Evidence-based Guidelines on Health Promotion for Older People:

Social determinants, Inequality and Sustainability

33 European Best-Practice Projects: A Case-Study Evaluation of Health Promotion for Older People

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Introduction

Healthy aging has been a key issue in political discussions in the last years. Health promotion is one of the main strategies to improve the physical, mental, social, and spiritual health of older individuals and groups since the WHO Ottawa Charta was written in 1986. Older people can – with successful health promotion interventions – be empowered to lead a healthy life, increase their social contacts, stay physically mobile and live independently.

There has been a long tradition of health promotion interventions in Europe in the last decade. Many Member States have implemented regional or national health promoting interventions for older people. This report summarizes the main factors of success of 33 best-practice examples from eleven Member States which were elaborated in the healthPROelderly project (2006-2008). The purpose of this report is to identify the key factors for successful health promotion for a target group as heterogeneous as the group of older people (50+).

For this purpose an evaluation concept was developed which brings a pluralistic evaluation and a case study approach together. Eleven European partner countries selected three national best-practices for older people and analysed existing material and conducted interviews with key persons of the health promotion projects.

A detailed description of the evaluation design, its aims, the concept and the methods is provided in *chapter 1* of this European evaluation summary report. *Chapter 2* gives an overview of the national selection procedures of the best-practice examples and highlights initial details of the European sample of 33 health promotion projects for older people.

Whereas chapter 2 gives an overview of the projects, *chapter 3* gives a detailed description of the results of all national case studies in three major sub-section: *Section 3.1* results from the structures of the projects, e.g. target group, theoretical approaches, health determinants, settings, goals and management aspects (including financial structures). *Section 3.2* deals with the implementation process again by a number of categories such as target group activation and involvement, theory implementation, accessibility of settings, stakeholder involvement and the use of health strategies. *Section 3.3* reports the outcome evaluation characteristics which are presented by a methods description, cost-effectiveness aspects, health effects, sustainability and transferability of the analysed projects, etc.

The conclusion of these results can be found in *chapter 4* and deduce aspects for successful health promotion for older people in general and under specific facets of the healthPROelderly project which looks more specifically at health determinants, sustainability, and social inequality.

We want to thank all project partners of the healthPROelderly project for their important contributions. In addition we especially want to thank all involved representatives of the 33 health promotion projects. The rich insights were only possible due to their active contributions.

We hope that these evaluation results of successful health promotion projects will be a valuable information source and will build an evidence basis for the development and implementation of further health promoting activities for older people in the future.

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1 Evaluation design: aims, concept and methods

1.1 Aims of the project and the evaluation phase

The main aim of the healthPROelderly project is to develop evidence-based guidelines on health promotion for older people. The evaluation of existing health promotion projects, initiatives and programs can contribute a lot – as we are convinced – to such a compilation of guidelines. Hence the aim of this evaluation report – which is based on eleven national evaluation reports – is to show how and to highlight which elements are of importance in current health promotion practices for older people.

In the structure of the healthPROelderly project the collection and the analysis of European health promotion literature for older people formed the first step (Phase 1). Secondly, the project collected good-practice examples in the field of health promotion for the aged and categorised them according to a scheme with 16 quality criteria of health promotion for older people (Phase 2). Then, the Evaluation Phase of best-practices (Phase 3), followed. Based on the evidence-based results of these three project phases and amended by the project's International Conference (Phase 4) the aim is to deduce guidelines for practitioners and policy (makers) in last project phase (Phase 5).

This report is the European summary report of Phase 3 of the healthPROelderly project.

The specific objectives of the Evaluation Phase of healthPROelderly are

- to define a set of methods to be used when evaluating and identifying the models of best-practice,
- to identify the most relevant and successful models of best-practice (with the focus on vulnerability, sustainability and inequality) and
- to define evaluation methods and tools (Grant Agreement, 2006, p. 54).

1.2 Initial remarks on health promotion evaluation

Health promotion evaluation is an assessment of the extent to which health promotion actions achieve a "valued" outcome (WHO, 1998). Hence, the extent to which health promotion actions enable individuals or communities to exert control over their health represents a central element of health promotion evaluation. But in real-life of health promotion it is sometimes difficult to trace the pathway between particular health promotion activities and health outcomes. This may occur for a

number of reasons, e.g. because of the difficulty of isolating causes and effects in complex situations.

In many cases “value” is also placed on the process by which different outcomes are achieved. In terms of valued processes, evaluations of health promotion activities may be participatory (involving all those with a vested interest in the initiative), interdisciplinary (by involving a variety of disciplinary perspectives), integrated (into all stages of development and implementation of a health promotion initiative) and helping to build the capacity of individuals, communities, organizations and governments to address important health problems.

In addition, each evaluation contains two major elements, (i) the identification and definition of the ranking of criteria (values and aims) and (ii) the collection of data. These data are used to assess whether or not the criteria are actually executable (Peberdy, 1997, p. 269). Therefore, according to Vedung, evaluation research shows limits and merits of interventions. It can answer the questions: “*How can the intervention be improved?*” or “*How can it become more effective, service-oriented, adapted to the client’s concern and needs?*” Evaluation research is used for guiding future events and processes (Vedung, 2004, p. 124). Evaluation research is the basis to show which health promoting initiatives and measures are successful in reaching their aims. Due to evaluation effective practices can be differentiated from ineffective measures. Effective measures can be adopted by others.

Therefore evidence-based health promoting practices are needed. From the WHO point of view evidence-based health promotion presents “*the use of information derived from formal research and systematic investigation to identify causes and contributing factors to health needs and the most effective health promotion actions to address these in given contexts and populations*” (Smith, Tang, & Nutbeam, 2006).

It is important to highlight that evaluation research has to take into account that health cannot easily be quantified (Loidl-Keil, 2006, p. 21). Evaluations have to be oriented towards the practical context of the target group, which means the social world of older people in this case. On the other hand evaluators have to keep in mind that any intervention can only contribute to the reduction of social problems (e.g. poverty, crime, mental health disorders), but cannot fully banish them (Shadish, 1990, p. 162). Changes in one’s health behaviour are almost always determined by several different sources. Direct effects are hard to show and hard to assess[1].

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[1] In order to carry out an evaluation, certain premises have to be taken into account. Kirschner, Elkeles and Kirschner (2006, p. 87) claim that a programme has to have clearly defined goals, identifiable measures, some kind of documentation, and a defined amount of time and financial resources. Looking in detail at one or the other intervention can have interesting facets.

Health promotion interventions, projects and programmes include several stakeholders who have different kinds of interest of the project. Nevertheless, various stakeholder groups have different interests, priorities and – last but not least – understandings of what constitute success. For instance users, carers, patients, funding institutions, researchers or managers have their own needs and perspectives on an intervention.

One specific approach which takes all the mentioned aspects into account is the *pluralistic evaluation approach*. Pluralistic evaluation seeks to take several stakeholder views into account by using success criteria from different stakeholder views and by the use of methodological triangulation (see below). "*The pluralistic approach acknowledges that each service is unique and that uncontrollable variables do exist in the care context*" (Hall, 2004, p. 24). It is a meaningful measure of success pursuing all potential interest groups. It is also acknowledged that professional knowledge and views do not always fully reflect the success or the limitations of an intervention. Hence, user perspectives should contribute to evaluations because excluding users from evaluation research means not achieving a pluralistic and thus realistic view of a health promotion project. The outcome of such pluralistic evaluations are real, deep illustrations of projects and success as defined by the various stakeholder groups.

1.3 Evaluation concept adopted

The objective of this phase of health*PRO*elderly is to evaluate existing health promoting projects for older people across Europe. The selection of projects is described with the terms "relevant" and "successful".

In Phase 2 of the project app. 167 good-practice examples from eleven European countries were collected. This is a relevant sample of health promoting projects in the participating European countries. All health promotion projects were classified by 16 quality criteria gained from the analysis of health promotion literature for older people carried out within the health*PRO*elderly project. Each partner had to choose three health promotion projects per country (in total 33 health promotion cases) and a case study approach was chosen for evaluation.

A case study is an "*in-depth examination of a social unit, such as an individual, family, household, worksite, community, or any type of institution as a whole*" (McKenzie, Neiger, & Smeltzer, 2005). According to the definition of Scott and Marshall, a case study is "*a research design that takes as its subject a single case or a few selected examples of a social entity* […] *and employs a variety of methods to study them. The criteria which inform the selection of the case or cases for a study are a crucial part of the research design and its theoretical rigour. Case studies*

include descriptive reports on typical, illustrative, or deviant examples; descriptions of good practice in policy research; […]; *studies that focus on extreme or strategic cases* […]" (Scott & Marshall, 2005, p. 54).

A variety of methods can be used in order to carry out case studies, while qualitative methods are on the fore, since they provide the necessary depth and openness for evaluation research. (Methodological) triangulation, an idea put forth by Norman Denzin in 1970 (Denzin, 1970, 1989), means bringing in a variety of methods and data to bear upon one problem or case (Flick, Bohnsack, Lüders, & Reichertz, 2008; Trend, 1979, p. 84).

In this application the basis for the case studies of good health promotion practices form the collection of health promotion projects (online database, see phase 2). Each project is represented by descriptions of national models, projects or interventions of health promotion for older people from 11 countries with 16 inclusion (quality) criteria[2]. Also pluralistic evaluation easily goes hand in hand with the case study approach. Looking at one particular case (i.e. a health promotion project) from different perspectives is aimed at in health*PRO*elderly. A case study is understood as an in-depth study of a single case in order for the researcher to grasp the striking and most characteristic distinguishing features of the case (Campbell, 1979).

1.4 Overall evaluation research questions

The basic idea of the evaluation of health promotion projects here is to find out *why* the selected project examples were successful health promoting cases, which outcomes they brought, how they were reached and in which way the framework conditions contributed to the success of the health promotion projects. Furthermore it was defined to find out *which* of the quality criteria were the most important and *how* they were implemented into practice?

Table 1: Overall Evaluation Research Questions

1. **Why** was the selected example a successful health promoting project?
    a. **Which** outcomes were reached? (*outcome evaluation*)
    b. **How** were the outcomes reached? (*process evaluation*)
    c. **In which way** did the framework conditions contribute to the success of the selected example? (*structure evaluation*)
2. **What** are the most important inclusion criteria[3] in the selected example?
3. **How** were the inclusion criteria implemented?

[2] Accessible at www.healthPROelderly.com/database (18th of March 2008).
[3] A list of 16 quality criteria and their explanation is provided in the Annex

In addition, the evaluation framework consists of the following basic evaluation points, namely the structure, the process and the outcome evaluation. In terms of a (health promotion) project (a) the structure relates to the development and the planning phase of a project, the (b) process evaluation relates to the implementation of a project into practice and (c) the outcome evaluation relates to the achieved results and sustainability (e.g. documented by the evaluation) of the project[4].

Accordingly the overall aim of the Evaluation Phase is not to show that an effect has been achieved, but to find out, ***how*** *the effect has been achieved (e.g. strategy, project design, target group) and why it was successful (e.g. success stories, interviews, numeric data). The intention is not to measure the effects of health promotion projects and initiatives but to collect, analyse and compare existing and evaluated results in health promotion for older people.*

1.5 Step-by-step working process

To reach the goals of the evaluation phase a step-by-step working process was decided on. In the healthPROelderly consortium it was agreed to define the evaluation criteria and project selection procedure in a *first step*. *Secondly* the specific evaluation research questions were defined and in the *third step* the necessary evaluation methods and tools (toolbox) were developed. The *fourth step* was the data collection and analysis of the evaluation data which were presented in eleven National Evaluation Reports.

