireland") OR LIMIT-TO (AFFILCOUNTRY , "New	466		

	Zealand") OR LIMIT-TO (AFFILCOUNTRY , "Finland") OR LIMIT-TO (AFFILCOUNTRY , "Italy") OR LIMIT-TO (AFFILCOUNTRY , "Poland") OR LIMIT-TO (AFFILCOUNTRY , "Portugal") OR LIMIT-TO (AFFILCOUNTRY , "Romania") OR LIMIT-TO (AFFILCOUNTRY , "Austria") OR LIMIT-TO (AFFILCOUNTRY , "Bulgaria") OR LIMIT-TO (AFFILCOUNTRY , "Croatia") OR LIMIT-TO (AFFILCOUNTRY , "Estonia") OR LIMIT-TO (AFFILCOUNTRY , "Lithuania") OR LIMIT-TO (AFFILCOUNTRY , "Slovakia") OR LIMIT-TO (AFFILCOUNTRY , "Cyprus") OR LIMIT-TO (AFFILCOUNTRY , "Greece") OR LIMIT-TO (AFFILCOUNTRY , "Hungary") OR LIMIT-TO (AFFILCOUNTRY , "Slovenia") OR LIMIT-TO (AFFILCOUNTRY , "Undefined"))			
Scopus	TITLE-ABS-KEY ("poverty" AND "quality of life" OR "QoL" AND "child" OR "children") AND PUBYEAR > 2012 AND (LIMIT-TO (DOCTYPE , "re")) Reviews	25		
PubMed	("poverty"[MeSH Terms] OR "poverty"[All Fields]) AND ("health"[MeSH Terms] OR "health"[All Fields]) AND (Review[ptyp] AND "loattrfree full text"[sb] AND "2013/03/21"[PDat] : "2018/03/19"[PDat] AND "humans"[MeSH Terms] AND (English[lang] OR Dutch[lang]) AND ("child, preschool"[MeSH Terms] OR "child"[MeSH Terms:noexp]))	91		
PubMed	("poverty"[MeSH Terms] OR "poverty"[All Fields]) AND ("health"[MeSH Terms] OR "health"[All Fields]) AND (systematic[sb] AND "loattrfull text"[sb] AND "2013/03/22"[PDat] : "2018/03/20"[PDat] AND "humans"[MeSH	114		

	Terms] AND (Dutch[lang] OR English[lang]) AND ("child, preschool"[MeSH Terms] OR "child"[MeSH Terms:noexp]))			
PubMed	poverty[Title/Abstract] AND health[Title/Abstract] AND ("loattrfull text"[sb] AND "2013/03/22"[PDat] : "2018/03/20"[PDat] AND "humans"[MeSH Terms] AND (Dutch[lang] OR English[lang]) AND ("child, preschool"[MeSH Terms] OR "child"[MeSH Terms:noexp]))	771	Too many results, specify on (systematic) reviews	
PubMed	poverty[Title/Abstract] AND health[Title/Abstract] AND ((systematic[sb] OR Review[ptyp]) AND "loattrfull text"[sb] AND "2013/03/22"[PDat] : "2018/03/20"[PDat] AND "humans"[MeSH Terms] AND (Dutch[lang] OR English[lang]) AND ("child, preschool"[MeSH Terms] OR "child"[MeSH Terms:noexp]))	93		
PubMed	((poverty[Title/Abstract]) AND quality of life[Title/Abstract]) OR QoL[Title/Abstract]	864		
PubMed	(poverty[Title/Abstract] AND quality of life[Title/Abstract]) OR QoL[Title/Abstract] AND ((Review[ptyp] OR systematic[sb]) AND "loattrfull text"[sb] AND "2013/03/24"[PDat] : "2018/03/22"[PDat] AND "humans"[MeSH Terms] AND (Dutch[lang] OR English[lang]) AND ("child"[MeSH Terms:noexp] OR "child, preschool"[MeSH Terms]))	88		
Cochrane Library	"Child" in Title, Abstract, Keywords and "poverty" in Title, Abstract, Keywords and "health" in Title, Abstract, Keywords in Cochrane Reviews	10		
Google Scholar	allintitle: child AND review AND health OR wellbeing OR "quality of life" AND poverty	2		
Web of Science	You searched for: (TS=(poverty* AND health* AND children*)) AND LANGUAGE: (English	61		

