EUNAAPA – Work Package 5

Expert Survey on Physical Activity Programmes and Physical Activity Promotion Strategies for Older People

Cross-National Report
14 July 2008
(Appendices 2 & 3 corrected 05 November 2008)

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CONTENTS

        - **Instructors' qualifications and training**
        - **Client safety**
        - **Finance, transport and refreshments**
        - **Publicity, marketing and promotion**
        - **Tables 11-52**

- **'SUCCESSFUL' PA PROMOTION STRATEGIES**
    - **Methods**
        - **Selection of promotion strategies (including definitions)**
        - **Distribution and return of promotion strategy questionnaires**
    - **Results**
        - **Selection of promotion strategies**
        - **Return of promotion strategy questionnaires**
        - **Promotion strategy directors' educational backgrounds**
        - **Prevailing national context**
        - **Description of promotion strategies**
        - **Characteristics of strategies' target populations**
        - **Design of promotion strategies**
        - **Evaluation and sustainability of effect of promotion strategies**
        - **Finance**
        - **Tables 53-80**

- **SYSTEMATIC SEARCH FOR EVIDENCE BASED GUIDELINES**
    - **Objective**
    - **Methods**
        - **Definitions**
        - **Criteria for inclusion in inventory of guidelines**
        - **Search to identify candidate publications for inclusion in the inventory of guidelines**
        - **Scrutiny to select publications for inclusion in the inventory of guidelines**
    - **Results**

- **CONCORDANCE OF QUALIFICATIONS WITH GUIDELINES**
    - **Discussion & recommendations**
        - **Basic level qualification**
        - **Higher level qualification**
        - **Assessment, validation and revalidation**

▪ INTRODUCTION

The European Network for Action on Ageing and Physical Activity (EUNAAPA) is committed to improving the health, wellbeing and independence of older people throughout Europe by the promotion of evidence-based physical activity.

The first stage of EUNAAPA work package No. 5 (Identify Existing Programmes for Physical Activity and Physical Activity Promotion for Older People) was to identify and describe, with the help of national experts, examples of physical activity (PA) programmes and PA promotion strategies for older people which were deemed to be 'successful'. The second stage was to use systematic search methodology to compile an inventory of evidence-based, professional guidelines for the provision and/or promotion of safe and effective physical activity by older people. The third stage was critically to compare the PA programmes and PA promotion strategies with the evidence-based best-practice guidelines and to formulate appropriate recommendations.

In May 2007, the EUNAAPA Partners in each participating country were asked to enlist the help of eleven PA Experts in their country, all recognised authorities on PA for older people. Each Expert was asked to:

- complete a short questionnaire concerned principally with the availability in their country of national qualifications in the supervision or guidance of physical activity for adults in general and for older adults in particular.
- identify a successful PA programme for older people in their country and assist its director to complete a second (longer) questionnaire, concerned primarily with the characteristics of the chosen PA programme.
- identify a successful PA promotion strategy for older people in their country and assist its director to complete a third questionnaire, concerned primarily with the characteristics of the PA promotion strategy.

The resulting data were submitted to the leader of work package 5 (University of Edinburgh) for incorporation into this cross-national report. The participating countries were Austria, Belgium, Czech Republic, Denmark, Finland, France, Germany, Greece, Italy, Netherlands, Norway, Poland, Portugal, Sweden, and United Kingdom.

THE EXPERTS

Methods

Selection of Experts

As requested by the leader of Work Package 5, fifteen national partners each attempted to select eleven PA Experts, with the help of the matrix below (Table 1). Partners were instructed that they should use the matrix to guide the selection of eleven Experts – ideally one from each of the 11 boxes but not more than two from any one box. They were advised that the matrix should be used flexibly, bearing in mind that, for example, several organisations could be located in more than one box. EUNAAPA Partners were also advised that, ideally, all of their selected Experts should be knowledgeable both in the field of PA Programmes and in the field of PA Promotion Strategies. If this was not possible, it was particularly important that the Partners should ensure that both fields were adequately represented in the group of 11 Experts as a whole.

Partners were asked to contact their selected Experts by telephone. Where necessary, e-mail or an answering service was to be used to arrange a mutually convenient appointment for the telephone conversation, in order that Partners could explain the purpose of the project to the potential Expert and request their support.

Distribution and return of Experts' questionnaires

On 1st June 2007 an electronic copy of the PA Expert Questionnaire was sent to all EUNAAPA Partners for distribution to their nominated PA Experts. All EUNAAPA Partners were instructed to send each Expert who had agreed to participate, an electronic and/or a paper copy of the PA Expert Questionnaire, accompanied by an explanatory letter, by the 11th June 2007. Also included on 1st June 2007 were a template of a further explanatory letter and copies of the other two questionnaires for distribution, by 11th June 2007, to the directors of their chosen PA programme and PA promotion strategy.

EUNAAPA Partners were instructed to encourage participating PA Experts to complete and return the PA Expert questionnaires as soon as possible before 24th August 2007. The WP5 Coordinator reminded defaulters in mid-July (e-mail), mid August (e-mail), late August (telephone) and early September (e-mail). These reminders were intended to be passed on to PA Experts by EUNAAPA Partners. The last reminder included a warning that if questionnaires were not returned by 20 September, it might not be possible for their data to be included in the final analysis and in the national and cross-national reports. The deadline was later extended to 6th November.

- **Results**
  - **Selection of Experts**

According to the agreed methodology, each country was to recruit 11 individuals recognised as authorities on physical activity (PA) for older people, ideally one from each of the 11 fields in Table 1.

The results of this process are summarised in Table 2. Only 6 of the 15 countries succeeded in recruiting 11 PA Experts. (In the cases of Belgium and Finland, 13 PA Experts were recruited but only 11 PA Experts were included in the cross-national report, as originally agreed.) The median number of PA Experts per country was 9 (range 3 to 11).

Some countries attributed more than one 'primary' matrix field to some of their experts (e.g. Austria and Belgium). Even allowing for this, the overall picture is a reasonably even spread of matrix fields, with no matrix field consistently neglected. Only a few individual countries showed evidence of selection bias (e.g. Finland, Greece and Poland).

  - **Return of Experts' questionnaires**

By 10th August 2007, none of the PA Expert Questionnaires (in the form of data from the EUNAAPA Partners) had been returned to the WP5 Coordinator. By 30 August, despite several reminders (see above), only four countries had returned their PA Expert questionnaires data. On the deadline of the 20th September, only one further country had returned their questionnaire data. A decision was made to extend the deadline to the 6th November. On the 6th November 2007, two countries were still to return their questionnaire data. All of the PA Expert data were finally received by the WP5 Coordinator at the beginning of December 2007.

  - **Experts' educational background**

The educational backgrounds reported by the PA Experts themselves show an overall predominance of Exercise/Sport Science, most pronounced in the case of Portugal (Table 3).

There were substantial differences between countries in the proportion of Experts with an educational background in Medicine or another health profession. Austria, Germany, Portugal and Denmark recruited no PA Experts with an educational background in these areas. The situation is quite different for Finland, Netherlands, Norway, Poland, Sweden and UK.

Most countries recruited some PA Experts who reported an 'other' educational background. This was most striking in the case of Austria, with 10 Experts reporting an educational background in diverse 'other' areas, such as political science, sociology, health sociology, agriculture, education, theatre studies, nutritional sciences, public relations, commercial communication and social work.

Some of the differences between countries may be real but it is likely that others merely reflect an awareness bias on the part of those who selected the Experts. If real, it may be instructive to compare the PA opportunities offered in countries whose PA Experts have very different educational backgrounds (e.g. Portugal v Austria v Sweden). However, this sort of comparison is not possible with the data from the present survey.

- **Experts' areas of practice**

The PA Experts were asked to describe aspects of the areas for which they considered they were answering as experts (Table 4).

Field

All countries recorded Experts in both the area of PA Programmes and the area of PA Promotion Strategies, with more in the former area than in the latter (Table 4). Some Experts reported themselves expert in both areas.

Organisational Level

In nearly all countries, there were Experts reporting themselves working at a national level, at a regional level and at the level of a city, town or local neighbourhood, with no apparent tendency for any one level to predominate (Table 4). Some Experts reported themselves to be answering from more than one level.

Client Group

In all but one country, some of the Experts reported themselves answering with authority on PA for community dwelling older adults and some with authority on PA for institution dwelling older adults (Table 4). There was a marked tendency for the former to predominate. Some Experts reported themselves to be answering as authorities on PA for both client groups.

Sector

With only one exception, all countries had selected experts from both the governmental sector and the non-governmental sector (Table 4). The

latter tended to predominate and only a few Experts saw themselves as answering from both sectors.

Professional Expertise

Overall, the professional expertise of the PA Experts recruited seems to be well distributed (Table 4). However, with the exception of Finland, there appear to be few Experts with expertise in the area of health-related exercise facility management.

	sport sector		health sector and/or social services sector		education sector (including training and professional development)	
	government	**other**	**government**	**other**	**government**	**other**
National or Regional	Ministry of Sport (or equivalent) 1	NGO specialising in the delivery of recreational or competitive physical activity for older people 2	Ministry of Health or Ministry (or department) with particular responsibility for older people 3	NGO specialising in the delivery of health-related exercise for older people or sickness funds or health insurance or NGO addressing age-related issues 4	Department specialising in the training of those who deliver recreational, competitive or health-related physical activity for older people 5	NGO specialising in the training of those who deliver recreational, competitive or health-related physical activity for older people 6 Professional association for those specialising in old age healthcare or social care 7
	government	**other**	**government**	**other**		
City or local neighbourhood	Municipal department for sport, recreation and leisure services 8	Sport or dance organisation with special interest in older people or Other organisation providing physical activity opportunities for older people 9	Municipal department responsible for healthcare services for older people or Municipal department responsible for social care services for older people 10	Local branch of a sickness fund or health insurance or Commercial provider of health-related exercise or Local branch of an NGO addressing age-related issues/providing social care for older people 11		

Table 1. Matrix used to guide the selection of national Experts for WP5

Country(N)		Primary matrix fields										
		1	2	3	4	5	6	7	8	9	10	11
Au	11	x	xx	xx	xxxx			xx		x	xxx	
Be	11	xx	xx	x	x	x	xx	x	x	xx	x	x
CR	4	x		x			x				xx	
De	3		x	xx			x					
Fi	11	xxxxxx	x	x	xx							
Fr	8		x		x		x		x	x	x	x
Ge	7		x		x	x	x	x	x	x	x	x
Gr	8				x	xxxx	x	x			xxx	x
It	9	x	x	x	x	x	x	x	x	x	x	x
Ne	11	x	xx		xx		xx	x	x	x	x	xx
No	7	x		x	x	x			x		x	x
Pol	9			x		xx	x	x	x	x	xxxx	x
Por	11			x	xx	x	x	x	x	xx	x	x
Sw	6			xx		x			xx		x	
UK	11	x	x	xx	x	x	x		x	x	x	x

Table 2. Primary matrix fields (see Table 1) of the national Experts, as perceived by the national partners when selecting the Experts. (N = number of Experts selected for each country, Tables 2-10)

Key to abbreviated names of the participating countries

Austria	Au
Belgium	Be
Czech Republic	CR
Denmark	De
Finland	Fi
France	Fr
Germany	Ge
Greece	Gr
Italy	It
Netherlands	Ne
Norway	No
Poland	Pol
Portugal	Por
Sweden	Sw
United Kingdom	UK

Country (N)		Educational Backgrounds					
		Medicine	Other Health Profession	Exercise/ Sport Science	Other	Missing data	Total
Au	11	0	0	4	10	0	14
Be	11	0	1	7	3	0	11
CR	4	1	0	3	1	0	5
De	3	0	0	2	2	0	4
Fi	11	1	6	5	3	0	15
Fr	8	0	1	6	1	0	8
Ge	7	0	0	4	3	0	7
Gr	8	0	2	7	0	0	9
It	9	2	0	7	2	0	11
Ne	11	1	6	2	6	0	15
No	7	0	5	3	0	0	8
Pol	9	2	2	4	2	0	10
Por	11	0	0	10	2	0	12
Sw	6	4	1	2	2	0	9
UK	11	0	5	6	4	0	15

Table 3 - Expert Questionnaire Question 9 (XQ9). Educational backgrounds of national Experts for WP5

Country	Au	Be	CR	De	Fi	Fr	Ge	Gr	It	Ne	No	Pol	Por	Sw	UK
N	**11**	**11**	**4**	**3**	**11**	**8**	**7**	**8**	**9**	**11**	**7**	**9**	**11**	**6**	**11**
FIELD															
Physical activity programmes	8	9	4	1	7	6	6	8	7	10	7	6	11	5	9
Physical activity (promotion) strategies	5	8	2	2	7	5	5	1	4	4	2	5	2	3	7
ORGANISATIONAL LEVEL															
National	3	2	2	2	7	4	5	0	5	6	3	2	2	2	8
Regional	6	9	1	2	1	2	2	2	2	3	0	5	2	2	2
City, town or local neighbourhood	4	1	2	0	4	5	2	7	4	7	5	4	7	3	1
CLIENT GROUP															
Community-dwelling older adults	10	10	4	3	11	5	7	7	8	10	6	8	11	5	8
Institution-dwelling older adults	5	3	2	0	1	6	3	2	2	5	1	3	4	3	3
SECTOR															
Government	4	4	0	1	5	3	3	3	3	4	4	2	4	4	4
Non government organisation	6	7	3	2	6	6	4	5	5	8	7	5	7	2	8
PROFESSIONAL EXPERTISE															
Health care	0	1	1	0	2	5	0	1	3	5	4	5	1	3	2
Health promotion	6	4	2	3	7	5	2	3	5	8	5	6	1	4	8
Sport/ recreation/ physical activity facility management	2	5	0	1	3	4	2	2	1	0	0	0	2	2	3
Sport/recreation/ physical activity instruction/ supervision/guidance	3	7	1	0	5	6	4	4	2	3	1	4	8	1	6
Health–related exercise facility management	2	2	0	0	4	2	1	0	0	0	0	1	0	0	0
Health–related exercise instruction/ supervision/guidance	3	3	3	0	5	3	4	3	1	5	4	2	0	2	5
Education	4	4	3	1	5	5	3	2	8	4	1	2	2	2	5
Research	0	1	3	0	5	1	3	4	4	6	0	3	4	4	1
Social services, social care or social welfare	2	3	2	0	0	3	2	0	1	1	0	1	1	2	1
Socio–cultural organisation	3	3	0	0	1	3	1	0	1	0	0	2	1	0	2

Table 4 (XQ10). Number of national Experts working in different areas of practice

- **NATIONAL QUALIFICATIONS IN THE SUPERVISION/GUIDANCE OF PHYSICAL ACTIVITY**
    - **Methods**

The questionnaire completed by each country's PA Experts also asked about the availability in their countries of national qualifications in the supervision or guidance of physical activity for adults in general and for older adults in particular. It asked whether such qualifications (if they existed) were optional or compulsory. It also requested detailed information about assessment, validation and revalidation of the higher level, older-person-specific qualification (if such existed). Finally, it asked about the existence in their country of a professional register of qualified instructors (*i.e.* a regulatory body that holds a current record of those qualified to guide or supervise physical activity and of their level of specialist qualification).

    - **Results**
        - **Basic level qualification**

The percentage of PA Experts reporting the availability (in their country) of a basic level qualification for those supervising or guiding physical activity or exercise by adults in general varied considerably from country to country (median = 64%, range = 0-91%) (Table 5).

It seems likely that a basic level qualification is, indeed, available in countries with a high proportion of its PA Experts reporting that this is the case (e.g. Germany, Belgium, France, Greece and UK). A low percentage is harder to interpret. It is hard to know whether it means that (1) there is, in fact, no basic level qualification in that country, (2) there is a basic level qualification but it is not widely promoted, or (3) there is a basic level qualification but the PA Experts are less than knowledgeable.

Overall, the number of PA Experts who considered that a basic level qualification was implemented as a compulsory requirement in their country was only about half as many as reported that it was available (Table 5). At first sight, there appear to be large differences among the countries but these data must be treated with great caution as the denominators are small.

        - **Higher level qualification**

The percentage of PA Experts reporting the availability (in their country) of a higher level qualification for those supervising or guiding physical activity or exercise by older adults also varied from country to country (median = 27%, range = 0-75%) (Table 6). With only three exceptions,

fewer Experts reported the existence of a higher level qualification (Table 6) than reported the existence of a basic level qualification (Table 5).

It seems likely that a higher level, old age specific qualification is, indeed, available in countries with a high proportion of its PA Experts reporting that this is the case (e.g. France and Poland). Again, as with the basic level qualification, low percentages are hard to interpret.

Overall, the number of PA Experts who considered that a higher level qualification was implemented as a compulsory requirement to lead exercise by older adults in their country was less than half as many as reported that it was available (Table 6). It must be stressed that these data must be treated with even greater caution as the denominators are even smaller. Nevertheless, Poland's figures stand out as possibly different from those for the other countries. Not only did 6 of 9 Experts report that higher level qualifications are available, all 6 reported that their implementation was satisfactorily enforced.

Although, overall, only 37% of the PA Experts considered that a higher level qualification was available, 57% responded 'yes' to the question whether "it is necessary that this higher level qualification is implemented properly". This is despite the fact that our intention had been that the question would be answered only by those who thought that a higher level qualification was available. Clearly, this question is open to more than one interpretation. Nevertheless, it is equally clear that many of the PA Experts consider it important that there should be a properly implemented, higher level, old age specific qualification.

It appears that different countries have different interpretations of the question regarding a higher level qualification being available and also being implemented properly in their country. This has made the data in table 6 difficult to interpret. For example, none of the PA Experts in the Czech Republic has reported that a higher level qualification is available, but then one expert has reported that it should be implemented properly (Table 6). In the Netherlands, only two PA Experts have reported that a higher level qualification is available, but then five Experts have reported that it is necessary that this higher level qualification is implemented properly (Table 6).

In Belgium and the UK, nearly the same number of PA Experts reported that an older person specific higher level qualification was available and that this higher level qualification should be externally verified (Table 6). In these countries it could be interpreted that the higher level qualification

is academically acceptable, This could also be true in Austria and Germany, although there is a smaller number of PA Experts reporting that the higher level qualification is available in these countries.

Overall, more than half of the PA Experts reported that they did not know what proportion of instructors guiding/supervising older participants have the basic, entry level qualification (Table 7a). Austria was the only country where more Experts were able to estimate the proportion of instructors with an entry level qualification than reported that they did not know.

Similarly, the majority of PA Experts reported that they did not know what proportion of instructors guiding/supervising older participants have the higher level qualification (Table 7b). Germany was the only country to have more PA Experts able to estimate the proportion of instructors with a higher level qualification than report that they did not know.

- **Assessment, validation and revalidation**

The PA Experts were asked "What does the assessment for the older person specific, higher level qualification involve?" Overall, the number of Experts answering 'yes' to the four options offered were rather similar (34 of 127 to 46 of 127, Table 8) to the number of Experts indicating that a higher level qualification was available (Table 6). But the data (Table 8) include several anomalies. For example, 5 Netherlands Experts reported that a Summative assessment of knowledge is part of the assessment for the older person specific higher level qualification whereas (in table 6) only 2 Netherlands PA Experts reported that a higher level qualification was available. Similarly, 5 German PA Experts reported that verification of current cardiopulmonary resuscitation (CPR) certification is part of the assessment for the higher level qualification, whereas (in table 6) only 4 German Experts reported that a higher level qualification was available. One can only guess whether the Experts thought they were answering a question about what was actually happening (as had been the intention) or what they felt ought to be happening.

The PA Experts were also asked about the requirements for retention of the higher level, older person specific qualification (Table 9). Anomalous responses were less evident here, at least partly because affirmative responses to the 5 positive options offered were rather infrequent (Table 9). In particular, very little would seem to be happening in respect of a requirement to hold current CPR certification. Whilst the data are not

incontrovertible, this suggestion is a cause for concern and merits closer examination.

- **Professional Register**

The PA Experts were asked if their country had a professional register of qualified instructors (i.e. a regulatory body that holds a current record/registration of those qualified to supervise/guide physical activity). All 11 of the UK PA Experts knew that a professional register exists (The Register of Exercise Professionals of the United Kingdom - http://www.exerciseregister.org/). The picture for the rest of Europe is quite different (Table 10), with only 21% of the non-UK PA Experts indicating that they thought that there was such a professional register in their country (Table 10). The low number of affirmative responses from Experts outwith the UK may reflect the absence of professional registers, or it may mean that such registers as do exist have only a low profile.

Country (N)		Number (%) of Experts answering 'YES'	
		Available (% of N)	Enforced (% of available)
Au	11	6 (55%)	3 (50%)
Be	11	10 (91%)	2 (20%)
CR	4	3 (75%)	3 (100%)
De	3	0 (0%)	0 (NA)
Fi	11	7 (64%)	3 (43%)
Fr	8	7 (88%)	3 (43%)
Ge	7	6 (86%)	4 (57%)
Gr	8	6 (75%)	2 (33%)
It	9	4 (44%)	0 (0%)
Ne	11	3 (27%)	2 (67%)
No	7	1 (14%)	0 (0%)
Pol	9	6 (67%)	7 (117%)
Por	11	6 (55%)	3 (50%)
Sw	6	2 (33%)	0 (0%)
UK	11	8 (73%)	2 (25%)

Table 5 (XQ11 & 13). Number (%) of PA Experts confirming the availability and enforcement of a basic level qualification for supervising or guiding physical activity or exercise by adults in general.

Country (N)		Number (%) of Experts answering 'YES'			
		Available (% of N)	Enforced (% of available)	Important (% of available)	External verification. (% of available)
Au	11	3 (27%)	2 (67%)	8 (267%)	2 (67%)
Be	11	7 (64%)	1 (14%)	6 (86%)	6 (86%)
CR	4	0 (0%)	1 (NA)	3 (NA)	1 (NA)
De	3	0 (0%)	0 (NA)	0 (NA)	0 (NA)
Fi	11	3 (27%)	2 (67%)	5 (167%)	1 (33%)
Fr	8	6 (75%)	2 (33%)	3 (50%)	2 (33%)
Ge	7	4 (57%)	1 (25%)	6 (150%)	3 (75%)
Gr	8	2 (25%)	0 (0%)	6 (300%)	0 (0%)
It	9	0 (0%)	0 (NA)	5 (NA)	0 (NA)
Ne	11	2 (18%)	2 (100%)	5 (250%)	1 (50%)
No	7	0 (0%)	0 (NA)	0 (NA)	0 (NA)
Pol	9	6 (67%)	6 (100%)	7 (117%)	2 (33%)
Por	11	8 (73%)	1 (13%)	8 (100%)	3 (27%)
Sw	6	1 (17%)	0 (0%)	4 (400%)	1 (100%)
UK	11	5 (45%)	1 (20%)	7 (140%)	5 (100%)

Table 6 (XQ 14 & 16-18). Number (%) of PA Experts confirming the availability, enforcement, importance and verification of a higher level qualification for supervising or guiding physical activity or exercise by older adults.