1.5.1 Set of methods and tools

The evaluation literature claims that both quantitative and qualitative methods should be used in evaluation research. Filstead and Vedung also suggest consulting several data sources (Filstead, 1979; Vedung, 2004, p. 114). The qualitative methods provide the context of meanings in which quantitative results are to be understood (Filstead, 1979, p. 45). In the course of the evaluations of health promotion initiatives it was important to stay close to the contextual world of the people in the actual projects, therefore qualitative methods were chosen as more important in this working phase (and quantitative results from existing evaluations were considered).

[4] When thinking in terms of guidelines and recommendations and those practitioners in the health and social sector who will convert this structure for practical projects (structure, process and outcome), this information gained from evaluation will help make evaluation results transferable into practice.

The following reactive and non-reactive instruments were selected for evaluation purposes[5]:

- *Document Analysis*: The tool followed a reduction process in three steps. Texts from original documents (e.g. evaluation reports, final reports, website texts) were reduced to a minimum – extracting the most important contents. The template for this tool was an excel sheet. It was used in the national language of the respective project (in order to stay close to the contextual world and *actual words* of the project's reports).

- *Qualitative Interviews*: After having carried out the document analysis all partners carried out qualitative interviews with key persons from the health promotion projects (e.g. key researcher, manager, and older people). For this purpose a semi-structured interview guide was developed containing the research questions[6] (see above). It also included a protocol (date, time frame of the interview etc.) and basic instructions for interviewers. All interviews were carried out in the national language of the interviewees. The interview guide was structured according to the research questions: structure, process and outcome evaluation questions. All interviews were taped and transcribed afterwards. 2-3 interviews per case were defined as minimum per healthPROelderly partner.

- *Cost-effectiveness Analysis*: Where possible a cost-effectiveness analysis was carried out in 7 steps. Data was drawn from documents and also from interviews. A large number of documents and reports did not include concrete numbers about the project's cost-effectiveness. The analysis follows the cost-effectiveness analysis of McKenzie et al. (2005).

- *SWOT-analysis*: The SWOT-analysis was used as a summarizing tool at the end of the data collection phase. With the help of the 4 items (strengths, weaknesses, opportunities and threats) the results of the three case studies were integrated in a brief 2 by 2 table. All partners used this tool which was provided in a word format.

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[5] A list of all evaluation tools is also provided in the annex (chapter 5).
[6] Not all questions had to be asked in the actual interviews. If questions had already been answered before by the document analysis these specific questions were left out in the interview, to save time.

1.5.2 Data collection and reporting

Data collection took place from October 2007 until January 2008. Each participating country had to choose three health promotion initiatives and evaluate them according to the healthPROelderly evaluation outline and research questions. All results were summarized in National Evaluation Reports. These eleven national reports serve as the basis for the European Evaluation Report at hand[7].

All reports have the same structure and are arranged in national selection procedure, short presentation of the three cases, and structure, process and outcome evaluation results. Also, all reports include specific recommendations for health promotion for older people in the end of the report. The average page number is 30 pages, the longest being 41 pages and the shortest 19[8].

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[7] For a list of all National Evaluation Reports see the references section (chapter 6).
[8] All National Evaluation Reports are available online at the project's website www.healthproelderly.com (13. June 2008)

2 Overview of the evaluated health promotion cases for older people

2.1 National selection procedures

Selection of the three best practice projects

Health promotion cases were selected on the basis of the Online Database of good practices in health promotion developed in 2007 (www.healthproelderly.com/ database) within the second phase of health*PRO*elderly. 167 projects were included in the database and described according to relevant administrative criteria, like duration, executing organisation, and contact details, but also according to content criteria (16 inclusion criteria), like sustainability, gender, theoretical background, transferability etc.

Each partner country chose three of their national project entries from the database for further evaluation (i.e. 33 best practice initiatives). This was done using a ranking system, whereby points were assigned to each project. The final selection was not based on a fixed procedure because some countries had many projects and other sonly had a few.

In the course of the evaluation five partners stated that they chose those initiatives with a large number of points – those that scored high in the national selection procedure. Three partner countries chose initiatives which fulfilled the most inclusion criteria, e.g. the Netherlands only selected initiatives with at least 10 out of 16 inclusion criteria. Most partner countries selected their best practices with the help of the scoring system but also in a second step with regard to themes. In the Czech Republic diversity was a crucial issue, in Austria gender was the main criterion to include the third project (the first two were chosen by high score), and in the UK projects were picked because of their focus on socio-economic and ethnic inequalities. Two partners discussed their choice of projects with the experts of their National Board (Germany and the Netherlands).

Initiatives were also chosen with respect to the criteria (1) evidence-based project, (2) innovative project, and (3) project with a broader focus. Three countries explicitly state choosing projects according to this scheme: The Netherlands picked two evidence-based projects and one innovative one. Italy and the Czech Republic selected one project out of each category.

Methods used to evaluate the case studies

All partners used the document analysis and the semi-structured interview guide in their analyses for all selected case studies. The SWOT analysis was also used by all

partners at the end of the evaluation phase as a summary tool. Because there were many difficulties in getting information about final and detailed costs of the projects not all partners de facto applied the cost-effectiveness-analysis. In total the data basis of this report are 33 document analyses, 33 SWOT-analyses, 70 semi-structured interviews, and 4 cost-effectiveness analyses.

Document analysis

Mainly partners analysed project reports (annual, final, progress, and interim reports). Some additionally had evaluation reports at hand since the selected cases had already been evaluated before (United Kingdom and the Netherlands). Supplemental to these documents, other types of literature and publications were included in the analysis: leaflets, books, journal articles, grey literature, proceedings, monographs and newsletters. It was possible for all partners to resort to evidence-based documents (evaluation reports, final reports, scientific journal articles). In addition several other audio-visual media were analysed by the Eastern European countries (Poland, Slovakia and the Czech Republic): DVD's, CD's, and a website.

Semi-structured interviews

All partners carried out interviews with key persons from the health promotion initiatives they selected. Key persons were defined as key researchers, managers, coordinators, older people themselves, and other relevant stakeholders.

In total 70 interviews were performed during the evaluation period.

Table 2: Number of Interviews by Country

Country	Freq
Slovenia (SI)	12
Poland (PL)	9
United Kingdom (UK)	8
Czech Republic (CZ)	7
Germany (DE)	7
Italy (IT)	6
Austria (AT)	5
Netherlands (NL)	5
Slovakia (SK)	4
Spain (ES)	4
Greece (GR)	3
Total	**70**

A considerable number of interviews (23%) were performed by telephone. The key persons of the *interviews* were researchers, coordinators and managers, initiators and founders, and older people themselves. Initiators and founders had most of the information on costs and benefits of the health promotion initiatives, while coordinators and managers knew most about structures and processes of the interventions. Older people themselves also added a valuable perspective to the evaluation results.

Four partners performed a *cost-effectiveness-analysis* (CEA) in the course of the evaluation phase (Greece, Poland, Italy, Slovenia). In all other countries there was no data on costs of the intervention and interviewees were not able to make solid statements on the topic of costs.

The *SWOT-analysis* was used by all partners as a summarizing tool at the end of the evaluation phase in order to collect strengths, weaknesses, opportunities and threats again. The results are listed in the conclusions section of this report.

3 Results of the national case studies

The aim of the selection of the N=33 cases for older people was to have an optimal sample of health promotion projects in total. Each partner healthPROelderly partner selected three health promotion projects. A mapping of an initial categorisation of all these 33 cases resulted in the final project sample[9].

The 33 cases are well distributed across the time frame between 1996 and 2007. Many of them already started at the beginning of this century. 23 out of 33 cases started after the year of 1999 (2000-2003: n=10 projects; 2004-2007: n=13). 17 out of 33 projects are still running (on-going), 6 projects finished in 2007 and the rest even earlier. A large number of projects are run by a non-profit organisation (82%) and/or a public organisation (67%). Only a smaller number of projects are in the hand of private/profit organisations.

Two thirds of the projects were initially classified as evidence-based, established models on health promotion for older people (64%). 8 out of 33 cases are innovative projects for the target group (24%) and the rest of the projects address a broader theme (interesting lessons to be learned for health promotion of older people). In addition health promotion projects can be described preliminarily by their focus on health aspects. The selection of health promotion projects for older people covers all three different aspects of health very well: about 20 cases cover either physical health aspects (i.e. life-style factors), mental or social aspects of health. In other words most of the projects address several aspects of health.

3.1 Structure evaluation results

3.1.1 Target group definition

Very often the target group of the analysed health promotion projects is defined by its age. Of all age groups of the projects there are two distinctive features: First of all there are not so many projects for the youngest group of older people and there are not many projects especially for very old populations. Secondly, most of the projects have a target group between 55 and 65 years of age.

In addition many projects define their target group with certain group characteristics. Hence, only 8 out of 33 projects aim at the general population without further group characteristics. “Invisible” older people are chosen most often whereas invisible is often defined as older people who cannot participate fully in society, who live alone,

[9] A description of all 33 cases is also provided in table 8 & 9 in the Annex (chapter 5).

who are socially isolated [PL-1], who suffer from feelings of loneliness [NL-14] or cognitive issues [UK-1].

Furthermore there are lots of projects who define disadvantaged groups (12 out of 33). Then they have mainly educationally, economically, socially or geographically disadvantaged older people as their main target group [e.g. AT-16, ES-5, NL-14, NL-21, UK-3]. Because invisibility and disadvantage is often associated with frailty of older people 11 out of 33 additionally cover frail older people or those who are at high risk of falling [UK-5].

Surprisingly, about 40 per cent are health promotion projects which especially cover gender aspects (14 out of 33) and if so, there are more projects for older women than for men. In addition, there is also a project from the Netherlands which addresses older homosexuals [NL-14].

Furthermore eight European projects specifically cover older people from ethnic minority groups (migration groups) and three other projects have other target group characteristics (e.g. the experience of a critical life-event).

Table 3: Target group of health promotion projects

Age	Freq
Not defined	*1*
50+	*6*
55+	*7*
60+	*11*
65+	*8*
70+	*0*

Group Characteristics	Freq
General population (none)	*8*
Invisible groups	*14*
Disadvantaged groups	*12*
Frail older people	*11*
Gender (female/male)	*10/5*
Migrants, ethnic minorities	*8*
Other specific groups	*3*

3.1.2 Theoretical foundation

The analysis of the theoretical background of health promotion projects is very challenging. The reason lies in the scientific width of different approaches and in the broad variety of practical applications. Another reason is that the 33 cases are examples from practice and no scientific projects.

But by analysing the 33 European health promotion projects the above mentioned reasons become evidence. There is such a huge spectrum of scientific disciplines and practitioners involved in health promotion that a compact categorisation must fail. Therefore only the most apparent aspects will be discussed.