	OR Dutch) AND DOCUMENT TYPES: (Review) Refined by: Open Access: (ALL OPEN ACCESS OR GOLD OR GREEN ACCEPTED OR GREEN PUBLISHED) Timespan: 2013-2018. Indexes: SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, ESCI.			
Scopus	TITLE-ABS-KEY (poverty AND health AND children AND "high-income" OR "developed") AND DOCTYPE (re) AND PUBYEAR > 2012	51		
Scopus	TITLE-ABS-KEY ("child poverty" AND health) AND DOCTYPE (re) AND PUBYEAR > 2012	8		
Cochrane Library	"poverty" in Title, Abstract, Keywords and "health" in Title, Abstract, Keywords and "children" in Title, Abstract, Keywords in Cochrane Reviews	10		

IN- AND EXCLUSION MINI-REVIEW

This Appendix can be found in the file ‘Appendix 2 Mini-review’

APPENDIX 3: ETHICAL APPROVAL

Dit deel is vertrouwelijk en wordt daarom niet weergegeven.

APPENDIX 4: INFORMED CONSENT

INFORMATION FLYER

GEZONDE KINDEREN IN KRAPPE TIJDEN

WAT?

- 5 bijeenkomsten met andere ouders
- 3 vragenlijsten voor het onderzoek

VOOR WIE?

Gezinnen die in een armoedesituatie leven.

DOEL

Het programma heeft als doel de *gezondheid van kinderen* te vergroten die opgroeien in armoede. Ook heeft het programma als doel om de *gezondheid van ouders* te verbeteren. Een verbeterde gezondheid van de ouders zorgt voor een betere gezondheid van de kinderen.

BIJEENKOMSTEN

Elke bijeenkomst staat in het teken van een onderdeel van gezondheid en welzijn. Zo is er een bijeenkomst over *meedoen*. We bespreken hierin mogelijkheden voor activiteiten en steun in de eigen gemeente.

Ook is er een bijeenkomst over *lekker in je vel zitten*. We bespreken hierin de invloed van stress op het brein. Deelnemers gaan in deze bijeenkomst aan de slag met oefeningen die je kunt doen om stress te verminderen.

BIJEENKOMSTEN

1. Hier en nu
2. (Mijn) lichaam, gevoelens en gedachten
3. Meedoen & dagelijks leven
4. Nu en later
5. Lekker in je vel!

VERGOEDING

- U krijgt €75 in waardebonnen voor het invullen van de vragenlijsten.
- Deelname aan het programma is gratis.

ACADEMISCHE WERKPLAATS JEUGD IN TWENTE

In de academische werkplaats werken de 14 Twentse Gemeenten, GGD Twente, Universiteit Twente en Saxion samen. Hun doel is om de gezondheid van kinderen die opgroeien in armoede te verbeteren. Ze gaan uit van eigen kracht en de zes onderdelen van gezondheid en welzijn.

PROGRAMMA

We hebben het programma verdeeld over 5 bijeenkomsten van elk 2 uur. In elke bijeenkomst staat een onderdeel van gezondheid en welzijn centraal. Deze onderdelen zijn:

- Mijn lichaam
- Mijn gevoelens en gedachten
- Nu en later
- Lekker in je vel zitten
- Meedoen
- Dagelijks leven

Deelnemers bepalen zelf wat hun doelen zijn en er is veel ruimte voor eigen invulling. Twee mensen leiden de bijeenkomsten: een professional en een persoon die zelf in armoede leeft of leefde.

'Met weinig middelen een gezond gezin'

Contactpersoon gemeente [GEMEENTE]

[naam contactpersoon]

Telefoon: [telefoonnummer contactpersoon]

E-mail: [mailadres contactpersoon]

Contactpersoon onderzoek

[Naam onderzoeker]

Telefoon: [Nummer]

E-mail: [e-mail]

academische werkplaats jeugd in twente

ONDERZOEK

Met het onderzoek kijken wij of het programma het gewenste resultaat heeft.
Van de eerste 20 gezinnen die zich aanmelden starten er 10 meteen. De andere 10 gezinnen starten in het najaar. Alle 20 gezinnen vullen op drie momenten een vragenlijst in over het gezin en over het kind. De eerste vragenlijst wordt vlak na aanmelding ingevuld. De tweede vragenlijst na ongeveer 2 maanden. De laatste vragenlijst na ongeveer 5 maanden.