Country (N)	Number (%) of experts giving this response for basic, entry level qualification							
	0%	25%	50%	75%	100%	Don't know	Not applic.	Missing data
Au 11	0	2	0	3	0	4 (36%)	0	2
Be 11	0	2	0	1	0	7 (64%)	1	0
CR 4	0	0	0	0	1	2 (50%)	0	1
De 3	0	0	0	0	0	0 (0%)	3	0
Fi 11	1	0	0	1	1	7 (64%)	1	0
Fr 8	0	0	0	0	0	7 (88%)	0	1
Ge 7	0	0	0	2	1	3 (43%)	0	2
Gr 8	0	2	1	0	0	5 (63%)	0	0
It 9	0	0	1	2	0	5 (56%)	1	0
Ne 11	0	0	0	1	0	8 (73%)	2	0
No 7	0	0	0	0	0	3 (43%)	3	1
Pol 9	0	0	0	0	0	8 (89%)	0	1
Por 11	0	0	0	2	0	4 (36%)	5	0
Sw 6	0	0	1	0	0	3 (50%)	2	0
UK 11	0	1	0	0	1	6 (55%)	2	1

Table 7a (XQ21). PA Experts' estimates of the prevalence of the basic, entry level qualification among instructors guiding or supervising physical activity by older participants

Country (N)		Number (%) of experts giving this response for higher level qualification							
		0%	25%	50%	75%	100%	Don't know	Not applic.	Missing data
Au	11	1	2	0	0	0	5 (45%)	1	2
Be	11	0	2	1	0	0	4 (36%)	4	0
CR	4	0	1	0	0	0	2 (50%)	0	1
De	3	0	0	0	0	0	0 (0%)	3	0
Fi	11	1	0	0	1	1	7 (64%)	1	0
Fr	8	0	0	0	0	0	7 (88%)	0	1
Ge	7	0	2	0	1	0	2 (29%)	0	2
Gr	8	0	0	0	0	0	0 (0%)	8	0
It	9	0	1	0	1	0	5 (56%)	2	0
Ne	11	0	0	0	1	1	7 (64%)	2	0
No	7	0	0	0	0	0	3 (43%)	3	1
Pol	9	1	0	0	0	0	6 (67%)	1	1
Por	11	0	1	0	0	0	8 (73%)	2	0
Sw	6	0	1	0	0	0	3 (50%)	2	0
UK	11	1	1	0	0	0	7 (64%)	2	0

Table 7b (XQ22). PA Experts' estimates of the prevalence of the higher level (older-person-specific) qualification among instructors guiding or supervising physical activity by older participants

Country (N)		Number (%) of Experts answering 'YES'					
		A	B	C	D	Not applic.	Don't know
Au	11	4	4	3	4	1	2
Be	11	6	7	5	7	4	0
CR	4	0	2	1	0	0	1
De	3	0	0	0	0	3	0
Fi	11	1	1	0	1	3	5
Fr	8	0	2	1	2	0	0
Ge	7	5	3	2	4	0	0
Gr	8	2	4	4	4	0	0
It	9	0	1	0	1	5	2
Ne	11	5	5	4	5	2	2
No	7	0	0	1	1	3	0
Pol	9	5	6	7	6	2	0
Por	11	2	6	3	4	2	3
Sw	6	1	1	1	1	3	2
UK	11	3	4	3	4	0	0

A = Verification of current cardiopulmonary resuscitation (CPR) certification
B = Summative assessment of knowledge
C = Practical teaching competence assessed with participants of any age
D = Practical teaching competence assessed with older participants

Table 8 (XQ19). PA Experts' responses concerning the components of the assessment for the higher level (older person specific) qualification

Country (N)		Number (%) of Experts answering 'YES'							
		A	B	C	D	E	F	G	Not applic
Au	11	2	2	3	1	2	1	0	2
Be	11	0	0	0	0	0	0	7	4
CR	4	0	0	2	1	1	0	0	1
De	3	0	0	0	0	0	0	0	3
Fi	11	0	1	3	0	1	1	1	4
Fr	8	0	0	1	2	1	1	0	0
Ge	7	0	2	2	2	4	1	0	0
Gr	8	0	2	2	1	2	0	0	1
It	9	0	1	0	1	1	0	0	3
Ne	11	1	2	2	4	5	0	1	1
No	7	0	0	0	1	1	2	0	3
Pol	9	0	3	1	2	2	1	0	2
Por	11	0	2	1	0	1	1	3	5
Sw	6	1	1	1	0	0	1	0	3
UK	11	2	1	3	2	2	4	1	3

A = Payment of fee
B = Evidence of current CPR certification
C = Evidence of continuing professional development (CPD)
D = A test of knowledge
D = A practical test of teaching competence
E = Other
F = Nothing

Table 9 (XQ20). PA Experts' responses concerning the requirements for retention of the higher level (older person specific) qualification

Country (N)		Professional register		
		Exists	Membership requires	
			Entry level*	Higher level**
Au	11	2 (18%)	0	0
Be	11	4 (36%)	2	0
CR	4	2 (50%)	2	1
De	3	0 (0%)	0	0
Fi	11	3 (27%)	4	0
Fr	8	4 (50%)	2	1
Ge	7	1 (14%)	0	0
Gr	8	0 (0%)	1	1
It	9	1 (11%)	1	0
Ne	11	2 (18%)	2	0
No	7	0 (0%)	0	0
Pol	9	3 (33%)	3	2
Por	11	2 (18%)	1	0
Sw	6	0 (0%)	0	0
UK	11	11 (100%)	7	4

Table 10 (XQ23 & 25-26). Number (%) of PA Experts confirming the existence in their country of a professional register of PA instructors and their qualifications and concerning its membership requirements for registration to supervise PA by adults in general (a basic, entry level qualification*) and by older adults in particular (a higher level qualification**).

- **'SUCCESSFUL' PA PROGRAMMES**
  - **Methods**
    - **Selection of programmes (including definitions)**

Each national Expert was asked to identify a successful PA programme for older people in their country and assist its director to complete a questionnaire concerned primarily with the characteristics of the chosen PA programme. Translation of questionnaires was permitted if required. The national Experts were instructed that their choice should be guided by the following definitions.

Physical activity (or PA) – Any bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure *e.g.* running, walking, swimming, lifting or carrying a heavy weight.

PA programme – A schedule of selected physical activities in which individuals can choose to engage. *e.g.* An overall programme of activities and PA opportunities for older people OR the components of such a programme, such as a programme of old time dancing classes, supervised resistance training, supervised, seated exercise classes, hill walking groups or aqua classes etc.

A successful PA programme – A PA programme is 'successful' if a PA expert in that country considers it to be successful. This judgment may be based on some or all of a wide range of possible effects of the programme. These might include, for example, demonstrable improvements in physical fitness or quality of life, growing membership, client loyalty, etc.

To be eligible for consideration a successful PA programme must have been running for at least 6 months and if it has ceased, this must have occurred no more than 2 years previously**.**

- **Distribution and return of programme questionnaires**

On 1st June 2007 all EUNAAPA Partners were sent an electronic copy of a template of an explanatory letter of invitation and the PA Programmes Questionnaire. EUNAAPA Partners were instructed to distribute this to participating PA Experts in their country by 11th June 2007. These PA Experts were then to be encouraged by their EUNAAPA Partner to distribute the letter of invitation and PA Programme Questionnaire to their nominated PA Programme Directors. If an invitation was declined,

because the programme did not agree to participate or because the programme had already been chosen by another PA Expert, then the PA Expert was to identify another successful PA Programme and send another invitation letter. PA Experts were not permitted to select their own PA Programme.

The PA Experts were encouraged to give their PA Programme Director on-going support and to ensure that the questionnaire was returned to the WP5 coordinator by 24th August, 2007. The WP5 Coordinator issued reminders to EUNAAPA Partners in mid-July (e-mail), mid August (e-mail), late August (telephone) and early September (e-mail). These reminders were intended to be passed on to PA Experts by the EUNAAPA Partners. The last reminder included a warning that if questionnaires were not returned by 20 September, it might not be possible for their data to be included in the final analysis and in the national and cross-national reports. This deadline was later extended to 6th November.

- **Results**
  - **Selection of programmes**

Not only were some National Partners unable to recruit 11 Experts. Some Experts were unable to identify a 'successful' PA Programme. Occasionally, in an effort to nominate the required 11 Programmes per country, a National Partner would nominate a Programme or an Expert would nominate more than one programme.

Of the 15 countries, only 2 succeeded in recruiting 11 PA Programme directors. (One of these two countries, Finland, actually recruited 13 PA Programmes but only 11 PA Programmes were included in the cross-national report, as originally agreed.) Four countries were unable to recruit more than 4 'successful' PA Programmes. Fifteen Partners yielded a total of 112 'successful' PA Programmes (median = 9 per country, range = 1-11) (Table 11).

  - **Return of programme questionnaires**

By 10th August 2007, none of the PA Programme questionnaires (in the form of data from the EUNAAPA Partners) had been returned to the WP5 Coordinator. By 30 August, despite several reminders (see above), only four countries had returned their PA Programme questionnaires data. On the deadline of the 20th September, only one further country had returned their questionnaire data. A decision was made to extend the deadline to the 6th November. If a PA Programme Director had not returned their questionnaire, their PA Expert was contacted via email and telephone,

and was asked to contact their nominated PA Programme Director and encourage the immediate return of the PA Programme Questionnaire. On 6th November 2007, two countries were still to return their questionnaire data. All of the PA Programme data were finally received by the WP5 Coordinator at the beginning of December 2007.

- **Programme directors' educational backgrounds**

Some PA Programme Directors reported more than one educational background. Overall, the 112 PA Programme Directors reported 126 educational backgrounds, of which 66 were in Exercise / Sports Science, and 30 were classified as 'other'(table 11). 'Other' included a wide range of subjects, e.g. social work, social science, law, teaching, psychology, theology, communications and community development.

Except in Sweden, only a few of the Programme Directors had an educational background in medicine. Finland and Denmark reported that more than half of the Programme Directors had had a health related education whereas Belgium and Portugal reported no Programme Directors from such a background.

- **Catchment areas of programmes**

The most commonly occurring geographical classification of the programmes was 'limited to a city/town' (39%) and the least common was 'limited to a local neighbourhood' (11%). The other half of the programmes was more or less evenly divided between 'national' and 'regional' programmes (Table 12).

- **Ages of programmes**

The PA Programme Directors' reports of how long their programme has existed showed that most programmes were quite well established (Table 13). In Belgium, Finland and the UK, at least four of the programmes had run for more than ten years.

- **Components of overall programmes**

Many of the PA Programme Directors reported multiple component programmes in their overall programme. The most prevalent component programme included was community based senior fitness programmes (groups) (76% of overall programmes) (Table 14). Many of the component programmes were healthcare-related, with falls prevention programmes being particularly common (44% of overall programmes). Healthcare-related component programmes were prominent in the UK and Greece (and perhaps also in France and the Czech Republic after

allowance is made for the small number of programmes reporting from these countries (Table 14).

One might not expect many programmes to cater for the elite, older competitor but even they recorded 9 mentions (8% of overall programmes).

The PA Programme Directors' description of their overall programmes showed that programmes tended to be group activities rather than individual activities (Table 15). Programmes are more often held indoors but outdoor activities are not unusual. Similarly, responses showed more land-based programmes than water-based programmes but the latter were not unusual.

Given the wide range of component programmes, it is not surprising that the PA Programme Directors reported that they used a wide range of types of facilities (Table 16). Most commonly reported were sport/ physical recreation facilities and community centres. Day resource centres, participant's private dwellings, sheltered housing, assisted living facilities, care homes or nursing homes and other facilities were also used.

- **Characteristics of programmes' clients**

The PA Programme Directors who gave valid responses gave varied reports as to the age group for which their overall programme was intended. In most cases each country had programmes that catered for the 45/50 to 90/100 year age group as well as programmes that catered for the 60/65 to 80 year age group. The UK was the only country where nearly every programme catered for the 45/50 through to 100 year age group.

Of the 106 PA Programme Directors who gave valid responses, more than half (60%) reported that their programmes were intended only for community-dwelling older adults (Table 17). Of the 42 programmes which include institution-dwelling older adults, less than one third (29% of 42) included them in the same groups as the community-dwelling older adults.

People able to walk outdoors with no walking aids and no assistance or supervision by another person are the 'category' of participant (by level of functional mobility) for whom overall programmes were most commonly reported to be intended (82% of overall programmes) (Table 18). Those able to walk outdoors with a walking aid but no assistance or

supervision by another person were also commonly reported to be catered for (66% of overall programmes). Participants who walk outdoors only with assistance and/or supervision by another person and those who never walk outdoors were also catered for by some programmes (38% and 29% respectively).

Nearly three-quarters of the PA Programme Directors estimated that 75% of the participants in their programme are women (Table 19). In only one programme were men reported to be more numerous than women.

- **Characteristics of programmes' classes**

There was a wide range of reported group sizes (Table 20). In 9 of 15 countries, the group size most commonly reported was 11-15 participants (Table 20). Some programmes use surprisingly large groups; a quarter of the programme directors reported groups of more than 25 people, including some with more than 50.

In 12 of the 15 countries the commonest (or equal commonest) ratio of instructors to participants in a typical session of their programme was between 1:11 and 1:25 (Table 21). Overall, this accounted for about half of all programmes. A further third of all programmes had instructor:participant ratios between 1:2 and 1:10. A few programmes had 1:1 instruction but a few had only 1 instructor to more than 25 participants.

The maximum possible frequency of attendance ranged from less than once a week (1 programme) to at least 8 times per week (4 programmes) (Table 22a). In a fifth of all programmes, participants could attend only once a week. In a further fifth, they could attend twice a week. In a further two fifths, they could attend 3 or 4 times a week. In a further fifth, they could attend at least 5 times a week (Table 22a).

The usual frequency of attendance, however, was reported more commonly to be once or twice a week (two thirds of all programmes) or 3 to 4 times a week (almost a quarter of all programmes) (Table 22b).

After discounting the 'do not know' responses, nearly two thirds of all Programme Directors estimated that 75% or 100% of their current participants had attended their programme for at least a year (Table 23).

- **Objectives, outcomes, monitoring and feedback**

Aims of programmes

The PA Programme Directors reported what they understood to be the two most important overall aims of their Programme, from the point of view of its sponsoring organisation. By a substantial margin, the two aims most commonly selected were Health Promotion (28%) and Improved Physical Function (28%) (Table 24). In third place was Opportunities to Socialise (14%).

At first sight, nominations of Improved Mood were surprisingly uncommon (4%). On reflection, however, it is possible that this may not be an accurate insight into the Directors' opinions of the aims of their sponsoring organisations. Instead, it may be an artefact, in that the choice of response options provided may have produced a three way split of a potential, generic Psychological Wellbeing vote (Table 24, columns E, F and G).

Satisfaction of participants
Nearly half of the PA Programme Directors estimated that the satisfaction of participants in their programme was formally measured once or twice per year (Table 25). However, at least a quarter of the Directors reported that participant satisfaction was measured less than once a year. The UK PA Programme Directors were unusual in that at least half of them reported measuring participant satisfaction 3 to 6 times a year.

Aims of participants
Nearly two thirds of the PA Programme Directors reported that participants were formally surveyed for the aims of their involvement in the programme (Table 26). Most of these Directors also reported that their programmes were adjusted according to the participants' stated aims (Table 26).

Outcome measures
Overall, 60% of PA Programme Directors reported that objective outcome measures were recorded for participants at regular intervals (Table 26). This tended to be less common in Norway and Belgium. There was no obvious association between surveying participants' aims and the measurement of objective outcomes.

Of the objective measures that PA Programme Directors reported as being recorded at regular intervals, Balance was reported the most frequently (Table 27), followed by Mood/Depression, 'other' and Strength or Explosive Power. It is striking that 19 programmes (in 10 countries) reported that they made regular measurements of their

participants' Level of Social Support. Unfortunately, the questionnaire did not ask what instruments were used for such measurements.

- **Pre-participation assessment**

Only half of the PA Programme Directors reported that eligibility for entry to their programme requires the potential participant to have a health check (Table 28). A health check tended to be required less commonly by programmes in Norway, Sweden and Belgium. Of course, it is possible that some of the variation in these responses may be due to effects of translation and to variations in what is considered to amount to a 'health check'. (The latter is addressed in Table 29, despite some anomalous disparities between the 'Yes' column in Table 28 and the 'Total' column in Table 29.)

Overall, nearly half of those who reported that a health check was a requirement said that the form of health check required was assessment by a doctor (Table 29). Indeed, this was the commonest (or equal commonest) response in 13 of the 15 countries. In contrast, fewer than a third of Programme Directors using a health check reported that completion of a health screening tool was the type of health check required.

Table 30 details the responses to a question which attempted to address the use of a health screening tool more closely. It reveals further disparities, this time between the responses in its 'yes' column and responses in Tables 28 and 29. In Table 30, 34 Directors said self completion of a health screening tool was required to be eligible to enter their programme. But, in Table 29, only 14 Directors had indicated that a health screening tool was the form of health check required for potential participants to be eligible to enter their programme. It would seem that a substantial number of Directors may not consider 'self completion of a health screening tool. to be a form of 'health check'.

Directors whose programmes used a health screening tool were asked to name the instrument used. Only one health screening tool was named more than once. The Physical Activity Readiness Questionnaire (PAR-Q) or adaptations of it was named by 9 Directors (including 6 in the UK).

Of the 34 Directors reporting the use of a health screening tool (Table 30), 25 confirmed that it included questions on 'dizziness', 14 that it included questions on 'hearing', and 12 that it included questions on 'eyesight' (Table 32). (NB The PAR-Q does not include any questions on hearing or vision.)

If the health screening tool identifies the presence of a potential problem, much the most frequently chosen course of action (but still barely half of those giving any response other than 'not applicable' (23 of 48)), was that an applicant must obtain 'approval' from their doctor in order to be permitted to enter the programme (Table 33). (Curiously, some of these 23 directors had said that their programmes did not use a health screening tool (Table 30)). Note that none of the responding Programme Directors would simply exclude a potential participant whose health screening tool identified a possible health problem.

- **Programme content**

The programmes were reported typically to target more than one aspect of fitness. The aspect(s) of physical fitness most commonly addressed by the PA Programmes are endurance and coordination/balance, closely followed by strength and joint range of motion (Table 34). Explosive power was reported by only 15 Directors (13%) as an aim for improvement, despite its acknowledged functional importance in old age. Bone density was reported by only a third of Directors as an aim for improvement, despite its probable importance for fracture prevention in later life.

The modalities of physical activity reported by the PA Programme Directors as offered in their programmes were very varied (Table 35). Resistance training modalities and endurance training modalities were both well represented (Table 35). Walking, movement, and exercise to music were highly reported. Clinical condition-specific, adapted exercise programmes were highly reported, including falls prevention programmes in particular.

Progression

Sixty two per cent of the PA Programme Directors reported always incorporating progression as part of their overall programme (Table 36). This refers to a systematic increase in the intensity or resistance, the frequency and/or duration of exercise. Eighteen percent of Directors incorporated progression for only the first few weeks or months and the remaining 13% did not include it at all.

Warm up

Seven Programme Directors (in 5 countries) reported that they did not have a warm up period at the beginning of a session of their programme (Table 37a). About a quarter of all Programmes had 5 minutes or less of

warm up but more than half had warm up periods lasting between 6 and 15 minutes.

Cool down
The picture was much the same for the most common length of a usual cool down (or 'wind down' or 'warm down') at the end of a session .(Table 37b). Twelve Programme Directors (in 8 countries) reported that they did not have a cool down period at the end of a session of their programme (Table 37b). A third of all Programmes had 5 minutes or less of cool down but more than half had cool down periods lasting between 6 and 15 minutes.

Five programmes (two in Finland, and one each in Belgium, Denmark and the UK) had no warm up and no cool down.

Duration of workout component
Estimates of the length of a usual workout component of a session varied from 10 minutes to more than 1 hour (Table 38). For more than four fifths of the programmes, the estimates ranged from around 30 minutes upwards, with the great majority lasting from around 30 minutes to around 40 minutes.

Exercise sessions for older people with chronic medical conditions
More than half of the PA Programme Directors reported that their programme caters for the exercise needs of older people with chronic medical conditions by providing adapted exercise, with participants included in the mainstream older person's group(s) (Table 39). A further quarter of the Directors reported using adapted exercise, with participants in disease-related groups (16 programmes) or in frailty- (or disability-) related groups (11 programmes) (Table 39).

In contrast, 14% of Directors felt that it was not possible, within their programme, to cater for the exercise needs of older people with chronic medical conditions such as osteoporosis, ischaemic heart disease, arthritis, Parkinson's disease or stroke. This appears to contradict the reluctance to exclude potential participants which was evident in Table 33. The responses in Table 33 suggest that an explanation which might reconcile the apparent contradiction is that some of those answering 'not possible' in Table 39 actually meant 'not possible without further assessment', an option which we had failed to offer.

- **Instructors' qualifications and training**

The 112 PA Programme Directors were asked to report the minimum level of qualification required for instructors delivering their programme to older participants. This question yielded 124 responses (Table 40), some Directors having selected more than one response. In more than a third of programmes, instructors required only a basic, 'entry level' qualification in order to deliver the programme to older participants. In a further third of Programmes (from 12 of the 15 countries), a higher (old-age specific) qualification was required.

In a final third of programmes, a wide range of 'other' qualifications was listed. These included programme-specific qualifications, healthcare professional qualifications, and no formal qualification . Most of the 'other' entries seemed to be a description of the person currently in post, rather than a statement of a requirement.

Half of the PA Programme Directors (from 12 countries) estimated that all the instructors guiding/supervising older participants, in their programme, have an entry level qualification (Table 41a). Ten per cent of Directors (from 8 countries) estimated that none of the instructors guiding older participants in their programme had even an entry level qualification (Table 41a).

One third of PA Programme Directors (from 10 countries) estimated that all the instructors guiding/supervising older participants, in their programme, have a higher level qualification (Table 41b). An eighth of Directors (from 9 countries) estimated that none of the instructors guiding older participants in their programme had a higher level qualification (Table 41b).

Professional register

In only one third of the PA Programmes was it compulsory for instructors to be members of a professional register (Table 42). Indeed, in two countries, none of the programmes stipulated that the instructors must be members of a professional register (Table 42).

In-service training

Nearly half of the PA Programme Directors reported that their programme did not provide ongoing in-service training for their instructors or provided less than 5 hours/year (Table 43). Although it must be acknowledged that these programmes are not necessarily the instructors' sole source of continuing professional development (CPD), this statistic is in stark contrast with the 18 programmes (in 8 countries)

reported to provide more than 30 hours /year of in-service training (Table 43).

Programme Directors were each asked to give three examples of topics recently covered in in-service training for their instructors. Topics reported included (in no particular order):-

- Equipment maintenance
- Heart failure
- Exercise referral
- First aid
- Nutrition
- Falls prevention
- Walk leader training
- Chair-based exercise training
- Thematic dance work
- Boccia
- Social supports
- Asahi-health
- Pilates
- Group dynamics
- Marketing
- Motivational interviewing
- Cross-generational work
- Diabetes
- Risk assessment
- Mental health awareness
- Disability
- Stroke awareness
- Nordic walking
- Session planning
- Psychological aspects of ageing
- Exercise physiology in old age
- Laugh-yoga for older people
- Special problems of supervision
- Leading a walking group
- Medication and physical activity
- Behaviour modification
- Osteoporosis

Unpaid volunteers

Nearly half of the PA Programme Directors reported that unpaid volunteers contribute to their programme (Not shown). The use of volunteers is particularly prominent in the UK and in Finland (Table 44).

Unpaid volunteers were commonly reported to contribute by providing refreshments or transport, or by undertaking administrative tasks (Table 44). Unpaid volunteers were also commonly reported to fulfil roles which were more specifically exercise-related, such as 'buddying' or peer-mentoring other participants. Even more specifically exercise-related contributions were also common, such as acting as an instructor's assistant or even giving instruction. Unfortunately, the questionnaire did not pursue this issue any further. As a result we are unable to answer the important questions which it raises concerning, for example, the training given to volunteers before they are permitted to deliver instruction.

- **Client safety**

Only half of the PA Programme Directors (53%) reported that their programme had specific protocols to be followed in emergency situations

(Table 45). Only half of these directors (53% of 53%) reported that they train all their staff in emergency protocols at least annually (Table 46). Only two directors claimed to train at least 6 monthly.

Fewer than half of the Directors (46%) reported that their programme had specific protocols and/or procedures to be followed in respect of equipment use, storage or maintenance (Table 45). Fewer than half of these directors (42% of 46%) reported training all their staff in these protocols and/or procedures at least annually (Table 46). Only one director claimed to train at least 6 monthly.

- **Finance, transport and refreshments**

Forty of the PA Programme Directors were unable (or unwilling) to estimate the total cost (per participant per session) of providing their programme (excluding transport and refreshments but including the cost of the room, lighting, heating, maintenance, instructor's fee and administration) (Table 47). The other 72 Directors reported a wide range of estimated costs. More than a third of these 72 directors estimated their programme to cost 5 euros or less per participant per session but almost a third estimated a cost of more than 10 euros per participant per session (Table 47).

The proportion of this cost paid by each participant varied considerably. Of the 84 programmes for which an estimate was provided, 45% were free to the participant and only 12% were paid for wholly by the participant (Table 48).

Transport was reported to be provided for participants in more than a third of programmes, usually selectively (Table 49). In more than two thirds of the programmes in which it is provided, transport is free or almost free to the participant (Table 50a).

Refreshments were reported to be offered to participants in nearly a half of programmes, to everyone more often than not (Table 49). In two thirds of the programmes in which it is provided, refreshments are free or nearly free to the participant (Table 50b).

- **Publicity, marketing and promotion**

The PA Programme Directors reported that a wide range of methods was used to publicise, market or promote their programmes (Table 51). Multiple methods were commonly used for the same programme.

The method most commonly reported was word of mouth. Other methods frequently reported were websites, advertising in local newspapers, targeted leafleting and features in local newspapers.

More than a third of the PA Programme Directors reported that they had found it useful to capitalise on national or regional campaigns related to aspects of ageing and health in order to improve recruitment of new participants and/or maintain motivation of existing participants (Table 52). Nearly a quarter, however, had not tried this approach (Table 52).

Numerous successful examples were reported, several more than once:-

- International Day for Older Persons
- Walk for Life
- National Walking Day
- British Heart Foundation Happy Hearts
- Get Active in the Community
- Osteoporosis Week
- Men's Health Week
- Walking your Way to Health
- Senior Week
- National Outdoor Day of Older People
- Diabetes Awareness
- 30 a day... any way
- Cancer Research events
- Falls Awareness
- Healthy Living Week
- Age Concern Week
- Fight Diabetes Day
- World Alzheimer's Day

Sixty percent of the PA Programme Directors reported that they had found it useful to build partnerships with local healthcare professionals or organisations (Table 52). Again, numerous examples were offered, ranging from health promotion agencies to local acute hospitals, and from individual primary care practices to geographically defined community interdisciplinary healthcare providers. Several reported forming partnerships with healthcare organisations in order to pursue joint funding.

