



Evidence-based Guidelines on Health
Promotion for Older People:

Social determinants, Inequality and
Sustainability

National Evaluation Report – The Netherlands

Katja van Vliet

Trudi Nederland

Marit Moll

Verwey-Jonker Instituut

March 2008



Co-financed by the European Commission



**Fonds Gesundes
Österreich**

Co-financed by Fund for a Healthy Austria

**Verwey-
Jonker
Instituut**

Co-financed by the Ministry of Health Welfare and Sport The Netherlands

This project has been funded with support from the European Commission. This report reflects the views only of the authors, and the Commission cannot be held responsible for any use which may be made of the information contained therein.

Contents

1 The Evaluated Health Promotion Cases for Older People	1
1.1 <i>National Selection Procedure</i>	<i>1</i>
1.2 <i>Short Presentation of the Three Health Promotion Cases for Older People</i>	<i>3</i>
2 Results of the National Case Studies	5
2.1 <i>In-depth Analysis of Case 1: Big!Move</i>	<i>5</i>
2.1.1 <i>Structure Evaluation Results</i>	<i>5</i>
2.1.2 <i>Process Evaluation Results</i>	<i>8</i>
2.1.3 <i>Outcome Evaluation Results</i>	<i>11</i>
2.2 <i>In-depth Analysis of Case 2: Buddy Care for the homosexual elderly</i>	<i>13</i>
2.2.1 <i>Structure Evaluation Results</i>	<i>13</i>
2.2.2 <i>Process Evaluation Results</i>	<i>15</i>
2.2.3 <i>Outcome Evaluation Results</i>	<i>18</i>
2.3 <i>In-depth Analysis of Case 3: Aspiring to Healthy Living</i>	<i>20</i>
2.3.1 <i>Structure Evaluation Results</i>	<i>20</i>
2.3.2 <i>Process Evaluation Results</i>	<i>23</i>
2.3.3 <i>Outcome Evaluation Results</i>	<i>26</i>
3 Conclusions	28
3.1 <i>Recommendations for Successful Health Promotion for Older People</i>	<i>28</i>
3.2 <i>Specific Recommendations for Project Aims</i>	<i>30</i>
4 References	31

1 The Evaluated Health Promotion Cases for Older People

1.1 National Selection Procedure

Selection of the cases

The selection of the cases for phase 3 consisted of five steps.

First, for the selection of the projects, the following selection criteria were formulated:

1. Two evidence-based projects, one innovative project
2. Number of inclusion criteria
3. Evaluated and sustainable
4. Themes addressed

Second, the projects were ranked on the basis of the scores on criteria 1-3 (see table).

Project	Inclusion criteria (ranking)	Remarks
NL-1 Successful ageing	11/16	Sustainability: no
NL-2 Health centre for the elderly	8/16	
NL-4 Big!Move	14/16 (2)	
NL-5 Activating home visits for and by elderly immigrants	9/16	
NL-6 Be down and brighten up	11/16 (5)	
NL-7 Memory training	6/16	
NL-8 Healthy and vital for the Turkish elderly	12/16	Sustainability: no
NL-9 Grip on life	10/16 (6)	
NL-10 In anticipation of the golden years	8/16	Evaluated in Healthy Ageing
NL-11 Looking for meaning in life	7/16	Evaluation: no (?)
NL-13 Friendship enrichment project for older women	9/16	
NL-14 Buddy Care for the homosexual elderly	13/16 (3)	
NL-15 Internet Community 50+ net	11/16	Evaluation: no (in preparation)
NL-16 Flash! Moving campaign for 55+	12/16 (4)	Limited to moving. Next years directed towards other target groups
NL-17 Groningen Active Living Model	9/16	Evaluated in Healthy Ageing
NL-18 Fall Clinics	7/16	
NL-19 Protocol fall prevention	8/16	
NL-20 A matter of balance	3/16	
NL-21 Aspiring to healthy living	10/16 (6)	Innovative.
NL-22 Heartbeat Limburg	16/16 (1)	Not specifically directed to the elderly

Third, the thematic division of projects with inclusion criteria 10 > /16, which are sustainable and have been evaluated, were examined.

Theme	Project
Empowerment	NL-21 Aspiring for healthy living
Lifestyle/physical activity/prevention of disease	NL-22 Heartbeat Limburg NL-4 Big! Move NL-16 Flash! Moving Campaign 55+
Addressing depression	NL-6 Be down and brighten up
Cognitive issues: memory training	-
Life-long learning/ education of older people (health)	NL-21 Aspiring to healthy living (see also empowerment)
Coping/self-management	NL-9 Grip on life
Social support/network	NL-13 Friendship enrichment project for older women NL-14 Buddy Care for the homosexual elderly
Safety (prevention of falls, accidents, injuries)	-

Fourth, the selection proposal was formulated:

1. Big!Move (instead of Heartbeat Limburg, because of specific groups for the elderly).
2. Buddy Care for the homosexual elderly.
3. Aspiring for healthy living (different aspects of healthy living, explicit focus on empowerment, innovative).

Finally, we have presented this proposal to several members of our national board. They agreed to our proposal after some discussion. Finally, the coordinator of phase 3 also agreed with our selection.

Methods

For all three cases data have been gathered and analysed in three steps by means of document analysis, interviews, and a SWOT-analysis using the developed formats.

Case 1: Big!Move

During the document analysis, several documents were analysed, in particular three evaluation reports and articles in professional and scientific journals. The interview was conducted with two people simultaneously at the Health Centre Venserpolder in Amsterdam, where Big!Move started in 2003. One of the two initiators and coordinators of Big!Move and one of the supervisors, who also coaches groups for elderly people, were interviewed together. Next to general aspects of the structure, process, and effects of the programme, the interview focused on (the groups for) elderly people, as Big!Move is a broad programme for the whole population living in a city area.

Case 2: Buddy care for the homosexual elderly

For the document analysis of the Buddy Care project, chiefly the project's effect evaluations were used. The main objectives of our analysis were to determine the specific position of homosexual and lesbian elderly people, as well as the effects of the intervention. Next, we interviewed the coordinator about the set-up, the structure,

and the organizational functioning of the Buddy Care project. After this, we interviewed an experienced buddy. During this interview, the buddy was invited to join in a reflection on her motivation and experiences, and also on the reciprocity of the buddy-client relationship.

Case 3: Aspiring to Healthy Living

For the document analysis the articles were used that the project team and others published in several journals. The project leader of phase 3 of the project was interviewed by telephone. It took quite some time to arrange the interview, due to illness of the respondent. She is responsible for the dissemination of the intervention. She felt that too much time had passed since the project and that it was not relevant to interview any other project member. Neither the intervention nor the training are currently being carried out, and therefore it was not possible to interview a second person who has experience with using the intervention.

1.2 Short Presentation of the Three Health Promotion Cases for Older People

Case 1: Big!Move

Big!Move is a health promotion method in a local setting, focused on healthy behaviour and human power¹. During the course, participants are encouraged to participate in local activities and to organise activities themselves. People can participate in dance activities at local community centres or in swimming, walking or cycling groups. There are also special groups for elderly people, which convene in residential homes. Big!Move aims at helping inhabitants of the area to become more conscious of the influence they can have upon their own life. This consciousness, together with the understanding and experience that one gains more with healthy behaviour, leads to a healthier lifestyle.

Health Centre Venserpolder in Amsterdam started the programme in 2003. It was initiated by a general practitioner and physiotherapist working at the centre. In principle, the programme aims to address all the inhabitants of a city area or neighbourhood, where the majority of the population often consists of socio-economically disadvantaged people or people from ethnic minority groups.

¹ The word 'big' in Big!Move is the abbreviation of 'beweging in gedrag' ('behaviour on the move')
healthPROelderly – National Report (The Netherlands)

Case 2: Buddy Care for the homosexual elderly

Homosexual men and lesbian women of age suffer from loneliness and depression more often than heterosexual elderly people do. Research shows that they often do not have a positive self-identity, and that their social network is not sufficient either. They often come from a generation for whom homosexuality was taboo. 'Buddy Care for older homosexuals' is aimed at reducing loneliness and improving mental well-being. Pink buddies are well-trained volunteers. They help homosexual, lesbian and transgender elderly people (55+) to get out of their social isolation, by visiting them once a week for support.