MEER WETEN OF MEEDOEN?
NEEM CONTACT OP MET DE CONTACTPERSOON VAN UW GEMEENTE

INFORMED CONSENT

TOESTEMMINGSFORMULIER ONDERZOEK

academische werkplaats jeugd in twente

In de Academische Werkplaats Jeugd in Twente werken de 14 Twentse Gemeenten, GGD Twente, Universiteit Twente en Saxion samen. Hun doel is om de gezondheid van kinderen die opgroeien in armoede te verbeteren. Daarom is een programma ontwikkeld. In de bijgevoegde brochure 'Gezonde kinderen in krappe tijden' vindt u meer informatie over dit programma en het onderzoek.

Titel onderzoek: Gezonde kinderen in krappe tijden

Verantwoordelijke onderzoeker: [Naam onderzoeker – vertrouwelijk], Saxion – Academische Werkplaats Jeugd in Twente

In te vullen door de deelnemer

De uitleg over het onderzoek was duidelijk. Ik weet waar het onderzoek over gaat en wat de reden is van het onderzoek. Ik weet hoe het onderzoek zal gaan en wat ik daarin zal doen.

Ik weet dat de gegevens en resultaten van het onderzoek alleen zonder persoonlijke gegevens, zoals mijn naam, met anderen worden gedeeld. Ik ben tevreden over de antwoorden op de vragen die ik had. Ik begrijp dat de informatie uit de vragenlijsten alleen voor analyse en/of wetenschappelijke presentaties is bedoeld. Ik doe helemaal vrijwillig mee aan dit onderzoek. Ik heb het recht om op elk moment zonder uitleg te stoppen met het onderzoek.

Naam deelnemer: .....

Datum: ..... Plaats .....

Handtekening deelnemer: .....

In te vullen door de uitvoerende onderzoeker

Ik heb een mondelinge en schriftelijke toelichting gegeven op het onderzoek. Ik zal resterende vragen over het onderzoek naar vermogen beantwoorden. De deelnemer zal van een eventuele voortijdige beëindiging van deelname aan dit onderzoek geen nadelige gevolgen ondervinden.

Naam onderzoeker: [Naam onderzoeker – vertrouwelijk]

Datum: .....

Handtekening onderzoeker: .....

APPENDIX 5: QUESTIONNAIRE OVERVIEW

This Appendix can be found in the file ‘Appendix 5: Questionnaire overview’

GEZONDE KINDEREN IN KRAPPE TIJDEN

VRAGENLIJST 1

Beste heer/mevrouw,

U ontvangt deze vragenlijst omdat u meedoet aan het onderzoek 'Gezonde kinderen in krappe tijden'. Voor dit onderzoek zal u drie keer een vragenlijst invullen. Dit is de eerste vragenlijst.

We verwachten dat het invullen van de vragenlijst ongeveer 15-30 minuten zal duren. De vragenlijst heeft 5 onderdelen.

1. Algemene vragen over uzelf
2. Algemene vragen over uw kind
3. Vragen over uw gezondheid en dagelijks leven
4. Vragen over de gezondheid en het dagelijks leven van uw kind
5. Afsluiting

Vul alle vragen in. Er zijn geen goede of foute antwoorden. Als u twijfelt over het antwoord op een vraag, vul dan het antwoord in dat u het beste lijkt.

Hoe vult u de vragenlijst in?

Zo kunt u een antwoord aankruisen

	A	B	C
	o	o	•

Zo kunt u een antwoord veranderen

	A	B	C
	o	•	• X

Voor het invullen van deze vragenlijsten ontvangt u Jumbo cadeaubonnen. Voor het invullen van de eerste vragenlijst ontvangt u een bon van 20 euro. Voor het invullen van de tweede vragenlijst ontvangt u een bon van 25 euro. Voor het invullen van de derde vragenlijst ontvangt u een bon van 30 euro. In totaal ontvangt u dus 75 euro aan cadeaubonnen voor het meedoen aan dit onderzoek. Deze bonnen zijn te besteden bij een Jumbo bij u in de buurt.

Als u vragen heeft, kunt u altijd contact opnemen met *[onderzoeker Saxion]* (zie onderaan deze pagina). We zullen uw gegevens alleen gebruiken voor het onderzoek. Na het invullen van de vragenlijst kunt u deze opsturen in de antwoordenvelop. Een postzegel is niet nodig.