Country (N)		Educational Backgrounds				
		Medicine	Other Health Profession	Exercise/ Sport Science	Other	Total
Au	7	1	0	1	5	7
Be	11	0	0	7	4	11
CR	3	1	0	1	0	2
De	7	0	5	2	1	8
Fi	11	2	4	3	5	14
Fr	3	0	0	3	0	3
Ge	4	0	1	2	0	3
Gr	9	0	1	8	0	9
It	9	1	0	9	1	11
Ne	10	0	3	5	3	11
No	10	0	3	6	2	11
Pol	1	0	0	1	0	1
Por	8	0	0	8	0	8
Sw	9	5	2	6	3	16
UK	10	0	1	4	6	11

Table 11 - Programme Questionnaire Question 4 (ProgQ4).
Educational backgrounds of the Directors of the PA Programmes selected by the national Experts (N = number of PA Programmes selected for each country, Tables 11-52)

Country (N)		Geographical classification of PA programmes				
		National	Regional	Limited to a city/town	Limited to a local neighbrhd.	Total
Au	7	2	3	2	0	7
Be	11	2	7	1	1	11
CR	3	1	0	2	0	3
De	7	3	2	2	0	7
Fi	11	4	1	4	2	11
Fr	3	3	0	0	0	3
Ge	4	2	0	0	0	2
Gr	9	1	0	8	0	9
It	9	0	2	7	0	9
Ne	10	7	2	0	1	10
No	10	1	1	5	3	10
Pol	1	0	0	1	0	1
Por	8	0	2	5	1	8
Sw	9	0	3	3	3	9
UK	10	3	3	3	1	10

Table 12 (ProgQ9). PA Programme Directors' responses concerning the geographical classification of their programme

Country (N)		Length of time programmes have existed (years)					
		<1	1 - 5	6 - 10	>10	Missing data	Total
Au	7	1	2	3	1	0	7
Be	11	2	3	1	5	0	11
CR	3	0	2	0	1	0	3
De	7	0	4	2	1	0	7
Fi	11	1	6	0	4	0	11
Fr	3	0	1	0	2	0	3
Ge	4	1	2	0	1	0	4
Gr	9	0	4	3	2	0	9
It	9	1	3	2	3	0	9
Ne	10	1	4	2	3	0	10
No	10	0	7	2	1	0	10
Pol	1	1	0	0	0	0	1
Por	8	1	3	3	1	0	8
Sw	9	0	6	1	2	0	9
UK	10	0	5	1	4	0	10

Table 13 (ProgQ10). PA Programme Directors' responses concerning the length of time their programme has existed

Country (N)		Component programmes included in overall programmes										
		A	B	C	D	E	F	G	H	I	J	K
Au	7	1	5	2	1	0	2	0	0	0	0	3
Be	11	2	9	5	7	2	4	2	2	1	1	2
CR	3	0	1	0	0	1	0	1	2	1	1	2
De	7	0	1	0	0	1	0	1	1	1	1	1
Fi	11	0	8	3	7	3	6	2	2	2	1	1
Fr	3	0	3	2	2	0	3	2	1	1	1	3
Ge	4	0	4	1	1	3	3	1	0	0	0	0
Gr	9	2	8	1	0	2	4	5	4	3	5	2
It	9	0	8	1	1	2	3	2	1	0	0	1
Ne	10	0	8	4	4	4	5	2	1	1	2	3
No	10	1	7	2	0	3	6	2	1	0	0	3
Pol	1	0	1	0	1	0	0	0	0	0	0	0
Por	8	0	7	1	0	0	3	2	0	0	1	1
Sw	9	0	6	3	2	2	4	3	2	2	2	2
UK	10	3	9	7	5	6	6	7	4	3	5	2

A = Masters (elite competitor) programmes
B = Community based senior fitness programmes (groups)
C = Community based senior chair-based programmes
D = Home based exercise programmes (individual)
E = Exercise referral / General Practitioner referral programmes
F = Falls prevention programmes
G = Cardiac rehabilitation
H = Pulmonary rehabilitation
I = Arthritis programmes
J = Other medical, condition-specific programmes
K = Other programmes

Table 14 (ProgQ11). PA Programme Directors' responses concerning which component programmes are included in their overall programmes

Country (N)		Description of overall programmes					
		Group	Individual	Indoors	Outdoors	Water-based	Land-based
Au	7	7	2	7	3	1	6
Be	11	10	5	9	8	3	11
CR	3	2	1	2	1	1	0
De	7	6	3	6	4	2	7
Fi	11	11	6	10	5	3	11
Fr	3	3	2	3	1	1	1
Ge	4	4	1	4	1	1	2
Gr	9	8	2	6	2	2	5
It	9	9	1	9	4	3	8
Ne	10	9	2	10	1	1	8
No	10	10	0	10	2	1	9
Pol	1	1	1	1	1	0	1
Por	8	6	1	6	3	6	6
Sw	9	8	3	9	3	2	9
UK	10	8	4	9	6	4	9

Table 15 (ProgQ12). PA Programme Directors' responses concerning the description of their overall programmes

Country (N)		Facilities used by overall programmes					
		A	B	C	D	E	F
Au	7	5	6	1	0	2	3
Be	11	8	4	3	2	1	3
CR	3	0	1	0	1	1	1
De	7	2	3	0	5	4	1
Fi	11	6	5	7	3	3	4
Fr	3	1	1	0	0	2	1
Ge	4	4	3	3	1	2	1
Gr	9	7	5	6	1	2	0
It	9	7	6	2	0	1	3
Ne	10	6	6	4	1	5	1
No	10	6	4	3	0	2	3
Pol	1	1	0	1	0	1	0
Por	8	8	2	2	0	2	2
Sw	9	5	7	0	1	1	0
UK	10	9	9	4	3	4	2

A = Sport / physical recreation facility
B = Community centre
C = Day resources centre
D = Participant's private dwelling
E = Sheltered housing, assisted living facility, care home or nursing home
F = Other

Table 16 (ProgQ13). Programme Directors' responses concerning the types of facilities used by their overall programmes.

Country (N)		'Category' of intended participants (by type of dwelling)				
		A	B	C	D	Total
Au	7	3	2	0	2	7
Be	11	5	0	3	3	11
CR	3	2	0	1	0	3
De	7	4	0	1	2	7
Fi	11	7	0	0	3	10
Fr	3	0	0	1	1	2
Ge	4	3	0	0	1	4
Gr	9	5	0	1	3	9
It	9	6	1	0	2	9
Ne	10	4	1	2	3	10
No	10	10	0	0	0	10
Pol	1	0	0	0	1	1
Por	8	5	0	1	2	8
Sw	9	7	1	0	0	8
UK	10	3	0	2	2	7

A = Community-dwelling older adults
B = Institution-dwelling older adults
C = Both, together (in the same group)
D = Both, separately (in different groups)

Table 17 (ProgQ16). PA Programme Directors' responses concerning the 'category' of participant (by type of dwelling) for whom their overall programme is intended.

Country (N)		'Category' of intended participants (by level of functional mobility)				
		A	B	C	D	E
Au	7	4	6	5	3	5
Be	11	7	11	5	5	5
CR	3	1	3	2	1	0
De	7	0	5	7	3	3
Fi	11	2	7	10	7	3
Fr	3	3	2	1	2	2
Ge	4	2	4	3	2	1
Gr	9	7	6	2	3	0
It	9	5	9	3	1	0
Ne	11	2	8	8	5	4
No	10	5	5	7	2	2
Pol	1	0	1	1	0	0
Por	8	0	8	3	0	0
Sw	9	6	8	7	2	2
UK	10	4	10	10	6	6

A = Frequently walks vigorously or runs

B = Walking outdoors with no walking aids and no assistance or supervision by another person

C = Walks outdoors with a walking aid but no assistance or supervision by another person

D = Walks outdoors only with assistance or supervision by another person

E = Never walks outdoors

Table 18 (ProgQ17). PA Programme Directors' responses concerning the 'category' of participant (by level of functional mobility) for whom their overall programme is intended.

Country (N)		Proportion of participants who are female (%)						
		0%	25%	50%	75%	100%	Don't know	Total
Au	7	0	0	0	7	0	0	7
Be	11	0	0	4	4	1	2	11
CR	3	0	0	0	2	1	0	3
De	7	0	0	0	6	1	0	7
Fi	11	0	0	0	11	0	0	11
Fr	3	0	0	0	2	0	1	3
Ge	4	0	0	2	2	0	0	4
Gr	9	0	1	1	4	2	1	9
It	9	0	0	0	8	1	0	9
Ne	10	0	0	2	7	1	0	10
No	10	0	0	3	5	2	0	10
Pol	1	0	0	0	1	0	0	1
Por	8	0	0	0	6	2	0	8
Sw	9	0	0	0	9	0	0	9
UK	10	0	0	0	8	0	1	9

Table 19 (ProgQ18). PA Programme Directors' estimates of the proportion of participants in their overall programme that are women

Country (N)		Group sizes used in overall programmes								
		1	2-5	6-10	11-15	16-20	21-25	26-50	51+	Do not know
Au	7	0	0	1	3	2	0	1	0	0
Be	11	1	1	0	3	3	4	2	0	1
CR	3	0	0	1	1	2	1	1	1	0
De	7	3	2	3	4	0	1	0	0	0
Fi	11	4	2	8	6	3	3	3	2	0
Fr	3	0	0	0	3	0	0	0	0	0
Ge	4	0	0	1	4	1	0	0	0	0
Gr	9	1	2	4	6	2	0	1	0	0
It	9	1	0	1	3	3	5	1	0	0
Ne	10	0	1	4	5	4	1	0	0	0
No	10	1	2	3	7	6	3	3	3	0
Pol	1	0	0	0	1	0	0	0	0	0
Por	8	0	0	0	0	3	3	2	0	0
Sw	9	1	2	4	5	3	3	2	1	0
UK	10	2	4	6	5	7	5	6	1	1

Table 20 (ProgQ19). PA Programme Directors' estimates of group sizes used in their overall programmes

Country (N)		Number of participants per instructor in a typical session of the programme						
		1	2-10	11-25	26-50	51+	Do not know	Total
Au	7	0	1	4	1	0	0	6
Be	11	1	2	6	1	0	1	11
CR	3	0	1	2	0	0	0	3
De	7	1	2	2	0	0	0	5
Fi	11	0	6	3	0	0	0	9
Fr	3	0	1	2	0	0	0	3
Ge	4	0	3	1	0	0	0	4
Gr	9	2	3	4	0	0	0	9
It	9	0	1	8	0	0	0	9
Ne	10	0	4	6	0	0	0	10
No	10	0	4	3	2	0	0	9
Pol	1	0	0	1	0	0	0	1
Por	8	0	4	4	0	0	0	8
Sw	9	1	2	5	1	0	0	9
UK	10	1	4	5	0	0	0	10

Table 21 (ProgQ20). PA Programme Directors' estimates of the ratio of instructors to participants in a typical session of their programme

Country (N)		Maximal possible frequency of participation (occasions per week)							
		<1	1	2	3-4	5-7	8+	Do not know	Total
Au	7	0	3	1	1	1	0	0	6
Be	11	1	1	2	5	2	0	0	11
CR	3	0	2	0	1	0	0	0	3
De	7	0	2	1	2	1	1	0	7
Fi	11	0	1	4	1	3	1	0	10
Fr	3	0	1	0	2	0	0	0	3
Ge	4	0	0	3	1	0	0	0	4
Gr	9	0	0	1	8	0	0	0	9
It	9	0	0	2	5	2	0	0	9
Ne	10	0	5	2	3	0	0	0	10
No	10	0	5	1	2	1	0	0	9
Pol	1	0	1	0	0	0	0	0	1
Por	8	0	0	0	6	2	0	0	8
Sw	9	0	0	3	4	2	0	0	9
UK	10	0	2	0	1	4	2	1	10

Table 22a (ProgQ21). PA Programme Directors' estimates of the maximum possible frequency (per week) with which individuals may participate in their overall programme.

Country (N)		Usual frequency of participation (occasions per week)							
		<1	1	2	3-4	5-7	8+	Do not know	Total
Au	7	1	3	2	0	0	0	0	6
Be	11	1	4	3	2	0	0	1	11
CR	3	0	3	0	0	0	0	0	3
De	7	0	2	4	1	0	0	0	7
Fi	11	1	4	2	2	1	0	0	10
Fr	3	0	1	0	2	0	0	0	3
Ge	4	0	2	2	0	0	0	0	4
Gr	9	0	0	2	6	0	0	0	8
It	9	1	1	4	2	0	0	1	9
Ne	10	0	8	2	0	0	0	0	10
No	10	2	5	3	0	0	0	0	10
Pol	1	0	0	0	1	0	0	0	1
Por	8	0	0	3	5	0	0	0	8
Sw	9	0	0	7	2	0	0	0	9
UK	10	0	3	4	2	0	0	1	10

Table 22b (ProgQ22). PA Programme Directors' estimates of the usual frequency (per week) with which individuals participate in their overall programme.

Country (N)		Percentage of current participants who have attended for at least 1 year						
		0%	25%	50%	75%	100%	Do not know	Total
Au	7	1	1	2	2	0	1	7
Be	11	1	0	1	4	0	5	11
CR	3	0	1	1	0	1	0	3
De	7	0	2	2	1	1	1	7
Fi	11	1	1	2	4	0	2	10
Fr	3	0	1	0	1	1	0	3
Ge	4	0	0	1	1	0	2	4
Gr	9	0	1	2	6	0	0	9
It	9	1	0	1	6	1	0	9
Ne	10	3	0	0	4	1	1	9
No	10	0	1	2	5	0	2	10
Pol	1	0	0	0	1	0	0	1
Por	8	0	0	0	5	2	1	8
Sw	9	1	0	0	4	1	1	7
UK	10	0	0	2	5	1	2	10

Table 23 (ProgQ23). PA Programme Directors' estimates of the proportion of current participants that have attended their overall programme for at least a year

Country (N)		Sponsors' two most important aims									
		A	B	C	D	E	F	G	H	I	J
Au	7	2	0	2	3	1	3	3	0	0	14
Be	11	9	0	0	3	1	5	1	2	0	21
CR	3	2	0	1	2	1	0	0	0	0	6
De	7	0	0	4	6	2	2	0	0	0	14
Fi	11	3	0	0	8	1	5	1	0	0	18
Fr	3	4	0	0	0	0	0	0	2	0	6
Ge	4	4	0	1	2	0	0	0	1	0	8
Gr	9	8	0	4	2	2	1	2	0	0	19
It	9	5	0	0	5	0	2	5	0	0	17
Ne	10	5	0	2	4	0	3	2	4	0	20
No	10	4	1	2	7	0	3	3	0	0	20
Pol	1	1	0	0	1	0	0	0	0	0	2
Por	8	5	0	2	6	0	3	0	0	0	16
Sw	9	6	0	2	7	0	1	0	2	0	18
UK	10	3	0	2	4	0	3	4	3	0	19

A = Health promotion
B = Improved competitive performance
C = Disease prevention
D = Improved physical function
E = Improved mood
F = Opportunities to socialise
G = Improved self esteem / confidence
H = Other
I = Don't know
J = Total

Table 24 (ProgQ24). PA Programme Directors' responses concerning the two most important overall aims of their programme, from the point of view of its sponsoring organisation.

Country (N)		Frequency of measuring participant satisfaction (times per year)					
		<1	1-2	3-6	>6	Do not know	Total
Au	7	0	7	0	0	0	7
Be	11	7	1	2	0	0	10
CR	3	0	2	0	1	0	3
De	7	1	3	2	0	0	6
Fi	11	1	8	0	0	1	10
Fr	3	0	1	1	0	1	3
Ge	4	1	2	1	0	0	4
Gr	9	3	4	1	1	0	9
It	9	4	2	0	0	2	8
Ne	10	2	7	0	0	1	10
No	10	5	3	0	1	1	10
Pol	1	0	0	1	0	0	1
Por	8	5	1	2	0	0	8
Sw	9	0	6	2	1	0	9
UK	10	1	2	5	0	2	10

Table 25 (ProgQ25). PA Programme Directors' estimates of the frequency (times per year) with which the satisfaction of participants in their programme is formally measured

Country (N)		Number of PA Programme Directors answering 'yes'		
		Survey of participants' aims	Programme adjusted according to participants' aims	Objective outcomes measured
Au	7	5 (71%)	5	3 (43%)
Be	11	5 (45%)	5	3 (27%)
CR	3	2 (67%)	2	2 (67%)
De	7	1 (14%)	1	7 (100%)
Fi	11	8 (73%)	6	8 (73%)
Fr	3	3 (100%)	2	3 (100%)
Ge	4	2 (50%)	3	4 (100%)
Gr	9	4 (44%)	4	5 (56%)
It	9	3 (33%)	3	6 (67%)
Ne	10	9 (90%)	7	7 (100%)
No	10	6 (60%)	6	2 (20%)
Pol	1	1 (100%)	1	1 (100%)
Por	8	7 (88%)	7	6 (75%)
Sw	9	8 (89%)	8	4 (44%)
UK	10	9 (90%)	9	6 (60%)

Table 26 (ProgQ26-28). PA Programme Directors' responses concerning whether (A) participants are formally surveyed for the aims of their involvement in the programme, (B) programmes are adjusted according to participants' aims, and (C) objective outcome measures are recorded for participants at regular intervals

Country (N)		Number (%) of PA Programme Directors answering 'YES'										
		A	B	C	D	E	F	G	H	I	J	K
Au	7	0	0	0	0	0	0	0	3	2	0	0
Be	11	0	0	2	1	1	2	0	1	0	1	8
CR	3	0	1	1	0	2	0	0	0	0	1	0
De	7	6	0	1	6	3	3	0	3	0	2	0
Fi	11	2	0	0	5	1	0	0	2	2	5	0
Fr	3	2	1	1	3	2	1	3	1	1	0	0
Ge	4	3	0	0	3	1	0	0	2	1	3	0
Gr	9	3	1	4	4	3	2	2	3	1	1	0
It	9	3	0	4	4	4	2	0	3	1	2	2
Ne	10	4	0	2	5	2	3	0	2	4	5	0
No	10	1	0	0	2	1	0	0	0	0	1	3
Pol	1	0	0	0	1	0	1	0	1	1	1	0
Por	8	4	3	4	5	5	5	3	4	0	3	0
Sw	9	3	0	2	3	1	3	0	3	2	4	1
UK	10	1	0	2	4	3	3	0	6	4	4	1

A = Strength or explosive power
B = Maximal oxygen uptake (directly measured)
C = Submaximal test of aerobic fitness
D = Balance
E = Joint range of motion
F = Body composition
G = Bone density
H = Mood / depression
I = Social support
J = Other
K = Not applicable

Table 27 (ProgQ29). PA Programme Directors' responses concerning which objective measures are recorded at regular intervals

Country (N)		Is a health check required to be eligible to enter programme?			
		Yes	No	Don't know	Total
Au	7	3	4	0	7
Be	11	2	9	0	11
CR	3	2	1	0	3
De	7	3	0	0	3
Fi	11	6	5	0	11
Fr	3	3	0	0	3
Ge	4	2	2	0	4
Gr	9	9	0	0	9
It	9	7	2	0	9
Ne	10	4	5	0	9
No	10	1	8	0	9
Pol	1	1	0	0	1
Por	8	6	2	0	8
Sw	9	2	7	0	9
UK	10	9	1	0	10

Table 28 (ProgQ30). PA Programme Directors' responses concerning whether eligibility for entry to their programme requires the potential participant to have a health check

Country (N)		Type of health check required to be eligible to enter programme						
		A	B	C	D	E	F	Total
Au	7	0	1	0	1	0	0	2
Be	11	0	1	0	0	1	0	2
CR	3	0	1	1	0	0	0	2
De	7	0	2	0	0	1	0	3
Fi	11	2	1	0	1	1	1	6
Fr	3	0	1	0	0	0	0	1
Ge	4	0	2	0	0	0	0	2
Gr	9	2	5	0	0	1	1	9
It	9	2	3	0	0	1	0	6
Ne	10	2	2	0	0	1	0	5
No	10	0	1	0	0	0	0	1
Pol	1	0	1	0	0	0	0	1
Por	8	1	4	0	1	0	0	6
Sw	9	0	2	0	0	0	0	2
UK	10	5	0	0	0	1	0	6

A = Completion of a health screening tool
B = Assessment by a doctor
C = Assessment by a doctor who is a sports medicine specialist or by the programme doctor
D = Assessment by some other healthcare professional
E = Assessment by an exercise instructor
F = Other

Table 29 (ProgQ31). PA Programme Directors' responses concerning the form of health check required for a potential participant to be eligible for entry to their programme

Country (N)		Is self-completion of a health screening tool required to be eligible to enter programme?			
		Yes	No	Don't know	Total
Au	7	0	6	1	7
Be	11	1	10	0	11
CR	3	1	2	0	3
De	7	2	4	1	7
Fi	11	4	7	0	11
Fr	3	2	0	0	2
Ge	4	0	3	1	4
Gr	9	3	5	0	8
It	9	3	6	0	9
Ne	10	5	5	0	10
No	10	0	10	0	10
Pol	1	0	1	0	1
Por	8	5	3	0	8
Sw	9	1	8	0	9
UK	10	7	3	0	10

Table 30 (ProgQ32). PA Programme Directors' responses concerning whether eligibility for entry to their programme requires completion of a health screening tool by the potential participant.

Country (N)		The programme's health screening tool is	
		Internationally recognised	Adapted for the programme
Au	7	0	0
Be	11	N/A	N/A
CR	3	0	1
De	7	1	2
Fi	11	1	3
Fr	3	1	1
Ge	4	N/A	N/A
Gr	9	2	3
It	9	1	2
Ne	10	3	2
No	10	N/A	N/A
Pol	1	N/A	N/A
Por	8	2	5
Sw	9	0	2
UK	10	4	5

Table 31 (ProgQ33 & 35). PA Programme Directors' responses concerning whether their health screening tool is internationally recognised and whether it had been adapted for their programme

Country (N)		Number of PA Programme Directors confirming that their health screening tool includes questions on		
		Dizziness	Eyesight	Hearing
Au	7	0	0	0
Be	11	1	0	1
CR	3	0	0	0
De	7	0	0	0
Fi	11	3	2	2
Fr	3	2	2	2
Ge	4	0	0	0
Gr	9	2	2	2
It	9	2	1	1
Ne	10	4	1	1
No	10	0	0	0
Pol	1	0	0	0
Por	8	4	3	3
Sw	9	0	0	0
UK	10	7	1	2

Table 32 (ProgQ36). PA Programme Directors' responses concerning the questions included in the health screening tool used by their programme

Country (N)		Requirements for programme entry after health screening tool has identified a potential problem								
		A	B	C	D	E	F	G	H	Total
Au	7	0	0	2	0	0	0	0	1	3
Be	11	0	0	0	0	0	1	0	10	11
CR	3	0	0	1	0	0	0	0	1	2
De	7	0	0	3	0	0	1	0	2	6
Fi	11	1	1	1	0	0	3	0	4	10
Fr	3	1	0	1	0	0	0	0	0	2
Ge	4	0	0	0	0	0	0	0	3	3
Gr	9	0	1	1	0	0	2	0	4	8
It	9	0	0	2	1	0	0	2	4	9
Ne	10	1	0	3	1	0	1	0	4	10
No	10	0	0	0	0	0	1	0	5	6
Pol	1	0	0	1	0	0	0	0	0	1
Por	8	0	2	3	0	0	0	0	3	8
Sw	9	0	0	0	0	0	1	0	8	9
UK	10	1	1	5	0	0	1	0	1	9

A = The applicant need only sign a liability waiver
B = Applicant must obtain ‘approval’ from any healthcare professional
C = Applicant must obtain ‘approval’ from their doctor
D = Applicant must obtain ‘approval’ from a doctor who is a sports medicine specialist or from the programme doctor
E = It is not possible for the applicant to be permitted to enter the programme
F = Other
G = Don’t know
H = Not applicable

Table 33 (ProgQ37). PA Programme Directors’ responses concerning what is done so that an applicant can be permitted to enter a programme after a potential problem has been identified by the health screening tool

Country (N)		Number (%) of PA Programme Directors selecting this component/aspect of physical fitness							
		A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Au	7	2	0	6	5	3	1	0	3
Be	11	5	1	7	9	6	4	2	4
CR	3	1	0	2	2	2	1	0	2
De	7	5	4	0	0	3	2	2	0
Fi	11	9	1	11	10	9	4	3	5
Fr	3	2	1	3	2	1	1	2	1
Ge	4	3	1	3	3	1	0	1	1
Gr	9	6	1	9	7	7	1	4	1
It	9	7	1	9	9	9	3	3	3
Ne	10	9	0	9	9	7	2	2	4
No	10	8	1	10	8	5	1	4	3
Pol	1	1	1	1	1	0	1	0	0
Por	8	8	2	8	8	8	6	4	1
Sw	9	9	0	9	9	7	5	3	1
UK	10	7	1	7	9	8	4	7	3

A = Strength (as in response to ProgQ40)
B = Explosive power (as in response to ProgQ40)
C = endurance (as in response to ProgQ38)
D = Coordination / balance (as in response to ProgQ38)
E = Joint range of motion (as in response to ProgQ40)
F = Body composition (as in response to ProgQ40)
G = Bone density (as in response to ProgQ40)
H = Other (as in response to ProgQ40)

Table 34 (ProgQ38 & 40). PA Programme Directors' responses concerning the component(s) or aspect(s) of physical fitness which their PA Programme aims to improve.