Support mostly takes place in three domains: practical (helping in the house), emotional (talking to each other) and social (engaging in activities together outside the house). The majority (74%) of the clients with a buddy feels less lonely. And 80% of the clients find Buddy Care to be of great value. Both results come from a field experiment in which the effectiveness of the Buddy Care for older homosexuals was evaluated by obtaining data at three moments in time in an experimental group (receiving Buddy Care) and a control group (not receiving Buddy Care).

Case 3: Aspiring to Healthy Living

The Aspiring to Healthy Living project (AHL) is a pilot that involves older Dutch and Moroccan men and women. AHL focuses on the development, execution, and evaluation of a programme for Healthy Living (HL), with diversity, empowerment, and savoir-vivre as underlying principles. Special attention is paid to the categories of difference that influence HL (i.e. sex, ethnic background, class, and age) and the social, cultural, and existential dimensions of HL. This takes place in a form of action research, in which users (m/f), intermediaries, the UvH, and the collaborating organisations (the Rotterdam Municipal Health Service and TransAct) act as equal partners.

The Aspiring to Healthy Living project consists of three phases. 1. During the first phase, a frame of reference is developed that is both gender- and ethnicity-aware; 2. During the second phase, this frame of reference is transformed into a script for an HL programme, on the basis of which an experimental intervention is executed with, for, and by older Dutch and Moroccan people; 3. During the final phase, an evaluation is carried out of the gender-specific, ethnic-specific, and generic elements of the HL programme, and of the added value of the multidimensional and diversity-aware approach as well.

Based on the interventions of the HL programme, an AHL box with materials, methods, and a manual was developed, in order to help professionals to implement the Healthy Living programme. It helps to start a conversation about healthy living among the elderly people themselves. By discussing healthy living, the elderly develop and strengthen their capacities for healthy living. The AHL box is now available to all Municipal Health Services and other organisations working with the

elderly. A training course is provided for people and organisations wanting to work with the AHL box.

2 Results of the National Case Studies

2.1 In-depth Analysis of Case 1: Big!Move

2.1.1 Structure Evaluation Results

Target group

The target groups of Big!Move are all the inhabitants of a particular neighbourhood or city region who are suffering from health problems. A lot of them are socio-economically disadvantaged people and people from ethnic minority groups. Among these older people is one of the specific groups Big!Move is targeting. Older people can participate in a group in the neighbourhood (either mixed in age or consisting of elderly people) or in the residential home. The initiators of the programme do not like to speak of 'target groups', but rather of 'groepen met een doel' ('groups with a purpose').

Big!Move started in the Venserpolder. Most inhabitants of the Venserpolder in Amsterdam are socio-economically disadvantaged and/or from migrant groups (mostly Surinamese and Antillean). In city areas where these populations live, more people suffer from more illnesses and diseases and die earlier. The Venserpolder health care centre services many patients with symptoms and diseases related to an unhealthy lifestyle, such as obesity, cardiovascular diseases, diabetes, or mental disorders.

The programme reaches most people during their visits to the general practitioner or another of the Centre's health care workers (the physiotherapist, dietician, or a general practice assistant). The Venserpolder health care centre has 7000 registered patients. Sometimes, participants to the programme have also been stimulated to take part by other professionals, such as social workers. The general practitioner refers inhabitants (with health problems like diabetes, overweight, cardiovascular diseases, stress, and tiredness) to the programme.

Theoretical foundation

Both the vision of the health care organisation and the Big!Move method are based on the scientific knowledge of the WHO on health promotion: 'the process of enabling people to increase control over and to improve their health'. The health centre Venserpolder Amsterdam has developed a vision on primary care focused on health promotion, next to its usual medical care and disease treatment. A separate health promotion department has been set up and a new method called Big!Move has been

developed. Big!Move forms a bridge between health care and individual participation in local activities in the neighbourhood.

Although the WHO knowledge is the most important, other theoretical models are used as well: the Theory of Complexity (Pisek, 2003), the Trans-theoretical model, and a developmental approach, all used in contrast to the rational, managerial approach (Van den Nieuwenhuizen).

Health determinants

The addressed health determinants are based on the domains brought forward in the WHO vision. In practice, this means:

- Strengthening people's health;
- The redistribution of power and control with regard to individual and collective health issues;
- The reduction of the negative impact of health determinants associated with social, political, and economic circumstances (such as disability, unemployment, and isolation within a multicultural environment);
- A shift in the use of the possibilities within the existing medical care: more prevention instead of treatment;
- Attention to be paid to health domains that do not fall under any physical category, such as mental, social, and possibly spiritual domains;
- A more ecological approach;
- The acknowledgement of both developments within the neighbourhood community and of participation as legitimate and effective strategies.

Setting

The main setting is a city area or neighbourhood, because in principle, the programme is directed toward all inhabitants of such an area. Within this area, the programme settings are the health care centre, community centres, residential homes, schools, et cetera.

Stakeholders

Stakeholders involved are the health care centre and its workers (general and paramedical professionals). In the area, other health care-, social care-, and social organisations are involved, like residential homes, social work, community centres, or housing corporations. These stakeholders are involved with an eye to the goals of the programme. Furthermore, on the local policy and funding level, stakeholders are a health care insurance organisation (Agis), the municipality, and the district council. These stakeholders are involved in order to achieve a broader dissemination of the programme, as well as its structural embedding and funding.

Goals

Big!Move aims at helping inhabitants of the area to become more conscious of the influence they can have upon their own life. This consciousness, together with the understanding and experience that one gains more with healthy behaviour, leads to a healthier lifestyle. The coordinator: “The focus is on the person, health, empowerment, and development instead of on symptoms and diseases. From prevention to promotion.” The initiators’ more personal aims were: demedicalisation, the substitution of medical treatment by health promotion, which brings about a reduction of medical costs. Some aims were motivated by frustration: it must be possible to somehow make things better and more fun.

Management structure and budgetary arrangements

In the health care centre, a separate Health and Behaviour (Gezondheid en Gedrag (GG)) Department has been set up beside a Cure and Care (Ziekte en Zorg (ZZ)) Department.

The Foundation Big!Move Institute has been founded for the dissemination of the Big!Move method and the vision on health promotion, and for supporting the transference of local knowledge and experiences. By now, Big!Move is being carried out at four other locations in the Netherlands. In addition, it will be started in a number of (disadvantaged) neighbourhoods in Amsterdam as part of the municipal programme ‘Move Better’. Other cities and regions are showing an interest as well in starting with the method. A potential problem is the limited capacity for training and coaching in relation to the enormous demand. “At present, we are struggling to grapple with the demand coming from all kinds of locations, professionals, and institutions, since the quality and capacity at our disposal to meet with this demand are only limited.” (Interview 1).

Until now, the participants, Health Care Insurer Agis, and the district council provided the funds for Big!Move. The participants pay a (small) contribution, 60 euros in total (10 for the intake, 20 for phase 1, and 30 euros for phase 2). “It was a conscious decision to make these amounts mount up, making it normal to pay for something for yourself, and also making the transition to a neighbourhood activity, such as a sport, easier.” Thus, people pay for phase 3 themselves. This might consist of swimming, for example, to which the municipality contributes a small subsidy for the rent of the swimming pool, making this a feasible undertaking. Phase 3 can consist of any regular activity on offer or under development in a neighbourhood. Usually, hiking groups are for free, or they have some small fund. Venserpolder has a hiking and training group, the participants of which pay 10 euros a month as a stimulus, which enables them to engage a trainer or to go on an outing.

“At this moment, we have an agreement with Agis for 2008 and 2009, which obliges them to pay 495 euros per participant for the intake, phase 1, and half of phase 2. I

hop and think that this commitment will make the municipality more willing to pay for the second part of phase 2. Although the district council has not yet committed itself, we have made a lot of progress with regard to the transference of knowledge and building a good relationship with the municipality. Right now, our main interest and priority is to succeed in arranging this part of our funding.” (Interview 1).

In the Netherlands, a more general ongoing development is to include prevention (on prescription, that is, prescribed by the GP or another physician) in the health insurance package, specifically for people who are more at risk. Furthermore, The Netherlands is currently in the middle of the implementation of new legislation: the Social Support Act. This Act could provide the finances for more general preventive and health-promoting activities among the population.