[Contactgegevens onderzoeker Saxion]

Algemene vragen	
Persoonlijke code	
Wat is de datum waarop u deze vragenlijst invult? *dd/mm/jjjj*	
Mijn 'Gezonde kinderen in krappe tijden'-bijeenkomsten vinden plaats in:	Almelo Losser
Deze vragenlijst wordt ingevuld door:	Moeder Vader Anders, namelijk_____
Wat is uw geboortedatum? *dd/mm/jjjj*	
In welk land bent u geboren?	Nederland Suriname Nederlandse Antillen/Aruba Marokko Turkije Anders, namelijk_____ _____ _____
Wat is uw woonsituatie?	Alleen Met partner Met kinderen Met partner en kinderen Anders, namelijk_____ _____ _____
Wat is uw burgerlijke staat?	Ongehuwd Gehuwd Gescheiden Samenwonend Anders, namelijk_____ _____ _____

Wat is de hoogste opleiding die u met een diploma heeft afgesloten?	Geen opleiding Lagere school/Basisonderwijs VMBO/LBO/MAVO HAVO/VWO/MBO HBO/Universiteit Anders, namelijk_____ _____ _____
Wat omschrijft uw huidige situatie het best?	Ik werk full time Ik werk part time, namelijk _____ uur per week Ik heb geen betaald werk Anders, namelijk_____ _____ _____
Wat is uw beroep? *Als u dit heeft*	Ik heb geen betaald werk Mijn beroep is _____ _____ _____
Hoe wordt het inkomen in uw gezin (van u en uw eventuele partner) verkregen? *Meer dan één antwoord mogelijk*	Via een betaalde baan Via een uitkering (bijstand, WAO, ANW, WW) die uw gezin **korter** dan drie jaar ontvangt Via een uitkering (bijstand, WAO, ANW) die uw gezin **langer** dan drie jaar ontvangt Anders, namelijk_____ _____ _____
Weet u hoeveel geld u ongeveer te besteden heeft nadat de vaste lasten zijn betaald?	Ja, _____ euro per **week** Ja, _____ euro per **maand** Nee
Hoeveel kinderen wonen er **altijd** bij u in huis?	_____ kinderen
Hoeveel kinderen wonen er **gedeeltelijk** bij u in huis?	_____ kinderen

Wat zijn de leeftijden van uw kinderen? *Invullen voor het aantal kinderen dat u heeft*	_____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud _____ jaar oud

Vul de volgende vragen in over <u>uw oudste kind dat op de basisschool</u> zit.

Algemene vragen over uw kind	
Mijn kind is een	Jongen Meisje
Wat is de geboortedatum van uw kind? *dd/mm/jjjj*	☐☐ ☐☐ ☐☐☐☐
In welke groep op school zit uw kind?	Groep 1 Groep 2 Groep 3 Groep 4 Groep 5 Groep 6 Groep 7 Groep 8 Anders, namelijk_____ _____ _____
Bij wie woont uw kind?	Bij vader en moeder Alleen bij moeder (met eventueel nieuwe partner) Alleen bij vader (met eventueel nieuwe partner) Afwisselend bij moeder en vader (met eventueel nieuwe partner) Anders, namelijk_____ _____ _____

Vragen over uw gezondheid	
Hoe is over het algemeen uw gezondheid?	Zeer goed Goed Gaat wel Slecht Zeer slecht
Heeft u één of meer langdurige ziekten of aandoeningen? *Langdurig is 6 maanden of langer*	Ja Nee
In welke mate bent u vanwege problemen met uw gezondheid **sinds 6 maanden of langer** beperkt in activiteiten die mensen gewoonlijk doen?	Ernstig beperkt Wel beperkt maar niet ernstig Helemaal niet beperkt

Hierna volgen 12 uitspraken over hoe u met dingen in uw eigen leven en in het leven van uw kind omgaat. We vragen u per uitspraak aan te geven in hoeverre deze voor u geldt door een van de bolletjes in te kleuren.
U kunt kiezen uit:

"Zeer mee oneens"
"Mee oneens"
"Niet mee oneens, niet mee eens"
"Mee eens"
"Zeer mee eens"

Kies voor elke uitspraak het antwoord dat volgens u het meest van toepassing is. Denk niet te lang na, uw eerste indruk is meestal de beste. Er zijn geen goede of foute antwoorden mogelijk. Als u denkt een vergissing gemaakt te hebben, dan zet u een kruis door dat antwoord en kiest u alsnog het juiste antwoord. Wilt u alle uitspraken beantwoorden?