TABLE 35 (ProgQ39)

	Au	Be	CR	De	Fi	Fr	Ge	Gr	It	Ne	No	Pol	Por	Sw	UK
Aquatics															
Swimming	1	5	0	0	2	1	0	2	2	1	1	0	3	0	5
Aqua exercises	1	5	1	2	5	1	1	4	5	3	1	1	6	2	4
Cycling															
On Road/ Paths	0	5	0	0	0	0	1	1	0	1	0	0	0	0	3
Off Road/ Track/ Hills	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Group Sports/ Ball Games															
Badminton	0	5	0	0	1	0	0	0	1	2	1	0	0	2	4
Billiard Sports	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Boules	0	3	0	0	1	0	0	0	1	3	1	1	0	2	1
Bowling	0	1	0	0	0	0	0	1	0	1	0	0	0	1	4
Golf	0	2	0	0	1	0	0	0	0	0	1	0	0	0	2
Minigolf	1	1	0	0	0	0	0	0	0	0	0	1	0	0	1
Short tennis	0	1	0	0	0	0	0	0	0	0	0	0	0	1	3
Tennis	0	3	0	0	0	0	1	0	0	1	0	0	0	0	4
Recreational Movement															
Dance	5	5	1	1	6	0	1	5	3	4	3	1	4	2	8
Movement	6	5	0	0	6	2	3	7	9	8	4	0	0	3	8
Exercise to music	5	5	0	3	5	1	2	7	7	6	7	1	0	6	7
Derived from Pilates	0	1	0	1	1	0	1	2	2	2	3	0	0	2	5
Derived from Tai Chi	0	4	0	1	1	2	2	0	0	2	1	1	2	1	6
Derived from Qigong	0	1	0	0	0	0	0	0	0	2	2	0	1	3	2
Derived from Yoga	0	3	2	0	1	1	0	1	2	2	2	1	1	1	5
Running															
Indoor running (not on treadmill)	0	3	0	0	0	0	0	6	4	0	2	0	0	1	2
Outdoor running/ Track	0	2	0	0	1	0	0	3	2	0	0	0	0	0	2
Orienteering	0	2	0	0	1	0	0	1	0	0	2	0	0	0	0
Skiing															
Cross Country Skiing	0	1	0	0	1	0	0	0	0	0	1	0	0	0	1
Downhill (Alpine Skiing)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
Ski Touring	2	0	0	0	1	0	0	0	0	0	1	0	0	3	1
Walking															
Indoor Walking (not treadmill)	2	1	0	4	6	0	1	6	4	2	4	0	2	2	1
Outdoor Walking on path/ track	2	3	0	0	6	1	0	1	1	1	0	1	3	3	6
Outdoor Walking groups	1	3	0	2	5	0	1	4	7	3	0	0	4	1	7
Rambling or Hill Walking	1	0	0	1	0	0	0	0	1	0	1	0	0	0	2
Trekking	1	0	0	0	0	0	0	1	0	0	1	0	0	1	0
Nordic Walking	1	5	0	1	5	0	2	0	3	1	2	1	1	2	1

TABLE 35 (continued)

	Au	Be	CR	De	Fi	Fr	Ge	Gr	It	Ne	No	Pol	Por	Sw	UK
Machine based equipment															
Circuits	0	2	0	3	5	0	1	1	2	1	0	0	2	2	1
Treadmill	0	1	0	0	2	0	1	1	1	2	1	0	3	2	5
Cycle	0	4	1	3	5	1	1	2	4	2	2	0	4	3	5
Rowing	0	1	0	0	2	0	1	0	0	2	2	0	2	2	5
Stepper	0	2	0	0	5	0	1	1	3	2	1	0	2	1	5
Cross – trainer	0	3	0	0	3	0	1	0	0	2	0	0	2	2	5
Fixed resistance machines	0	2	0	4	3	0	1	2	2	1	1	0	2	3	4
Dumbells / Free weights	0	2	0	4	5	0	3	8	6	1	1	0	1	4	5
Physioballs, for balance	1	1	0	2	5	1	2	3	5	1	2	0	3	3	4
Resistance balls, bands etc	0	3	1	4	4	1	2	3	6	1	2	0	3	2	5
Wobbleboards etc	0	1	0	3	5	1	3	2	0	0	3	0	1	2	4
Other	0	2	0	0	3	0	0	2	1	3	0	0	1	0	1
Competitive sport															
Any	1	3	0	0	0	0	0	1	0	0	0	0	1	0	1
Adapted exercise															
Back pain prevention	1	2	2	0	2	1	1	9	7	2	5	1	3	4	4
Osteoporosis prevention	1	3	1	0	3	2	1	7	3	3	3	0	3	4	3
Falls prevention	3	3	1	0	5	2	3	5	3	6	6	1	5	6	7
Pelvic Floor exercise	0	1	1	0	2	2	1	6	3	2	2	0	2	3	4
Chair-based exercise	4	1	0	5	5	1	3	5	5	5	0	0	0	4	6
Cardiac rehab	0	2	2	0	4	2	0	5	2	1	1	0	0	0	6
Pulmonary rehab	0	3	1	0	4	1	0	4	0	1	0	0	0	0	3
Other	0	0	0	0	2	1	0	0	0	3	2	0	1	2	2

Table 35 (ProgQ39). PA Programme Directors' responses concerning the modalities of physical activity offered in their programme.

Country(N)		Directors reporting progression as part of the programme				
		Never	First few weeks only	First few months only	Always	Don't know
Au	7	5	0	0	1	1
Be	11	4	0	0	5	2
CR	3	0	0	1	2	0
De	7	1	1	2	3	0
Fi	11	1	1	4	4	1
Fr	3	0	0	0	3	0
Ge	4	0	0	1	3	0
Gr	9	0	0	0	9	0
It	9	1	0	1	6	1
Ne	10	1	1	0	7	1
No	10	1	1	2	5	1
Pol	1	0	0	0	1	0
Por	8	0	1	1	6	0
Sw	9	1	0	1	6	0
UK	10	0	0	2	8	0

Table 36 (ProgQ41). PA Programme Directors' responses concerning the extent to which 'progression' of participants is part of their overall programme.

('Progression' defined as a systematic increase in the intensity or resistance, the frequency and/or duration of exercise.)

Country (N)		Reported length of usual warm up (minutes)						
		0	1-5	6-10	11-15	16-20	Don't know	Total
Au	7	0	2	3	1	0	0	6
Be	11	1	3	2	1	1	3	11
CR	3	0	1	1	1	0	0	3
De	7	2	0	1	2	2	0	7
Fi	11	2	0	3	3	1	1	10
Fr	3	0	0	0	0	2	1	3
Ge	4	0	1	2	0	1	0	4
Gr	9	0	2	2	4	1	0	9
It	9	0	1	3	5	0	0	9
Ne	10	1	5	3	1	0	0	10
No	10	0	2	4	3	0	1	10
Pol	1	0	0	0	1	0	0	1
Por	8	0	1	5	2	0	0	8
Sw	9	0	3	4	1	0	0	8
UK	10	1	2	2	4	0	1	10

Table 37a (ProgQ42). PA Programme Directors' estimates of the length of a usual warm up at the beginning of a session in this programme.

Country (N)		Reported length of usual cool down (minutes)						
		0	1-5	6-10	11-15	16-20	Don't know	Total
Au	7	3	0	3	0	0	0	6
Be	11	1	3	3	1	0	3	11
CR	3	0	0	2	1	0	0	3
De	7	1	3	1	1	1	0	7
Fi	11	2	0	1	4	0	3	10
Fr	3	0	0	0	1	1	1	3
Ge	4	0	1	3	0	0	0	4
Gr	9	0	5	3	1	0	0	9
It	9	0	2	4	3	0	0	9
Ne	10	1	4	5	0	0	0	10
No	10	1	4	3	1	0	1	10
Pol	1	0	0	0	1	0	0	1
Por	8	0	3	5	0	0	0	8
Sw	9	1	1	5	1	0	0	8
UK	10	1	2	4	2	0	1	10

Table 37b (ProgQ43). PA Programme Directors' estimates of the length of a usual cool down (or 'wind down' or 'warm down') at the end of a session in this programme.

Country (N)		Reported length of usual workout component of a session (minutes)									
		0	10	20	30	40	50	60	>60	Don't know	Total
Au	7	0	2	0	0	3	1	0	0	0	6
Be	11	0	0	3	0	2	0	2	1	3	11
CR	3	0	0	0	0	1	0	0	2	0	3
De	7	0	0	0	2	0	0	3	2	0	7
Fi	11	0	1	0	3	2	1	2	0	1	10
Fr	3	0	0	0	2	1	0	0	0	0	3
Ge	4	0	0	0	3	1	0	0	0	0	4
Gr	9	0	0	0	4	2	2	1	0	0	9
It	9	0	0	0	4	5	0	0	0	0	9
Ne	10	0	0	1	4	3	1	0	1	0	10
No	10	0	0	1	0	7	0	0	2	0	10
Pol	1	0	0	0	0	1	0	0	0	0	1
Por	8	0	0	1	4	3	0	0	0	0	8
Sw	9	0	0	1	3	5	0	0	0	0	9
UK	10	0	1	2	3	2	1	0	1	0	10

Table 38 (ProgQ44). PA Programme Directors' estimates of the length of a usual workout component of a session in this programme

Country (N)		Catering for the exercise needs of older people with chronic medical conditions					
		A	B	C	D	Don't know	Total
Au	7	2	0	2	2	0	6
Be	11	4	0	1	4	2	11
CR	3	0	1	0	2	0	3
De	7	0	3	1	3	0	7
Fi	11	1	2	2	4	0	9
Fr	3	0	3	0	0	0	3
Ge	4	1	1	1	1	0	4
Gr	9	0	3	1	5	0	9
It	9	1	1	2	5	0	9
Ne	10	2	0	0	8	0	10
No	10	2	1	0	6	0	9
Pol	1	0	0	0	1	0	1
Por	8	3	0	0	4	1	8
Sw	9	0	0	1	6	0	7
UK	10	0	1	0	6	0	7

A = This is not possible

B = Adapted exercise, with participants in disease-related groups

C = Adapted exercise, with participants in frailty-related or disability-related groups

D = Adapted exercise, with participants included in the mainstream older person's group(s)

Table 39 (ProgQ 45). PA Programme Directors' responses concerning how, within this programme, they cater for the exercise needs of older people with chronic medical conditions**.**

Country (N)		Number of PA Programme Directors reporting as minimum level of qualification				
		Basic (entry level)	Higher (old-age specific)	Other	Don't know	Total
Au	7	6	0	2	0	8
Be	11	4	3	4	1	12
CR	3	0	1	2	0	3
De	7	2	0	7	0	9
Fi	11	6	4	3	0	13
Fr	3	1	1	0	0	2
Ge	4	1	2	2	0	5
Gr	9	5	4	0	0	9
It	9	4	1	5	0	10
Ne	10	1	7	1	1	10
No	10	2	7	4	1	14
Pol	1	0	1	0	0	1
Por	8	6	0	2	0	8
Sw	9	3	4	3	0	10
UK	10	3	4	3	0	10

***Table 40 (ProgQ46*).** PA Programme Directors' responses concerning minimum level of qualification required for instructors delivering this programme to older participants

Country (N)		Estimated prevalence of basic, entry level qualification amongst instructors delivering the surveyed programmes to older people						
		0%	25%	50%	75%	100%	Don't know	Total
Au	7	0	2	0	2	1	0	5
Be	11	2	1	1	2	3	2	11
CR	3	1	0	0	0	0	2	3
De	-	-	-	-	-	-	-	-
Fi	11	1	1	1	1	4	1	9
Fr	3	0	0	0	0	3	0	3
Ge	4	0	0	1	0	3	0	4
Gr	9	0	0	0	2	3	2	7
It	9	3	1	0	0	5	0	9
Ne	10	1	0	2	3	3	1	10
No	10	0	0	0	0	7	2	9
Pol	1	1	0	0	0	0	0	1
Por	8	1	0	0	1	6	0	8
Sw	9	0	0	0	1	8	0	9
UK	10	1	0	0	0	7	2	10

Table 41a (ProgQ48). PA Programme Directors' estimates of the proportion of instructors guiding/ supervising older participants, in this programme, that have the entry level qualification..

NB No Danish data available

Country (N)		Estimated prevalence of higher, old age specific qualification amongst instructors delivering the surveyed programmes to older people						
		0%	25%	50%	75%	100%	Don't know	Total
Au	7	1	2	1	1	0	0	5
Be	11	3	1	2	1	2	2	11
CR	3	0	0	0	0	1	2	3
De	-	-	-	-	-	-	-	-
Fi	11	1	2	2	0	3	2	10
Fr	3	0	0	0	1	0	0	1
Ge	4	0	0	1	0	2	0	3
Gr	9	1	1	1	1	3	2	9
It	9	2	1	0	1	3	2	9
Ne	10	1	0	2	3	2	1	9
No	10	0	0	0	0	7	2	9
Pol	1	1	0	0	0	0	0	1
Por	8	1	5	0	0	0	2	8
Sw	9	0	0	0	1	8	0	9
UK	10	2	0	0	1	4	0	7

Table 41b (ProgQ49). PA Programme Directors' estimates of the proportion of instructors guiding/ supervising older participants, in this programme, that have the higher level, old age specific qualification.

NB No Danish data available

Country (N)		Do instructors for this programme have to be a member of a professional register?			
		Yes	No	Don't know	Total
Au	7	1	6	0	7
Be	11	2	8	1	11
CR	3	2	1	0	3
De	7	1	4	0	5
Fi	11	6	5	0	11
Fr	3	2	0	1	3
Ge	4	2	2	0	4
Gr	9	0	4	5	9
It	9	2	5	1	8
Ne	10	7	3	0	10
No	10	3	6	1	10
Pol	1	1	0	0	1
Por	8	0	8	0	8
Sw	9	4	5	0	9
UK	10	4	6	0	10

Table 42 (ProgQ47). PA Programme Directors' responses concerning whether instructors for this programme have to be a member of a professional register

Country (N)		In-service training provided (hours/year)											
		0	1	3	5	10	15	20	30	>30	DNK	NA	T
Au	7	4	0	0	1	0	1	0	0	1	0	0	7
Be	11	0	0	0	1	0	1	1	0	0	1	7	11
CR	3	1	0	0	0	0	0	0	0	0	0	1	2
De	7	2	1	1	2	0	0	0	0	0	0	1	7
Fi	11	0	1	1	0	0	0	2	1	3	1	2	11
Fr	3	0	0	0	0	1	0	1	0	1	0	0	3
Ge	4	0	0	1	0	1	1	0	0	0	0	1	4
Gr	9	0	0	0	0	0	0	2	0	1	1	5	9
It	9	0	0	1	0	2	2	0	0	2	0	2	9
Ne	10	0	0	0	2	2	0	1	0	0	2	3	10
No	10	1	0	2	0	1	0	0	0	1	1	4	10
Pol	1	0	0	0	0	0	0	0	0	0	0	0	0
Por	8	0	5	0	0	0	0	0	0	0	0	3	8
Sw	9	0	0	0	0	0	1	0	0	5	0	2	8
UK	10	1	0	0	1	0	0	2	0	4	2	0	10

Table 43 (ProgQ51). PA Programme Directors' estimates of the number of hours in–service training provided each year for the instructors in this programme

Country (N)		Reports of contributions from unpaid volunteers										
		A	B	C	D	E	F	G	H	I	J	K
Au	7	0	1	1	0	0	4	0	1	3	0	0
Be	11	0	5	1	2	1	2	1	1	0	0	3
CR	3	0	0	0	0	0	0	0	0	2	0	0
De	7	3	1	0	2	1	1	0	3	1	0	0
Fi	11	2	3	6	4	2	1	2	2	2	0	2
Fr	3	0	0	0	0	0	0	0	0	0	0	1
Ge	4	0	1	1	0	0	0	0	0	0	0	3
Gr	9	0	1	3	3	0	0	1	0	0	0	4
It	9	0	0	0	1	0	1	0	1	0	1	1
Ne	10	3	0	2	1	1	2	2	3	1	0	2
No	10	2	3	1	2	0	2	1	1	1	0	3
Pol	1	0	0	1	0	0	0	0	0	0	0	0
Por	8	0	1	3	2	1	0	1	0	2	0	2
Sw	9	5	0	1	1	0	1	1	0	1	0	2
UK	10	1	6	4	7	6	6	4	6	0	0	0

A = Not at all
B = Instruction
C = Instructor's assistant
D = 'Buddying' a participant
E = Peer mentoring participants
F = Administration
G = Transport
H = Refreshments
I = Other
J = Don't know
K = Not applicable

Table 44 (ProgQ54). PA Programme Directors' responses concerning ways that unpaid volunteers contribute to this programme.

Country (N)		Emergency protocols				Equipment protocols			
		Yes	No	DK	T	Yes	No	DK	T
Au	7	3	4	0	7	1	5	1	7
Be	11	4	6	1	11	6	4	1	11
CR	3	1	2	0	3	1	2	0	3
De	7	2	5	0	7	2	5	0	7
Fi	11	7	4	0	11	6	4	0	10
Fr	3	3	0	0	3	3	0	0	3
Ge	4	1	3	0	4	1	3	0	4
Gr	9	3	3	2	8	3	5	1	9
It	9	6	3	0	9	4	5	0	9
Ne	10	4	5	1	10	4	6	0	10
No	10	8	2	0	10	5	5	0	10
Pol	1	0	1	0	1	0	1	0	1
Por	8	2	6	0	8	4	4	0	8
Sw	9	5	4	0	9	6	3	0	9
UK	10	10	0	0	10	6	4	0	10

DK = Don't know
T = Total

Table 45 (ProgQ55 and 57). PA Programme Directors' responses concerning whether their programme has specific protocols to be followed in emergency situations or in respect of the use, storage and maintenance of equipment

Country (N)		Emergency protocols							Equipment protocols						
		A	B	C	D	E	F	G	A	B	C	D	E	F	G
Au	7	0	0	0	0	0	1	1	0	0	0	0	0	7	7
Be	11	0	0	3	0	0	8	11	0	0	3	0	0	8	11
CR	3	0	0	0	0	0	1	2	0	0	0	0	0	2	2
De	7	0	0	0	0	0	4	4	0	0	0	0	0	4	4
Fi	11	0	0	4	0	1	1	6	0	0	3	0	2	1	6
Fr	3	0	0	0	0	0	1	1	0	0	0	0	0	3	3
Ge	4	0	0	0	0	0	2	2	0	0	0	0	0	3	3
Gr	9	0	1	1	0	1	5	8	0	1	0	0	1	5	7
It	9	0	0	2	1	3	3	9	0	0	1	0	6	2	9
Ne	10	0	1	3	0	0	3	7	0	0	1	0	0	5	6
No	10	0	0	5	0	0	2	7	0	0	1	0	2	3	6
Pol	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Por	8	0	0	2	0	0	6	8	0	0	4	0	0	4	8
Sw	9	0	0	3	0	1	5	9	0	0	4	0	1	4	9
UK	10	0	0	6	0	0	0	6	0	0	4	0	0	1	5

A = 3 monthly
B = 6 monthly
C = Annually
D = Never
E = Don't know
F = Not applicable
G = Total

Table 46 (ProgQ56 and 58). PA Programme Directors' responses concerning the frequency of staff training in the protocols to be followed in emergency situations or in respect of the use, storage and maintenance of equipment

Country (N)		Reports of cost					
		€ ≤2	€ >2-5	€ >5-10	€ >10	Don't know	Total
Au	7	1	1	1	1	1	5
Be	11	3	2	1	3	2	11
CR	3	2	0	0	1	0	3
De	7	0	0	2	1	3	6
Fi	11	1	0	1	4	4	10
Fr	3	0	1	0	2	0	3
Ge	4	0	2	2	0	0	4
Gr	9	0	0	3	1	5	9
It	9	1	5	0	1	1	8
Ne	10	0	1	2	5	2	10
No	10	0	2	3	0	5	10
Pol	1	0	0	0	1	0	1
Por	8	1	0	2	2	3	8
Sw	9	0	1	0	1	7	9
UK	10	1	3	4	0	2	10

Table 47 (ProgQ59). PA Programme Directors' estimates of the total cost (per participant per session) of providing their programme (excluding transport and refreshments but including the cost of the room, lighting, heating, maintenance, instructor's fee, administration)

Country (N)		Directors' estimates of proportion of cost paid by each participant								
		0%	5%	10%	25%	50%	75%	100%	Don't know	Total
Au	7	5	0	0	0	0	1	0	0	6
Be	11	0	0	1	1	1	2	3	3	11
CR	3	1	0	0	0	0	1	1	0	3
De	7	4	1	0	1	0	0	1	0	7
Fi	11	5	2	1	0	1	0	0	2	11
Fr	3	0	1	0	0	0	0	0	0	1
Ge	4	2	1	0	0	1	0	0	0	4
Gr	9	4	1	1	1	0	0	0	2	9
It	9	1	1	1	0	1	0	1	4	9
Ne	10	3	0	0	2	0	1	0	4	10
No	10	4	0	0	0	0	2	1	2	9
Pol	1	0	1	0	0	0	0	0	0	1
Por	8	3	2	0	0	1	1	0	1	8
Sw	9	3	0	1	0	0	0	0	4	8
UK	10	3	0	0	2	1	0	3	1	10

Table 48 (ProgQ 60). PA Programme Directors' estimates of the proportion of the cost (defined as in caption to Table 47) paid by each participant in their programme

Country (N)		Transport					Refreshments				
		A	* B	C	D	E	A	** B	C	D	E
Au	7	0	3	4	0	7	2	0	5	0	7
Be	11	1	0	10	0	11	4	1	6	0	11
CR	3	0	0	3	0	3	1	0	2	0	3
De	7	1	1	5	0	7	6	0	0	0	6
Fi	11	2	6	3	0	11	4	0	6	1	11
Fr	3	0	0	3	0	3	0	0	3	0	3
Ge	4	0	0	4	0	4	0	2	2	0	4
Gr	9	1	2	6	0	9	2	0	7	0	9
It	9	1	1	7	0	9	1	0	8	0	9
Ne	10	0	5	5	0	10	6	3	1	0	10
No	10	0	3	7	0	10	3	2	3	0	8
Pol	1	0	1	0	0	1	0	1	0	0	1
Por	8	1	1	6	0	8	0	1	7	0	8
Sw	9	0	2	7	0	9	4	2	3	0	9
UK	10	2	5	3	0	10	6	3	1	0	10

A = Yes, to everyone
B = Yes, selectively (*some participants, some sessions)
(**some sessions)
C = No
D = Don't know
E = Total

Table 49 (ProgQ61 and 63). PA Programme Directors' responses concerning whether transport and refreshments are provided for participants in their programme

Country (N)		Directors' estimates of proportion of transport cost paid by each participant								
		0%	5%	10%	25%	50%	75%	100%	Don't know	Total
Au	7	1	0	0	0	0	0	0	0	1
Be	11	0	0	0	0	0	0	0	0	0
CR	3	1	0	0	0	0	0	1	0	2
De	7	1	1	0	0	0	0	5	0	7
Fi	11	7	0	0	0	0	0	0	3	10
Fr	3	3	0	0	0	0	0	0	0	3
Ge	4	0	0	0	0	0	0	0	0	0
Gr	9	3	0	0	0	0	0	1	1	5
It	9	1	0	0	0	0	0	0	1	2
Ne	10	1	0	0	0	0	0	1	3	5
No	10	1	0	0	0	0	0	2	1	4
Pol	1	1	0	0	0	0	0	0	0	1
Por	8	1	0	1	0	0	0	0	0	2
Sw	9	1	1	0	0	0	0	0	0	2
UK	10	2	2	0	0	0	0	1	2	7

Table 50a (ProgQ62). PA Programme Directors' estimates of the proportion of the cost of transport that is paid by each participant in their programme.

Country (N)		Directors' estimates of proportion of refreshment cost paid by each participant								
		0%	5%	10%	25%	50%	75%	100%	Don't know	Total
Au	7	2	0	0	0	0	0	0	0	2
Be	11	1	0	0	0	0	0	3	1	5
CR	3	1	0	0	0	0	0	1	0	2
De	7	3	0	0	0	0	0	1	2	6
Fi	11	3	0	0	0	0	0	0	2	5
Fr	3	3	0	0	0	0	0	0	0	3
Ge	4	1	0	0	0	0	0	0	1	2
Gr	9	1	1	0	0	0	0	1	1	4
It	9	1	0	0	0	0	0	0	0	1
Ne	10	3	0	0	0	0	0	3	3	9
No	10	3	0	0	0	0	0	1	0	4
Pol	1	1	0	0	0	0	0	0	0	1
Por	8	1	0	0	0	0	0	0	0	1
Sw	9	1	0	0	0	1	0	4	0	6
UK	10	3	2	0	0	0	0	2	2	9

Table 50b (ProgQ 64). PA Programme Directors' estimates of the proportion of the cost of refreshments that is paid by each participant in their programme.