It is safe to say that these developments hold certain prospects for the structural embedding and financing of health-promoting activities, provided that these are included, notwithstanding the bureaucratic process involved.

For structural funding, the proven effectiveness is important as well, for which it would be necessary to conduct a longitudinal effect study. “The problem with effects is that they are hard to substantiate. When it is proven that less visits have been paid to the GP, for instance, it is much harder to establish its effect on the quality of life or the permanence of its effects.” (Interview 1).

2.1.2 Process Evaluation Results

Target groups

The general practitioner (or another health care worker) informs, advises, and motivates a patient with lifestyle, behavioural or functional problems to actively counter his or her lifestyle factors. When the patient is sufficiently motivated, the GP then refers him or her to a health promotion organisation. Sometimes, the patient first needs the in-between step of attention being paid to his or her symptom as a way to get activated. The patient gains insight in his/her own part in and responsibility for his/her health.

Next, the intake is carried out, based on the ICF, the International Classification of Functioning. A blueprint is made of the patient’s functioning, divided into objective measures on the one hand, referring to the diagnosis of illnesses, and subjective measures on the other, which represent the patient’s view. Together with the person doing the intake, the patient sets goals for his/her change. He/she chooses between an individual trajectory or inclusion in a Big!Move group (or another offer), pays the mandatory contribution and becomes a participant. The intake is a crucial part of the process as this is often the moment when the patient sees possibilities for increasing his or her health and makes a commitment to participate.

The participant receives intensive coaching to improve his/her own health in a more active way, both personally and through group processes.

The GP is the key person. The group coach informs the GP about the state of functioning and the process of the participant. If necessary, the patient is motivated again (to undertake action with regard to his/her health and behaviour when he/she consults the GP or another primary health care professional after or during Big!Move (called 'flinging someone in'). They continue to encourage the patient to get a grip on his/her own health and functioning, if necessary by initiating change within his/her everyday surroundings.

It turns out that many more women than men participate in Big!Move. Men visit their GP less often, while the general practice is the entrance to the programme. In addition, women live to an older age; they also see their extra weight as more of a problem than men do. Maybe the used approach appeals more to women, as well (group activities, social contacts, empowerment). There is no active recruitment to involve more men.

Theoretical foundation

The theoretical foundation was implemented in the Big!Move method as well as in the organisation. In the organisation, health promotion was separated from medical care by forming a new discipline within the health care centre.

The theoretical foundation was implemented during the intake by using the WHO International Classification of Functioning (ICF), and in the activating approach in the method.

The health promoter and coach (a trained physical therapist) compiles a health profile with the referred person, based on the ICF. Apart from illnesses, the checklist also charts the participant's social environment, as well as external and personal factors.

Big!Move consists of three phases and an optional fourth phase. After the intake, people enter phase 1. In this phase, people participate in a group activity, with intensive counselling by two supervisors. In addition to their physical strength, they try to improve the mental and emotional strength of the participants as well. After 12 weeks, participants can go on to phase 2. The participants are encouraged to get more active in their own environment; they are invited to engage in other activities in the neighbourhood. In phase 3, participants are encouraged to keep exercising more, independent of the organisation. Beside this, the organisation organises some group activities to let participants reflect upon their own experiences. In the fourth phase, the participants organise a group or an activity themselves; they become social entrepreneurs. Only a few people reach this stage.

Health determinants

The programme focuses on the present situation and the desired change in someone's functioning, instead of on the illness or the reduction of someone's health

symptom. It pays attention to the aspects of the knowledge, skills, and motivation involved in living a healthy life. The Big!Move groups are coached by two supervisors, often paramedics with an additional education in behavioural coaching and group processes. They report back about the proceedings during the individual process to the GP. At the conclusion, the participant has acquired his/her own opinion about his/her behaviour and health, and about the possibilities in his/her everyday surroundings to work on it.

Setting

The health care centre is easily accessible. Most people visit their general practitioner regularly. For older people, a group was set up in the residential home as well. The Big!Move groups take place in the neighbourhood, the swimming pool, the local schools or a community centre.

Stakeholders

People, organisations, and/or NGOs were approached personally by the initiators/organisers, in regular local meetings with different stakeholders. They were also activated through information in local newspapers, et cetera.

Strategies and methods

As the respondents state: "The emphasis should be on the person, on health, on pleasure, on empowerment. We must let go of the medical point of view, taking it from the medical setting." (Interview 1). See also the above.

The GG/ZZ vision is innovative. Making an explicit distinction between GG (Health and Behaviour) and ZZ (Cure and Care) within primary health care gives a strong impulse to the innovation of what is on offer, the working method used for the organisation of primary health care, and the cooperation with the partners in the neighbourhood. In practice, this vision turns out to fit in well with the current national policy to strengthen prevention within primary health care.

Changes

As the coordinator states: "We should continue with whatever works. What does not work, we should let die off. We must go on, take risks; personal drive and fun are important. We can bend the rules a bit and cut through existing structures. We should apply the same process to all levels." (Interview 1).

2.1.3 Outcome Evaluation Results

Evaluation

Three evaluation studies were carried out, all three with a different character.

1/ The evaluation in 2004 consisted of a qualitative description of the Big!Move programme; of the programme's effects on its participants, professionals, and the organisation; of the organisation itself; of communication and expenses; it also examined the programme's feasibility and transferability (Overgoor & Aalders, 2004).

2/ An evaluation study in 2006 examined the experiences of those involved with the ongoing processes and programmes on offer in the Venserpolder project (Wieringen & Thomas, 2006).

3/ The third study evaluated the dissemination of Big!Move to three locations under the authority of Health Care Insurer Agis (Overgoor, et al, 2007).

In 2004, the effects of the programme were evaluated at several levels: the ICF outcome, the participation of the inhabitants, the change in their behaviour, the newly developed activities to exercise; the change of the demand for health services.

People of various nationalities take part in the programme; Moroccan, Turkish, Surinamese, Dutch, Ghanaian, and Antillean people. In the meantime, more than 700 people have been referred to the programme. For further results, see 'Outcomes on cost-effectiveness and Effects on health'.

Hardly any objective indicators could be found to establish a direct, causal relation between the activities of the project, through awareness-raising and behavioural change, and a measurable health gain. For this reason, an evaluation study on the experiences with the project's ongoing processes and programmes on offer in the Venserpolder was conducted in 2006 (Wieringen and Thomas, 2006). The results:

1/ Far from all the employees of the health care centre are familiar with the GG/ZZ vision. The intention of the exercise programmes is better known.

2/a. Many (former) participants have kept on exercising, still have more social contacts than before, and/or feel better. For this group of participants, we can consider this to be a very positive result; it is a (generally obese) group of people, who are hard to get to exercise, among other things because of their bad health, lack of social contacts, and low socio-economic status.

b. For a number of Big!Move participants, the programme has not been successful in making them aware of their own options for behavioural change.

3/ During the past year, the project leaders have focused much of their attention on making Big!Move known on the national level. Thus, they could spend less time and energy on the further development of phase-3 activities in the neighbourhood.

Outcomes concerning cost-effectiveness

The evaluation study in 2004 showed that the average frequency of visits to the general practitioner has decreased from 6 to 4.8 consults a year. The amount of physiotherapeutic individual treatments has decreased, while within Big!Move the number of groups has grown. Illness-related treatment has been changed into health promotion actions. This results in better care for less money.

Effects on health (physical, mental, social health)

The study in 2004 showed that the most important effect is the behavioural change in the participants: of the 100 participants, 84 exercise more than they did before starting with the programme. Eighty-eight percent has become more active in daily life, 69% has independently started to do a sport; 51% has become a member of a community centre or local association.

In the interviews conducted during the 2006 evaluation study, many (former) participants indicated that they continued to exercise, still had more social contacts than before, and/or are feeling better. For this group of participants, we can consider this to be a very positive result of the Big!Move programme, since the group concerned consists of (generally obese) people, who are hard to get to exercise, among other things because of their bad health, lack of social contacts, and low socio-economic status. Perhaps, the health gain resulting from these changes will be demonstrable by means of 'hard' indicators in the long run.

Sustainable and transferable effects

A broad, activating approach contributes to sustainable and transferable effects of the programme, as groups will continue independently (also see the section Effects on health, evaluation study 2006).