	Zeer mee oneens	Mee oneens	Niet mee oneens, niet mee eens	Mee eens	Zeer mee eens
Ik maak gebruik van raad of steun van mensen uit mijn omgeving, als dat nodig is	o	o	o	o	o
Ik maak me niet snel druk	o	o	o	o	o
Ik vecht altijd voor zaken die ik echt belangrijk vind	o	o	o	o	o
Ik heb veel vertrouwen in de toekomst	o	o	o	o	o
Ik heb mijn leven heel goed in de hand	o	o	o	o	o
Ik heb mezelf heel goed onder controle	o	o	o	o	o
Ik zoek zelf naar oplossingen wanneer ik een probleem heb met mijn kind	o	o	o	o	o
Ik heb controle op het gedrag van mijn kind	o	o	o	o	o
Ik heb de opvoeding van mijn kind heel goed in de hand	o	o	o	o	o
Mijn kind gedraagt zich altijd zoals ik dat wil	o	o	o	o	o
Ik stuur het gedrag van mijn kind wanneer dat nodig is	o	o	o	o	o

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	Zeer mee oneens	Mee oneens	Niet mee oneens, niet mee eens	Mee eens	Zeer mee eens
Ik grijp meteen in wanneer er problemen zijn met mijn kind	o	o	o	o	o

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De volgende vragen beschrijven gevoelens die mensen kunnen hebben. Lees iedere uitspraak zorgvuldig door en kleur het bolletje in dat het best weergeeft HOE VAAK u DAT GEVOEL HAD GEDURENDE DE AFGELOPEN MAAND.

In de afgelopen maand, hoe vaak had u het gevoel…	Nooit	Eén of twee keer	Onge-veer 1 keer per week	2 of 3 keer per week	Bijna elke dag	Elke dag
…dat u gelukkig was?	o	o	o	o	o	o
…dat u geïnteresseerd was in het leven?	o	o	o	o	o	o
…dat u tevreden was?	o	o	o	o	o	o
…dat u iets belangrijks hebt bijgedragen aan de samenleving?	o	o	o	o	o	o
…dat u deel uitmaakte van een gemeenschap (zoals een sociale groep, uw buurt, uw stad)?	o	o	o	o	o	o
…dat onze samenleving beter wordt voor mensen?	o	o	o	o	o	o
…dat mensen in principe goed zijn?	o	o	o	o	o	o
…dat u begrijpt hoe onze maatschappij werkt?	o	o	o	o	o	o
…dat u de meeste aspecten van uw persoonlijkheid graag mocht?	o	o	o	o	o	o
…dat u goed kon omgaan met uw alledaagse verantwoordelijkheden?	o	o	o	o	o	o
…dat u warme en vertrouwde relaties met anderen had?	o	o	o	o	o	o
…dat u werd uitgedaagd om te groeien of een beter mens te worden?	o	o	o	o	o	o
…dat u zelfverzekerd uw eigen ideeën en meningen gedacht en geuit hebt?	o	o	o	o	o	o
…dat uw leven een richting of zin heeft?	o	o	o	o	o	o

De volgende stellingen gaan over uw financiële situatie.

Dit deel van de vragenlijst is vertrouwelijk en wordt daarom niet weergegeven.

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De komende vragen gaan over uw oudste kind dat nog op de basisschool zit.

Let op! Wilt u onderstaande vragen beantwoorden als uw oudste kind op de basisschool JONGER DAN 7 JAAR is.

Wilt u bij het beantwoorden van de vragen op de volgende aanwijzingen letten.

- Lees alstublieft elke vraag goed door,
- Bedenk, hoe uw kind zich de afgelopen week gevoeld heeft,
- Kruis in iedere regel het antwoord aan, dat het beste past bij uw kind.