	Number of PA Programme Directors reporting use														
Country (N)	**Au** (7)	**Be (11)**	**CR (3)**	**De (7)**	**Fi (11)**	**Fr (3)**	**Ge (4)**	**Gr (9)**	**It (9)**	**Ne (10)**	**No (10)**	**Pol (1)**	**Por (8)**	**Sw (9)**	**UK (10)**
Advertising in local newspapers	6	6	2	3	8	2	1	6	2	5	6	0	3	5	6
Advertising in national/ regional newspapers	4	3	0	1	5	1	2	0	0	1	4	0	2	1	2
Advertising in elder-oriented magazines	5	5	0	0	4	1	1	2	0	1	2	1	0	2	4
Advertising through elder-oriented organisations	5	5	0	0	6	1	2	3	4	2	3	1	4	4	5
Features in local newspapers	5	3	2	4	6	2	2	3	3	8	2	0	3	2	8
Features in national/ regional newspapers	4	1	0	1	4	1	3	0	0	2	3	0	1	1	4
Features in elder-oriented magazines	3	3	0	1	4	1	3	1	1	4	1	0	0	2	4
Advertising on local radio	3	2	0	1	4	2	1	3	0	2	0	0	3	0	6
Advertising on national/ regional radio	3	2	0	1	3	1	1	0	0	1	0	0	1	1	2
Advertising on local TV	1	1	0	1	4	1	1	2	0	1	0	0	0	1	0
Advertising on national/ regional TV	1	1	0	0	3	1	0	1	0	1	0	0	3	0	0
Features on local radio	3	0	0	2	3	1	1	2	0	4	2	0	2	0	6
Features on national/ regional TV	2	1	1	1	3	1	1	0	0	1	1	0	0	1	3
Features on local TV	3	0	0	0	4	1	0	1	1	4	1	0	0	1	4
Features on national/ regional TV	3	1	0	0	3	1	1	0	0	2	0	0	0	0	3
Neighbourhood leafleting	5	4	1	2	4	0	2	3	5	6	6	1	2	1	8
Sports hall leafleting	0	5	0	2	2	0	2	4	3	0	2	1	3	2	7

Health premises leafleting	4	4	2	1	4	1	2	4	3	2	3	1	4	1	8
Leafleting in community centres for older people	5	6	1	2	7	1	2	6	4	3	5	1	2	0	8
Talks to local groups	6	4	1	4	6	1	2	3	4	2	7	1	5	3	8
Word of mouth	4	9	1	5	9	0	3	6	7	8	10	1	6	6	10
Websites	7	10	0	4	5	1	3	3	3	6	4	1	4	7	7
Open days	3	3	0	2	4	1	1	0	1	4	3	1	1	3	8
Bring a friend	1	3	1	2	5	0	1	2	1	5	5	1	3	7	6
Discounts	1	1	0	0	2	0	1	0	1	1	1	0	1	0	2
Multiple session bookings	0	1	0	0	3	0	0	0	0	0	1	0	0	1	2
Other	2	1	0	4	7	0	1	0	0	4	4	0	1	4	2

Table 51 (ProgQ65). Number of PA Programme Directors reporting methods which have been used to publicise, market or promote their programme.

Country (N)		Ageing & health campaigns					Partnerships with local healthcare				
		A	B	C	D	E	A	B	C	D	E
Au	7	4	2	1	0	7	7	0	0	0	7
Be	11	5	4	1	1	11	5	5	1	0	11
CR	3	0	2	0	0	2	2	0	0	0	2
De	7	2	3	2	0	7	4	2	1	0	7
Fi	11	4	3	3	1	11	10	1	0	0	11
Fr	3	1	0	0	0	1	3	0	0	0	3
Ge	4	1	2	0	0	3	4	0	0	0	4
Gr	9	1	2	4	2	9	1	3	3	1	8
It	9	1	0	5	3	9	4	1	2	2	9
Ne	10	5	0	4	1	10	8	0	1	1	10
No	10	0	4	4	0	8	3	3	3	1	10
Pol	1	1	0	0	0	1	0	1	0	0	1
Por	8	3	5	0	0	8	7	1	0	0	8
Sw	9	3	4	1	0	8	7	0	1	0	8
UK	10	9	0	1	0	10	10	0	0	0	10

A = Yes
B = No
C = Have not tried
D = Don't know
E = Total

Table 52 (ProgQ66 and 67). PA Programme Directors' responses concerning whether their programme had found it useful (1) to capitalise on national or regional campaigns related to aspects of ageing and health in order to improve recruitment of new participants and/or motivation of existing participants, and/or (2) to build partnerships with local healthcare professionals or organisations.

- **'SUCCESSFUL' PA PROMOTION STRATEGIES**
  - **Methods**
    - **Selection of promotion strategies (including definitions)**

Each national PA Expert was asked to identify a successful PA Promotion Strategy for older people in their country and assist its director to complete a questionnaire concerned primarily with the characteristics of the chosen PA Promotion Strategy. Translation of questionnaires was permitted if required. The national Experts were instructed that their choice should be guided by the following definitions.

Physical activity (or PA) – Any bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure *e.g.* running, walking, swimming, lifting or carrying a heavy weight.

PA promotion strategy – An intervention, device or plan which it is intended will increase the PA of a community *e.g.* Improved street lighting or an educational TV advertising campaign.

A successful PA promotion strategy – A PA promotion strategy is 'successful' if a PA expert in that country considers it to be successful. This judgment may be based on some or all of a wide range of possible effects of the strategy. These might include, for example, demonstrable improvements in swimming pool use, in self-reported physical activity, increasing bicycle sales *etc.*.

To be eligible for consideration a successful PA promotion strategy must have been running for at least 6 months and if it had ceased, this must have occurred no more than 2 years previously.

- **Distribution and return of promotion strategy questionnaires**

On 1st June 2007 all EUNAAPA Partners were sent an electronic copy of a template of a explanatory letter of invitation and the PA Promotion Strategy Questionnaire. EUNAAPA Partners were instructed to distribute this to participating PA Experts in their country by 11th June 2007. These PA Experts were then to be encouraged by their EUNAAPA Partner to distribute the letter of invitation and PA Promotion Strategy Questionnaire to their nominated PA Promotion Strategy Directors. If an invitation was declined, because the Director did not agree to participate

or because the promotion strategy had already been chosen by another PA Expert, then the PA Expert was to identify another successful PA Promotion Strategy and send another invitation letter. PA Experts were not permitted to select their own PA Promotion Strategy.

The PA Experts were encouraged to give their PA Promotion Strategy Director on-going support and to ensure that the questionnaire was returned to the WP5 coordinator by 24th August, 2007. The WP5 Coordinator issued reminders to EUNAAPA Partners in mid-July (e-mail), mid August (e-mail), late August (telephone) and early September (e-mail). These reminders were intended to be passed on to PA Experts by the EUNAAPA Partners. The last reminder included a warning that questionnaires not returned by 20 September might not be included in the final analysis and in the national and cross-national reports. Nevertheless, the deadline was again extended, this time to 6th November.

- **Results**
  - **Selection of promotion strategies**

According to the agreed methodology, the eleven PA Experts recruited in each country would each nominate a successful physical activity (PA) Promotion Strategy for older people, within that country. Ideally this should have resulted in 11 Promotion Strategy Directors being recruited in each country.

Of the 15 countries, 9 recruited fewer than 11 PA Promotion Strategy Directors. Three of these countries (Denmark, France and Germany) were unable to identify, and/or gain the cooperation of, any 'successful' PA Promotion Strategies. On the other hand, 4 countries recruited more than the 11 PA Promotion Strategies required.

- **Return of promotion strategy questionnaires**

Overall, there was a need to remind defaulters to return PA Promotion strategy questionnaires, in many cases several times. Nearly all countries reported giving a deadline of the 20th September 2007, after which it might not be possible for their data to be included in the final analysis and in the national and cross-national reports.

Unfortunately, even with encouragement and ongoing support from PA Experts to PA Promotion Strategy Directors, and several reminders, 8 countries were not successful in recovering a completed questionnaire from each PA Promotion Strategy Director identified. In contrast, 2 countries recovered more than the 11 completed questionnaires required by the agreed protocol; Belgium and Finland recovered 12 and 18

completed questionnaires, respectively. The Belgian and Finnish partners were therefore asked to select the 11 Strategies whose data would be included in the cross-national report, as originally agreed.

In the end, the PA Promotion Strategy data analysed for the cross-national report came from a median of 6 questionnaires per country (range 0 to 11). (See N values in Tables 53-80.)

- **Promotion strategy directors' educational backgrounds**

The educational backgrounds reported by PA Promotion Strategy Directors themselves were predominantly in the areas of Exercise/ Sport Science and 'other' (Table 53). The least reported background was that of medicine. In the case of Greece, Portugal and the UK, none of the recruited PA Promotion Strategy Directors had an educational background in medicine or other health profession (Table 53).

Many of the PA Promotion Strategy Directors reported having an educational background classified as 'other' (Table 53). This was especially the case with PA Promotion Strategy Directors nominated in Austria, Italy and the UK. The educational backgrounds classified as 'other' were quite diverse and included for example theology, classical philology, education, sociology, society planning and policy.

- **Prevailing national context**

All of the PA Promotion Strategy Directors in Finland and Portugal reported that they were aware of a legal or regulatory compulsion, in their country, to promote physical activity (Table 54). However, in Norway the opposite was the case.

When asked about their awareness of any legal or regulatory compulsion to promote physical activity especially for older people, in no country were the PA Promotion Strategy Directors unanimously aware (Table 54). On the other hand, none of the Promotion Strategy Directors in Austria, Belgium, Czech Republic, Sweden and the UK knew of such compulsion in their country.

Overall, more than half of PA Promotion Strategy Directors reported national level recommendations, in their country, for the promotion of physical activity especially for older people (Table 54). In Finland all of the nominated PA Promotion Strategy Directors reported national level recommendations. In contrast, in Austria, Belgium, Czech Republic and Greece reports were low.

- **Description of promotion strategies**

PA Promotion Strategy Directors located the development and delivery of their promotion strategies predominantly in local government and welfare/community organisations (Table 55). There were reports of development and delivery in national government and regional government organisations, research organisations and 'other'. The commercial sector was the least frequently reported location for development and delivery of PA Promotion strategies.

The most frequently reported level of delivery for PA Promotion strategies was at the city/town level (Table 56). There were also numerous reports of aiming to deliver at a national and regional level. The local neighbourhood level was reported least.

Overall, PA Promotion Strategy Directors reported that their promotion strategies encourage physical activity across a number of settings (Table 57). In most countries, centre based promotion strategies were reported more than home based settings (Table 57). Group exercise was generally reported more than independent exercise, except in Belgium, Finland, Sweden and the UK where they were reported as being about equally used for the promotion of physical activity (Table 57).

PA Promotion Strategy Directors reported that the settings/organisations taking part in their promotion strategies were multiple and varied (Table 58). Overall, about half of PA Promotion Strategy Directors reported social institutions, primary health care and community centres taking part. There were also reports of welfare organizations, 'other' and, to a lesser extent, workplaces.

Overall, nearly a quarter of PA Promotion Strategy Directors reported that no theoretical basis was used to develop and/or deliver their promotion strategy (Table 59).

The health belief model was reported most (27% of Promotion Strategies) (Table 59). The other theories or models offered in the questionnaire were also reported, including the protection motivation theory, theory of reasoned action, ASE model and the transtheoretical model, although not all by the one country (Table 59). The theory of planned behaviour had the least number of reports overall (10%). Respondents also volunteered that they drew on theories and experience in travel behaviour change, social marketing, action research, social ecological models, quality based theories and scientific findings.

Overall, more than a third of PA Promotion Strategy Directors reported that their promotion strategy had run for at least 6 years (Table 60).

Except for Italy, Poland and Portugal, there are more reports for promotion strategies running continually than running once only or periodically combined (Table 61). In Italy and Portugal there were more reports for promotion strategies being run periodically. Overall, reports for promotion strategies being run once only or 'other' were rare.

PA Promotion Strategy Directors reported that they use multiple intermediaries to reach the intended population (Table 62). All of the intermediary options given in the questionnaire were reported as being used to reach the intended population. However, more than half of the Promotion Strategy Directors reported using medical practitioners as intermediaries (more reports than any other category of intermediary). There were also frequent reports of the use of other healthcare professionals, PA professionals, community workers and volunteers. In Finland all of the PA Promotion Strategy Directors reported using physiotherapists as an intermediary.

- **Characteristics of strategies' target populations**

The Promotion Strategy Directors tended to report that their promotion strategies targeted more than one 'category' of participants (Table 63). All categories offered in the questionnaire were reported. However, promotion strategies targeting all older adults and the general population (including older adults) received the most reports.

Italy, Norway and the Czech Republic had no reports of promotion strategies targeting institution-dwelling older adults (Table 63). Italy and the Czech Republic had no reports of promotion strategies targeting older adults with chronic conditions. Overall the 'category' of participants least frequently targeted by promotion strategies was ethnic minority older adults.

When asked which cultural differences were catered for in their promotion strategies, 63% of PA Promotion Strategy Directors reported none (Table 64). Indeed, only in Norway, Portugal and the UK was this figure less than 50%. Nevertheless, there were some reports of different language (14% of promotion strategies), cultural perceptions (17%), education levels (20%) and income levels (23%) being catered for.

PA Promotion Strategy Directors were asked what levels of functional mobility would characterise the individuals the promotion strategies aimed to include. The individuals most commonly targeted ('categorised' according to their functional mobility) were those walking outdoors independently with (61% of Promotion Strategies) or without (74%) a walking aid (Table 65). Individuals who never walk outdoors were targeted the least overall, and not at all in Finland, Greece, Italy, Portugal and the Czech Republic.

More than half of the PA Promotion Strategy Directors (59%) reported that they did not screen the target population for their readiness for behaviour change prior to implementing their promotion strategy (Table 67). This is especially the case in Belgium and Norway, where none of the PA Promotion Strategy Directors claimed to screen for readiness for behaviour change.

- **Design of promotion strategies**

The PA Promotion Strategy Directors reported that they used multiple approaches to encourage behaviour change in relation to physical activity (Table 66). This included improved knowledge (81% of promotion strategies), improved motivation (78%), improved skill (64%), improved access (63%), reduction in misconceptions about ageing (54%), improved safety (47%) and fear reduction (44%). The approach least used overall was improved time management skills (18%).

More than three quarters of PA Promotion Strategy Directors reported that their promotion strategy was designed to surmount barriers to physical activity (Table 68). Multiple barriers were addressed, with lack of energy/motivation receiving the most reports overall (59%) (Table 69). The barriers suggested by the questionnaire were confirmed by at least one PA Promotion Strategy Director in each country (except for the Czech Republic, with only one promotion strategy), except for the barriers 'acute exacerbation of chronic conditions' and 'other'. These were the least reported barriers to physical activity that the promotion strategies were designed to surmount (12% and 9% respectively) (Table 69).

The approaches used by these 90 PA promotion strategies appear to be multiple and varied (Table 70). The most frequently reported information approach is group-based health education focused on information provision. The most frequently reported behavioural and social approach is health professionals' social support. The most frequently reported

environmental and policy approach is enhanced access to physical activity.

PA Promotion Strategy Directors' reports show that using a general message, general advice and/or specific advice are all popular (Table 71). Giving a general warning and/or a specific warning were reported less frequently or, in the case of Finland, not at all (Table 71).

The Directors reported that the message(s) of each PA promotion strategy was/were conveyed to the target population through multiple routes (Table 72). Overall, the most frequently reported methods of conveying messages to the target population were through intermediaries (*e.g.* healthcare professionals) (62%), through the media (52%) and through special events *e.g.* Falls Awareness Day (48%).

- **Evaluation and sustainability of effect of promotion strategies**

Surprisingly half of the PA Promotion Strategy Directors did not know what proportion of the target population had been reached by their promotion strategy overall since it had been running (Table 73). More than half of the Directors who ventured an opinion (53% of 40) estimated that their promotion strategy had reached 25% of the target population.

PA Promotion Strategy Directors were asked which approaches they had found effective in achieving the aims of their promotion strategies (Table 74). The information approaches most frequently reported to be effective were community wide campaigns and group-based health education focused on information provision. The behavioural and social approaches most frequently reported as effective were individually adapted behaviour change and non-family social support. The environmental and policy approach most often reported as effective was enhanced access to physical activity.

Only just over half (54%) of the PA Promotion Strategy Directors reported that their PA promotion strategies had been evaluated since being implemented (Table 75). Moreover, there was no country (apart from the Czech Republic, with only a single nomination) where all the nominated PA promotion strategies were reported to have been evaluated. In Belgium, only 2 of 11 PA promotion strategies were reported to have been evaluated.

When asked which aspects of their PA promotion strategy had been evaluated since it was implemented, reports were distributed across the

options presented in the questionnaire (Table 76). This included behaviour change (33% of all promotion strategies), population reached (38%), cost (17%) and 'other' (26%). In Belgium and Portugal most of the PA Promotion Strategy Directors reported 'not applicable', as in these countries hardly any of the nominated promotion strategies had been evaluated since they were implemented (Table 75).

The breadth of aspects evaluated is emphasised by some of the 'other' aspects volunteered by the respondents, viz.:-

- Activity levels
- Demographic aspects of usage
- Campaign recognition among target audiences
- Interactions with other policy objectives (e.g. climate change
- emissions)
- Contribution to building social capital
- Perceived barriers and opportunities
- Evaluation of education
- Number of participants
- Fracture outcome

More than half of the PA Promotion Strategy Directors (59%) reported that their PA promotion strategy included a specific plan or device to maintain the behaviour change achieved (Table 77). Of the tools used in the promotion strategies to maintain behaviour change, positive reinforcement/ feedback rewards and promotion days were reported most (31% of all promotion strategies) (Table 78). The use of printed material posted, social support, buddy groups and opportunities to socialise were also reported (20-28%), while the use of telephone (13%) and financial incentives (11%) were rarer.

- **Finance**

The reported total cost of the promotion strategies varied enormously (Table 79). The minimum cost reported was 250 euros per annum compared with a maximum of 4,000,000 euros per annum.

PA promotion strategies appear to be funded by more than one source (Table 80). Overall sources of funding are well spread across the national/regional and city/local government sectors, as well as across health and leisure budgets. However, our data do not tell us whether the amounts of funding are equally well spread.

Country (N)		Educational Backgrounds					
		Medicine	Other Health Profession	Exercise/ Sport Science	Other	Missing data	Total
Au	6	1	0	1	4	0	6
Be	11	0	2	6	5	0	13
CR	1	0	0	0	1	0	1
De	0	-	-	-	-	-	-
Fi	11	2	8	6	5	0	21
Fr	0	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-
Gr	6	0	0	5	1	0	6
It	9	3	1	2	6	0	12
Ne	6	0	1	3	3	0	7
No	9	0	6	2	2	0	10
Pol	10	3	1	4	2	1	12
Por	7	0	0	7	0	0	7
Sw	4	1	2	0	1	0	4
UK	10	0	0	3	7	0	10

Table 53 - Promotion Strategy Questionnaire Question 4 (PSQ4).
Educational backgrounds of the Directors of the PA Promotion strategies selected by the national Experts

(N = number of PA Promotion Strategy questionnaires received from each country and included in the analysis. Tables 53-80.)

Country (N)		(1)			(2)			(3)		
		Yes	No	Don't know	Yes	No	Don't know	Yes	No	Don't know
Au	6	1	5	0	0	6	0	1	4	1
Be	11	3	6	2	0	10	1	2	7	2
CR	1	0	1	0	0	1	0	0	1	0
De	0	-	-	-	-	-	-	-	-	-
Fi	11	11	0	0	7	4	0	11	0	0
Fr	0	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-
Gr	6	3	1	2	2	1	3	1	0	5
It	9	3	2	4	3	2	4	5	0	4
Ne	6	2	3	1	2	3	1	4	0	2
No	9	0	9	0	1	7	1	7	0	0
Pol	10	5	1	3	2	3	4	5	1	3
Por	7	7	0	0	2	3	2	3	2	2
Sw	4	1	1	2	0	4	0	3	0	1
UK	10	2	8	0	0	9	1	8	1	1

Table 54 (PSQ 8-10). PA Promotion Strategy Directors' responses concerning whether (1) there is a law or other regulations, in their country, for promotion of physical activity, (2) there is a law or other regulations, in their country, for the promotion of physical activity especially for older people, and (3) there are any national level recommendations, in their country, for promotion of physical activity especially for older people

Country (N)		Developed							Delivered						
		A	B	C	D	E	F	G	A	B	C	D	E	F	G
Au	6	0	1	2	0	2	3	1	0	1	1	0	4	2	1
Be	11	0	4	2	1	3	1	3	0	3	2	1	4	1	3
CR	1	0	0	1	0	1	0	0	0	0	1	0	1	0	0
De	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Fi	11	3	1	2	0	2	2	0	2	0	1	0	2	4	1
Fr	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Gr	6	2	0	1	0	2	0	1	1	0	2	0	2	0	1
It	9	1	3	4	1	1	2	3	0	3	3	1	2	2	2
Ne	6	0	0	1	0	2	2	4	0	1	1	1	2	2	3
No	9	2	1	5	1	5	3	2	1	2	3	1	4	1	1
Pol	10	3	1	3	0	3	1	1	3	1	3	0	3	1	0
Por	7	1	0	3	0	0	4	0	1	0	3	0	1	3	0
Sw	4	1	2	2	0	1	2	1	1	2	2	0	0	2	1
UK	10	3	1	4	0	2	0	3	2	3	6	1	4	1	4

GOVERNMENTAL
A = National government
B = Regional government
C = Local government

NON-GOVERNMENTAL
D = Commercial sector
E = Welfare/community organisation
F = Research organisation
G = Other

Table 55 (PSQ11 and 12). PA Promotion Strategy Directors' responses concerning the sectors to which belong the organisations that developed, and delivered, their promotion strategy.

Country (N)		Number of PA Promotion Strategies			
		National	Regional	City/town	Local neighbourhood
Au	6	2	4	1	0
Be	11	3	8	3	1
CR	1	0	0	1	0
De	0	-	-	-	-
Fi	11	10	4	2	2
Fr	0	-	-	-	-
Ge	0	-	-	-	-
Gr	6	2	1	4	3
It	9	1	4	6	2
Ne	6	5	3	2	3
No	9	2	2	3	2
Pol	10	4	3	5	5
Por	7	1	2	4	0
Sw	4	2	1	3	1
UK	10	4	4	7	4

Table 56 (PSQ14). PA Programme Directors' responses concerning the levels at which their promotion strategies aimed to deliver.

Country (N)		Number of PA Promotion Strategies						
		Centre based	Home based	Outdoors	Other setting	Group exercise	Indep. exercise	Other format
Au	6	4	0	2	4	6	1	0
Be	11	6	4	6	6	10	8	0
CR	1	0	0	0	1	0	0	1
De	0	-	-	-	-	-	-	0
Fi	11	8	7	8	1	11	10	2
Fr	0	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-
Gr	6	6	1	4	0	6	1	0
It	9	7	1	7	1	6	2	0
Ne	6	4	2	3	2	5	2	0
No	9	4	1	4	0	3	2	2
Pol	10	7	4	5	6	9	3	1
Por	7	5	0	5	3	6	1	0
Sw	4	2	2	4	0	4	4	0
UK	10	9	3	7	1	8	6	2

Table 57 (PSQ15) PA Promotion Strategy Directors' responses concerning the settings and formats in which they considered their promotion strategy encouraged physical activity

Country (N)		Number of PA Promotion Strategies						
		A	B	C	D	E	F	G
Au	6	6	3	3	2	1	5	0
Be	11	4	2	4	5	1	7	0
CR	1	0	0	1	0	0	0	0
De	0	-	-	-	-	-	-	-
Fi	11	6	10	5	11	3	5	0
Fr	0	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-
Gr	6	2	2	5	1	1	0	0
It	9	5	4	5	1	0	6	0
Ne	6	2	6	5	5	1	2	2
No	9	4	3	0	0	1	2	0
Pol	10	6	1	3	2	2	3	0
Por	7	3	4	3	1	1	3	0
Sw	4	3	3	3	3	3	2	0
UK	10	6	7	7	3	6	3	0

A = Social institutions
B = Primary health care
C = Community centres
D = Welfare organisations
E = Work places
F = Other
G = Don't know

Table 58 (PSQ16). PA Promotion Strategy Directors' responses concerning the settings/ organisations which they consider are taking part in their promotion strategy

Country (N)		Number of PA Promotion Strategies									
		A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Au	6	1	1	0	0	1	1	1	3	0	1
Be	11	6	1	1	0	1	1	1	2	1	0
CR	1	0	0	0	1	0	0	0	0	0	0
De	0	-	-	-	-	-	-	-	-	-	-
Fi	11	1	1	0	0	1	0	1	5	1	1
Fr	0	-	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-	-
Gr	6	1	4	2	1	0	1	0	1	0	1
It	9	3	0	0	1	0	0	0	1	2	0
Ne	6	1	0	0	0	0	4	4	1	0	1
No	9	1	5	1	1	2	3	0	1	1	2
Pol	10	2	6	4	3	1	4	1	1	0	0
Por	7	2	3	0	1	1	1	1	1	0	0
Sw	4	0	2	0	2	0	1	0	1	0	0
UK	10	3	1	1	0	0	0	2	4	0	2

A = None
B = Health belief model
C = Protection motivation theory
D = Theory of reasoned action
E = Theory of planned behaviour
F = ASE (Attitude, Social influence and self-Efficacy) model
G = Transtheoretical model
H = Other
I = Don't know
J = No response

Table 59 (PSQ17-18). PA Promotion Strategy Directors' responses concerning the theoretical basis(es) which they consider was/were used to develop and/or deliver their promotion strategy.