Some projects really build their practice projects on concrete theories. However, these projects are relatively seldom in comparison to projects which only use elements of theories (or theoretical premises) [e.g. AT-16]. Other projects construct

their projects on theoretical relations (theses and hypotheses). Well scattered are projects which focus on already tested empirical findings.

One can conclude that the only common denominator of the 33 project is that all want to promote health of older people. But this conclusion is too broad and unspecific because there are other underlying aspects, which are related to theoretical assumptions, e.g. the theoretical model in the background of a project. There is countable evidence that projects focus at (more or less only) one aspect of health and this can be the physical [PL-2, SK-1, UK-5], the mental [UK-1] or the social part of individuals' health [e.g. PL-1, SI-2]. In addition there are also approaches available which we call holistic because they work on more than one of the three aspects (or on all three elements of health) [e.g. NL-21].

In addition, another important theoretical facet of the projects is whether they "only" want to promote the health of individuals or if they want to promote a certain health determinant or even several health determinants (e.g. life-style). These approaches are very close to the individual but there are also projects which deal with health promoting structures. The underlying theoretical assumption is that healthy environments and structures simultaneously promote health because individuals are important part of these structures. Again, some health promotion projects for older people also cover the macro level. A smaller number includes both, the (macro or societal) structure (culture, norms, values; national and local policy; organisational and service structures; family, friends, acquaintances etc.) and individual – the micro or behavioural level (awareness, attitudes, knowledge, behavioural intention, health behaviour etc.).

3.1.3 Health determinants

According to Dahlgren/Whitehead (1991), at the individual level health outcomes and effects can be observed and the massive existence of health inequalities is present. For instance health has different levels when analysing it by age, sex and other constitutional factors. But health is not only a factor of age and sex. Moreover health (note: health is understood here as the existence of physical, mental and social health) is effected first of all by individual life-style factors such as physical activity, nutrition, alcohol consumption, smoking etc. But because human beings are not only a biological organism health in its broader sense is also created by the social environment they live in. Because individuals are additionally social beings they have to interact with other people in their community and social networks are very essential for their health. Especially their networks consist of family members, friends and acquaintances which play a major role for the development of (mental and physical) health. Moreover, individuals and social and community networks are surrounded by general socioeconomic, cultural and environmental conditions such as

education, living and working conditions and all kinds of production (food, water, sanitation etc.) and supply structures (health and social services etc.).

According to this model of determinants of health (e.g. Dahlgren & Whitehead, 1991) health promotion projects for older people targeting differently on determinants of health. Some only aim at individual and life-style factors, others cover the social and community aspects more and again other projects deal with broader determinants of health. Hence, the analysis of all 33 cases shows that the majority cover individual and life-style factors for health. 25 out of 33 projects promote physical activity (behaviour) and functioning, nutrition (diet) and individual mental aspects but also prevention aspects (in many different ways).

In these project cases the individual is seen as the target of health promotion and therefore in the centre of the intervention. But many cases also take the social and community networks into account or put the health promotion action directly on a meso level. These projects (15 out of 33) value the aspect that health is not only a function of life-style. These projects promote healthy social groups and healthy community networks by bringing people together (e.g. by networking) [AT-16, DE-29, UK-1], by strengthening groups, social integration and harmony [ES-12, EL-8] or for instance by community information, awareness raising and education [IT-10, SK-2].

Furthermore health promotion on the social level determines one's health by different effects, e.g. by the social involvement as buffering or protecting factor [IT-1], relationship between older people and immigrants [IT-10], social involvement enhances the use of health care [SI-2] or just by the fact that only a social individual can physically participate (in interventions) in a healthy way.

Last but not least under the 33 analysed cases there are some projects which are located on a broader or macro-societal level. Some projects cover various framework conditions on a socioeconomically, cultural or environmental level. For instance a Slovak health internet portal offers a virtual information and communication platform [SK-2]. Austrian and Italian projects implement healthy social services (e.g. accessible for older people) [AT-16, AT-40, IT-1, IT-7]. A Greek example aims to establish nutritional standards including social and economical aspects by health education and health promotion policy in order to impact cardiovascular diseases [ES-1].

In total the 33 health promotion cases cover a wide range of determinants of health which come from different levels: the individual (micro) level, the social and community (meso) level and the societal framework, the contextual (macro) level.

3.1.4 Settings suitable for older people

In health promotion the setting approach is useful to reach the target population. Hence, most of the projects were implemented in the community setting. 24 out of 33 health promotion projects for older people had such an approach. But within the

setting the category "community" varies a lot. 14 of these projects were in metropolitan areas, huge cities or towns (urban community setting). But there were also projects which addressed suburban areas or rural areas (10 out of 24). Population characteristics, publicity or accessibility were main reasons for this variation. For instance, an Austrian health promotion project for older people took place in the rural area because of the high percentage of older citizens there (above the national average) [AT-40]. This was also true for a German project [DE-29]. In another project the rural setting was chosen because of the availability of social services, community agencies [UK-3], NGOs [SI-2] or because of religious services (e.g. church buildings) [AT-17]. Above all, it was sometimes argued that the community setting (urban or rural) was chosen because of the typical population characteristics (e.g. SES, retirement rates, migration rates, social and health problems etc.) or just because the community is a (defined) cultural, social, economic or political unit.

Table 4: Settings in health promotion projects for older people

Setting	Freq
Community	**24**
Urban Area	*14*
Suburban Area	*4*
Rural Area	*5*
Older Peoples' Homes	**9**
Residential Homes	*5*
Institutional "Homes"	*5*
Others, not further specified	**5**

Note: multiple categorisations possible

The community setting is the most important for health promotion projects but not the only setting for health promotion for older people. Nine out of 33 projects also reported the setting of older peoples' homes. "Homes" is defined here as the main place of living and this can also be a residential home (5 out of 9) [NL-4, CZ-6] or institutional "homes" (5 out of 9) such as pensioners' homes [CZ-6, CZ-4, CZ-3], recreational centres [IT-1], care centres [IT-1], day care centres [UK-5] or (mental) hospitals [UK-1]. In addition there are five health promotion projects which are "unspecified" or do not have one specific setting to reach their target group(s).

3.1.5 Stakeholder involvement

Most of the projects involve different types of stakeholders from various geographical levels and different units. Stakeholders from the local level dominate health promotion projects for older people but also about the half of the projects have cooperation partners on the national level. Projects with international stakeholders and cooperation's [e.g. AT-16, PL-2] are of minor importance.

Stakeholders in European health promotion projects for older people are from the public sector, e.g. ministries, municipalities, city councils, public universities and academies), hospitals or health centres (e.g. geriatric, rehabilitation centres). Very equally, about two out of three projects have stakeholders from the non-profit sector, e.g. senior service organisations (e.g. senior clubs), local organisations, churches, special professional groups (e.g. Alzheimer Societies) [AT-16, CZ-3, DE-4, PL-2]. Significantly, only some projects have stakeholders from the private/profit sector, e.g. the IT or ICT branch [e.g. CZ-6, ES-12].

Stakeholders come from a big variety of backgrounds: There are most often health and social service providers and welfare institutions attached to the projects. In addition, some cover the educational field (institutions for further/higher education, (3rd age) universities) and some the sports and recreational spectrum. Furthermore many cultural organisations and institutions are involved in health promotion projects for older people.

The named stakeholders have different roles and tasks in the projects: Sometimes they are (co-)financer of the projects but they are sometimes involved for other purposes, e.g. for an intersectoral exchange and for networking [e.g. AT-16, DE-29], for dissemination and sustainability tasks [AT-40, SI-4], for their professional experience and expertise [CZ-3], for technical provisions [ES-5], or for evaluation/research purposes [NL-4, PL-2].

3.1.6 Project goals

The projects can be described according to the health promotion tradition which was first defined in the Ottawa Charta for health promotion (WHO, 1986). It defines action means by which health promotion can be put into practice.

This is reflected in the goals of the projects whereas many of them define goals on the older individual (from attitudes to behaviour) and others on a systemic level (healthy structures, environment). By breaking down in health promoting (action) means it becomes obvious that most of the selected best-practices in health promotion for older people are located on the individual level.

Their goals can be described best as *developing personal skills* (23 out of 33). They contribute to the development of the personality and to the social competences through information, health education and through an improvement of social competences and practical abilities. However they highly differ in their intention because some aim to improve physical ability (14 out of 23), some older people's mental constitution (13 out of 23) or their social competencies (13 out of 23).

Good examples for physical health promotion are life-style and nutritional programs [DE-19, IT-1, CZ-6], mobility, exercise and functioning trainings [AT-17, EL-8, CZ-4, PL-2, UK-1], safety and falls prevention programs [ES-5]. Mental health promotion projects for instance concentrate on emotional support [AT-16, DE-29, SK-6],

cognitive (memory) training [AT-17, UK-1], self-respect/dignity [IT-7, NL-4, NL-14] or reminiscence [CZ-4]. Project goals concerning the individual social aspect of health are to improve information, to raise education and to engage lifelong learning [SK-6, SK-1, IT-7, NL-14, NL-21], to strengthen social support and individual networking [NL-4, AT-16, CZ-6, ES-12, SI-2, UK-1], to use self-help groups and volunteering [SI-4].

On the other hand, goals of health promotion projects for older people also have a systemic aspect and concentrate on older individuals' environments and structures. Most of these aim to *create a supportive environment* because the health of individuals is strongly related to the environment in which they live in (10 out of 16). Thus projects try to enhance living, leisure time and working conditions in a way to be healthier through networking [AT-16, DE-4, EL-1], improving physical accessibility [DE-29], service development (administration, training) [ES-5, EL-2], and neighbourhood involvement [ES-12]. Secondly they aim at *strengthening community action* by their citizens by the development of health priorities, decisions or planning instruments and health programs (3 out of 16) or capacity building, inter-sectoral cooperation and knowledge/experience transfer [CZ-3, EL-1, SI-4]. Thirdly health promotion projects for older people aim to *restructure (existing) health and social services and infrastructures* (3 out of 16) [UK5, NL-14, AT-40].

3.1.7 Management and financing

The management structure varies a lot from health promotion project to project. This is mainly a matter of project duration, project finances and project dimension (e.g. goals, complexity, impact etc.). Hence the project structure is not easily comparable across all 33 health promotion cases for older people.

But nevertheless there are some general statements about these structures: It is first of all obvious that many projects in the field of health promotion are already highly professionalized and structured (including the project structure with a project coordination and/or a project management). Logically many health and social professionals are involved which are responsible for the implementation of the project. Also depending on the aims of the project scientists and evaluators are responsible for the scientific part of the projects. Furthermore it seems that some projects operate with a high number of volunteers.

There is usually an internal and external project structure and most of the projects work together with (collaborating) partners and stakeholders, again from various fields and different levels. They are located on a local or regional and on the national level but projects also involve organisations in an international cooperation. Whatever the level is, partners very often come from the government or local community, university departments and the social and health service sector (NGOs).

In addition, the complexity of health promotion projects for older people can be described also by its funding structures. In general one can deduce that health promotion projects for older people are funded by many different actors (on different administrative and political levels). Projects are funded from regional or national state funds (e.g. various Ministries such as Ministry of Health, Social, Labour, Sport etc.), from state-near institutions (e.g. health insurance, health promotion funds etc.) but also from representative organisations (e.g. senior organisations). Furthermore there are also supranational funders of health promotion projects (e.g. WHO, EU etc.).