Looking for structural embedding in local processes, as well as cooperative relations and municipal policy frameworks contribute to sustainable and transferable effects on the local level.

On the national level the foundation of the Big!Move Institute supports the dissemination and transference of the Big!Move vision and programme, as well as the transference of local knowledge and experiences. In addition, the locations are part of a national Big!Move network. Big!Move aims for cooperation and for joining regional and national supporting organisations, knowledge institutes, educational institutes, and professional organisations.

Public recognition

There is much interest in Big!Move, both from health organisations and policy makers. It has been referred to in a number of policy-making and professional

publications as a good example, e.g. in four of eight essays on prevention in the health care insurance for The Health Care Insurance Board (CVZ) (CVZ, 2007).

Big!Move has been nominated for several awards. In November 2006, Big!Move won the Cees Korver Award. This is a regional award for innovative projects within health care.

Consumer satisfaction

In the evaluation in 2006 (van Wieringen & Thomas), almost all respondents were positive about both the organisation and the content of the programme. The participants have enjoyed taking part, are sorry that the programme has ended for them, will keep on exercising, et cetera. The pleasure in the group and the support of the trainers seem to have been the most important motivators for the participants.

Empowerment

This has not been measured directly in the evaluation study in 2004, although the answer can be deduced from other effects. See the section Effects on health: of the 100 participants, 88% has become more active in daily life, 69% has independently started to do a sport; 51% has become member of a community centre or local association (evaluation study 2004). In the evaluation study in 2006, 63% of the respondents whose personal goal was to get more grip on their life have succeeded in attaining that goal.

2.2 In-depth Analysis of Case 2: Buddy Care for the homosexual elderly

2.2.1 Structure Evaluation Results

Goals

The Schorer Foundation is an organisation aimed at making accessible to homosexual, bi-sexual and transgender men and women the information, knowledge, and facilities that are necessary for their optimal health and well-being. For twenty years, Buddy Care has been part of the Schorer Foundation's activities. Buddy Care is an addition to the existing care and welfare services as well as to help provided by friends and family. Since 2001, there is also Buddy Care for the homosexual and lesbian elderly. The main features of Buddy Care for the elderly are that the help offered by buddies is dependent on the wishes and needs of the elderly, that buddies are very involved with their clients, and most of all, that personal contact between the buddy and his/her client is central. The goals of the project are to reduce loneliness and to improve the mental well-being of the elderly.

Target group

The target group consists of elderly people who are socially isolated and who suffer from feelings of loneliness. Research (Van de Meerendonk et al, 2003) shows that the characteristics of depression occur twice as often among homosexual and lesbian elderly people (33%) than among the general elderly Dutch population (15%).

Theoretical foundation/Health deterrents

Measuring the intensity of loneliness was done with the aid of a loneliness scale (De Jong Gierveld & Kamphuis, 1985), which discerns between a score for social loneliness and one for emotional loneliness (Bakker, 2004). Social loneliness relates to a lack of contacts with people with whom someone shares certain common characteristics, such as friends. Emotional loneliness primarily refers to the lack of someone with whom one has a close and intimate relationship, most often a life companion. Homosexual men and lesbian women experience both aspects in their daily lives. Yet, the background of these feeling of loneliness and depression among this group of elderly people, is also related to the lack of a positive identity (Bakker et al, 2003). During their youth, homosexuality was a forbidden and negative identity. The group that has this negative self-image consists of people from the generation aged 75 and older. The majority of this generation has led their lives as homosexual men and lesbian women in secret. A buddy tells that her client of 82 recounts that her mother used to say to her with regularity: "I'd prefer it if you were a whore, instead of a lesbian". The older generation of gay men and women grew up with negative connotations surrounding homosexuality and this affects them while they are ageing. The clients of Buddy Care lead a withdrawn and lonely existence. Thus, Buddy Care's coordinator reports: "Sometimes, you think: how can someone live like that? She or he is never visited by anyone." Likewise, an active buddy soon noticed that an elderly woman whom she visited one afternoon every week for three years, beside her, saw only her hairdresser once in a while.

Setting

The setting depends on the aims of the contact between buddy and client, and in particular on the needs of the client. Support mostly takes place in three domains: practical (helping in the house), emotional (talking to each other) and social (engaging in activities together outside the house).

Stakeholders/Management structure

The Buddy Care project functions with the aid of volunteers. At the Schorer Foundation, three paid staff members take care of the coordination, but the pool of voluntary workers and the volunteer policy provide the foundation of Buddy Care. At the beginning of 2008, this Amsterdam project can rely on more than 200 volunteers.

In majority, they are homosexual men and lesbian women from the world of care and welfare, often highly educated and very motivated. Each voluntary worker attaches him- or herself to the project for 8 hours a week. Approximately 25 volunteers fill key posts as trainers, or as contact- and group supervisors. Within the practice of volunteer policy, the reciprocity of the buddy care is central: what the buddy can take away and what the buddy can bring. This is the guiding principle of the training courses and group evenings provided to all the buddies. The training courses take up at least four evenings. The programme of these courses mainly focuses on practising the skills to guard the boundaries and to keep expectations clear. In one-on-one contact, there is always the danger of displaced responsibilities: the trap of helpfulness is waiting. The training courses take the practice of Buddy Care as guidance; the programme is adapted to the experiences arisen in practice. As a buddy relates about the training course: “Three years ago, the training course chiefly was about the buddy setting boundaries, but now the complexity of the contact between buddy and client is included more often as well.” Every month, the buddies have a group meeting, which are meant for mutual support. The exchange of experiences results in the promotion of expertise. A buddy recounts: “As a group, we have stayed together all these years from the beginning. It is a very jolly, diverse group. We meet every month, and twice a year we go out to do something sociable. Around Christmas, we have gone out for dinner. You really need those group meetings. You can tell your story and express your frustrations.”

2.2.2. Process Evaluation Results

Target groups

It is hard to reach this target group. The Schorer Foundation spends a lot of time making this project known. Beside the dissemination of folders and small articles written for the local newspaper, the most obvious way is to search intermediaries: people who are in contact with this group of elderly people. Yet, for this, the secret life of the group of homosexual men and lesbian women aged 75 and older constitutes an obstacle. The coordinator of Buddy Care encounters a lot of ignorance during attempts to make the project known in this way, for instance during phone calls with professionals working with the elderly. After the explanation and the request to give publicity to the project, their typical response is: “Yes, I would like to help, but we don’t have any homosexual men or lesbian women here!” It is easier to reach the group of elderly people aged 55 and older and they often are assertive. According to Buddy Care’s coordinator, they are very active searching for new ways of living during their old age, for instance by setting up networks for social contact.

The cultural background of these elderly people is very homogenous. The great majority of those enrolling in the project as clients, was born and grew up in the Netherlands. A few Eurasian and Latin-American elderly people form the exception.

Furthermore, it is remarkable that the project generally reaches far more men than women. There is no clear explanation for this. The project coordinator suggests that the women are more able to set up and maintain care networks among themselves, while the men are less good at this. A buddy thinks, however, that the difference between men and women that used to be made by society plays an important role. Because women were discriminated by society, in comparison to men, they could not capitalise on their role as breadwinner and the status attached to it. For men, this past has provided them with an easier social life, which causes them now to ask for help from the outside more easily than it is for the women.

Stakeholders

In its attempts to reach the target group, the Schorer Foundation cooperates with a number of organisations. To build up contacts with, for example, geriatric helpers, social workers, and psychiatric professionals, takes up a lot of the coordinator's time. Yet, the referral of these professionals provides homosexual elderly men and lesbian elderly women with the entrance to get a buddy.

Theoretical foundation/Health determinants

After an elderly person has thus applied for a buddy, often via a referral, an extensive intake will take place. Together with a contact supervisor, one of Buddy Care's coordinators will pay a visit to the elderly man or woman who has applied for a buddy, and will make an inventory of the kind of aid he or she asks for. This is done very meticulously and extensively. On the one hand, this is necessary to get a clear picture of what is happening in the applicant's living environment, and of the expectations that he or she entertains. Coordinator and supervisor will query the applicant about his/her housing- and living conditions, cultural background, education, daily activities, finances, physical, mental and psycho-social health, and health care use. On the other hand, the conversation will go into the elderly applicant's explicit need for contact and support, and will have to result in clarity about what Buddy Care can and cannot offer.