Country (N)		Number of PA Promotion Strategies					
		<1 year	1-5 years	6-10 years	>10 years	Don't know	Total
Au	6	2	1	3	0	0	6
Be	11	3	1	0	7	0	11
CR	1	0	0	0	0	0	0
De	0	-	-	-	-	-	-
Fi	11	0	8	0	3	0	11
Fr	0	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-
Gr	6	0	0	2	3	0	5
It	9	2	4	0	2	1	9
Ne	6	1	4	1	0	0	6
No	9	0	3	1	3	0	7
Pol	10	1	6	2	0	1	10
Por	7	1	4	2	0	0	7
Sw	4	0	1	1	2	0	4
UK	10	2	6	0	1	0	9

Table 60 (PSQ19). PA Promotion Strategy Directors' estimates of the time for which their promotion strategy has run

Country (N)		Number of PA Promotion Strategies					
		Once only	Periodically	Continually	Other	Don't know	Total
Au	6	2	0	4	0	0	6
Be	11	0	2	7	1	1	11
CR	1	0	0	1	0	0	1
De	0	-	-	-	-	-	-
Fi	11	1	2	6	2	0	11
Fr	0	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-
Gr	6	0	2	3	0	0	5
It	9	1	6	2	0	0	9
Ne	6	0	0	3	3	0	6
No	9	0	0	7	0	0	7
Pol	10	1	4	4	0	1	10
Por	7	1	4	2	0	0	7
Sw	4	1	0	2	1	0	4
UK	10	0	2	6	2	0	10

Table 61 (PSQ20). PA Promotion Strategy Directors' responses concerning the time pattern of the running of their strategy

Country (N)		Number of PA Promotion Strategies												
		A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**	**K**	**L**	**M**
Au	6	3	1	0	0	0	1	2	3	0	4	3	1	0
Be	11	1	2	1	1	0	1	5	5	4	4	6	2	1
CR	1	0	0	0	0	0	0	1	0	1	1	1	0	0
De	0	-	-	-	-	-	-	-	-	-	-	-	-	-
Fi	11	8	10	11	4	5	9	6	1	6	9	2	0	0
Fr	0	-	-	-	-	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-	-	-	-	-
Gr	6	2	3	3	0	0	2	4	4	3	2	0	0	0
It	9	7	1	1	1	1	1	5	0	4	2	2	1	0
Ne	6	3	1	5	2	1	4	3	0	3	1	1	0	0
No	9	5	4	7	3	3	6	3	2	4	4	0	0	0
Pol	10	6	3	6	2	3	4	3	3	6	4	5	1	0
Por	7	5	4	2	1	1	2	5	3	2	4	0	0	0
Sw	4	3	2	3	0	1	1	2	2	2	3	1	0	0
UK	10	7	5	6	5	5	6	7	5	7	8	5	0	0

A = Medical Practitioners
B = Nurses
C = Physiotherapists
D = Occupational therapists
E = Physiotherapy/ OT Assistants
F = Other Allied Health Care Professionals
G = Exercise/ dance instructors
H = Sports coaches
I = Community/Social Workers
J = Volunteers
K = Other
L = None
M = Don't know

Table 62 (PSQ26). PA Promotion Strategy Directors' responses concerning the intermediaries used to reach the intended population.

Country (N)		Number of PA Promotion Strategies						
		A	B	C	D	E	F	G
Au	6	1	4	2	4	1	2	1
Be	11	3	8	5	3	2	2	1
CR	1	1	0	1	0	0	0	0
De	0	-	-	-	-	-	-	-
Fi	11	5	5	5	3	5	0	3
Fr	0	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-
Gr	6	4	3	1	3	2	0	0
It	9	3	4	2	0	0	0	2
Ne	6	1	3	3	2	1	1	2
No	9	2	2	4	0	1	0	3
Pol	10	8	5	1	2	2	0	4
Por	7	2	4	2	1	1	0	0
Sw	4	3	1	2	1	2	2	3
UK	10	6	7	4	2	5	5	3

A = General population (including older adults)
B = All older adults
C = Community – dwelling older adults
D = Institution – dwelling older adults
E = Older adults with chronic conditions
F = Ethnic minority older adults
G = Other

Table 63 (PSQ22). PA Promotion Strategy Directors' responses concerning the 'category' of participants targeted by their promotion strategy

Country (N)		Number of PA Promotion Strategies						
		A	B	C	D	E	F	G
Au	6	4	2	2	2	2	1	0
Be	11	9	1	1	2	2	1	0
CR	1	1	0	0	0	0	0	0
De	0	-	-	-	-	-	-	-
Fi	11	8	2	0	1	1	1	0
Fr	0	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-
Gr	6	5	0	0	0	0	0	1
It	9	5	0	1	2	2	1	1
Ne	6	5	1	0	0	1	1	0
No	9	4	1	1	1	1	1	0
Pol	10	8	0	0	0	1	0	1
Por	7	3	0	2	3	3	0	0
Sw	4	3	1	1	1	0	0	0
UK	10	2	5	7	6	8	2	1

A = None
B = Different language
C = Different cultural perceptions
D = Different education levels
E = Different income levels
F = Other
G = Don't know

Table 64 (PSQ23 and 24). PA Promotion Strategy Directors' responses when asked which specific cultural differences were catered for in their promotion strategy

Country (N)		Number of PA Promotion Strategies				
		A	**B**	**C**	**D**	**E**
Au	6	4	5	3	3	3
Be	11	10	11	8	6	5
CR	1	0	1	1	0	0
De	0	-	-	-	-	-
Fi	11	4	10	9	5	0
Fr	0	-	-	-	-	-
Ge	0	-	-	-	-	-
Gr	6	4	4	1	2	0
It	9	2	6	3	2	0
Ne	6	2	4	5	3	2
No	9	4	4	6	1	1
Pol	10	4	3	4	3	2
Por	7	1	5	3	1	0
Sw	4	4	4	4	4	1
UK	10	4	10	8	6	5

A = Frequently walks vigorously or runs
B = Walks outdoors with no walking aids and no assistance or supervision by another person
C = Walks outdoors with a walking aid but no assistance or supervision by another person
D = Walks outdoors only with assistance or supervision by another person
E = Never walks outdoors

Table 65 (PSQ25). PA Promotion Strategy Directors' responses concerning the 'category' of individual (by level of functional mobility) their promotion strategy aimed to include.

Country (N)		Number of PA Promotion Strategies								
		A	B	C	D	E	F	G	H	I
Au	6	3	4	1	0	6	1	3	1	0
Be	11	8	7	4	0	8	5	6	7	1
CR	1	0	0	0	0	0	0	0	1	0
De	0	-	-	-	-	-	-	-	-	-
Fi	11	10	9	9	3	10	8	8	8	0
Fr	0	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-
Gr	6	5	3	4	3	4	2	4	3	0
It	9	9	6	3	3	7	5	4	6	0
Ne	6	5	5	2	1	5	3	4	1	0
No	9	4	2	5	1	5	6	5	4	0
Pol	10	9	9	3	3	6	1	9	6	0
Por	7	6	1	4	0	5	1	7	4	0
Sw	4	4	3	3	1	4	2	2	3	0
UK	10	10	8	4	1	10	6	6	5	0

A = Improved knowledge
B = Improved access
C = improved safety
D = improved time management skills
E = Improved motivation
F = Fear reduction
G = Improved skill
H = Reduction in misconceptions about ageing
I = Don't know

Table 66 (PSQ 28). Promotion Strategy Directors' responses concerning approaches used in their strategy to encourage behaviour change in relation to physical activity

Country (N)		Number of PA Promotion Strategies			
		Yes	No	Don't know	Total
Au	6	2	3	1	6
Be	11	0	10	1	11
CR	1	1	0	0	1
De	0	-	-	-	-
Fi	11	5	5	1	11
Fr	0	-	-	-	-
Ge	0	-	-	-	-
Gr	6	1	3	1	5
It	9	3	6	0	9
Ne	6	2	3	1	6
No	9	0	6	1	7
Pol	10	5	5	0	10
Por	7	2	5	0	7
Sw	4	3	1	0	4
UK	10	3	6	1	10

Table 67 (PSQ 29). PA Promotion Strategy Directors' responses concerning whether the target population was screened for their readiness for behaviour change prior to implementing the promotion strategy

Country (N)		Number of PA Promotion Strategies			
		Yes	No	Don't know	Total
Au	6	5	1	0	6
Be	11	8	1	2	11
CR	1	1	0	0	1
De	0	-	-	-	-
Fi	11	11	0	0	11
Fr	0	-	-	-	-
Ge	0	-	-	-	-
Gr	6	5	0	0	5
It	9	8	0	1	9
Ne	6	5	1	0	6
No	9	3	2	1	6
Pol	10	7	2	0	9
Por	7	5	2	0	7
Sw	4	3	0	1	4
UK	10	10	0	0	10

Table 68 (PSQ 30). PA Promotion Strategy Directors' responses concerning whether their promotion strategy was designed to surmount barriers to physical activity.

Country (N)		Number of PA Promotion Strategies												
		A	B	C	D	E	F	G	H	I	J	K	L	M
Au	6	2	1	1	0	2	1	4	1	1	0	0	0	13
Be	11	3	3	4	0	5	4	7	5	6	1	0	3	41
CR	1	1	1	0	0	0	0	1	1	1	0	0	0	5
De	0	-	-	-	-	-	-	-	-	-	-	-	-	-
Fi	11	7	3	9	1	7	2	8	9	7	2	0	0	55
Fr	0	-	-	-	-	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-	-	-	-	-
Gr	6	3	4	3	1	2	1	2	2	3	0	0	0	21
It	9	2	4	1	0	3	6	6	5	5	0	0	0	32
Ne	6	5	4	2	2	2	1	5	1	2	0	0	0	24
No	9	2	2	3	2	3	2	3	2	3	0	0	0	22
Pol	10	6	1	3	2	7	3	6	3	6	1	0	0	38
Por	7	1	2	1	0	4	2	2	0	2	0	0	1	15
Sw	4	2	2	2	1	3	1	2	2	3	1	0	0	19
UK	10	6	4	6	2	6	6	7	6	5	3	1	0	52

A = Perceived poor health
B = Symptoms associated with chronic conditions
C = Fear of injury
D = Acute exacerbation of chronic conditions
E = Lack of skill
F = Lack of time
G = Lack of energy / motivation
H = Environmental barriers
I = Misconceptions about ageing
J = Other
K = Don't know
L = Not applicable
M = Total

Table 69 (PSQ31). PA Promotion Strategy Directors' responses concerning which particular barriers to physical activity their promotion strategy was designed to surmount

	Au	Be	CR	De	Fi	Fr	Ge	Gr	It	Ne	No	Pol	Por	Sw	UK
INFORMATION APPROACHES															
Community wide campaigns	5	6	1	-	4	-	-	5	6	5	1	4	5	2	7
Group-based health education focused on information provision	3	7	0	-	9	-	-	6	3	2	5	5	3	4	6
Mass media campaigns	2	1	0	-	5	-	-	2	4	4	5	4	3	2	7
Point of decision prompts	0	0	0	-	3	-	-	1	0	1	0	3	3	0	3
Other	0	3	0	-	4	-	-	0	3	1	1	1	0	0	2
BEHAVIOURAL AND SOCIAL APPROACHES															
Individually-adapted behaviour change	3	4	0	-	8	-	-	3	4	2	3	2	2	3	6
Education with TV/video/DVD	1	0	0	-	2	-	-	1	0	2	1	2	0	1	2
Family-based social support	1	2	0	-	3	-	-	1	1	2	1	2	1	2	2
Health professionals social support	3	4	0	-	10	-	-	3	7	3	2	4	3	3	5
Non–family social support	3	3	1	-	7	-	-	3	1	3	2	4	5	2	4
Other	1	0	0	-	2	-	-	0	0	1	1	2	0	1	2
ENVIRONMENTAL AND POLICY APPROACHES															
Enhanced access to physical activity	3	6	0	-	11	-	-	6	5	1	2	8	6	4	8
Outreach activities	1	4	0	-	6	-	-	2	0	1	1	2	0	0	6
Transportation policy	2	1	0	-	5	-	-	0	1	2	0	1	0	2	3
Infrastructure changes to promote non–motorised transit	0	2	0	-	3	-	-	2	0	1	0	3	0	2	4
Urban planning approaches	0	1	0	-	2	-	-	1	0	1	0	3	0	1	3
Other	2	0	0	-	1	-	-	0	2	0	0	1	0	2	1
Don't know	0	0	0	-	0	-	-	0	0	0	0	0	0	0	1

Table 70 (PSQ32). PA Promotion Strategy Directors' responses concerning which approaches were used by their physical activity promotion strategy.

Country (N)		Number of PA Promotion Strategies							
		General message	General advice	General warning	Specific advice	Specific warning	Other	Don't know	Total
Au	6	4	2	0	2	0	2	0	10
Be	11	9	6	3	7	2	1	0	28
CR	1	1	0	0	0	0	0	0	1
De	0	-	-	-	-	-	-	-	-
Fi	11	7	6	0	9	0	3	0	25
Fr	0	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-
Gr	6	3	1	1	3	1	1	0	10
It	9	3	1	2	7	3	2	0	18
Ne	6	5	3	1	3	1	1	0	14
No	9	6	4	1	3	2	2	0	18
Pol	10	7	7	3	6	2	4	0	29
Por	7	5	4	1	4	1	1	0	16
Sw	4	2	3	0	2	1	0	0	8
UK	10	9	8	2	7	3	2	1	32

Table 71 (PSQ 34). PA Promotion Strategy Directors' responses concerning the nature of the message(s) used in their promotion strategy

Country (N)		Number of PA Promotion Strategies							
		A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
Au	6	6	0	2	3	1	5	1	0
Be	11	1	5	7	5	1	3	8	0
CR	1	1	0	0	0	1	1	0	0
De	0	-	-	-	-	-	-	-	-
Fi	11	7	6	4	11	6	7	3	0
Fr	0	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-
Gr	6	2	1	0	3	2	2	1	0
It	9	4	3	1	5	0	3	2	0
Ne	6	5	2	2	5	0	3	5	0
No	9	3	4	3	4	0	3	3	0
Pol	10	4	0	3	4	3	2	6	0
Por	7	3	2	4	5	1	3	4	0
Sw	4	3	2	0	3	1	3	1	1
UK	10	8	7	7	8	6	8	3	1

A = Media
B = Post
C = Internet / e-mail
D = Intermediaries, e.g. healthcare professionals
E = Models / opinion
F = Events (e.g. Falls Awareness Day)
G = Other
H = Don't know

Table 72 (PSQ 35). PA Promotion Directors' responses concerning how the message(s) used in their promotion strategy was / were conveyed to the target population.

Country (N)		Number of PA Promotion Strategies						
		0%	25%	50%	75%	100%	Don't know	Total
Au	6	1	1	0	1	1	2	6
Be	11	0	2	1	0	0	8	11
CR	1	0	0	0	0	0	0	0
De	0	-	-	-	-	-	-	-
Fi	11	0	4	1	0	0	6	11
Fr	0	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-
Gr	6	0	2	1	1	0	1	5
It	9	0	4	1	1	0	3	9
Ne	6	0	0	1	0	0	3	4
No	9	0	0	0	0	0	7	7
Pol	10	0	3	1	1	0	5	10
Por	7	0	3	0	1	0	3	7
Sw	4	0	1	0	2	1	0	4
UK	10	0	1	3	0	0	6	10

Table 73 (PSQ27). PA Promotion Strategy Directors' estimates of the proportion of the target population that has been reached by their promotion strategy since it has been running **.**

	Au	Be	CR	De	Fi	Fr	Ge	Gr	It	Ne	No	Pol	Por	Sw	UK
INFORMATION APPROACHES															
Community wide campaigns	4	6	1	-	3	-	-	5	4	5	1	5	3	2	6
Group-based health education focused on information provision	2	6	0	-	5	-	-	4	4	1	1	6	4	4	5
Mass media campaigns	2	1	0	-	2	-	-	3	1	4	3	4	3	1	4
Point of decision prompts	0	0	0	-	2	-	-	0	0	1	0	3	3	1	2
Other	0	2	0	-	3	-	-	0	1	2	2	1	0	1	0
BEHAVIOURAL AND SOCIAL APPROACHES															
Individually-adapted behaviour change	2	4	0	-	7	-	-	3	3	2	3	2	3	3	4
Education with TV/video/DVD	1	0	0	-	2	-	-	1	0	0	3	2	1	0	1
Family-based social support	0	1	0	-	2	-	-	2	1	2	1	2	2	2	1
Health professionals social support	1	3	0	-	7	-	-	2	5	2	3	3	1	2	3
Non–family social support	1	3	1	-	6	-	-	4	3	3	3	3	3	2	3
Other	1	0	0	-	3	-	-	0	0	1	1	1	0	1	0
ENVIRONMENTAL AND POLICY APPROACHES															
Enhanced access to physical activity	2	5	0	-	8	-	-	4	4	1	2	8	4	2	6
Outreach activities	0	4	0	-	3	-	-	3	0	0	1	1	0	0	3
Transportation policy	0	1	0	-	4	-	-	1	2	1	1	2	0	1	2
Infrastructure changes to promote non–motorised transit	0	2	0	-	4	-	-	1	1	1	1	3	0	1	2
Urban planning approaches	0	1	0	-	2	-	-	1	0	1	0	4	0	0	0
Other	1	1	0	-	2	-	-	0	0	0	1	1	0	1	0
Don't know	0	0	0	-	1	-	-	0	0	1	1	0	0	0	2

Table 74 (PSQ33). PA Promotion Strategy Directors' responses concerning which approaches they had found effective in achieving the aims of their physical activity promotion strategy.

Country (N)		Number of PA Promotion Strategies			
		Yes	No	Don't know	Total
Au	6	4	2	0	6
Be	11	2	7	2	11
CR	1	1	0	0	1
De	0	-	-	-	-
Fi	11	7	3	1	11
Fr	0	-	-	-	-
Ge	0	-	-	-	-
Gr	6	1	3	1	4
It	9	4	5	0	9
Ne	6	4	1	0	5
No	9	5	0	2	7
Pol	10	7	2	1	10
Por	7	3	4	0	7
Sw	4	3	1	0	4
UK	10	8	0	1	9

Table 75 (PSQ36). PA Promotion Strategy Directors' responses concerning whether their promotion strategy had been evaluated since it was implemented

Country (N)		Number of PA Promotion Strategies					
		Behaviour change	Population reached	Cost	Other	Don't know	Not applic.
Au	6	4	4	1	1	0	0
Be	11	1	2	0	1	0	8
CR	1	1	1	1	0	0	0
De	0	-	-	-	-	-	-
Fi	11	3	3	1	4	0	0
Fr	0	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-
Gr	6	1	1	1	0	1	0
It	9	2	3	2	1	0	0
Ne	6	2	4	2	1	0	1
No	9	4	3	1	2	0	0
Pol	10	4	5	2	3	0	0
Por	7	0	1	1	1	0	5
Sw	4	2	2	1	2	0	0
UK	10	6	5	2	7	1	0

Table 76 (PSQ 37). PA Promotion Strategy Directors' responses concerning which aspects of their promotion strategy had been evaluated since it was implemented

Country (N)		Number of PA Promotion Strategies			
		Yes	No	Don't know	Total
Au	6	4	2	0	6
Be	11	6	3	2	11
CR	1	1	0	0	1
De	0	-	-	-	-
Fi	11	8	2	0	10
Fr	0	-	-	-	-
Ge	0	-	-	-	-
Gr	6	4	0	1	5
It	9	4	4	1	9
Ne	6	5	1	0	6
No	9	3	1	2	6
Pol	10	6	2	1	9
Por	7	4	2	0	6
Sw	4	2	0	1	3
UK	10	6	3	1	10

Table 77 (PSQ38). PA Promotion Strategy Directors' responses concerning whether their promotion strategy included a specific plan or device to maintain the behaviour change achieved

Country (N)		Number of PA Promotion Strategies										
		A	B	C	D	E	F	G	H	I	J	K
Au	6	2	0	1	1	1	0	0	2	0	0	0
Be	11	0	1	2	0	1	1	1	2	3	0	5
CR	1	0	0	1	1	1	1	1	1	0	0	0
De	0	-	-	-	-	-	-	-	-	-	-	-
Fi	11	3	2	2	1	5	3	3	4	4	0	0
Fr	0	-	-	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-	-	-
Gr	6	0	2	3	0	2	1	2	0	1	1	0
It	9	0	0	1	1	2	3	3	3	0	0	0
Ne	6	0	0	3	1	2	3	1	2	2	0	0
No	9	4	0	3	3	2	3	2	3	1	0	0
Pol	10	4	1	5	0	1	1	1	5	4	0	0
Por	7	1	1	1	0	2	2	3	0	1	0	3
Sw	4	1	1	1	0	1	0	1	1	1	0	1
UK	10	3	4	5	2	4	6	7	5	2	0	1

A = Printed material posted
B = Telephone
C = Positive reinforcement / feedback rewards
D = Financial incentives
E = Social support
F = Buddy groups
G = Opportunities to socialise
H = Promotion days
I = Other
J = Don't know
K = Not applicable

Table 78 (PSQ39). PA Promotion Strategy Directors' responses concerning the tools used in their promotion strategy to maintain behaviour change

Country (N)		Total cost of PA Promotion Strategy (euros per year)			
		Median	Least	Most	Number of estimates
Au	6	75,000	2,000	100,000	3
Be	11	13,000	500	600	2
CR	1	-	-	-	0
De	0	-	-	-	-
Fi	11	74,500	10,000	1,600,000	7
Fr	0	-	-	-	-
Ge	0	-	-	-	-
Gr	6	120,000			1
It	9	30,000	10,000	50,000	3
Ne	6		537,000	1,600,000	2
No	9	250,000			1
Pol	10	12,500	500	200,000	4
Por	7		250	1,000,000	2
Sw	4		27,120	200,000	2
UK	10	66,000	2,000	4,000,000	8

***Table 79 (PSQ40*).** The median and range of the PA Promotion Strategy Directors' estimates of the total cost (euros per year) of developing and running their promotion strategy.

Country (N)		Number of PA Promotion Strategies										
		A	B	C	D	E	F	G	H	I	J	K
Au	6	4	2	1	0	0	0	0	1	0	1	0
Be	11	3	0	6	1	1	2	5	0	0	0	4
CR	1	0	0	0	0	0	1	0	0	0	0	0
De	0	-	-	-	-	-	-	-	-	-	-	-
Fi	11	6	2	5	1	3	3	2	2	1	0	3
Fr	0	-	-	-	-	-	-	-	-	-	-	-
Ge	0	-	-	-	-	-	-	-	-	-	-	-
Gr	6	0	0	3	1	0	1	5	1	0	0	0
It	9	2	1	0	3	1	1	1	1	0	0	6
Ne	6	2	0	3	2	2	1	3	1	0	0	2
No	9	3	1	1	1	4	1	2	2	1	0	0
Pol	10	1	0	4	2	1	2	4	0	0	1	2
Por	7	0	0	2	3	1	1	3	0	0	0	1
Sw	4	0	0	0	2	2	0	0	1	0	1	0
UK	10	3	1	3	2	3	1	4	1	3	2	2

NATIONAL/REGIONAL GOVERNMENT
A = Health budget
B = Social care budget
C = Leisure / sport budget
D = Other

CITY / LOCAL GOVERNMENT
E = Health budget
F = Social care budget
G = Leisure / sport budget
H = Other

OTHER SOURCES
I = Lottery
J = Charity
K = Other

Table 80 (PSQ41). PA Promotion Strategy Directors' responses concerning the source of the funding to run their promotion strategy

- **SYSTEMATIC SEARCH FOR EVIDENCE BASED GUIDELINES**
    - **Objective**

The objective was to conduct a logical, repeatable and thorough search for evidence-based, professional guidelines for the promotion and/or provision of safe and effective physical activity (PA) by older people.

The guidelines identified by the search constituted a readily accessible inventory of existing evidence based guidelines. It permits a critical comparison of the successful PA programmes and PA promotion strategies (identified by the WP5 Experts) with current evidence-based, best-practice guidelines.

- **Methods**
    - **Definitions**

Physical activity (PA) – Any bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure *e.g.* running, walking, swimming, lifting or carrying a heavy weight.

PA promotion strategy – An intervention, device or plan which it is intended will increase the PA of a community.
e.g. Improved street lighting or an educational TV advertising campaign.

Older person - In this systematic search the older person was defined as being 60 years and over, in good health or suffering from a medical condition.

- **Criteria for inclusion in inventory of guidelines**

The publications to be included in the inventory were those which we considered to be guidelines, position stands, consensus statements, standards or recommendations from a credible source, that addressed exercise and/or physical activity for older people and which satisfied <u>all five</u> of the following criteria.

- composed by a process involving a consensus of experts, and
- published under the auspices of government departments, international health organisations, age-related NGOs, or learned societies, and
- with sufficient information about the evidence on which they are based to allow the individual recommendations to be graded according to the strength of that evidence (see 'Key to evidence

statements and grades of recommendation', as published in SIGN Guideline No. 98, July 2007), and
- published from 1990 onwards, and
- addresses the delivery and/or promotion of physical activity for the older person (including old age specific sub-sections of guidelines for the role of physical activity for adults of all ages in health and/or disease).

- **Search to identify candidate publications for inclusion in the inventory of guidelines**

The search protocol took account of the fact that the guidelines which we sought might have been published in scientific journals, websites, or as free-standing publications.

We searched the following electronic databases:

Ovid Medline (1950 to June Wk 4 2007)
CINAHL (1982 to June Wk 5 2007)
EMBASE (1996 to 2007 Wk 26)
SPORTDiscus (1830 to May 2007)
AARP Ageline (1978 to June 2007)
Cochrane Review Library

Searches included no language restrictions and were limited to older adults.

The following two search strategies were used for Ovid Medline and adapted for the other databases.