The highest cost category of health promotion projects are personnel/staff costs. According to the project intentions costs for training and qualification are also mentioned. In addition material costs were mentioned. So the total budgetary situation of health promotion projects is mainly unclear. Most of the projects have not published more detailed information on funding, budget and detailed costs. This fact is an absolute lack in the current health promotion state.

3.2 Process evaluation results

3.2.1 Target group activation and involvement

The main question of the following section is (1) how older people were activated for health promotion in general and (2) how older people were kept involved in the course of health promotion activities. Being *activated* in this case means actively participating in project activities, while being *involved* means being a part of something.

Activating older people as participants

Intermediaries

One activation method used Europe-wide is to make use of intermediaries to reach older people. An intermediary is a person who is in direct contact with the target group on a regular basis, but is no member of the project team. 13 out of 33 cases stated making use of this method The most important activation strategy are “home visits” carried out by professionals. In the Dutch project “Big!Move” and the British project “The Warrington Falls Management and Prevention Service” GP’s work as intermediaries. Social workers are used in Austria, Spain and the Netherlands, and community nurses in Slovenia [SI-1]. Other professional groups are psychologists and migrant advisors. Older people are visited at home and professionals activate

them through counselling, goal setting, one-on-one advice in health issues, or interviews.

The group of intermediaries consists of people from (older) visible groups who have the aim of reaching invisible ones. Intermediaries also spread word about interesting interventions by word-of-mouth recommendations in Austria, the Czech Republic, and Poland.

Existing groups

Secondly, existing groups of and for older people are approached to activate their target groups for health promotion. Existing *informal groups* (friends, neighbours) are used with the "snowball effect", which means that one group informs another one and this one informs the next and so on. Existing *organised groups* (e.g. church groups, existing contact points for seniors, Local Health Units, Union of Seniors) are used in other cases. In the Polish project "Older Woman, Older Man" for example senior centers and Third Age Universities were visited.

PR and advertisement

16 out of 33 cases stated activating older people through massive advertising and informational campaigns. On the one hand written material was distributed to activate older people, like brochures, handouts, posters, leaflets, and were then allocated to different settings important for older people. On the other hand oral presentations were held on health promotion activities to motivate older people to take part (informational meetings, lectures, radio broadcasts etc.). Additionally, one project was indexed in internet finders and website lists [SK-2]. These activities have to be carried out in regularly in order to be effective!

Questioning methods

In three cases group discussions [CZ-4], group meetings [DE-19], and questionnaires [EL-2] helped to activate the target group.

Involvement of older people in planning and implementation

Several health promotion cases stated involving older people in planning activities. In the Czech project "Delicious Life" a small group of older people helped with the planning phase, and in the Greek Programme "Action Programme for older people" older people made proposals for both phases of the programme and were involved in defining evaluation standards.

In the Austrian project "LIMA" [AT-40] older people gave major inputs for the themes addressed in the working groups. In the Dutch project "Aspiring to healthy living" eight representatives of the target group were members of the project planning

group. The project “Senior Citizen Council of the district Antoniuk in Bialystok” is entirely run by older people.

Important aspects for effective involvement which have been mentioned several times are that trust needs to be established and that the specific needs of participants need to be addressed in the health promotion activity planned.

3.2.2 Theory usage

The main questions behind the following section are: How were the theoretical foundations of the health promotion projects used in practice? How was these theories applied?

Scientific evidence as “theories”

A number of health promotion projects had scientific evidence, research and studies as a basis for their concept. Most research in the form of e.g. the SIMA handbooks (LIMA from Austria), dance therapy concept by Veleta (“Dance Therapy” from the Czech Republic), research on multi-factorial interventions (“The Bromley-by-Bow Centre” from United Kingdom), or the empirical data on the connection of music and health (“Silver Song Clubs” from the United Kingdom) were used as a basis for interventions like courses, trainings, and lessons.

“Healthy concepts”

The most prevalent concepts used in health promotion for older people were “healthy ageing”, “healthy nutrition”, “active ageing” and empowerment. These concepts were in all respective cases *discussed* with older people and *explained* to them. In the Polish project “Older Man, Older Woman” constructive discussions and seminars took place about the concept. In the Greek project [EL-1] empowerment was discussed with and explained to older people. In the Dutch project “Aspiring to Healthy Living” older people were invited to participate not only in the process but also in decision-making as part of empowerment. In the Italian project [IT-7] information about the connection between technology and health was provided. “The result was a group of users able to select and enjoy the online services for their daily life.” (Pasetti 2005:2).

Questionnaires and other instruments

Some interventions based their project on a questionnaire and its results. Results of this theoretical background then formed the basis for a “second step”, a group activity or other involvement. In the Austrian project “Active Ageing” the WHOQOL questionnaire was used. In the Dutch project “Big!Move” the ICF was implemented as a health profile and was followed-up by a group activity. The Slovenian health

promotion project “Career Plan for 50+” used a competency test. In the evaluation of the “Programme of Physical Recreation for Older People” from Poland stated that applying scientific methods at each stage helped to implement the theory into practice.

Concluding, it can be said that mostly already *existing concepts* were used, like healthy ageing etc., but in other cases also *new data* was gathered with the help of questionnaires and other scientific methods. In “Big!Move” from the Netherlands the dealing with conceptional issues had an additional organisational benefit: health promotion and medical care were ideologically separated.

3.2.3 Implementation of health determinants

Behavioural determinants of health (physical, mental, social)

22 out of 33 cases reported addressing behavioural health determinants in the implementation phase of their project. This was realized by learning and education on health determinants [AT-17, ES-12], remembering and sharing experiences [CZ-4], dancing [CZ-3], personal conversations with older people [DE-4], editing texts together [ES-12] and by asking older people about the most important health determinants [NL-21]. Because the list of important determinants is unique in the “Aspiring to Healthy Living” [NL-21] project some[10] are listed here:

(1) being active; (2) being among people; (3) sharing stories/problems, having a good conversation; (4) having a positive outlook on things; (5) enjoying nature; (6) mental calm; (7) finding solutions for problems; (8) receiving support; (9) Feeling free, being as independent as possible; (10) being proud of your children.

Informing older people on health determinants

Another way of addressing health determinants was by simply informing older people about them. Short lectures were held in some cases [CZ-6, SK-6], by publishing articles [SK-2] or information material [SK-1].

Environmental health determinants

Another way of addressing health determinants is addressing environmental factors – healthy living conditions. This approach was chosen in 2 cases [DE-19, AT-40]. A

[10] In the original 15 health determinants are listed. This list has been shortened.

combination of an environmental and behavioural approach was selected in another six cases [UK-3, PL-6, IT-7, IT-10, DE-29, AT-16]. In these cases bridging individual needs with services in the local community was a common method of addressing living conditions [AT-16, DE-29, DE-19, IT-7].

Other health determinants were also addressed, but only in single cases, e.g. gender, socio-economic status, family structures etc.

3.2.4 Making settings accessible for older people

Health promotion activities for older people have to be made accessible in terms of little travelling effort and accessibility to buildings and infrastructure.

Geographical accessibility – travelling

By choosing a "local" approach many projects did not face any difficulties when activating older people. By placing activities and offers in the local community and in places older people regularly meet, access was granted. For these 14 out of 30[11] cases there was no need to travel for older participants. In "Action programme for older people" the gym of the municipality was used for health promotion, in "Programme for the promotion of healthy ageing" in Spain a gymnastics hall was used, and in "Big!Move" the general practitioner was approached. Two UK cases demonstrate the local approach by being accessible in day centers or churches or by being accessible in the midst of the community setting (Silver Song Clubs and Bromley-by-Bow Centre).

In several other cases the setting *"person's own home"* was chosen as the main setting and so accessibility was granted [AT-16, DE-4, SI-1, ES-5, NL-21, IT-7].

In Slovakia two projects "Programmes for active ageing" and "I'm 65+" several cities were chosen as places of implementation and so older people could access the project closest to their home.

A number of projects (n=8) mentioned the missing *networks of drivers* to bring older people to their projects and their innovative solutions to this problem. In the Austrian case "LIMA" relatives, welfare associations, or trainers helped out, in "Healthy and Active Aging Radevormwald" a "citizen bus (Bürgerbus)" was installed to pick people up from their homes or in the Italian case "Learning immigration and overcoming fear" older people from residential homes were transported to the site. As a characteristic example the "Warrington Falls Management and Prevention Service" also mentions a shortage of older people with own cars. In "Programme for the promotion of healthy

[11] In three cases there was no reference to accessibility of the setting.

ageing" in Spain a transportation service for dependent people was created to solve the "driver" problem.

Physical accessibility – buildings and infrastructure

5 out of 30 cases reported having access to *buildings without barriers* for older people. The Austrian case "Vitamin R. Ageing differently in Radenthein" worked in a building that was adapted specially to seniors, and in "Reminiscence Therapy" and "Dance Therapy" buildings were equipped with lifts, wheel chairs, hearing aids, and personal assistants. In two Spanish cases [ES-1, ES-12] no architectural barriers were reported.

Three cases state the need to renovate or reconstruct existing *buildings with barriers* in which seniors often meet: churches [AT-17] and the school setting [SK-6]. In "aktiv55plus" it was not possible to find a room for the project free of charge.

3.2.5 Stakeholder involvement and roles

This section deals with the issue of stakeholder involvement (multi-agency approach). How were public and private organisations involved throughout the projects? What was their specific role in the 30 best-practice examples?[12]

Regular meetings with stakeholders

App. 30% of all cases (9 of 30) involve stakeholders in regular meetings. In "Healthy and Active Aging Radevormwald" an interdisciplinary working group was founded. In two Greek examples [EL-1, EL-2] meetings with KAPI members were held on a regular basis. In one case the action plan of "Technical report for the definition of health objectives and strategies - older people" was presented to both public and private stakeholder organisations. In two Dutch cases a sounding board group was initiated (Aspiring to Healthy Living) and in "Big!Move" regular local meetings were carried out with the initiators and organisers. Involving stakeholders in informational meetings seems to be the easiest or best way to applying the multi-agency approach.

Stakeholders refer clients or intermediaries to the project

In 23% of all cases (7 of 30) stakeholders have the role of referring intermediaries (e.g. social workers, nurses) or clients (e.g. older frail people, older women) to the health promotion projects. In the "Buddy Care" project the Schorer Foundation cooperated with a number of organisations to set up contact with intermediaries

[12] Note: 3 cases did not contain any reference to stakeholder involvement.

(social workers, geriatric helpers and psychiatric professionals). In the “Self-help groups for older people” and the “Community Nursing Care” [SI-1] projects stakeholders are involved which normally approach older people (e.g. community nurses). In “I’m 65+” [SK-1] participants were selected and involved with help of the Regional Public Health Institute and the Union for Seniors. In the “Warrington Falls Management and Prevention Service” stakeholder organisations helped to refer clients into the system.

Stakeholders who finance the project

In 20% of all cases (6 of 30) stakeholders are involved because they are funders. In the Austrian case [AT-16] financiers were part of the advisory board and in the Spanish case [ES-12] coordination meetings with financing agencies were set up. In an Italian case the funding institution had the role of advertising the project [IT-10].