After the needs of the elderly client have been mapped out, it is important to come to a good match with a buddy. The personal contact between buddy and client constitutes the most important feature of Buddy Care. According to the coordinator, this match is about a search for parity between buddy and client. The starting point is taking care of each other mutually. The clients must not become dependent. Thus, parity is the foundation. At the base of the buddy's solidarity with the client is this realisation: "Now I am able to provide care, but later on, I will need it myself."

An interview with a buddy reveals that the motivation focused in a rather more practical manner. This particular buddy has visited an elderly lesbian women every Saturday afternoon for three years. She highly values the room needed to choose a

client: “At first, the choice you make depends on very practical matters and only after that follow the expectations and the personal matters.” This buddy emphasises that the personal contact is specific. “How does the client relate to you specifically? It is neither a business contact, nor a friend or a family member. On the one hand, you are close to one another, but on the other hand, you are not. After a year and a half, however, I did adopt my client as a sort of granny. It is quite customary in homosexual circles to choose your own family.”

Strategies and methods

This brings us to the content of the buddy care in practice. At the start of the project, the project goals were twofold: to counteract loneliness and depression among gay elderly people through contact with the buddies, and to encourage the elderly to participate more. Reciprocity in this contact is the guiding principle of the project. This reciprocity is central to the buddies, too, although they formulate their interest in the contact very practically. Thus, a 27 years old buddy states: “Since three years, I am the buddy of an 85 years old man, and since a year, I am buddy to a 77 years old woman as well. I see them every week. The man lives in a home for the elderly. He has suffered a stroke and has difficulty speaking. I read to him, or we listen to music together. We the woman, I can still really do things; sometimes, we visit a museum, for example. I find these people incredibly fascinating. They tell me about the past, about how they coped with their homosexuality. It makes me think about how it will be for me when I will be as old as they are now.”

In practice, the goals and content of Buddy Care do not completely seem to agree with each other. One of Buddy Care’s goals, for instance, focused on encouraging the social participation of the elderly. The expectation was that once they would be encouraged to take part in a homosexual activity, for example, they would subsequently initiate participation in other activities themselves. The elderly clients did not come up to this expectation. An effect study shows that Buddy Care is no longer able to stimulate them to take part in activities. The buddies, too, often soon recognise that their influence in this area is limited. One buddy recounts how, at the start of her contact with an 80 years old lesbian lady, she used to think up all kinds of activities to do during her visiting afternoon. However, she soon gave in to the biggest wish of her client. Her wish was to follow the same route within her own neighbourhood past a number of shops every Saturday afternoon, the highlight being the consumption of a salted herring at the fishmonger. “Following the same route every week was all that this elderly lady wanted.” For the buddy, these Saturday afternoons became the week’s moment of calm, after all the hectic goings-on of her working life.

Changes

In the past years, the goals have been adjusted during the execution of the buddy care. The coordinator states: “We wanted too much and were disappointed at first about the results we obtained. But now, we recognise that if we really give the needs of the elderly clients centre stage, we must deal with the physical limitations caused by the symptoms of old age, the biographical background of people, and their characters. Another adjustment concerns the duration of the buddy care. A duration of half a year used to be the guideline, yet this turned out to cause much unrest among the elderly. As a buddy recounts: “I noticed that the prospect that our contact might end made my client tense. I also noticed that the limit of half a year was based on the setting of concrete goals, but old people really don’t have a goal in the future. She only rested easy when I told her after a year and a half that I would only stop visiting her if she no longer wanted me to.” This form of commitment is an example of how the contact between buddy and client is at the heart of the project. In the meantime, Buddy Care has abandoned setting a limit to the duration of their service. The buddy care usually last at least a year, the coordinator told us. “If it is a healthy contact, it can last much longer.”

2.2.3 Outcome Evaluation Results

Evaluation

The first effect measurements of Buddy Care were carried out a few years ago. They showed that Buddy Care is a highly valued offer provided to homosexual men and lesbian women who suffer from loneliness and live in social isolation (Bakker, 2004). The Schorer Foundation wants to carry out another effect study on the effects for their clients in 2008. The main objective of this study is to find out what the points for improvement are.

Effects on health (physical, mental, social health)

Until now, both the clients and buddies mainly made themselves heard through positive comments, for example in a study on their contentment (Integron, 2005). The clients expressed their contentment with an average mark of 8,1 and the buddies with a mark of 7,5. The majority (74%) of the clients with a buddy feels less lonely. The conclusion of an effectstudy is that buddy care is a highly valued intervention within the total of intervention programmes for older homosexuals who struggle with loneliness and social isolation.

The coordinator wants to evaluate whether or not the aspect of being fellow-gays is a very important precondition for the positive effects of Buddy Care: “The point is that elderly clients feel that there is affinity with their lifestyle. Often, this group of elderly people does not want to discuss this explicitly, but when an elderly homosexual man goes to the park in the company of his buddy and together they watch the boys go

healthPROelderly – National Report (The Netherlands)

by, it gives this man the feeling that he does not need to keep his secret, but that he can live with it. That alleviates his loneliness.” At the same time, Buddy Care is and remains a very direct means to decrease feelings of loneliness among elderly homosexual men and lesbian women. They are visited every week!

Sustainable and transferable effects

An indirect effect is that Buddy Care is able to gather knowledge about the discriminating practices between the elderly themselves, as well as about the inattention of professionals working in care and welfare institutions when it comes to noticing and counteracting such practices. A buddy recounts that she has grown aghast of the bad relations between heterosexual and homosexual elderly people in a care institution: “I am shocked by the hostility between old people. You have no idea of the venom breaking free. That varies from excluding gay elderly people from conversations, since the grandchildren are the only subject talked about, to excluding these people from a card game. If they were allowed to hit these people, they would do it. With regard to the embedding of diversity within care and welfare institutions, there is still a world to gain.”

Outcomes concerning cost-effectiveness

Buddy care is not expensive. The Schorer Foundation has calculated that the costs of the present buddy care system amount to € 2.000 per client. This amount takes into account all the costs: the wages of the coordinators, the reimbursement of the expenses of the voluntary workers, and the overheads. The coordinator suspects that the provided buddy care causes people to make a delayed appeal to professional care services, since it increases the elderly’s quality of life. It would be useful to test this hypothesis and calculate its financial consequences.

Public recognition

The ‘Oranje Fonds’ (Orange Foundation) nominated the Pink Buddies project of the Schorer Foundation for an ‘Appeltje van Oranje 2007’. This annual award is given to initiatives in the area of social welfare and social cohesion and given by crown prince Willem-Alexander in the Noordeinde Palace. The theme of the year was ‘the best buddies’. Eventually, the pink buddies did not win first price. They did, however, belong to the first ten contenders, for which they were awarded a cash prize of €2.500.

2.3 In-depth Analysis of Case 3: Aspiring to Healthy Living

2.3.1 Structure Evaluation Results

Target group

Four diversity aspects were used to define the target group of the project. The frame of reference of the Healthy Living programme is both gender- and ethnicity-aware. The target group consisted of elderly people (both male and female) of Moroccan and Dutch descent, with a low socio-economic status (Jacobs et al., 2005; van Mens-Verhulst & van Bavel, 2006). The project leader: “In the original project plan, other ethnic groups were targeted as well, but due to practical reasons, only these two groups were chosen. The Municipal Health Care Centre of Rotterdam pointed out that the largest group of ethnic minorities in the cities was Moroccan, and that is the reason for singling out this group. The aspect of low socio-economic status has been included because it is known that this group suffers from health problems significantly more than those with a higher socio-economic status do. In addition, there are few health programmes that primarily focus on this group, or that are affordable to them”.

The Dutch elderly were aged between 55 and 75, while the Moroccan elderly ranged in age from 45 to 65 years. According to the project leader these different age categories were chosen because the experience of ‘getting old’ comes sooner in the last group. Furthermore, the number of Moroccan elderly people older than 70 is small in the Netherlands. (Interview 4).