Search 1 – Provision of physical activity for older people

1 exp exercise/
2 (exercise$ or physical activity or exercise prescription).mp
3 1 or 2
4 exp aged/ or exp "aged, 80 and over"/
5 (aged or elderly or senior$ or older adult or older person$ or older people).mp
6 4 or 5
7 guideline.pt
8 practice guideline.pt
9 exp guidelines/
10 exp health planning guidelines/
11 7 or 8 or 9 or 10

12 exp consensus/
13 (guideline$ or consensus or position stand or standard$ or recommendations$).ti
14 11 or 12 or 13
15 3 and 6 and 14

Search 2 – Promotion of physical activity for older people

1 exp exercise/
2 (exercise$ or physical activity).mp
3 1 or 2
4 exp health promotion/
5 (health promotion$ or promotion strategy or promotion strategies or health behaviour$ or campaign$).mp
6 4 or 5
7 exp aged/ or exp “aged, 80 and over"/
8 (aged or elderly or senior$ or older person$ or older people or older adult$).mp
9 7 or 8
10 guideline.pt.
11 practice guideline.pt
12 exp guidelines/ (61574)
13 exp health planning guidelines/
14 exp consensus/
15 (guideline$ or consensus or position stand or recommendation$ or standard$).ti
16 10 or 11 or 12 or 13 or 14 or 15
17 3 and 6 and 9 and 16

The following websites were chosen on our judgement and searched for relevant guidelines, position stands, consensus statements, standards or recommendations. Search terms were adapted from the two Ovid Medline searches outlined above.

WHO (World Health Organisation)
NIH (National Institutes of Health)
NIA (National Institute of Ageing)
CDC (Centre for Disease Control)
ACSM (American College of Sports Medicine)
AHA (American Heart Association)
NICE (National Institute for Health and Clinical Excellence)

- **Scrutiny to select publications for inclusion in the inventory of guidelines**

Two reviewers (FS, AY) independently scanned the titles of candidate publications identified by the searches to identify potentially relevant publications for more detailed review. Searches of bibliographies and texts were also conducted to identify additional relevant publications. Non-concordance of reviewers was resolved by discussion. The abstract was obtained for each title selected.

The abstracts were then independently studied by the two reviewers, to identify publications for full review. Non-concordance was resolved by discussion. From the full text, the reviewers independently identified the publications which met all five criteria for inclusion in the inventory. Once again, non-concordance was resolved by discussion.

- **Results**

Approximately 5120 titles were considered. Of these, over 650 abstracts were reviewed and, from them, 325 full publications were reviewed. Fifty-seven publications met all 5 criteria for inclusion in the inventory, where they have been listed under the following subheadings: habitual physical activity and PA promotion, resistance training, exercise referral, cardiovascular conditions, exercise testing and screening, hypertension, stroke, hypercholesterolaemia, diabetes, obesity, osteoporosis, falls, osteoarthritis and chronic pain. (See Appendix 4.)

- **CONCORDANCE OF QUALIFICATIONS WITH GUIDELINES**
  - **Discussion & Recommendations**

This section discusses the extent to which the European PA Experts' responses concerning qualifications in the supervision/guidance of PA are consistent with the advice of the inventory of evidence-based best-practice guidelines (Appendix 4). The guidelines are identified by a number in parentheses, relating to the numbering in Appendix 4.

Recommendations are offered in response to instances of incomplete concordance between current practice and the inventory of evidence-based best-practice guidelines.

Issues concerning qualifications are discussed briefly below and are discussed further in 'CONCORDANCE OF PROGRAMMES WITH GUIDELINES' (subsection 'Instructors' qualifications and training').

- **Basic level qualification**

The percentage of European PA Experts that believed a basic level qualification was available for the supervision of physical activity by adults in general varied considerably from country to country. Only about half of those that believed that a basic level qualification was available considered that it was enforced as an absolute requirement (Table 5). Little more than one fifth of PA Experts felt able to estimate the prevalence of the basic, entry level qualification among instructors guiding or supervising physical activity by older participants (Table 7).

Taken together, these responses suggest a low level of awareness of any basic level qualifications that may be available in Europe. This undermines the status of the higher level qualifications. This is particularly unfortunate, given the emphasis placed on "appropriate" qualifications by the NHS National Quality Assurance Framework (NQAF).(12)

- **Higher level qualification**

The percentage of European PA Experts reporting that an older person specific, higher level qualification was available to those supervising physical activity/exercise for older people varied considerably from country to country (Table 6). Fewer than half of the Experts who reported a higher-level qualification felt that it was enforced as an absolute requirement. However, more than half of Experts overall indicated that it was important that such a qualification should be

enforced (Table 6). Moreover, most of the Experts were unable to offer an estimate of the prevalence of a higher level, older person specific qualification among instructors guiding or supervising physical activity by older participants in their country (Table 7). Most responded with 'don't know.'

The advice from the inventory of evidence-based, best-practice guidelines is that the older the participant and the more complex their medical, social and emotional characteristics, the more complex is the process of tailoring an individualised exercise programme, and the more important is evidence that the Exercise Professional's competencies include the necessary high level of knowledge, experience and skill.(12, 16) Thus, the situation in Europe, as judged from Experts' responses, is not wholly consistent with the existing guidelines.

Recommendations:
Enforcement of higher level qualifications specifically related to physical activity and ageing, for those supervising physical activity by older people.

The attitudes, knowledge and competencies required to obtain such, higher level, qualifications must reflect the number, severity and complexity of the comorbidities and disabilities of the intended participants.

- **Assessment, validation and revalidation**

Fewer than a quarter of Experts knew if a higher level qualification (in physical activity and ageing) in their country was externally verified (Table 6). There is little optimism, therefore, as to Experts' awareness of the need for robust quality assurance and academic rigour, as stressed in the evidence-based guidelines.(12, 16)

Recommendation:
Quality assurance of assessment standards, validation and revalidation must be ongoing, impartial, external and conducted by a recognised, academically regulated validating body with current expertise in physical activity and ageing.

- **Professional register**

All UK Experts were aware of the existence of the Register of Exercise Professionals of the United Kingdom (REPs) (www.exerciseregister.org).

However, in the rest of Europe only 21% of non-UK PA Experts knew of such a professional register in their country. More than half of the Experts who indicated that there was a professional register in their country, believed that an entry level qualification was necessary for enrolment to this register (Table 10). However, only a quarter of those that knew of a professional register available in their country felt that the register demanded a higher level qualification for registration as a supervisor of PA by older adults (Table 10).

Whilst the high level of awareness of REPs is encouraging in the UK, greater clarity is required before it can be said effectively to provide the necessary check on qualifications and continuing professional development recommended by NQAF.(12) As for the rest of Europe, greater awareness and clarity of professional registers within each country are needed to meet NQAF recommendations.

Recommendations:
A professional register to be responsible for the scrutiny of the qualifications and of the continuing professional development of its members.

Membership (in good standing) of a professional register to be essential for professional indemnity and employment.

Enhanced awareness, among potential participants, referrers and employers, of the professional register and its functions, particularly with respect to the recognition of different levels of expertise.

- **CONCORDANCE OF PROGRAMMES WITH GUIDELINES**
  - **Discussion & Recommendations**

This section discusses the extent to which the European PA Programme Directors' responses concerning their programmes are consistent with the advice of the inventory of evidence-based, best-practice guidelines (Appendix 4). The guidelines are identified by a number in parentheses relating to the numbering in Appendix 4.

Recommendations are offered in response to instances of incomplete concordance between current practice and the inventory of evidence-based, best-practice guidelines.

- **Catchment areas of programmes**

The most common geographical classification of PA Programmes reported by PA Programme Directors was 'limited to a city/town' (Table 12). No evidence, as to the 'level' of geographical classification at which PA Programmes are best delivered, was found within the inventory of evidence-based, best-practice guidelines.

- **Ages of programmes**

Most of the European PA Programmes surveyed were quite well established (Table 13). In some cases, PA Programmes had run for more than ten years. It could be assumed that these PA Programmes are well established for a reason, such as providing a service that is needed, is of good quality and has regular ongoing attendance. No evidence relating to how long a PA Programme should run, or even how relevant this information is to a PA Programme, was found in the inventory of evidence-based, best-practice guidelines.

- **Components of overall programmes**

Many of the PA Programme Directors reported that multiple component programmes were included in their overall programme (Table 14). The programme included most often was community based senior fitness programmes (groups). Component programmes that were healthcare-related, such as falls prevention programmes, were popular. There were even programmes catering for the elite, older competitor. No evidence explicitly regarding multiple programmes being included in overall programmes was found in the inventory of evidence-based, best-practice guidelines.

However, it is evident from the inventory of evidence-based, best-practice guidelines that the heterogeneity of older adults means widely differing needs and requirements. Older adults are recommended to include aerobic, resistance, flexibility and coordination/balance components in their physical activity weekly plan.(2) Further, those older adults with chronic conditions (e.g. cardiovascular disease, diabetes, arthritis, or osteoporosis) all have different requirements, which cannot be catered for by just one programme. For these reasons it could be argued that multiple programmes within an overall programme are important for older adults.

The PA Programme Directors' description of their overall programmes showed that programmes tended to be group activities rather than individual activities (Table 15). From the inventory of evidence-based, best-practice guidelines, it appears that the choice between individual or group exercises is very much dependent on the purpose of the PA Programme and the clinical condition of the participant. For example, The American Geriatrics Society (AGS) recommends that sedentary healthy older adults with chronic pain should be referred to group exercise programmes delivering moderate intensity physical activity. (57) However, individual home-based physical activity of low intensity is recommended for individuals with severe osteoporosis who are frail, severely kyphotic, have balance difficulties and/or pain.(48) Similarly, individually tailored exercise is important in falls reduction programmes. (47, 54)

The PA Programmes surveyed are often held indoors but outdoor activities are also available (Table 15). Evidence as to whether indoors or outdoors activities are more effective was not found within the inventory of evidence-based, best-practice guidelines.

Facilities

The types of facilities used by the European PA Programme Directors for their overall programmes varied. Sport/physical recreation facilities and community centres were reported most (Table 16). WHO, however, reminds us that physical activity interventions can be effective in other settings, such as schools, workplaces and healthcare premises. (7)

No further evidence was found within the evidence-based guideline inventory to suggest that one facility is better than another for the purpose of delivering PA Programmes to older people. Nevertheless, it is recommended that PA Programmes with high risk coronary patients or delivering vigorous-intensity physical activity, should have immediate

access to a hospital emergency department.(25) It is also recommended that all facilities and settings used to deliver physical activity are able to handle an emergency situation (3). (This is discussed further below, in the section entitled 'Instructors' qualifications and training' and the sub-section 'in-service training').

Recommendation:
Consider broadening the range of settings in which PA programmes are held, e.g. to include schools, workplaces and healthcare premises.

- **Characteristics of programmes' clients**

Age
PA Programme Directors' reports varied as to the age group for which their overall programme was intended. In most cases reports were between 50 to 90/100 years or 60/65 to 80 years. We were unable to find anything in the inventory concerning the preferred age structure of membership of successful programmes. At first sight, one suspects that a wide age range is not a good thing. On the other hand, perhaps grouping participants by their levels of self-care ability or functional mobility is more relevant than grouping them by age.

Residence
Over half the PA Programmes surveyed were intended solely for community-dwelling older adults. There were PA Programmes that reported including institution-dwelling older adults. However, only a quarter of these included them in the same groups as the community-dwelling older adults (Table 17). No evidence was found in the inventory of evidence-based, best-practice guidelines as to whether successful programmes include community-dwelling older adults only, institution-dwelling older adults only, both in the same group or in different groups.

Functional mobility
People able to walk outdoors, with no walking aids and no assistance or supervision by another person, are the 'category' of participant (by level of functional mobility) for whom overall programmes were most commonly reported to be intended (Table 18). Programmes were less often intended for participants in the other 'categories' of functional mobility. Perhaps the assessment of degrees of functional mobility (as in Table 18) has practical usefulness when planning, designing and staffing a PA Programme.

No evidence was found in the inventory of evidence-based, best-practice guidelines as to the value (or otherwise) of categorising participants according to their level of functional mobility.

- **Characteristics of programmes' classes**

Group size

In nine of the fifteen countries, PA Programme Directors estimated that group sizes used in their overall programme are commonly 11-15 participants (Table 20). However, a quarter of PA Programme Directors reported groups of more than 25 participants. No recommendation as to the 'best' size of groups for PA Programmes was found within the inventory of evidence-based, best-practice guidelines.

Instructor:participant ratio

Over half of PA Programmes overall reported that the ratio of instructors to participants in a typical session of their programme was between 1:11 and 1:25 (Table 21). No evidence was found within the guidelines inventory regarding the best ratio of instructors to healthy participants in successful PA Programmes. In phase 3 cardiac rehabilitation, the Scottish Intercollegiate Guidelines Network recommends that the ratio of trained staff to participants should be 1 staff to no more than 10 patients (25). More recently, Northern Ireland's Clinical Resource Efficiency Support Team has been more cautious, recommending 1 staff to no more than 5 patients.(20) Small group sizes allow for a greater degree of individual tailoring, supervision, assessment and reassessment, all of fundamental importance when working with older participants.

Recommendation:

Convene a meeting of experts in an attempt to reach consensus on the instructor:participant ratios best suited to older participants and taking account of the functional ability and health status of the participants, the space and access aspects of the venue, and the expertise of the instructor(s).

Frequency

Of the PA Programmes surveyed, frequency of possible attendance ranged from once a week (1 programme) to eight times a week (4 programmes) (Table 22a). However, the usual frequency of attendance was reported more commonly to be once or twice a week in two thirds of all programmes and three to four times a week in almost a quarter of all programmes(Table 22b). The American College of Sports Medicine (ACSM) and the American Heart Association (AHA) recommend that

older adults "should perform moderate-intensity endurance physical activity for a minimum of thirty minutes, 5 days a week or vigorous-intensity endurance physical activity for a minimum of 20 minutes on 3 days each week."(2, 42) In 20% of programmes surveyed attendance at least 5 times a week is possible (Table 22a). It would seem that 20% of the PA Programmes surveyed should be complimented for ensuring that older adults can achieve the recommended frequency of endurance physical activity entirely within the programme, if they so choose.

Participant loyalty

It is regular, ongoing physical activity that provides health benefits (2, 25, 57) It is a good sign that nearly two thirds of all PA Programme Directors estimated that 75%-100% of their current participants had attended their programme for at least a year (Table 23). Sometimes, however, a change of circumstances means that it is more appropriate for a participant to change to a different programme. When this happens, it is recommended that exercise professionals, health professionals and participants are aware of other physical activity options and support groups available, and discuss them with the participant on completion of a PA Programme or if they decide to pursue individual exercise. (12)

Recommendation:
Participant loyalty should not inhibit informed discussion of the possibility of changing to another programme for greater benefit.

- **Objectives, outcomes, monitoring and feedback**

There may be a discrepancy between the overall aims of organisations sponsoring PA Programmes (as perceived by the programme directors) and the outcome measures reported as being recorded at regular intervals (Table 24 and Table 27). Sponsoring organisations of the European PA Programmes surveyed were reported to be rather unconcerned with the beneficial effect physical activity has on mood and depression in older people. However, when it comes to regular objective measures, mood and depression were reported as being one of the objective measures recorded the most. As discusssed in the Results section, however, the sponsors' apparent lack of interest in the mood elevating effect of physical activity may be an artefact, resulting from overlap among multiple answer options. Artefact or not, it is probably important to recognise that the aims of sponsoring organisations may not be exactly the same as the aims of the participants or the aims of those delivering the programmes.

There is persuasive evidence to suggest that physical activity can decrease symptoms of depression and anxiety, and improve mood in older people, especially if the programme includes aerobic and resistance training. (6) The importance that older adults themselves attach to the mood-enhancing properties of exercise was not surveyed nor is this documented in the inventory of evidence-based, best-practice guidelines. This could be because the systematic search conducted did not include key words specific enough to this subject.

Recommendation:
Recognition that the aims of sponsoring organisations may not be exactly the same as the aims of the participants or the aims of those delivering the programmes.

Nearly half of the PA Programme Directors reported that participant satisfaction was measured once or twice per year. This is considered important as programmes that provide support and feedback are linked to improved physical activity behaviours. (8) PA Programmes which are not measuring participant satisfaction should consider doing so.

Recommendation:
Encourage the practice of measuring participant satisfaction several times a year.

Almost two thirds of PA Directors reported that participants were formally surveyed for the aims of their involvement in the programme (Table 25) and most of these Directors also reported that their programmes were adjusted according to participants' stated aims (Table 26). It is important that participants are involved, with their exercise professional, in the process of developing and maintaining an exercise programme. (12) Ongoing follow-up, initially after 5-6 weeks and then after 10-12 weeks is recommended. (12) Progress can be monitored, new targets formulated and any continuing or new barriers to physical activity discussed. (12, 35) The majority of PA Programmes surveyed are meeting guideline recommendations by recording participant aims and adapting their programmes accordingly. The ACSM and AHA also recommend "older adults should be encouraged to self-monitor their physical activity on a regular basis and to re-evaluate plans as their abilities improve or as their health status changes." (2) It would be helpful to know whether European participants display this high degree of self-direction. Unfortunately, this was not addressed in our questionnaire.

Recommendation:
Maximise client involvement in an ongoing cycle of monitoring, evaluation and goal readjustment.

- **Pre-participation assessment**

Health check
Only half of the PA Programme Directors reported that a health check was required before a potential participant would be eligible to enter their programme (Table 28). Almost half of these directors reported that this health check was assessment by a doctor (Table 29). Fewer than a third of Directors who reported using a health check then reported that it was in the form of a health screening tool. Thus, assessment by a doctor was reported more often than the use of a health screening tool for the purpose of a preparticipation health check.

AHA/ACSM recommend pre-participation screening of prospective exercisers, primarily to identify those at increased risk of an adverse cardiac event.(16) They also advise that pre-participation screening should be effective, simple, easy to perform and unlikely to inhibit participation in exercise programmes. (16) Two simple questionnaires are suggested as examples which meet these criteria (the Revised Physical Activity Readiness Questionnaire and the AHA/ACSM Health/Fitness Facility Pre-participation Screening Questionnaire), preferably interpreted by qualified staff who can limit the number of unnecessary referrals for pre-participation medical evaluation, avoiding both undue expense and unnecessary barriers to participation. (16)

No particular health screening tool stood out as being used more often, between countries or even within countries, except in the UK. The UK PA Programme Directors commonly reported the PAR-Q or an adapted version of it.

Dizziness
Of the thirty-four PA Programme Directors reporting the use of a health screening tool, twenty five went on to report that 'their' health screening tool included questions regarding dizziness (Table 32). Questions regarding dizziness are included in the Revised PA Readiness Questionnaire (PAR-Q) and in the AHA/ ACSM Health Fitness Facility Participation Screening Questionnaire, the health screening tools recommended by the AHA/ACSM. (16)

Vision and hearing
Of the thirty-four PA Programme Directors reporting the use of a health screening tool, fewer than half reported that questions regarding eyesight and hearing were included in 'their' health screening tool (Table 32).

Questions regarding eyesight are mentioned in the inventory of evidence-based, best-practice guidelines only in the context of a falls evaluation (53, 54) but not as part of the standard, older person's preparticipation health check. Furthermore, nowhere in the inventory of guidelines is there any mention of questions regarding hearing.

We are of the opinion that these gaps in the guidelines (and the corresponding gaps in practice) are a cause for concern, even if the evidence base would be only at the level of 'expert consensus'. Bearing in mind that the PA programmes surveyed tended to be group-based, commonly with at least 16-20 participants (Table 20), any undetected impairment of vision or hearing represents an important, avoidable risk.

Recommendations:
***Pre-participation assessment always to include the use of one of the recommended health screening tools. (Revised PAR-Q or AHA/ACSM Health/Fitness Facility Pre-participation Screening Questionnaire*)**

The health screening tool should be strengthened by the addition of a simple question concerning visual impairment and another concerning impaired hearing.

Acting on the health check findings
None of the responding PA Programme Directors would simply exclude a potential participant whose health screening had identified a possible health problem (Table 33). In such a situation, the most frequently chosen course of action was for the potential participant to seek approval from a doctor in order to be permitted to enter the programme (Table 33). This is in keeping with the AHA and ACSM recommendation that following a health appraisal questionnaire, any participant identified to have a potential problem should be referred for medical evaluation. (16) In 2004, the ACSM's 'Best Practice Statement' indicated that the need to consult a doctor prior to commencing a PA programme depends on the older person's health status and on the level of physical activity being considered.(3) In addition, the decision of what constitutes a referable

'problem' depends on the knowledge and training of the person interpreting the health appraisal.(16)

ACSM recommended that asymptomatic older adults commencing a low intensity PA programme do not require a medical evaluation or an exercise test.(3) However, by implication, the potential participant is still recommended to have some kind of health screening assessment so as to establish whether they are, in fact, asymptomatic.

Since 2001, the American Heart Association has also stated that an apparently healthy, older person commencing a low-to-moderate intensity PA programme may not require an exercise test.(30) On the other hand, the AHA still appears to recommend that all adults, should have a medical evaluation (including a "focused" physical examination), before commencing a PA Programme. (30)

Recommendation:
Decisions concerning the action to be taken on the findings of the pre-participation health screening tool should be governed by a protocol which takes account of the health status of the potential participant, their customary level of physical activity, the level of physical activity being considered and, importantly, the knowledge and training of the staff member concerned.

Communication and record keeping
The effectiveness of the health check depends on the adequacy of communication and record keeping. Communication, both written and verbal, among PA programme staff, the medical practitioner and the potential participant is crucial. (3, 12, 16) This should occur before, during and after the individual's participation in a PA Programme, and also in the event of any clinical changes.(3,12)

All information should be recorded in the individual's records. Health/fitness facilities should record and store confidentially all information regarding health appraisal questionnaires and any other screening. (12,16)

Enabling not excluding
None of the responding PA Programme Directors reported that they would exclude a participant whose health screening revealed a possible health problem (Table 33). The purpose of health screening is to enable potential participants to be involved in physical activity rather than to

exclude them. Adequate assessment, adaptation and tailoring of physical activity programmes results in very few older adults denied access to safe and effective physical activity.

Potential participants with a chronic condition are recommended to seek advice from their medical practitioner and exercise professional as to the form of physical activity appropriate for them and the recommended intensity/duration. (3) For example, potential participants with type 2 diabetes are recommended to have a medical evaluation so as to identify any associated conditions such as hypertension, peripheral neuropathy, autonomic neuropathy, retinopathy or macular oedema. (37) These conditions may heighten their risk of cardiovascular disease, contraindicate certain modes of physical activity and/or increase the risk of injury. (37). Those with existing complications are recommended to have a medical evaluation before commencing suitable physical activity. (40)

Recommendation:
Encourage extensive use of inventory document (12) ('Exercise Referral Systems: a National Quality Assurance Framework') as a suitable system to guide high quality communication and collaboration among the potential participant, the exercise professional and the healthcare team.

- **Programme content**

Target aspects of physical fitness
The aspect(s) of physical fitness most commonly addressed by the PA Programmes in Europe are endurance and coordination-balance, closely followed by strength and joint range of motion (Table 34). This represents an adequate degree of concordance with the ACSM and AHA recommendation that older adults should include aerobic (endurance), resistance, flexibility and balance/ coordination exercises into their overall physical activity weekly routine (2). The specific exercise prescriptions for these aspects of physical fitness for older adults were not surveyed in the PA Programmes Questionnaire and therefore are not discussed here. However, they are available in the inventory of evidence-based, best-practice guidelines and can be consulted there. (e.g. endurance 2, 10; resistance 2, 4, 6, 11, 13, 15, 24; flexibility 2, 13; balance/coordination 51, 53, 54).

Only 33% of programmes surveyed reported bone density as being addressed. The ACSM recommends that even the frailest elderly people

need to maintain a level of weight-bearing to preserve skeletal integrity (44, 48, 50, 55), remembering to avoid loading the spine in rotation or flexion (48, 51)

Only fifteen PA Programme Directors reported explosive power as an aim for improvement (Table 34), despite its acknowledged functional importance in old age. (2, 11, 15)

Recommendations:
PA programmes for older people should continue to include aerobic (endurance), resistance, flexibility and balance/coordination exercises in the overall physical activity weekly routine .

In addition, PA programmes for older people should address bone health as an important aim for improvement.

Commission research to identify exercises which improve explosive muscle power without risk of soft tissue injury, loss of balance or exercise-induced rhabdomyolysis (i.e. exercise-induced muscle breakdown).

Modalities of physical activity
The modalities of physical activity reported by PA Programme Directors to be offered in their programmes were varied. Resistance training modalities and endurance training modalities were frequently reported (Table 35). Walking, movement, exercise to music and condition-specific adapted exercise programmes, such as falls prevention programmes were also highly reported.

No evidence was found in the inventory of evidence-based, best-practice guidelines as to which specific modalities are recommended. However, balance exercises (as opposed to balance activities, such as dance) are recommended because the evidence (either way) is so much less for balance activities.

Warm up, workout and cool down
Over half the PA Programme Directors estimated that the most common length of a usual warm up at the beginning of a session and cool down at the end of the session were both between 5 and 15 minutes. This is in accordance with recommendations, which are equally varied, over the same range.(20, 25, 30, 41, 55) However, about a quarter of PA Programme Directors reported a warm up of 5 minutes or less and a third

of directors reported a cool down of less than 5 minutes. Seven PA Programme Directors (5 countries) reported having no warm up at the beginning of a session and twelve Directors (in 8 countries) reported having no cool down at the end of a session. There were five programmes that had no warm up and no cool down. This is not in accordance with recommendations and needs to be reconsidered.