Stakeholders are involved because they offer the project to older people

For another 20% of all cases (6 of 30) stakeholders are supposed to offer health promotion in their own facilities and organisations and are therefore involved. In “Delicious Life” NGOs showed their interest in healthy nutrition and took over elements of the project in their own activities. The Polish case “A Programme of Physical Recreation for Older People” is “marketed to all organizations interested in applying it into practice” (Tobiasz-Adamczyk et al., 2008).

Stakeholders are involved in development and implementation

In 17% (5 of 30 cases) stakeholders are involved in developing and implementing health promotion offers for older people. In “Vitamin R. Ageing differently in Radenthein” the stakeholders were invited to the working groups with older people and in “Programme for the promotion of healthy ageing” volunteers together with the Navarre Red Cross designed the programme. In “Career plan for 50+” cooperating institutions built up and adapted the educational programmes for the participants. Persons from Regions.sk were directly involved in “Portal www.senior.sk”.

Stakeholders bring competences and expertise to the project

Some reports stated that stakeholders brought special expertise or competence to the project (3 of 30 cases). In the “Silver Song Clubs” art organisations provide the project with expertise and talented people. In “Vitamin R. Ageing differently in Radenthein” experts are part of the working groups with older people and bring their know-how on ageing relevant topics to the groups. In the German case expertise on excersise was drawn from one stakeholder (Landessportbund) [DE-19].

3.2.6 Health strategies suitable for older people

The following section gives an overview of applied health promotion strategies in the 33 cases. A combination of strategies is useful for a holistic approach to health promotion for older people, e.g. health education combined with maintaining functional capabilities and stimulating social networks.

The strategy "health education" is the most applied strategy in European best-practice. It is applied by explaining the concept (of healthy aging, healthy nutrition etc.) to older people. Health education can be put into practice through 1:1 peer education or group activities (seminars, lectures etc.).

The table hints at the most important strategies in health promotion for older people.

Table 5: Strategies in Health Promotion for Older People

Health promotion strategy	No. of cases	Example cases
Health education	15 of 33	[AT-17, AT-40, CZ-6, DE-19, EL-2, IT-1, NL-21, PL-2, PL-6, SK-1, UK-5, EL-1, IT-10, SI-4, SK-6]
Empowerment and participation	11 of 33	[UK-1, UK-3, AT-16, AT-17, AT-40, DE-4, NL-4, NL-14, PL-1, SI-1, SI-2]
Maintaining functional capabilities	5 of 33	[AT-17, CZ-6, EL-8, PL-2, UK-5]
Stimulating social networks	4 of 33	[AT-17, DE-29, EL-8, UK-3]
Building up health promoting structures	3 of 33	[AT-16, IT-1, IT-7]

Maintaining functional capabilities

Older people were trained in psychomotor functioning and in learning practical abilities, e.g. a kinesiology training was carried out in 2003 including exercises for eyes and ears, relaxation of the neck etc. [AT-17]. In "Delicious Life" physical activity was performed with older people. In the "Dance Therapy" project dancing was done with older frail people to keep them fit. The Greek project [EL-8] applied several elements of the strategy "maintaining functional capabilities": aerobic, breathing exercises, stretching, exercises for joints and muscles, balance and various games. Functioning was maintained through gymnastics and jogging in one case (supervised by an instructor twice a week) [PL-2].

Stimulating social networks

In LIMA [AT-17] social networking was enforced and older people exchanged material from their training courses. In a German project also networking between older people was enhanced [DE-29]. The Greek project [EL-8] is all about keeping good relationships, team spirit and mutual encouragement.

Health education

In “Delicious Life” theoretical lectures and workshops took place on cooking and healthy eating habits. In informational lectures and meetings interest of older people in health promotion was aroused [DE-19]. In EL-2 training materials were produced including instructions for healthy nutrition and recipes. The Italian project [IT-1] meant to inform informal caregivers of older dementia patients about their health resources, learning opportunities etc. In “Aspiring to Healthy Living” health education was applied through exercises with health portraits, story telling and visual material. Life-long learning strategies were applied in LIMA [AT-17]. In the Polish case education was implemented through lectures (once a month) [PL-2], five months of physical exercise and a field trip with older people. In another case [PL-6] older people were informed about violence and prevention and support strategies through a crisis hotline and different support groups. Health education was put into practice through consultations. In SK-1 it is reported that “peer to peer” health education took place. In the British case [UK-5] health education was combined with physical exercises.

Building up health promoting structures

Linking older people to existing services was done in one Austrian project [AT-16], and one Italian project [IT-1] applied strategies of building up networks between dementia counselling centres for older people, consultancy on health care, legal and social issues, and quality standards in health care services. Another Italian case chose an integration strategy between different structures and actors [IT-7].

Empowerment and participation

Developing personal skills [AT-17], social activation [AT-40], and home visits [AT-16, DE-4] are empowering strategies in the work with older people. In NL-14 social participation was encouraged to counteract loneliness and depression among gay and lesbian older people. The strategy was applied with “buddies” – older people who activate the target group 1:1. In PL-1 participation was implemented through mutual gymnastics lessons, sightseeing trips of older people, holidays in the countryside and in doing technical work together. The Slovenian cases [SI-2, SI-1] both applied the empowerment strategy by setting up self-help groups with and for older people and by home visits by community nurses.

3.2.7 Challenge and changes in the project

Changes and contingencies in the projects were addressed in regular retreats [AT-40], with evaluation methods [AT-16, ES-12], and memory workshops [ES-12].

The largest amount of changes occurred in the team structure (8 of 33 cases) and in the up-coming of new features in the interventions (also 8 of 33 cases). Other changes concern changes in the target group, financial difficulties and others. 7 cases reported no significant changes in the course of their projects [PL-2, SI-4, EL-8, EL-2, EL-1, IT-7, IT-10].

Changes in the team (structure)

In an Austrian case not enough experienced key personnel was available [AT-16]. In another case changes in the team led to the stopping the project [CZ-1] and to problems in trusting each other because of personnel changes [DE-29]. The small number of key staff members was seen as a general problem in DE-4. One case reported that the facilitator became pregnant [CZ-4] and that one PhD student joined the team [CZ-3]. More home visits necessary in a Polish project and so the number of hours of staff had to be increased [PL-6]. The changing roles of community nurses was mentioned as a contingency in SI-1.

New features

Changes can also be positive. In one case the executing association expanded its efforts [PL-1]. Two other cases also report the growth of the health promotion project [UK-1, ES-5, IT-1], increased public interest [SK-6] and the development of a "new version" of the project [AT-17]. On the other hand a lack of interest was also reported in one case [SK-2].

Changes in target group (demographic change) activation of older people

Five projects state a change concerning the target group. One case decreased the age in the target group addressed [SK-6], another mentioned more diverse target groups than expected [SI-2] and three cases state that it was harder to activate older people than they thought [AT-17 AT-40, AT-16]. These projects had fewer participants than expected and had to employ different innovative strategies to get in touch with the target group.

Financial changes/difficulties in funding

4 of 33 cases stated financing problems in connection to contingencies and changes [SK-6, SK1, UK-3, CZ-1]. The issues which were raised are the difficulty of ongoing funding and that funding was cut entirely. This can be (partly) avoided by having several funders from the beginning of the project – if there are problems with one, other funds still work.

Others changes

7 of 33 cases reported other changes, like goal adjustment [NL-14], restriction of goals [SK-2], change of project location [PL-1], lack of cooperation from GPs [DE-4], and having to reduce material costs [ES-5]. In one case the cooperation with specific stakeholders was frozen [AT-16] and in another one responsible actor left the project [DE-19].

All these changes had to be approached with a great amount of flexibility and motivation of the key actors to keep the initiative going.

3.3 Outcome evaluation results

3.3.1 Evaluation methods

In the 33 analysed health promoting projects a large spectrum of evaluation designs, methods and instruments were used. 15 of 33 either used a process or an outcome evaluation approach. Again qualitative (14) and quantitative methods (16 out of 33) are more or less equally distributed. In addition four projects adopted a scientific or exploratory pre-study [UK-1, EL-8, PL-1, PL-2].

Under the qualitative evaluation designs focus groups, observations and qualitative interviews were often counted (e.g. qualitative feedbacks) and under the quantitative methods interviews and questionnaires were most often adopted, some of them as randomized controlled trials (RCT) [CZ-4, DE-4, UK-5].

Interestingly 9 out of 33 project evaluation approaches can be called “mixed” because in their evaluation they adopted both, process and outcome evaluation. Nine other projects carried out the evaluation in a multi-methods approach, using both, qualitative and quantitative techniques.

3.3.2 Cost-effectiveness in health promotion projects

The non-existence of cost-effectiveness analysis is maybe the most criticized circumstance. Also the analysis of the underlying 33 health promotion cases shows that there are almost no quantitative outcome indications for cost-effectiveness in the relation of financial input and health (promotion) outcomes.

In 18 out of 33 cases the cost-effectiveness is not known. The reasons for this are at least twofold: The first problem comes up due to a lack of information about financial project resources. Many projects do not report their budgetary structure and the implementation costs of the projects [AT-16, AT-40, SK-6, SK-1]. The second

problem arises in relation to the evaluation adopted. If there are no or limited quantifiable effects of the projects no calculations with costs are possible.

Positively, there were also some health promotion projects for older people which stated some insights concerning the relation between effects and costs. But the underlying arguments of these cases were mainly qualitative or descriptive in nature. These examples try to explain why there is a good relation between project inputs and outputs. Some argue by saying that the project was not demanding with respect to personnel and material. The financial requirements of these projects were not high, the projects were not very expensive [SI-2, PL-2, NL-14, CZ-3, CZ-4]. Conversely other projects use the good cost-effectiveness relation as an argument for the enumeration of gained improvements and health effects such as the "*social benefits and its ability to encourage citizen participation*" [ES-12], "*good effects in the participants' feeling and in their physical and social health"* [ES-1], "*positive reducing risk factors* (…) *as well as in increasing compliance with the treatment"* [EL-1], "*improvement in social relations* (…) *and cognitive activities"* [IT-10] or "*better care for less money*" [NL-4] and "*lower time consumption*" (Note: which means lower budget consumption) [ES-1].

In total, little is known about hard indicators and quantifiable relations between project inputs and the effected health benefits on the basis of the analysed cases of health promotion for older people.

3.3.3 Effects on Health

The 33 cases of health promotion for older people report from many effects on health due to project activities. Because health in health promotion has three aspects, the achieved effects will be discussed separately for physical, mental and social health.

Physical Health

Achievements of health concerning the physical part can be best categorised in several aspects: First of all effects concerning changed food consumption and healthier nutritional habits were reported [CZ-6, DE-4]. In one Polish case this led to a decrease in body fat and to an improved cardiovascular wellbeing [PL-2]. A third case reports a higher body vitality [SK-6].

Another group of projects, which involve physical activation, report (slight) improvements in physical exercise of older people. This happened due to the adopted psychomotor training which led to a better functioning and to strengthened muscles [AT-17, IT-7]. Moreover, other projects report a changed/higher activity level. Older people were more active and exercised more than before the project involvement (e.g. through sports) [DE-4, NL-4]. Despite these "qualitative" outcome reports some projects report better fitness tests or better motor functioning [CZ-3, AT-17].