The members of the project group, peers and intermediaries who belong to the target group themselves, were found in the networks of the professionals in the project group. This posed no problem, although the peers and intermediaries were sometimes hesitant, because they wondered whether they would have enough time, and whether they were able to do the job well. The support of the professionals in the group and a financial compensation for their time convinced them to participate. (Braakman, 2004; Jacobs et al., 2005; Jacobs, 2006). According to the project leader it was harder to find people to interview who belonged to the target group within the network of peers and intermediaries. Their network was smaller than expected. It was sometimes difficult to convince them to participate in an interview, because they felt self-conscious about the fact that the interview would be taped. Finding pilot locations to test the intervention also proved to be a time-consuming process. In the end, the project group managed to test the intervention four times in three different groups. However, there was no pilot group with Moroccan men.

Theoretical foundation

The project group started out by defining a diversity framework of Healthy Living. To this end, they interviewed the target group about their norms, experiences, and views on this matter. These interviews were analysed using three focuses: empowerment, the attribution of meaning, and diversity (van Bavel, 2007). Throughout this process, healthPROelderly – National Report (The Netherlands)

special attention was paid to the social differences between people, not only in age and social class, but also in gender and culture. This is essential, because every individual is more or less unique with regard to his/her personal configuration of these dimensions (van Mens-Verhulst & van Bavel, 2006). Participatory action research was used because, in health promotion, many interventions are created for the target group, but seldom with or by the target group itself. The projectleader: “the theoretical foundation of the project is the idea that you can only create an effective intervention for a target group when you give this target group an active voice. This is done by including members of the target group in the project group, by interviewing the elderly, and by testing the intervention with groups of elderly people. However, there is a tension between practice and theory. Professionals wrote the project proposal; it would have been better to also include the voice of the target group during that stage. One of the consequences of this was that time was lost during the project period because the members of the target group could not work and progress as fast as the professionals did. It was not only the interaction between elderly people and professionals that sometimes was problematic, since the professionals from different organisations needed time to pick up the same pace as well.” (Interview 4).

In the project, health was defined more broadly than just physical or mental health and individual lifestyles. Cultural, socio-economic, and social factors play a role as well. Health is considered to be more than just the absence or prevention of disease; it is a positive concept that included themes such as vitality, zest for living, resilience or power, connectivity, and the feeling the one can influence one’s own life. This is a positive definition, aimed at empowerment. Empowerment was defined as a strategy to give the elderly the opportunity to develop their strength and vitality, enabling them to make conscious choices in favour of Healthy Living. Health promotion and – prevention were defined as the process of influencing the factors that enhance or diminish Healthy Living, enabling the people themselves to advance their Healthy Living (Jacobs, 2006).

Health determinants

The project used this broad definition of Healthy Living, the lifelong process of learning on a physical, social, and mental level. Healthy Living is about the values and norms of the individual, and the social and cultural influences of his/her surroundings. Self-respect, dignity, practical support, having sufficient means at one’s disposal, undertaking activities, being in contact, and emotional support are all key issues. In the interviews with elderly people, the following questions were central themes: how do elderly peoples experience Healthy Living; what is important for them; which sources of vitality do they use; and which barriers to they encounter? The interviews were not only about sickness and health as medical topics, but also about the social, cultural, and existential dimensions of Healthy Living. At first, no specific determinants were set, because it was up to the target group to define these without being influenced by the project group.

The behaviours used in the project to discuss Healthy Living are the so-called BRAVO themes: exercise, non-smoking, less alcohol, healthier food, safe sex, safety in and around the house, and sufficient relaxation (van Mens- Verhulst & van Bavel, 2006).

Setting

The city of Rotterdam was chosen as the setting for the project, with the people of the target group living independently in the city. The choice for the city of Rotterdam is a result of the co-operation with the Municipal Public Health Care Service of Rotterdam (GGD). This project partner had great access to the target group and to organisations dealing with elderly people. The peers and intermediaries who were part of the project group were all living in Rotterdam, as were as the respondents of the interviews. The four pilot sessions took place on different locations. The first took place in a home for the elderly, the second and third in a Moroccan association's building, and the last one in a housing complex for life-course-resistant forms of living (Braakman, 2004).

Stakeholders

Aspiring to Healthy Living was developed by a partnership of the University for Humanistics, a Dutch expertise centre for domestic violence, sexual violence and questions of gender and ethnicity, and the Municipal Public Health Care Service of Rotterdam (GGD). Each of these three institutions brought something to the project. The University for Humanistics is specialised in (evaluation) research and an expert on the attribution of meaning, the art of living, and existential factors. The Rotterdam Public Health Care Service has great connections and experience in the practical field. TransAct is an organisation that coaches processes in which science and practice meet. The people of Transact are also specialists on the topics of diversity and empowerment. Representatives of these organisations were part of both the project group (those carrying out the project) and the sounding board group (management representatives). This last group also included representatives of care and welfare institutions, expert centres, and migrant organisations. This was done to create support for the intervention in the field of action (Jacobs, et al., 2005; van Mens- Verhulst & van Bavel, 2006).

Goals

The aim of the project is to develop an intervention that encourages elderly people to share their views on Healthy Living among themselves and, by doing that, to develop the mood and vitality to create a strategy for Healthy Living for themselves. It enables elderly people to discover the sources for health promotion that work for them, by listening to others and to themselves (van Bavel, 2007). "The AHL box helps them by offering materials and suggestions. These are derived from the interviews with

people from the target group. These interviews provided clear suggestions for the topics that the elderly deal with, as was expected. The final aim was to introduce the intervention in organisations that work with elderly people throughout the whole of the Netherlands, as a tool to address Healthy Living. So far, it has not been used by any organisation, although several organisations followed the available training course (about 25 trainees).”

Management structure and budgetary arrangements

The project group consisted of 14 members: 8 representatives of the target group and 6 professionals. Both the project group and the sounding board group were heterogeneous in composition. The 8 representatives (4 peers and 4 intermediaries) of the project group were diverse in gender and ethnicity, to mirror the target group. The six professionals were all autochthonous. One of them was a man, the others were women. A project leader was assigned to supervise the project group. All members of the project group were paid (van den Ende & Jacobs, 2005; van Mens-Verhulst & van Bavel, 2006). Due to delays in the execution of the project, they received an additional sum of money to compensate for the extra time spent on the project.

2.3.2 Process Evaluation Results

Target group

The target group was involved in all stages of the project, except for its designing phase. For two years, 8 representatives of the target group were a member of the project group. They were two men and two women of Dutch and Moroccan descent. The four intermediaries were a social worker, a migrant advisor of Moroccan descent, and a geriatric worker and advisor of seniors of Dutch descent. The peers and intermediaries contacted a person in their surroundings that fit the profile of the target group. They then contacted a second person, who differed on one or more characteristics (for example gender, physical symptoms, or marital status). The members of the project group interviewed 32 respondents. The intermediaries and peers received an interview training to support them in the execution of their task. They used a topic list regarding five dimensions of Healthy Living: its meaning; factors of influence; ideal and reality; expectations for the future; and its importance. Not all interviews were useable for the analyses, because they did not cover all 5 dimensions, or topics were not discussed thoroughly enough, or the peers and intermediaries (unfortunately) had been influencing the respondent by imposing their personal views on life, health and religion. Eighteen interviews were analysed: five with Dutch women and five with Dutch men, five with Moroccan women and three with Moroccan men. Six of the eight Moroccan respondents were interviewed in their native Berber language, with the interviewer acting as translator (Jacobs, et al., 2005;

van den Ende & Jacobs, 2005; Braakman, 2004, van Mens- Verhulst & van Bavel, 2006; Jacobs, 2006).

According to the project leader the diversity factor of low socio-economic status posed a problem when it came to inviting participants. “The organisations hosting the session thought it offensive to list this as a trait of the respondents. At the first pilot session that took place in a home for the elderly, 13 Dutch women were present, aged between 50 and 89 years (mostly widows). During the second and third session, Moroccan women aged between 45 and 62 years came together. The fourth session was visited by 12 Dutch men and women older than 55, who lived in a commune. The participants of the sessions decided for themselves which materials from the AHL box they wanted to use. They could also bring along materials themselves.” (Interview 4). The AHL box contains materials, working methods, and manual for groups, such as quotes, visual material, key words, vignettes, symbols, a deck of special cards, and other items (van Houten, 2005).