1. Lichamelijk welbevinden					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… heeft mijn kind zich ziek gevoeld	o	o	o	o	o
… had mijn kind hoofdpijn of buikpijn	o	o	o	o	o
… was mijn kind moe en futloos	o	o	o	o	o
… had mijn kind veel kracht en uithoudingsvermogen	o	o	o	o	o
2. Psychisch welbevinden					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… heeft mijn kind veel gelachen en plezier gehad	o	o	o	o	o
… had mijn kind nergens zin in	o	o	o	o	o
… heeft mijn kind zich eenzaam gevoeld	o	o	o	o	o
… heeft mijn kind zich bang of onzeker gevoeld	o	o	o	o	o
3. Eigenwaarde					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… was mijn kind trots op zichzelf	o	o	o	o	o
… zat mijn kind lekker in zijn vel	o	o	o	o	o
… vond mijn kind zichzelf aardig	o	o	o	o	o
… zat mijn kind vol goede ideeën	o	o	o	o	o
4. Gezin					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… kon mijn kind goed met ons als ouders opschieten	o	o	o	o	o
… voelde mijn kind zich thuis op zijn gemak	o	o	o	o	o
… hadden wij thuis erge ruzie	o	o	o	o	o
… voelde mijn kind zich door mij betutteld	o	o	o	o	o
5. Vrienden					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… heeft mijn kind iets samen met vrienden gedaan	o	o	o	o	o
… kwam mijn kind bij anderen goed over	o	o	o	o	o
… kon mijn kind goed opschieten met zijn vrienden	o	o	o	o	o
… had mijn kind het gevoel dat het anders is dan anderen	o	o	o	o	o

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6. School					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… heeft mijn kind de opdrachten op school goed gedaan	o	o	o	o	o
… vond mijn kind het leuk op school	o	o	o	o	o
… heeft mijn kind zich op school verheugd	o	o	o	o	o
… heeft mijn kind veel fouten gemaakt bij kleine opdrachten of thuisopdrachten	o	o	o	o	o

Ga nu verder op **pagina 14** voor de rest van de vragenlijst.

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Let op! Wilt u onderstaande vragen beantwoorden als uw oudste kind op de basisschool 7 JAAR OF OUDER is.

Wilt u bij het beantwoorden van de vragen op de volgende aanwijzingen letten.

- Lees alstublieft elke vraag goed door,
- Bedenk, hoe uw kind zich de afgelopen week gevoeld heeft,
- Kruis in iedere regel het antwoord aan, dat het beste past bij uw kind.

1. Lichamelijk welbevinden					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… voelde mijn kind zich niet lekker	o	o	o	o	o
… had mijn kind last van hoofdpijn of buikpijn	o	o	o	o	o
… was mijn kind moe en slap	o	o	o	o	o
… had mijn kind veel kracht en uithoudingsvermogen	o	o	o	o	o
2. Psychisch welbevinden					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… heeft mijn kind veel gelachen en plezier gehad	o	o	o	o	o
… had mijn kind nergens zin in	o	o	o	o	o
… heeft mijn kind zich alleen gevoeld	o	o	o	o	o
… was mijn kind angstig of onzeker	o	o	o	o	o
3. Eigenwaarde					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… was mijn kind trots op zichzelf als het iets had gepresteerd	o	o	o	o	o
… voelde mijn kind zich niet prettig	o	o	o	o	o
… vond mijn kind zichzelf aardig	o	o	o	o	o
… zat mijn kind vol goede ideeën	o	o	o	o	o
4. Familie					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… kon mijn kind goed met mij overweg	o	o	o	o	o
… maakte mijn kind thuis in het gezin een tevreden indruk	o	o	o	o	o
… had ik ruzie met mijn kind thuis	o	o	o	o	o
… voelde mijn kind zich door mij betutteld	o	o	o	o	o
5. Contacten					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
… heeft mijn kind iets samen met vrienden gedaan	o	o	o	o	o
… had mijn kind “succes” bij anderen	o	o	o	o	o
… had mijn kind een goed contact tot zijn vrienden	o	o	o	o	o
… had mijn kind het gevoel dat het anders was dan anderen	o	o	o	o	o

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6. Basisschool					
In de afgelopen week …	Nooit	Zelden	Soms	Vaak	Altijd
... ging het huiswerk mijn kind gemakkelijk af	o	o	o	o	o
... ging mijn kind met plezier naar school	o	o	o	o	o
... heeft mijn kind zich zorgen over de toekomst gemaakt	o	o	o	o	o
... heeft mijn kind bij kleine opgaven of huiswerk veel fouten gemaakt	o	o	o	o	o

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Vanaf hier vullen alle deelnemers de vragen weer in.