All in all effects can also result in a healthier living and in a sustained or even improved (physical) health of older people (e.g. better overall ratings) [UK-1]. An improved self-reliance was observed in one British falls prevention case also a reduction of accidents [UK-5] was described.

Mental Health

To measure mental health effects is a difficult task. That is why most of the health promotion cases again “only” state qualitative evidence. Nevertheless the list of mental health effects is impressive.

Health promotion cases mainly report a general reduction of mental ill health or the improvement of mental health. For instance there were reports about the reduction of depression and respective symptoms [DE-4, SK-6]. Older people also felt less lonely [NL-14, PL-2, UK-1].

Therefore positive mental health (i.e. future optimism) was affected through health promotion. Moreover other projects report better mood, more mental vitality (spirit), better morale, confidence and self-esteem [PL-2, PL-6, UK-5, SK-6].

Last but not least one British health promotion project was able to reduce the stigmatisation due to mental disease or illness and forced a higher social participation [UK-3]. In general projects were able to enhance a better mental wellbeing [SK-6, NL-4, AT-16].

Social Health

Many cases reported that older people got new and more social contacts (e.g. friends and acquaintances) [PL-2, AT-16, DE-29, DE-4, NL-2, SI-2]. Projects were able to include older people in social activities and enforced social support and helping activities [PL-2, PL-6, AT-16].

Through contacts an increase of mutual communication and interaction was observed [CZ-6]. A process was started which led to a collective process and to collective social structures [AT-40]. Social effects were established simply by bringing people together [UK-3].

Needless to say that these social activities resulted in participation, in higher integration and lower social exclusion (isolation). It improved the social inclusion of many older beneficiaries of health promotion through a strong supportive network. Social capital was built up.

Overall health status and quality of life

Every health promotion project has its own scope and this leads to certain results and health effects. Therefore all 33 cases analysed here are difficult to compare. But one common denominator is the overall health effects that were reported and which are maybe the most important health promotional effects.

Health promotion projects very many times reported improvements in the individual quality of life. A sustained and increased life quality was often the effect. To be more concrete, some cases reported better feelings of happiness [AT-17], improved life satisfaction [DE-4, ES-5, IT-7, PL-1, PL-2] and a gained responsibility of one's own health [DE-26]. The feeling of well-being, the feeling of usefulness empowers older people and leads to a change in behaviour and can lead to a new/better meaning of life which is expressed in a higher subjective health and a better quality of life [ES-5, NL-4, SK-6]. For these aspects there is striking descriptive evidence in the 33 analysed health promotion cases for older people.

3.3.4 Sustainability of health promoting projects

In terms of sustainability all analysed health promotion projects for older people can be described the best in some few categories: the role of the service provider, the established networks and publicity for sustainability.

The role of service providers

The factor described most often for the sustainability of health promotion projects for older people was the role of service providers. 18 out of 33 projects mentioned this fact with some variety in contents. First of all the enabling organisation of the health promotion project has an important role for the sustainability of a project. The reason for sustainability can be the high profile and knowledge of the service provider (e.g. church, older people's organisation, health provider etc.) [AT-16, AT-40, CZ-4]. Secondly, service sustainability can be reached by the broad coverage of additional services or the involvement of other providers who want to take part in the programme [CZ-4, PL-1]. Thirdly sustainability of health promotion programmes is also an effect of the involved staff [SK-1, SK-6, UK-1, EL-8]. Many health promoting initiatives are only ongoing because of the personal motivation, engagement and professional experience of key actors and funders (sometimes also on a voluntary basis). This points to a very crucial aspect of sustainable health promotion projects.

Networks

Another highly significant category (8 out of 33) for the sustainability of health promotion project is (1) the network of services of the project and (2) the network of the established target groups (i.e. older people). The first point covers the fact that many health promoting projects increased the collaboration with other services and tried to build up better co-operation with them. It turned out to be sustainable in that way that other service providers took advantage of the results and improved their service quality [AT-16] also because of this involvement and the structural embedding in the local processes [NL-4]. They learned from the health promotion

project and incorporated it in their service. In addition the established network of health and social services got to know each other in a better way.

The second networking success story about health promotion projects for older people is the established network of older people through the project. Again many projects report the sustainable effect that the target group is still involved and that the target group is constantly growing which is "an achievement itself" [AT-17, ES-1, PL-1, SI-2].

Dissemination and Publicity

It is not very surprising that some health promoting projects had a sustainable effect because of their constant dissemination and publicity activities (7 out of 33). Publicity is used very broadly and can be located on different levels. For instance publicity can be useful geographically, e.g. on the local but also on a national level. But publicity also needs certain media which was realised in print (i.e. books, magazines, articles, newspapers) [CZ-4, ES-12, NL-4, ES-12] or audio-visual media (i.e. film, DVDs etc.) [CZ-3, CZ-4]. Another significant example is that sustainability was reached because of a national award (i.e. German Prevention Award). Due to an award publicity was reached and the project was implemented as a standard health promotion program afterwards [DE-4]. (see chapter 3.3.6)

3.3.5 Transferability of projects and effects

The main question around the issue of transferability is: Would these 33 projects work in a different context and which effects could be transferred?

Evidence of transferability

Evidence of transferability can be found in two ways: (1) The health promotion model was transferred into other contexts or settings, and (2) the model is an already transferred model from another country, setting, or context.

(1) Model was transferred into other contexts (5 of 33): The Austrian project was transferred to the Czech Republic and piloted there [AT-17]. A Polish health promotion project [PL-2] was transferred to different cities and there is evidence that it works well in urban areas. The transferability of "Older Man, Older Woman" (with some modifications) was confirmed by experiences of Centres for Social Services in Poland. The Spanish model PAPPS [ES-1] is implemented in Health Centres nationwide and the UK "Silver Song Clubs" model (with adjustments) was transferred to many setting and a wide range of socio-economic settings while the basic premise of the idea remains the same.

(2) Model is a transferred project: Also 5 of 33 projects stated to be transferred projects already or that some elements had been transferred from previous projects. The Slovakian health promotion project "Programmes for active ageing" was based on the experiences from other countries, and another Slovakian example [SK-2] is a transferred project from the Czech Republic and Poland. One Italian project [IT-10] was transferred by the Third Age University in Acropoli. The Austrian project LIMA [AT-17] is a transferred project from Germany which uses a training manual from a previous project and the leaflet from the Greek project EL-2 was also transferred from a previous project.

Possibility of transferability

A number of projects stated the possibility of being transferred to other settings but could not cite any evidence for this assumption.

It is seen as an easier task to transfer the project if one part is flexible and can easily be adjusted to other settings or contexts. Especially written tools which are used in one project can also be used in a different context: The questionnaire used in the Austrian project "Active Ageing" could be used anywhere, the collection of healthy recipes from the Czech project "Delicious Life" could also be adapted to other nutrition projects, and the AHL Box by the Dutch health promotion model "Aspiring to Healthy Living AHL" could be used elsewhere. Other projects from Germany, Italy, Poland, Slovenia and the UK could be transferred with modifications according to the key actors in the projects.

To transfer a project sometimes requires certain prerequisites which are clearly stated in some health promotion examples: For transferring the "Reminiscence therapy" project trained reminiscence trainers should be available, but apart from that: "The material equipment is not costly and most activities can be provided by the regular staff" (Krížová, 2008). For the "Dance therapy" project trained dance therapists would be needed but no further financial resources are necessary. For the transferability of the Slovenian model "Career Plan 50+" specially educated teachers should be available.

One way to make projects transferable is to make a *massive dissemination effort* to win others for the project idea and then to transfer the idea to other settings. In the Italian case "Old people as a key to learn immigration and to overcome fear. Immigration as a social resource" the model was promoted in Italy through key stakeholders like managers or volunteers and a DVD was produced. In the Dutch case "Big!Move" the foundation still supports the dissemination of the programme.

Other projects have *no transferable effect* and are tailored to specific contexts and target groups, e.g. the Austrian project AT-40 or the Greek example EL-8 which had difficulties with transferring the project to other Greek municipalities because of infrastructural and organizational problems.

A model seems to be transferable if it is adjustable to new contexts and settings, which means that one part has to be flexible and another can be fixed. In order to guarantee transferability structure, process, and outcomes of projects need to be documented (for other settings to copy them).

3.3.6 Award-winning and publicly known projects

Since the 33 chosen projects are – according to 16 quality criteria – best-practice examples for successful health promotion, it is self-evident that some projects are also award-winning and have received public recognition. There is few information on the detailed criteria for winning single awards, sometimes the category of the award is mentioned.

Award-winning projects

App. one fourth of all projects (8 out of 33) have won awards for their initiative in health promotion for older people. The Austrian project “LIMA” was awarded in the category “adult education” from the Danube University of Krems in 2005 and the Slovenian project “Career Plan for 50+” received an award from the Institute for Adult Education. The Italian project IT-7 won the “Open Public Administration 2005 Award” for developing better services for vulnerable groups. “Big!Move” won the Dutch “Cees Korver Award” for regional innovative projects in 2006 and was also nominated for several other prizes. The “Aspiring to Healthy Living” initiative received a cash price of 2.500 € by the “Appeltje van Oranje” Award in the Netherlands. In Spain ES-12 was awarded for being the best innovative project on a national level by the Red Cross and Mutua Pelayo. In 2006 the “Technical Aids Service for self-sufficiency and adapting to one's environment” won the first prize in the Technical Help Bank Initiative in Spain. One health promotion example from the United Kingdom also won the “Award For Volunteering Excellence” in 2007 [UK-1].

Publicity

Dissemination via mass media

13 of 33 health promotion initiatives have put great effort into disseminating via the mass media. Several projects were widely spread through local media [DE-19, EL-8, PL-1, PL-6, AT-40]. Others are known on a national level [AT-16: public closing event, CZ-4: broadcasting for seniors, SK-6: in the mass media, SK-1: disseminated through the media, SK-2: in the web, SI-2: known by officials, UK-3: known nation-wide).

Scientific publications and presentations

8 of 33 have published scientific articles or other publications on health promotion for older people. [AT-16: demonstration project of the WHO several publications, EL-2: published articles, NL-4: four essays were written, NL-21: repeatedly published articles in professional and scientific journals). One project (Delicious Life) was placed in an international database of health promotion projects (EuroHealthNet). Three other initiatives were presented at conferences: "Dance Therapy" was presented at conferences and published, "Action programme for older people" was presented at two conferences, and "Programmes for active ageing" was presented at conferences and workshops.

Little publicity

Less than 4% of the projects (9 out of 33) are recognized but are not known on a national level or even international level. The responsible managers or researchers have not put as much effort into dissemination and publication as the other 24 projects. [AT-17, DE-4, EL-1, IT-1, IT-10, ES-1, ES-12, SI-1, UK-5].

3.3.7 Consumer satisfaction of older people

The following section answers the questions: Which effects were reached in terms of consumers satisfied within the project? How were older people satisfied?

Table 6: Consumer Satisfaction

Type	*Number of cases*
Measured Satisfaction	18 out of 33
Observed Satisfaction	11 out of 33

Note: There were four cases without reference to consumer satisfaction

Measured satisfaction

Consumer satisfaction was measured with quantitative (in 8 of 18 cases) and qualitative (in 11 of 18 cases) methods. One case reported both methods.