Theoretical foundation

The project’s theoretical foundation is the idea that elderly people must be involved in all phases and aspects of the project. The focus on empowerment leads to a participatory and dialogical approach. This means that the target group was not just invited to participate in the process, but also in the decision making (Jacobs, et al., 2005; van Mens- Verhulst & van Bavel, 2006). “Sometimes, however, this was hard to realise due to time constraints and the chemistry between people. The concepts of diversity, empowerment, and the broad concept of Healthy Living were used continuously and gave a strong (necessary) direction for the project group. The existential focus of the project was somewhat snowed under, due to the fact that the expert in the project team was unable to continue working on the project.” (Interview 4).

Health determinants

In interviews and pilot sessions, respondents were asked to give their personal view of what, for them, were important aspects within the concept of Healthy Living. Based on the interviews with Dutch and Moroccan elderly people, 15 themes were extrapolated that were used to create a deck of cards in the AHL box. Those themes were: (1) being active; (2) having pursuits or activities, having a good time with it; (3) being among people; (4) sharing stories/problems, having a good conversation; (5) having a positive outlook on things; (6) enjoying nature; (7) mental calm; (8) finding solutions for your problems; (9) getting support; (10) getting recognition or appreciation; (11) Feeling free, being as independent as possible; (12) being proud of your children; (13) doing one’s best for others; (14) what you yourself make of your life; and (15) the will of Allah.

Setting

Respondents were interviewed at their own homes. The pilot session took place on the location where those groups meet regularly (usually elderly homes which are facilitated for elderly and handicapped people). Because of this strategy, accessibility was not an issue during the project.

Stakeholders

Some important organisations were part of the sounding board group, which enabled them to have an active voice in the development of the intervention. It was not the intention, however, to involve still more organisations than during the project's execution, therefore no networking activities took place. When the intervention was completed, all relevant organisations were informed about the possibilities of the AHL box and the training courses.

Strategies and methods

During the first phase of the project, the framework for the AHL box was created, using in-depth interviews with representatives of the target group. These results were used to create the content of the AHL box. These contents were reviewed by the peers and intermediaries of the peer group, professionals of welfare organisations, as well as later on, in pilot sessions. The box contains four decks of cards (one for each group of gender/ethnicity combinations), with exercises that address questions like 'I am proud at myself for ...', and 'I get energy from'. Vignettes and health portraits were developed, too. Some materials were found to be too linguistic for the Moroccan elderly. Therefore, new, visual material was added (van Mens- Verhulst & van Bavel, 2006).

According to the project leader the supervisor of the 'Zest for Healthy Living' meetings is not an advisor, but more of a coach. The most important thing is to enable the participants to tell their stories and acquire their own experiences. The supervisor does not dispense information, but leads the meeting, thus enabling the elderly people to find out for themselves what they think and want. During the meeting, the supervisor continually focuses the attention of the group on the following questions: what does healthy living mean to you personally? At this moment, what do you do to live a healthy life? What goes well, and what is hard to do? What would you want to be different? What do you need for that?

Changes

Yes, see other paragraphs for specifics.

2.3.3 Outcome Evaluation Results

Evaluation

A qualitative evaluation of the project took place. A member of the project team acted as observer during pilot sessions, and interviewed members of the project group and respondents of the target group. No data about the effectiveness of the intervention were collected. The project aims to stimulate the elderly people to really think about Healthy Living, which is hard to measure in the view of the project group. TransAct is currently looking into the possibility to test the effectiveness of the intervention on a national level (van Mens- Verhulst & van Bavel, 2006; van Bavel, 2007).

Based on the minimal qualitative evaluation it is concluded that the AHL box is a successful intervention. It was recommended to disseminate the intervention and to train the people from organisations using the AHL box. The contents of the AHL box had to be slightly adapted as a result of the intervention (changes were, for example, to include facts in clear and understandable language, and to pay more attention to the effects of a being a migrant) (Braakman, 2004; van Bavel, 2007).

Outcomes concerning cost-effectiveness

“The project resulted in a good intervention. It is unfortunate that the financing of this type of projects focuses on their development, but not on their dissemination. The lack of funds for supervising the dissemination process is a big obstacle.” (Interview 4).

Effects on health

According to the project leader the project group is under the impression that participants live their lives in a more conscious manner (although this can not be supported with data from the qualitative evaluation), and that they make conscious choices with regard to Healthy Living. Five strategies for healthy living can be discerned: acceptance; changing one’s mind; not listening to stories/ distancing oneself / putting matters into perspective; and sharing stories /looking for help and support / actively trying to change one’s own behaviour or the situation.

Sustainable effects

“Unknown.”

Transferable effects

At the project’s conclusion, the project team has consulted all sorts of professionals, who might use this material in their work. When asked what they thought of the AHL Box and whether or not they were interested in it, almost everybody answered that

they had a positive opinion, both of the idea behind the Box and of the option of using it (van Bavel, 2007).

The AHL box can be used by all organisations in the Netherlands that work with the elderly. It is recommended that they follow a training course, where they learn how to stimulate, facilitate, and support the group, instead of issuing information, as they usually do. Furthermore, they are made aware of the diversity aspects involved in discussing Healthy Living. In 2006, approximately 25 people completed the training. It was cancelled in 2007, due to a lack of interest. It is unknown how many organisations are currently using (part of) the AHL box. It was clear, however, that organisations found it difficult to implement the intervention.

Public recognition

The project received no awards, but project group members repeatedly published articles in professional and scientific journals. In addition, researchers from the University for Humanistics who were not involved in the project itself, used the project's experiences and data for their articles. The presentation of the results on conferences elicited a positive response, although adherents to regular methods for health promotion and quantitative researchers were a bit more critical.

Consumer satisfaction

Participants appeared to be enthusiastic about their participation and experienced talking about Healthy Living as liberating, this was observed and concluded by the researcher that carried out the qualitative evaluation and the supervisor of the intervention that met with the groups.

Empowerment

Participants appeared to be empowered because they were strengthened in their ability to make grounded choices for Healthy Living, this was observed and concluded by the researcher that carried out the qualitative evaluation and the supervisor of the intervention that met with the groups.

3 Conclusions

3.1 Recommendations for Successful Health Promotion for Older People

Concerning structures

An important strength concerning the structure of Big!Move is that both the vision on health promotion and the Big!Move method are embedded in organisational and financial arrangements. A Big!Move Institute has been founded for the dissemination of the vision and the method. Another strength is the cooperation with different stakeholders. Furthermore, new opportunities for structural implementation and for financing the programme have arisen with the implementation of the new Social Support Act and the inclusion of prevention in health insurance in the near future. However, with regard to the new Act, a lobby is necessary to exert influence on the priorities and activities that will be financed (the new law will be implemented by the municipalities and each municipality will have its own priorities).

The selection and recruitment of well-qualified volunteers is crucial to the Buddy Care project. Yet, supporting and coaching these volunteers is even more important. In part, this is done by voluntary workers as well.

The low-cost set-up of the buddy system makes it easily transferable to other locations.

A strength concerning the structure of the Aspiring for Healthy Living project is that partners from different organisations have been involved in the project. Each of them brought a unique and essential skill or knowledge to the project team. The University for Humanistics is specialised in (evaluation) research and an expert on the attribution of meaning, the art of living, and existential factors. The Rotterdam Public Health Care Service has great connections and experience in the practical field. TransAct is an organisation that coaches processes in which science and practice meet. The people of Transact are also specialists on the topics of diversity and empowerment. It still proved to be difficult to find elderly people for interviews and pilot locations to test the AHL box through the networks of these organisations.

Concerning processes

Strengths concerning the process of Big!Move are the initiators' personal and professional drive, a broad vision on health and health promotion, and the fact that the emphasis is on participation and empowerment. Strong points with regard to the method are access to the programme through the general practitioner; the intake with the aid of a standardised health profile form; the involvement of the patient/participant; a matching of health status and personal goals with group

activities; the Health and Behaviour File; the activating approach; an emphasis on the person, on health, having fun, and empowerment.

A careful intake is an important strength in the process of Buddy Care for the homosexual elderly. During the intake of new clients, the needs of the elderly people are sorted out extensively. After that, meeting these needs is at the heart of the buddy contact. For the buddy, it is essential that there is room to carefully decide for or against taking on a particular client. Making a good match is the first matter of importance. The buddy system is suitable for embedding in care- and welfare institutions for the elderly.