Wilt u alstublieft voor iedere vraag het bolletje aankruisen voor "Niet waar", "Een beetje waar" of "Zeker waar". Het is van belang dat u alle vragen zo goed mogelijk beantwoordt, ook als u niet helemaal zeker bent of als u de vraag raar vindt. Wilt u alstublieft uw antwoorden baseren op het gedrag van het kind de laatste zes maanden of het huidige schooljaar.

	Niet waar	Een beetje waar	Zeker waar
Houdt rekening met gevoelens van anderen	o	o	o
Rusteloos, overactief, kan niet lang stilzitten	o	o	o
Klaagt vaak over hoofdpijn, buikpijn, of misselijkheid	o	o	o
Deelt makkelijk met andere kinderen (bijvoorbeeld speelgoed, snoep, potloden, enz.)	o	o	o
Heeft vaak driftbuien of woede-uitbarstingen	o	o	o
Nogal op zichzelf, neigt er toe alleen te spelen	o	o	o
Doorgaans gehoorzaam, doet gewoonlijk wat volwassenen vragen	o	o	o
Heeft veel zorgen, lijkt vaak over dingen in te zitten	o	o	o
Behulpzaam als iemand zich heeft bezeerd, van streek is of zich ziek voelt	o	o	o
Constant aan het wiebelen of friemelen	o	o	o
Heeft minstens één goede vriend of vriendin	o	o	o
Vecht vaak met andere kinderen of pest ze	o	o	o
Vaak ongelukkig, in de put of in tranen	o	o	o
Wordt over het algemeen aardig gevonden door andere kinderen	o	o	o
Gemakkelijk afgeleid, heeft moeite zich te concentreren	o	o	o
Zenuwachtig of zich vastklampend in nieuwe situaties, verliest makkelijk zelfvertrouwen	o	o	o
Aardig tegen jongere kinderen	o	o	o
Liegt of bedriegt vaak	o	o	o
Wordt getreiterd of gepest door andere kinderen	o	o	o
Biedt vaak vrijwillig hulp aan anderen (ouders, leerkrachten, andere kinderen)	o	o	o

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	Niet waar	Een beetje waar	Zeker waar
Denkt na voor iets te doen	o	o	o
Pikt dingen thuis, op school of op andere plaatsen	o	o	o
Kan beter opschieten met volwassenen dan met andere kinderen	o	o	o
Voor heel veel bang, is snel angstig	o	o	o
Maakt opdrachten af, kan de aandacht goed vasthouden	o	o	o

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Wat kunt u zeggen over de activiteiten van uw kind in het afgelopen half jaar?	Nooit	Soms	Vaak
Mijn kind maakt uitstapjes naar een bioscoop, pretpark, dierentuin, museum of muziekfestival enz.	o	o	o
Mijn kind wordt uitgenodigd voor verjaardagen van vriend(inn)en	o	o	o
Mijn kind gaat naar verjaardagen van vriend(inn)en	o	o	o
Mijn kind nodigt vriend(inn)en thuis uit	o	o	o
Ik kan verjaardagscadeautjes voor andere kinderen betalen	o	o	o
Ik kan nieuwe kleren en/of schoenen voor de kinderen betalen	o	o	o
Ik kan schoolevenementen (bijvoorbeeld schoolreisje) en/of andere schoolkosten van het kind betalen	o	o	o

Wat kunt u zeggen over de activiteiten van uw kind?		
Mijn kind zit op een sport, zwemles, hobby- of culturele activiteiten of scouting	Ja, namelijk _____ _____ _____	Nee
Mijn kind is afgelopen zomer op vakantie of kamp geweest	Ja	Nee
Mijn kind heeft vriend(inn)en uitgenodigd voor zijn/haar laatste verjaardag	Ja	Nee
Ik kan een verjaardagsfeestje voor de eigen kinderen betalen	Ja	Nee

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Dit was het einde van de vragenlijst, bedankt voor het invullen!

Om u de waardebon van €20 toe te kunnen sturen, vragen wij om uw adresgegevens. Uw adres zal alleen hiervoor gebruikt worden.

Naam _____

Straat _____

Huisnummer _____

Postcode ☐☐☐☐ ☐☐

Plaats _____

Als u nog opmerkingen en/of suggesties heeft over het onderzoek of deze vragenlijst, dan kunt u deze hieronder opschrijven.

Opmerkingen