Quantitative measurement

According to a questionnaire 94% of all older people wanted the project to continue in case of "Delicious Life". 58% of all older participants assessed the project as very good, 34% as good in „Reminiscence Therapy". According to the outcome evaluation in EL-2 96% were satisfied with contents and in one Polish case [PL-2] 98% participants wanted to continue training. A survey of the "Programmes for active ageing" [SK-6] case expressed that 97% of older people were fully satisfied and only 0.7% were unsatisfied with the intervention. In the Spanish project [ES-12] a high

level of user satisfaction was measured – 4.43 out of 5 points on a satisfaction score are average for the intervention.

Qualitative measurement

In the Italian project [IT-7] a discussion forum on the project website showed that users valued the project's concreteness and usefulness and in IT-10 interviews were carried out and a DVD showed the satisfaction of older people (fun, new experiences, new people). A researcher concluded and observed satisfaction in qualitative evaluation in the Dutch cases "Aspiring to Healthy Living" and "Big!Move" showed positive effects too. In the Polish case "Senior Citizen Council of the district Antoniuk in Bialystok" interviews with older people were performed. In the Slovakian case "I'm 65+" the evaluation showed the overall satisfaction with statements like "it was useful", "eye-opening", "expanded our knowledge" (Katreniakova, 2008). In interviews with participants in one Austrian project [AT-17] all older people recommended the training courses for other older people. All three UK health promotion cases showed a high level of satisfaction by users evident in the reports and by narratives of participants.

Observed satisfaction

In other cases satisfaction of older people was "only" observed by key players in the intervention or mentioned towards someone. It was observed that older people were very happy with the Austrian project [AT-40] and positive reactions from older people on the local approach and the specific interventions in people's mother tongue were stated for "Active Ageing" [AT-16]. In the German case DE-4 satisfaction was mentioned towards people who are in touch with the project as regular counsellors. Consumer satisfaction can also be observed on a website, as in the case of "Portal www.senior.sk" by measuring the number of visitors etc.

3.3.8 Empowerment of older people

Empowerment can be achieved through activation of individuals and also whole groups. Group empowerment works with methods like health education or involvement of groups in decision making processes. Individual empowerment can be done by strengthening individual abilities and competences or by offering practical know-how.

Group empowerment

Raising *information and knowledge on health* issues were achieved in 6 cases. 6 out of 29 projects[13] empowered their participants through increasing knowledge [AT-40, PL-2, SI-2], learning with older people [IT-7], psychoeducation [PL-6] or health education [ES-1]. In four projects the *own involvement* of older people was seen as an empowering result. In the "Delicious Life" and "Programmes for active ageing" projects older people influenced content and structure of the projects. In DE-19 a group of seniors initiated activities on their own. In the Slovenian case "Community Nursing Care" self-help groups were seen as empowering.

Individual empowerment

Strengthening personal abilities

In other cases cognitive issues like increased respect [CZ-4], meaning [IT-10, AT-16], freedom of choice [NL-21], responsibility [PL-1] and a better expression of one's own needs and feelings [ES-12, SI-4] were achieved. As an empowering outcome social isolation was reduced, e.g. in "The Warrington Falls Management and Prevention Service" [UK-5].

Four cases state having increased the self-esteem or motivation in older people [SK-1, DE-19, UK-1, ES-5]: self-esteem, confidence, self worth, self-fulfillment. Three cases list increased autonomy and independence as the most important result of empowerment: DE-19, PL-2 and IT-7.

Practical know-how as empowering factor

The Austrian case "Active Ageing" empowered older people in home visits and identified offers which could be of interest in the local community and then referred older people there. In three cases older people were empowered with practical know-how in physical exercise: EL-8, UK-5 and NL-4 in which 69% of older people now do a sport on their own. Three other cases taught older people how to increase their cognitive skills: In the Austrian case "LIMA" practical know-how in memory training, psychomotor training etc. was provided. In "Programme for the promotion of healthy ageing" older people made use of tools to evoke memories, and in "Silver Song Clubs" new skills in singing and music making were achieved. In "The third age and the new technology in order to improve quality of life" [IT-7] older people were trained and assisted to use new technology and 51% of the participants became members of a community. Also in "Warrington Falls Management and Prevention Service" improved social networks can be listed as an empowering outcome.

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[13] 4 projects did not contain any information on empowerment.

4 Conclusions

In this section recommendations for successful health promotion initiatives for older people are given on the basis of the 33 best-practice examples from all across Europe. These are the main arguments by partners about successful health promotion in the eleven country reports.

4.1 Successful health promotion for older people

On the basis of this report and the analyses undertaken, there are numerous factors which should be considered when planning, implementing and evaluating health promotion initiatives. The recommendations are structured in structure, process and outcome recommendations.

Structure

- Successful health promotion is a complex issue and needs massive planning.
- Health promotion for older people needs to be very specifically tailored to the heterogeneous target group of older people. When planning an intervention address the target group specifically, e.g. older migrant workers or older women from a specific community or district etc.
- Documentation and a theoretical background help make interventions clearer. Plan to use a (theoretical) concept from the beginning. Choose a concept which best suits your intervention (physical, mental and social determinants of health).
- Choose a setting for your intervention. In the 33 best practice interventions the community setting and people's own homes were the most successful settings for health promotion for older people. The setting approach needs to be combined with a suitable activation strategy to get older people involved (see process).
- It is possible to define goals which are located on an individual level (strengthening personal abilities) and on the structural level of health promotion (creating healthy environments) or to define goals in both directions. Goals should be in line with the five strategies of the WHO Ottawa Charta.
- Management structures of health promotion interventions are very complex, involving many professional groups and volunteers. Roles need to be clearly defined. Also collaboration with stakeholders from outside the project structure needs to be made clear when planning a project. Managers need to be open to change (of staff), depending on the duration of an intervention, and need to be flexible. Job descriptions of managers are said to be useful for health promotion interventions.
- Funding of health promotion can be done by national funds, state-near institutions, or representative organizations of older people. The largest amount of

costs are personnel costs. Training of staff and professionals who are supposed to be carrying out interventions should not be forgotten in the planning phase.

Process

- Keeping older people involved (planning – implementation – evaluation) grants success of health promotion initiatives. Activating older people best works with intermediaries, massive dissemination efforts and by activating older people from existing (informal or formal) groups.
- The most often used setting for older people is the community setting (regional, local approach). It grants older people access to interventions. Person's own homes are also often used settings for (isolated) older people.
- To grant geographical access to health promotion travelling for older people has to be reduced to a minimum. If travelling is necessary, a network of drivers has to be organized (through welfare organizations, informal networks etc.).
- To grant physical access to health promotion interventions buildings have to be made barrier-free. If not possible, again places which are easily reachable for older people are crucial.
- Theoretical background and concepts help make interventions clearer. Then it is undoubted what the intervention is based on (e.g. health aging, health nutrition, empowerment etc.) and outcome indicators can more easily be worded. Using already existing concepts is more broadly practiced than inventing new theories.
- There are numerous ways of involving stakeholders in interventions for older people: regular informational meetings, stakeholders with the role of referring older people to interventions, stakeholders who bring in their expertise for an intervention, or funding of health promoting interventions.
- A combination of health promotion strategies is useful for a holistic approach to health promotion for older people, e.g. health education combined with maintaining functional capabilities and stimulating social networks.

Outcomes

- Both qualitative and quantitative evaluation designs can be useful for evaluating effects of health promotion for older people. Both process and outcomes evaluation designs can be useful for evaluating effects of health promotion for older people.
- Report costs and health effects of interventions in detail. Make explicit which inputs are necessary for the intervention and which effects on health (and others) have been reached. For this purpose clear indicators are necessary.
- In order to be able to acquire funding for health promotion an evaluation has to be undertaken. With the results of the evaluation clear arguments can be made

about the effects of the intervention on the target group and their health and funders can more easily be convinced of the usefulness of the intervention.

- Health effects can be manifold: physical, mental and social health benefits or a combination of all three.
- The most important factor for sustainability are motivated PEOPLE (individuals and networks).
- For transferability a minimum of documentation is needed in order to transfer the intervention to another context or setting. Using interventions which have already been transferred (or parts of it) makes it realistic to transfer them in the future.
- Public recognition and winning awards can mostly only be possible through massive dissemination efforts of the executing organisation (both in scientific media and non-scientific channels).
- Satisfaction of older people can either be measured or observed. Measuring it is the more common method in health promotion for older people, through questionnaires, interviews, discussion forums etc.
- There are many ways of empowering older people: individual (through strengthening personal abilities and practical know-how) and group empowerment (through information and health education and people’s own involvement).

4.2 Specific recommendations for project aims

Specific recommendations deduced by the analysis of all 33 cases are provided here. There are three subsections which represents the main target categories of the healthPROelderly project. This project aims to develop guidelines on health promotion for older people with a special focus on social determinants, inequality and sustainability. Hence specific recommendations are sorted by these criteria.

However we want to highlight that all three categories are overlapping to a high extend. For instance social determinants of health are closely related to health inequalities and both of them are highly connected with sustainable health promotion projects or programs.

Determinants of Health

- It is very important to take various determinants of health into account and it is a central focus point in all stages (planning, implementing, analysing) of health promotion projects for older people.
- Health determinants can be located on different levels. Thus clarify from the beginning which health determinants the health promotion initiative is mainly dealing with. These levels can be differentiated roughly: the individual (behavioural), the relational (social contacts with family, friends and

acquaintances) and the regional/societal level (cultural, socio-economic, political, social or environmental framework conditions).

- Be aware of the kind of your health interventions (e.g. behavioural, educational, and environmental) and think of their effects on health. They can effect the physical health (or the life-style of individuals), the social aspect (e.g. social networks) or the mental (e.g. self-respect) aspect of the individuals' health (i.e. older people).
- Also take the possibility into account that health interventions can have several effects on more than one aspect of health (e.g. social involvement diminishes feelings of loneliness as a mental aspect of health): It is likely that health promotion measures can have positive (and negative) side effects on other aspects of health too (e.g. shown by a total increase of the quality of life).

Health Inequality

- Health promotion sometimes has limited success because the activities promote health of privileged people and do not cover the most disadvantaged and vulnerable groups in society adequately enough.
- Hence take the fact into account that the results of health promotion are a consequence of project planning (e.g. target group selection), designing (e.g. theoretical foundation and project aims) and implementing (e.g. selection of health interventions).
- Many health promotion cases showed manifold health effects. They also affected a reduction of various health inequalities. The point is that health inequalities can be diminished by physical, mental and social health effects induced by health promotion activities and interventions. The crucial point is how to measure these effects. Therefore the entire project design must be logic, coherent and assessable.
- It is important to highlight that there is no single prioritisation of one type of health effect which is better suitable to reduce health inequalities. The recommendation is to approach health needs of the target group in a holistic – and therefore more realistic way – and provide (more adequate, innovative, and proven) intervention methods to guarantee success.

Sustainability

- The analysis has shown that the role of service providers (i.e. health promotion enabling organisation) is very central for project sustainability, mainly due to their high profile and knowledge.
- In addition a key actor in health promotion projects is the included staff. Health promotion activities are always a function of their personal motivation, their

engagement and – last but not least – their professional experience which is maybe the best enhancement factor for sustainability.