In the Aspiring to Healthy Living project, the development process has been strengthened by a clear definition of the concepts of diversity, empowerment and Healthy Living, along with a model of Participatory action research to guide the actions of the members of the project group that involves representatives of the target group in all phases of the project. Involving representatives of key organisations in the sounding board group provided the opportunity to create an interest for and awareness about the intervention.

Concerning outcomes

In Big!Move, a standardised scientifically-based health profile and a Health promotion file make it easier to evaluate outcomes. (Short-term) outcomes show demedicalisation (less visits to the general practitioner and physiotherapy), more pleasure in exercising, empowerment, and more social participation. It is difficult to establish effects on QOL and long-term effects. The health of these socio-economically disadvantaged and migrant groups is generally worse than that of the population in Amsterdam and shows no improvement. Perhaps the programme is too short to reach sustainable effects. Longitudinal evaluation research is necessary (and will need extra funds).

In the evaluation of the Buddy Care for the homosexual elderly, it turned out during the process that imposing a goal like activation often does not correspond with the needs of the elderly concerned. This was subsequently revised.

A cost effectiveness analysis of this project could clarify the financial return of the project, because it causes the elderly to make a delayed appeal to professional care services.

In the Aspiring to Healthy Living project, the willingness of the members of the project team to follow the model of Participatory action research makes sure that the intervention is based on, and is a response to, issues that arise when discussing healthy living with elderly people.

The aim of the intervention is merely to make the elderly aware of the possibilities and obstacles of Healthy Living; to encourage them to live their lives in a more conscious manner, and to make conscious choices with regard to Healthy Living. The AHL box is a tool that can be used by all organisations working with the elderly, as an

addition to their regular programs. The AHL box is now available to all Municipal Health Services and other organisations working with the elderly. A training course is provided for people and organisations wanting to work with the AHL box. Several people have been trained, but no organisation has used the AHL box so far. The project team was funded to develop the AHL box, but there was no funding available to facilitate the dissemination and continuance of the project.

3.2 Specific Recommendations for Project Aims

- Develop a collective (scientifically founded) vision on health and health promotion as the foundation of both the organisation and the programme's content. Develop instruments based on the vision. Derive indicators for determining the intended effects from this vision. Adjust the organisational structure and the financial structure to the vision and the method.
- Especially for these target groups, the entrance to the programme should be provided by the GP (and for elderly people in particular, by the home for the elderly).
- Build on individual needs, possibilities, and personal goals.
- A broad vision on health, an emphasis on having fun, and on the effects of empowerment and social participation.
- A buddy system can work well when the objective is to counteract loneliness and social exclusion among different groups of elderly people. For this, however, a number of conditions must be met: well-qualified voluntary workers must be found, who are willing to act as a buddy for a substantial part of their time; a solid professional coordination must be set up, that takes care of making contact with care- and welfare organisations for the elderly; and, last but not least, a careful matching of buddy and client must take place, since a good personal contact between buddy and client is at the heart of the project.
- During the development and execution of the programme, all relevant partners, including representatives of the target group and the necessary experts, should be represented and should be able to make their contributions in all phases.
- Both the embedding in practice and the cooperation of the organisations that are to carry out the method are essential. Therefore, an intervention or programme should not only be developed on the basis of a scientific model, but also on the basis of the everyday practice supported by the organisation carrying out the programme by means of its policy.
- During this process, the opportunities for representatives from the target group to make their contribution should be monitored continuously. They should be presented with methods and approaches that fit in with the competences and

living environment. Finally, it is important that there will be funding for the implementation and dissemination of the method as well.

4 References

Bakker F., & Fokkema, T. (2006). Effectiviteit van de Schorer Buddyzorg voor homoseksuele ouderen in een sociaal isolement. *Tijdschrift Sociale Geschiedenis* 84 3, pp. 151-159.

Bakker F., & Vanwesenbeeck, I. (2004). *Waarderings- en effectonderzoek naar de Schorer buddyzorg voor homoseksuele ouderen in een sociaal isolement*. Utrecht: Rutgers Nisso Groep, 2004

Bakker, F., Vogelsanger, A. en Fokkema, T. (2003). Buddyzorg voor homoseksuele ouderen in Amsterdam. *Gerōn*, 5, 2003, 4, p. 63-67.

Bavel, M. van (2007). *Verslag vervolg project Zin in Gezond Leven ten behoeve van implementatie ZGL-koffer* (internal document). Movisie, Utrecht.

Bavel, M. van, & Scherpenzeel, R. (2006) Abstract van de poster Zin in Gezond Leven. *Tijdschrift voor Gerontologie en Geriatrie*, 37, 26-27.

Braakman, M. (2004), *Evaluatie proefinterventies Zin in Gezond Leven*, Utrecht, University for Humanistics.

CVZ (2007). *Essaybundel: van Preventie verzekerd. Acht invalshoeken op preventie en de verzekerde zorg*, 13-25. Diemen: College voor Zorgverzekeringen.

Engelberts, J., & Beentjes, B. (2006). Big!Move gaat uit van kracht. *Vraag in beeld*, 3, 4-5.

Ende, T. van den, & Jacobs, G. (2005). 'Waarde(n)vol onderzoek : onderzoekers en hun dilemma's in een participatief onderzoeksproject' in: *Tijdschrift voor Humanistiek* 6 (22) (July), pp 29-45.

Fokkema, T., & Tilburg, T. van (2006). *Aanpak van eenzaamheid: Helpt het? Een vergelijkend effect- en procesevaluatieonderzoek naar interventies ter voorkoming en vermindering van eenzaamheid onder ouderen*. The Hague: NIDI.

Houten, D. van (2005). Interactieve gezondheidsbevordering van ouderen. *Geron*, 7, 52-55.

Integron (2005). *Tevredenheidsonderzoek Schorer Buddyzorg* (2005). Rotterdam: Integron BV.

- Jacobs, G. (2006). Wij blijven alle problemen verzamelen. Gezond leven, migrantenouderen en empowerment. *CMG*, 3, 88-100.
- Jacobs, G. (2005). Participatie en empowerment in de gezondheidsbevordering. Professionals in de knel tussen ideaal en praktijk? *Sociale Interventie*, 6, 29-39.
- Jacobs, G., Braakman, M., & Houweling, J. (2005). *Op eigen kracht naar gezond leven. Empowerment in gezondheidsbevordering: concepten, werkwijzen en onderzoeksmethoden*. Utrecht, University for Humanistics).
- Jong Gierveld, J. de, & Kamphuis, F.H. (1985). The development of a Rash-type loneliness-scale. *Applied Psychological Measurement*, 9, 289-299.
- Meerendonk, B. van de, Adriaensen, R., & Vanwesenbeeck, I. (2003). *Zorgbehoeften van en zorgverlening aan lesbische en homoseksuele ouderen in Nederland*. Utrecht/Amsterdam: Rutgers Nisso Groep/Schorerstichting.
- Mens-Verhulst, J. van, & Bavel, M. van (2006). Marokkaans of vrouw? Over variatie in opvattingen over gezond leven onder oudere vrouwen en de mogelijke consequenties daarvan voor gezondheidsbevorderende interventies. *Tijdschrift voor Humanistiek*, 7, 86-96.
- Overgoor, L., Aalders, M., & Statius Muller, I. (2006). Big!Move, beweging in gedrag van patiënt en huisarts. *Huisarts en Wetenschap*, 49, 42-45.
- Overgoor, L., & Aalders, M. (2004). *Big!Move. Evaluatieverslag april 2003 – juni 2004*. Amsterdam: Gezondheidscentrum Venserpolder.
- Overgoor, L. & Aalders, M., & Reitsma, S. (2007). *Evaluatieverslag verspreiding Big!Move in opdracht van Agis op drie locaties*. Amsterdam: Big!Move Institute.
- Wieringen, J. van, & Thomas, R. (2006). *Verslag evaluatiestudie GG/ZZ Venserpolder*. Amsterdam: Gezondheidscentrum Venserpolder.

Appendix Interviews

Interview 1: One of the initiators and coordinators of Big!Move and one of the supervisors who also coaches elderly groups t(gether)

Interview 2: The coordinator of Buddy care for the homosexual elderly

Interview 3: A buddy of the Buddy care project

Interview 3: The project leader of Aspiring to Healthy Living