- Furthermore networking is another important point here with two different aspects: First of all networking of (health and social) services is of high importance for the single organisations and stakeholders involved. In cooperating in a health promotion activity they have the chance to improve their own services. But it is also crucial to prioritise networking of target group members which is a second highly significant factor with the potential to increase the sustainability of both, the project and its health effects. The most important factor for sustainable projects is a motivated champion or groups of older champions.
- Publicity of project aims, activities and results helps to enhance the sustainability of projects. A coherent dissemination plan should address all kinds of media (e.g. newspapers, magazines, professional journals) on different levels (e.g. local, regional, national, international) and support the project's visibility.

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5.2 List of evaluation tools

Table 7: Evaluation Tools

No.	Tool Name	Short Description	Download
1	**Document Analysis**	This tool (excel sheet) follows a reduction process in three steps. Texts from original documents (e.g. evaluation reports, final reports, website texts) can be reduced to a minimum – extracting the most important contents.	http://www.healthproelderly.com/pdf/healthPROelderly_Document_Analysis.xls
2	**Interview Guide**	This tool is a semi-structured interview guide. It was already used to ask different key persons from health promotion projects for older people about the success of their projects (e.g. key researcher, manager, older people themselves). It also includes a protocol (date, time frame of the interview etc.) and basic instructions for the interviewer. The interview guide is structured according to structure, process and outcome evaluation questions.	http://www.healthproelderly.com/pdf/healthPROelderly_Interview_guide.doc
3	**SWOT-analysis**	The SWOT-analysis tool can be used for the evaluation of already existing health promotion projects (for older people and other target groups). It can be filled out by any person who knows the project well (manager, key researcher, evaluator, participant etc.). The SWOT-analysis helps to see strengths and weaknesses of already existing projects and seeks to be an instrument for improving current and sustainable interventions. It can also be used to evaluate ended health promotion projects.	http://www.healthproelderly.com/pdf/healthPROelderly_SWOT-Analysis.doc
4	**Cost-Effectiveness Analysis**	This tool is a cost-effectiveness analysis following 7 steps. Data for the analysis can be drawn from documents, from interviews and also from other reliable sources.	http://www.healthproelderly.com/pdf/healthPROelderly_Cost-effectiveness_analysis.doc

Note: All evaluation tools are available electronically on the healthPROelderly website (Link: http://www.healthproelderly.com/hpe_phase3_products.php)

5.3 List of quality criteria

Table 8: List of quality criteria

No.	Quality Criterion	Description
1	Well-grounded theoretical approach	methodology based on a well-grounded theoretical approach
2	Evidence cost effectiveness	health and social and economic gains for government (local, regional, national)
3	Sustainability	proof of long-term implementation; Social and economic resources; projects of continued proven effectiveness
4	Voice of older people	active involvement of older people on 5 areas: participation, involvement in project design, responding to older people's feedback in project design, contribution to the project (volunteers, project designers, project monitoring, management), as multiplicators and trainers
5	Visible and invisible target groups	visible (older people in general) and invisible (ethnic groups, socially isolated, low SES, cognitive impairment) older people
6	Diversity	addresses diversity in gender, age, ethnic background, social-economic differences, social accessibility, culture of communication, financial issues
7	Geographical and physical accessibility	addresses transport, good infrastructure, e.g. accessing people in remote areas; accessibility of buildings
8	Gender sensitivity	sensitive on gender issues
9	Multi-faceted – holistic	looks at more than one health promotion issue (alcohol and nutrition) / at least two aspects from: a biological, psychological social approach
10	Projects that include empowerment	addresses independence, autonomy, increase knowledge, self-esteem, dignity, motivation
11	Transferability	project was transferred, potential transferability: project was designed in such a way as to be transferred
12	Consumer satisfaction	result in satisfaction of consumers
13	Public recognition/award	achieved public recognition, was awarded, widely published in recognized journals, widely disseminated and reached various target groups
14	Strategy	wide variety of innovative strategies (e.g. social determinants)
15	Multi-agency approach	more than one type of professional, governmental, non governmental organisation associated
16	Evaluation	clearly identified evaluation results based on evidenced-based practice

5.4 33 European best-practice projects

Table 9: 33 European Best-Practice Projects

No.		Project Name (in English)	Project Name in national language	id	Country	Short Description
1	1	Active Ageing! Investment in the health of older people	Aktiv ins Alter! Investition in die Gesundheit älterer Menschen	AT-16	Austria	A project dedicated to activating isolated population groups in three distinct urban areas of Vienna.
2	2	Life Quality in old age	Lebensqualität im Alter	AT-17	Austria	A community-based project with the aim of increasing social capital and health communication in 13 Styrian communities.
3	3	Ageing differently in Radenthein	Anders Altern in Radenthein	AT-40	Austria	A project for older people and those who work with them to increase their QOL through memory and fitness training.
4	1	Delicious Life	Chutný zivot	CZ-6	Czech Republic	The project aimed at improvement of dietary habits and physical activity of older people and at their activation.
5	2	Effect of reminiscence therapy on the health status and quality of life of residents of care homes	Vliv reminiscencní terapie na zdravotní stav a kvalitu zivota seniorù zijících v institucích	CZ-4	Czech Republic	The project introduced reminiscing in small groups into care homes for older people. Positive effects on quality of life were found.
6	3	Effect of dance therapy on health status and quality of life of residents in care homes	Vliv tanecní terapie na zdravotní stav a kvalitu zivota seniorù zijících v institucích	CZ-3	Czech Republic	The project examined the effect of dance therapy on the physical, mental and social health of older people with dementia.
7	1	Healthy and Active Aging Radevormwald	Gesundes und Aktives Altern Radevormwald „aktiv55plus“	DE-29	Germany	The project aims at improving an active and independent way of living of older people in the community.
8	2	Healthy Aging	„Gesund älter werden“ in Hannover	DE-4	Germany	The programme aims at improving the health status and quality of life of older insurants and at supporting local networks.
9	3	Healthy Aging in the District	Gesund älter werden im Stadtteil	DE-19	Germany	The project aims at sensitising older socially disadvantaged people to health promotion programmes in their social environment/district.
10	1	Preventive Activities and Health Promotion Programme	Programa de Actividades Preventivas y de Promoción de la Salud	ES-1	Spain	An action based programme aimed at evaluating the efficiency of health promotion approaches in primary health care.
11	2	Programme for the promotion of healthy ageing	n.a.	ES-12	Spain	n.a.
12	3	Technical support for adaptation in the social environment	Ayudas Técnicas y Adaptación ambiental	ES-5	Spain	Teaches and provides technical support for adaptation and engagement with the local community.
13	3	Action programs for older people	Προγράμματα κίνησης στα ηλικιωμένα άτομα	EL-8	Greece	The project aims to improve and maintain the mobility and functional ability of older people, via the implementation of an exercise program.
14	1	The involvement and the Role of older volunteers in promoting healthy diet for the prevention of cardiovascular diseases	Η συμμετοχή και ο ρόλος των ηλικιωμένων εθελοντών στην προαγωγή υγιεινής διατροφής για την πρόληψη των καρδιαγγειακών νοσημάτων	EL-2	Greece	The aim of the project was the active involvement of elderly volunteers in promoting healthy diet.
15	2	The role of health education in improving compliance for the prevention of cardiovascular diseases	Ο ρόλος της αγωγής αγωγής υγείας στη βελτίωση της συμμόρφωσης για την πρόληψη των καρδιαγγειακών νοσημάτων	EL-1	Greece	A health education programme, focusing on access to and adoption of healthier lifestyles towards cardiovascular risks amongst older people.
16	2	Technical report for the definition of health objectives and strategies - older people	Rapporto tecnico per la definizione di obiettivi e strategie per la salute. Anziani	IT-1	Italy	Dealing with issues of cognitive impairment and falls amongst frailer older people.
17	1	Improving the quality of life in the third age through new technology	Per usare il computer vecchio sarai tu. La terza età e le nuove tecnologie per migliorare la qualità della vita	IT-7	Italy	To improve the quality of life of older people and their ability to contact the Public Administration through online services.
18	3	Immigration as a social resource, rather than a source of fear	Gli anziani per conoscere l'immigrazione e superare ogni paura. L'immigrazione come risorsa sociale	IT-10	Italy	To increase the quality of life of elderly through the multi-cultural awareness.

Table 10: 33 European Best-Practice Projects *(continued)*

No.		Project Name (in English)	Project Name in national language	id	Country	Short Description
19	1	Big! Move	Big! Move	NL-4	Netherlands	Big! Move is a Health Promotion Method in a local setting, focused on healthy behaviour and human power.
20	2	Buddy care for homosexual elderly people / Pink buddies	Buddyzorg voor homoseksuele ouderen / Roze maatjes	NL-14	Netherlands	A care intervention programme aimed at reducing the loneliness and improving the mental well-being of older homosexuals in Amsterdam.
21	3	Aspiring to Healthy Living	Zin in Gezond Leven (ZGL)	NL-21	Netherlands	A programme for Healthy Living, with diversity and empowerment as underlying principles.
22	1	Encouraging mutual support amongst older people in Antoniuk in Bialystok	Metody stymulacji aktywności samopomocowej ludzi starych na modelu dzielnicy Białystok-Antoniuk	PL-1	Poland	Self-help groups of older people in the local community.
23	3	A Programme of Physical Recreation for Older People	Program Rekreacji Ruchowej Osób Starszych	PL-2	Poland	Programme of physical activities.
24	2	Older Man, Older Woman	Starszy Pan, Starsza Pani	PL-6	Poland	Prevention of abuse and neglect within families, support for older people.
25	2	Self-help groups for older people	Skupine starejsih za samopomoc	SI-2	Slovenia	Prevention of isolation, covering social needs.
26	1	Community Nursing Care	Patronazna zdravstvena nega	SI-1	Slovenia	Community nurses meet older people on the basis of planned visits to all people aged 65+.
27	3	Career plan for 50+	Karierni nacrt 50+	SI-4	Slovenia	During this transitional period we have to discern who in fact we are, our goals in life and plans for the future.
28	1	Programmes for active ageing	Programy pre aktívne starnutie	SK-6	Slovakia	Programmes for active ageing create a platform for discovering new knowledge, as well developing social networks.
29	2	I am 65+ and happy to live the healthy life	Mám 65+ a teší ma, že žijem zdravo	SK-1	Slovakia	Aim of the project is to improve quality of life, knowledge and behaviour related to health, and health awareness in older people.
30	3	Portal www.senior.sk	Portál www.senior.sk	SK-2	Slovakia	Project for direct support of ICT literacy and life-long learning mainly amongst older people and those belonging to disadvantaged groups.
31	1	Silver Song Clubs	Silver Song Clubs	UK-1	United Kingdom	Arranging social music making for older people who may be socially isolated or suffering from the effects of age related health problems.
32	2	Warrington Falls Management and Prevention Service	Warrington Falls Management and Prevention Service	UK-5	United Kingdom	Multi-faceted approach to falls prevention.
33	3	Bromley-by-Bow Centre	Bromley-by-Bow Centre	UK-3	United Kingdom	Older people participate in all aspects of the Centre's life, as well as in dedicated projects. Inter-generational approach is fundamental.

Note: the database with all European health promotion projects can be accessed electronically on the healthPROelderly website (Link: http://www.healthproelderly.com/database/)

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