Recommendation:
Any PA Programme with warm up and/or cool down periods lasting less than 5 minutes each, should be reviewed so that this departure from the evidence-based, best-practice guidance can be rectified.

Most of the PA Programmes estimated the length of a usual workout component to be ≥30 minutes (Table 38). In a cardiac rehabilitation session, the workout component is recommended to be 20-30 minutes (20, 25). For obesity, the workout phase to prevent obesity is recommended to be 45-60 minutes and to prevent the regaining of weight the workout session is recommended to be 60-90 minutes (42).

Progression
Sixty two per cent of the PA Programme Directors reported always progressing programme participants, in terms of a systematic increase in the intensity, resistance, frequency and/or duration of exercise (Table 36). Eighteen percent of Directors incorporate progression for only the first few weeks or months. Thirteen percent never incorporate progression into their programme.

The inventory guidelines recommend that all physical activity programmes begin at a low intensity and duration, taking into account individual disabilities and diseases. (2, 3, 43) Intensity and duration can then be increased gradually over weeks or months. For most older adults, moderate-intensity PA has the most favourable risk-to-benefit ratio and should be the goal.(3)

Vigorous-intensity physical activity should be prescribed only to older adults who have adequately progressed to this level, with appropriate fitness levels, experience, knowledge, motivation and adherence. (2, 30)

Recommendation:
Any PA Programme which does not incorporate progression over the first few months departs from evidence-based, best-practice guidance and should be reviewed. (The absence of progression

probably implies that the programme was too demanding initially or insufficiently demanding subsequently.)

Participants with chronic medical conditions
Over half the PA Programme Directors reported that they catered for the exercise needs of older people with chronic medical conditions by providing adapted exercise, with participants included in the mainstream older person's group(s) (Table 39). A quarter of Directors reported using adapted exercise, with participants in disease-related groups or in frailty-related groups. At most, 14% of Directors reported that it was impossible to cater for the exercise needs of older people with chronic medical conditions.

"Modification of the components of the exercise prescription should be considered for elderly patients particularly those ≥ 75 years of age and those with significant co-morbidities that limit mobility."(15) In most cases, after a thorough assessment, the physical activity can be tailored to the individual participant's diseases, disabilities, needs and preferences so that they are enabled to participate in regular physical activity and avoid sedentary behaviour. (2, 5, 7)

Recommendation:
With assessment, adaptation and alternatives, it should usually be possible for an appropriately trained exercise professional to enable safe and effective exercise by older people with chronic medical conditions.

- **Instructors' qualifications and training**

The issues discussed below have already been discussed (more briefly) and recommendations offered in 'CONCORDANCE OF QUALIFICATIONS WITH GUIDELINES'.

Instructors' qualifications
The 112 PA Programme Directors were asked to report the minimum level of qualification required for instructors delivering their programme to older participants (Table 40). Some Directors gave more than one response resulting in 124 responses. In over a third of programmes, instructors were required to hold only a basic 'entry level' qualification in order to deliver the programme to older participants. In a further third of programmes a higher-level, old age specific qualification was required. The final third consisted of varied 'other' qualifications.

The PA Programme Directors were also asked about what was actually happening in their programme. Only half of the PA Programme Directors (from 12 countries) estimated that 100% of instructors guiding/supervising older participants, in their programme, have an entry level qualification (Table 41a). Only one third of the Directors (from 10 countries) estimated that 100% of instructors guiding/supervising older participants, in their programme, have a higher level (old age specific) qualification (Table 41b).

The International Curriculum Guidelines for Preparing Physical Activity Instructors of Older Adults, endorsed by the International Society for Aging and Physical Activity (Ecclestone and Jones, 2004[1]) offers a way forward. It acts as a basis for the training of physical activity instructors of older adults, acknowledging the fact that it will need to be modified between and even within countries. Although this document did not satisfy all our criteria for inclusion in the inventory of evidence-based, best-practice guidelines, it is nevertheless a landmark of international consensus on best practice in the training of exercise professionals.

Ecclestone and Jones (2004) argue strongly that well recognised qualifications for the guiding/supervising of older adults need to be provided and enforced by the industry as a whole. They stress the fact that older people have PA needs and risks that are different from, and more varied than, those of younger adults. Moreover, the NHS National Quality Assurance Framework (12) recommends that even healthy older people should be guided by an 'Advanced Instructor', with skills, knowledge and qualifications beyond the more basic, generic 'Instructor'.

Recommendation:
Encourage extensive use of the International Curriculum Guidelines (Ecclestone & Jones, 2004) and of inventory document (12) ('Exercise Referral Systems: a National Quality Assurance Framework') as templates for the development and review of the curricular requirements for qualifications for those guiding PA by older people. (It is implicit in this recommendation that curricular development, validation and revalidation are done by people with current expertise in PA and ageing.)

Professional register

[1] Ecclestone NA & Jones CJ. *Journal of Aging and Physical Activity* 12(4) 467-479 2004.

Self-governance by a strong professional organisation should include responsibility for ensuring quality assurance of qualifications, possession of appropriate professional indemnity, participation in appropriate continuing professional development, maintenance of ethical standards etc.. (12) In the UK, these issues are the responsibility of the Register of Exercise Professionals.

It was disappointing to find that in only one third of PA Programmes was it compulsory for instructors delivering programmes to older participants to be members of a professional register (Table 42). It is recommended that further efforts are made within Europe to encourage instructors to be a member of a their professional register.

Recommendation:
Further efforts within Europe to require employers to insist that exercise instructors working with older people are members of an appropriate professional register and hold the register's recognised older person specific qualification.

In-service training
Almost half of the PA Programme Directors reported that their programme did not provide ongoing in-service training for their instructors (Table 43). It is recommended that all exercise professionals undertake continuing professional development, which may include for example completion of accredited courses, reading, peer evaluation and/or self-evaluation.(12) Staff training in CPR, first aid, emergency response plans, equipment, equipment storage and maintenance is also a requirement. (16)

For a taste of the range of topics covered in the in-service training for the staff of the surveyed programmes, please refer to the 'Results' text pertaining to Table 43. These topics compare favourably with the modules in the International Curriculum Guidelines (Ecclestone and Jones, 2004)

Recommendation:
Ensure a uniformly high level of continuing professional development by exercise professionals.

Volunteers

Almost half of the PA Programme Directors reported that unpaid volunteers contribute to their programme (Table 44). Commonly these contributions included providing refreshments or transport, or undertaking administrative tasks. Nevertheless, they were also commonly reported to fulfil roles which were more specifically exercise-related, such as 'buddying' or peer-mentoring other participants and in some circumstances even acting as an instructor's assistant or giving instruction. The training provided to these volunteers before they deliver instruction is unknown, as the questionnaire did not explore this issue. Further investigation is warranted, with a view to a clearer delineation of responsibilities and training needs and the protection of all parties.

Recommendation:
Develop a clear statement of the roles, boundaries, responsibilities and training needs of volunteers contributing to PA programmes.

- **Client safety**

Emergencies
Only half of PA Programme Directors reported having emergency protocols in place (Table 45) and only half reported that staff were trained at least annually in these protocols (Table 46). (In fact, only two directors reported that staff are trained more often than annually.) It is recommended that all facilities/settings that offer physical activity, be prepared to handle an emergency situation (3). "All health/fitness facilities must have written emergency policies and procedures that are reviewed and practised regularly." (16) The AHA/ACSM recommend that all staff supervising PA Programmes be trained in CPR, first aid and emergency response plans (16). The Scottish Intercollegiate Guidelines Network recommends that all staff delivering group PA programmes to participants with low and moderate coronary risk should have basic CPR training and defibrillator training. (25)

It is essential that all staff are not only aware of the emergency protocols, but have also had experience in implementing the protocol effectively. (16) When an incident occurs, staff will need to react quickly and this will only be possible if they have sound knowledge and experience of the emergency protocol. (16) "Emergency drills should be practised once every 3 months or more often with changes in staff. Retraining and rehearsals are especially important." (16)

The European PA Programmes surveyed do not all meet the requirement to have emergency protocols and do not all meet the requirement to train their staff in emergency protocols and procedures at least every 3 months.

Recommendations:
Ensure compulsory training in CPR, first aid and emergency response plans for all PA instructors working with older people.

Increase the prevailing frequency of retraining and practical rehearsals of emergency protocols and procedures for all staff.

Equipment
Fewer than half of the PA Programme Directors reported having specific protocols and/or procedures to be followed in respect of equipment use, storage and maintenance (Table 45). Fewer than half of these reported training their staff in these protocols at least annually (Table 46).

It is essential that staff have training and experience in the use of equipment, its storage and maintenance (16). It is recommended that a first aid kit be available at all times, and that at least one phone remains in a specific location known to all staff, with instructions as to how to proceed in an emergency (3, 16). Appropriate resuscitation equipment must be available and all equipment must be maintained on a regular basis (20).

Recommendation:
Increase the prevailing frequency of retraining in the use, storage and maintenance of all equipment.

- **Finance, transport and refreshments**

Finance
Of the 72 Directors who estimated the total cost (per participant per session) of providing their programme (excluding transport and refreshments but including the cost of the room, lighting, heating, maintenance, instructor's fee and administration), over a third estimated less than 5 euros per participant per session (Table 47). However, around a third estimated a cost of more than 10 euros per participant per session. The proportion of this cost paid by each participant varied considerably (table 48). The inventory of evidence-based, best-practice guidelines provided no evidence regarding finance and PA Programmes for older adults. This may be because the search strategy used in the systematic

review did not include key words specific to finance and cost effectiveness.

Transport
Over a third of the PA Programmes surveyed offered transport but most of these offered it only selectively (Table 49). Accessibility is a key barrier to older people taking part in physical activity, along with safety issues related to road traffic and weather (6, 7). It could be argued that transport deserves greater consideration, especially for the promotion of PA Programmes for older, older people and for increasing attendance.

Of the PA Programmes reported to provide transport, more than two thirds provided it for free or almost for free to the participant. (Table 50). No evidence regarding the cost of transport for PA Programmes for older adults was found in the inventory of evidence-based, best-practice guidelines. For example, it would be helpful to know what percentage contribution from participants to the cost of transport strikes the best compromise between reducing the 'travel' barrier and increasing the 'expense' barrier.

Recommendation:
The more frail the participants, the greater the importance of ensuring an adequate financial budget for transport of participants.

Refreshments
Almost half of the PA Programme Directors reported offering refreshments to PA Programme participants, and in most cases this was to everyone (Table 49). Of the programmes offering refreshments, two thirds provided them free or almost free to the participant (Table 50). No explicit evidence regarding the supply or cost of refreshments for PA Programmes for older adults was found in the inventory of evidence-based, best-practice guidelines. Nevertheless, indirect support for its importance is given by the AHA's reminder that exercise programming should take account of the importance of socialisation. (15)

Recommendation:
PA Programme Directors should allow adequate time for effective socialisation by participants, with all that this means for the availability of facilities and staff for other duties.

- **Publicity, marketing and promotion**

The PA Programme Directors all reported that word of mouth was the most commonly used method to publicise, market or promote their programmes (Table 51). All Programme Directors reported using several methods, such as websites, advertising in local newspapers, features in local newspapers and targeted leafleting. Supporting evidence regarding the most effective method of publicising, marketing and promoting a PA Programme for older people was not found within the inventory of evidence-based, best-practice guidelines.

More than one third of the PA Programme Directors reported that they had found it useful to capitalise on national and regional campaigns relating to aspects of ageing and health in order to improve recruitment of new participants and/or maintain motivation of existing participants. Similarly, seven percent of PA Programme Directors had found it useful to build partnerships with local healthcare professionals or organizations. The World Health Organization would agree, stating that it is "Important to enter into partnerships with community agencies, voluntary organizations, religious organizations, and sports clubs etc to promote active living for older people." (7)

- **CONCORDANCE OF PROMOTION STRATEGIES WITH GUIDELINES**
    - **Discussion & Recommendations**

This section discusses the extent to which the PA Promotion Strategy Directors' responses concerning their promotion strategies are consistent with the advice of the inventory of evidence-based best-practice guidelines (Appendix 4). The guidelines are identified by a number in parentheses relating to the numbering in Appendix 4.

The inventory of evidence-based, best-practice guidelines yielded by the systematic search of the literature provided much less evidence-based guidance for Physical Activity Promotion Strategies than for Physical Activity Programmes. This may mean that the systematic search was too narrow or it may reflect the smaller evidence base for PA promotion strategies than for PA programmes.

Whatever the cause, the result was that it was frequently impossible to comment on whether current European promotion strategies (as represented by the responses to the promotion strategy questionnaire) were in accord with evidence-based guidelines. A few examples are given below.

Recommendations have been offered not only in response to instances of incomplete concordance between current practice and the inventory of evidence-based, best-practice guidelines. They have been offered also in response to instances where (a) an inventory publication explicitly identified a gap in the evidence base, (b) our reading of an inventory item suggested a gap in the evidence base, or (c) we suspected incomplete concordance between current practice and evidence-based guidance but have been unable to demonstrate this from the questionnaire data.

- **Prevailing national context**

Amongst those of the PA Promotion Strategy Directors who claimed to know, opinion was divided between those who said that there was no legal or regulatory compulsion, in their country, to promote physical activity, and those who said that there was (Table 54). The inventory of evidence-based guidelines provided no guidance on whether legal or regulatory compulsion would influence the effectiveness of a PA promotion strategy.

When considering the promotion of physical activity, specifically amongst older people, affirmation of legal or regulatory compulsion became more rare but affirmation of national level recommendations became more frequent. Once again, however, the inventory of evidence-based guidelines gave no guidance on the value (or otherwise) of such recommendations for an effective PA promotion strategy. Indeed, an 'Evidence Briefing' from the Health Development Agency (8) drew attention to the absence of review-level evidence of the effectiveness of population-based approaches to promoting physical activity.

Recommendation:
Commission research to identify the strategies which are most effective at engaging older adults in increasing their participation in health-related physical activity. Such research to have a special emphasis on the relevant regional or national settings, people aged 75+, and outcomes free of self-report.

- **Description of promotion strategies**

The PA Promotion Strategies were developed and delivered by both government (especially local government) and non-government (especially welfare/community organisations) sectors (Table 55). The level of intended delivery reported the most was city/town, followed by national and regional levels. Promotion Strategies aiming to deliver at a local neighbourhood level were reported the least. The levels offered in the questionnaire were sometimes reported in combination (Table 56). The inventory of evidence-based guidelines gave no indication of favouring any particular 'level' of intervention for a PA promotion strategy to be effective. However, the surveyed PA Promotion strategies do appear to be in keeping with at least part of the World Health Organisation's view that "promoting physical activity requires the involvement and cooperation of all levels of government (national, regional and local) with clear roles and commitments for each level".(7)

Overall, PA Promotion Strategy Directors reported that their promotion strategies encourage physical activity across a number of settings (Table 57). Centre based promotion strategies were reported more than home based promotion strategies. Group exercise was reported more than independent exercise. The NHS Health Development Agency comments that "Many different combinations of interventions have been shown to be associated with changes in physical activity. Successful interventions have included group-based and/or home-based exercise sessions, and have commonly incorporated behavioural and/or cognitive approaches.

No single approach or combination of approaches has emerged as consistently more effective than the others." (8).

PA Promotion Strategy Directors reported that the settings/organizations taking part in their promotion strategies were varied and multiple (Table 58). Social institutions, primary health care, community centres, welfare organizations and workplaces were all reported. The inventory of evidence-based guidelines provided no guidance on which settings/organizations were more effective.

All of the theories or models offered in the questionnaire, plus some 'others', were reported as being used to develop and/or deliver the Promotion Strategies (Table 59). These approaches are consistent with the recommendations in our inventory of evidence-based, best-practice guidelines (2,3,8,14,26) although none of the inventory guidelines actually names a particular model or theory.

On the other hand, nearly a quarter of the PA Promotion Strategy Directors reported that no theoretical basis was used to develop and/or deliver their promotion strategy (Table 59). (For further comment on strategies to induce behaviour change, see below.)

Promotion Strategy Directors reported using multiple intermediaries in order to reach the intended population (Table 62). The intermediary reported the most by Directors was medical practitioners, closely followed by exercise/dance instructors, volunteers and physiotherapists. This is in keeping with the emphasis that WHO has put on the importance of forging effective partnerships and of enlisting the cooperation of the healthcare sector. (7)

- **Characteristics of strategies' target populations**

The PA Promotion Strategy Directors who gave valid responses gave varied reports as to the age group for which their overall strategy was intended. In most cases each country had PA Promotion Strategies that catered for the 45/50 to 90/100 year age group as well as programmes that catered for the 60/65- 80 year age group. None of the Promotion Strategies in Greece was intended for individuals over 80 years of age.

Inventory items stress the importance of making a special effort to enable increased physical activity by disadvantaged subgroups of older people, defined, for example, by nature of domicile, level of functional mobility, or cultural differences.(e.g. 7,9,15) On the other hand, the inventory items offer little help on how best to achieve this, apart from the sound

advice to design interventions with input from the target population.(9) PA Promotion Strategy Directors tended to report that their strategies targeted more than one 'category' of participant, with all older adults and the general population (including older adults) receiving the most reports (Table 63). Overall, ethnic minority older adults were reported to be the least targeted of the 'categories' offered in the questionnaire. In addition, well over half of PA Promotion Strategy Directors reported that they did not cater for any specific cultural differences (Table 64).

Classified by their functional mobility, the individuals most commonly targeted were those who walk outdoors independently with or without a walking aid. In contrast, those individuals who never walk outdoors were targeted the least (Table 65).

Recommendation:
PA promotion strategies should incorporate a greater emphasis on targeting potentially disadvantaged subgroups of older people, e.g., catering for cultural differences, ethnic minorities and older people with restricted functional mobility.

A surprising gap in the reported European practice was that very few PA Promotion Strategy Directors reported that the target population was screened for its readiness for behaviour change before implementation of the strategy (Table 67). This would seem short-sighted.

Recommendation:
Consider screening the target population for its members' readiness for behaviour change, thus enabling the selection of interventions appropriate to the prevailing stage of readiness for change.

- **Design of promotion strategies**

Behaviour change
Multiple approaches are used throughout Europe to encourage PA behaviour change. The Promotion Strategy Directors reported that increasing knowledge, motivation, skills, access, reduction in misconceptions about ageing and safety are all commonly used throughout Europe as strategies to improve physical activity participation (Tables 66 & 68-70). This is consistent with the warning from the inventory of evidence-based, best-practice guidelines that long-term behaviour changes are dependent on identifying, understanding and addressing barriers preventing older adults from becoming physically

active. (3) It is also consistent with the suggestion that strategies to encourage behaviour change include reducing costs, providing transport and increasing support, especially for older adults. (12) WHO stressed the importance of having a range of intervention strategies, as no one approach was consistently and significantly superior. (7)

The ACSM recommends that individual and community approaches with an evidence, theory and research base are required for behaviour change.(2) Moreover, in 2003 ACSM had already endorsed an AHA Scientific Statement (14) which, in turn, had cited the conclusions of an evidence-based review by the US Task Force in Community Preventive Services[2], viz. that effective community strategies included (a) large scale, intense, highly visible, community-wide campaigns, (b) point of decision prompts to use stairs, (c) social support programmes (such as buddy systems and walking groups), (d) individually adapted behaviour change programmes, and (e) enhanced access to places for PA.

Recommendations:
Encourage the use of inventory document (14) (AHA scientific statement: 'Exercise and physical activity in the prevention and treatment of atherosclerotic cardiovascular disease') as a checklist of characteristics for inclusion when planning an effective community strategy.

Consider the possibility that an annual, nation-wide 'Fitness for All Seniors' Day could be designed readily to have many of the characteristics recommended in inventory document (14).

- **Evaluation and sustainability of effect of promotion strategies**

Target populations
More than half of the PA Promotion Strategy Directors did not know the proportion of the target population that had been reached by their promotion strategy since it had been running (Table 67).

Information approaches
The information approaches most frequently reported to be effective were community wide campaigns and group-based health education focused on information provision (Table 74). This is in keeping with the recommendation of the Task Force on Community Preventative Services

[2] Increasing physical activity: a report on recommendations of the Task Force on Community Preventive Services, *MMWR Recomm Rep* October 26, 2001. 50 (RR-18) 1-14.

that large-scale, highly visible, community-wide campaigns are effective. (Cited by (14))

Behavioural and social approaches
The behavioural and social approach most frequently reported as effective was individually-adapted behaviour change and non-family social support (Table 74). This finding is also supported by the evidence-based review completed by The Task Force on Community Preventative Services. (Cited by (14))

Environmental and policy approaches
The environmental and policy approach most often reported as effective was enhanced access to physical activity (Table 74). This is also in agreement with the evidence-based review completed by the Task Force on Community Preventative Services. (Cited by (14))

Evaluation
Overall, more than half of the PA Promotion Strategy Directors reported that their promotion strategy had been evaluated (Table 75). Aspects evaluated included population reached, behaviour change and/or cost. No recommendations regarding evaluation of promotion strategies were found in the inventory of evidence-based, best-practice guidelines, except insofar as a degree of evaluation is essential in order to apply many of the techniques recommended for maintaining behaviour change (see below).

Maintaining behaviour change
Overall, more than half of the PA Promotion Strategies were reported to include a specific plan or device to maintain the increased level of physical activity achieved (Table 77). Devices used included positive reinforcement/feedback rewards and promotion days. The ACSM advises that these factors influence the likelihood of individuals to sustain a new PA behaviour (3) and the Task Force on Community Preventative Services also recommends social support programmes, such as buddy systems and walking groups as effective community strategies (Cited by (14)).

Recommendation:
Increase the quality and quantity of the evaluation of the effectiveness of PA promotion strategies, recognising that this may require the development of new interdisciplinary partnerships e.g. with marketing science.

▪ ACKNOWLEDGMENTS

We are grateful to the PA Experts, PA Programme Directors and PA Promotion Strategy Directors in all the participating countries for the time and trouble which they took to complete the questionnaires.

This report would not have been possible without the EUNAAPA partners' dedicated commitment to the recruitment of their national PA Experts and to the collection of their national data.

We gratefully acknowledge also the contribution made by our EUNAAPA colleagues to the development of the questionnaires, and by Barry Cronin (Central YMCA), Trish Tenn (Camden Active Health Team), Fiona Wernham (Edinburgh Leisure) and Anita Jefferies (Edinburgh Leisure) to the piloting of early versions of the questionnaires.

We particularly thank Bob Laventure (British Heart Foundation – National Centre for Physical Activity and Health) for support and advice throughout .

EUNAAPA has been supported by a grant from the European Commission (DG SANCO) Public Health Programme 2003-2008.

- **APPENDIX ONE - IDENTIFICATION DETAILS OF NATIONAL PA EXPERTS**

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- Belgium
  - **Senioren sportdag Limburg**
    Bloso
    www.bloso.be
    Tom Willems
    Regional inspector sports and outdoor recreation
    Gouv. Verwilghensingel 13
    B-3500 Hasselt
    Tom.willems@bloso.be

  - **50+ Sportclub**
    City of Tienen
    www.tienen.be
    Michel Roskin
    sport functionary of the city of Tienen
    Reizigerstraat 81
    B-3300 Tienen
    Michel.roskin@tienen.be

- **Fit en Fel**
  Seniorencentrum Brussel
  www.seniorencentrum-brussel.be
  Anick David
  teacher
  Leopoldstraat 25
  B-1000 Brussel
  Clubs-sport@seniorencentrum-brussel.be

- **Seniorobics**
  FROS
  www.fros.be
  Dora Vandenbroele
  teacher gym for seniors, staff trainer
  Oude Voordelaan 30
  B-3080 Vossem
  dvandenbroele@hotmail.com

- **"Dans je fit"**
  Dansclub Dans Je Fit
  www. Dansjefit.bravehost.com
  Monique De Moor
  director and teacher dance club
  Dr Demoorstraat 18
  B-9300 Aalst
  Demoor.monique@skynet.be

- **Tai chi voor senioren**
  Vlaams Instituut voor Gezondheidspromotie
  www.vig.be
  Jean-Marie Willems
  Tai Chi Teacher
  Regentiestraat 23/b21
  B-9100 Sint-Niklaas
  Jim.tao@skynet.be

- **Fitbus**
  Province of Antwerp
  www.provant.be/sport
  www.fitbus.be
  Olivia Verelst
  Sports promoter

Sportdienst Antwerpen
Boomgaardstraat 22/1
B-2600 Berchem
Olivia.verelst@sportdienst.provant.be

- **Neighbourhood sports New Ghent (community work, region of New Ghent)**
  City of Gent
  www.gent.be
  Caroline Antonowicz
  Assistant director
  Head of department senior services city of Ghent
  Seniorenhuis
  Begijnhofdries 33
  B-9000 Gent
  Caroline.antonowicz@gent.be

- **Nordic Walking Programme**
  S-sport vzw
  www.s-sport.be
  Jan Moortgat
  sport technical assistent
  Sint-Jansstraat 32
  B-1000 Brussel
  Jan.moortgat@socmut.be

- **Gym je fit**
  Okra-sport
  www.okrasport.be
  Ingrid Peeters
  sports technical coordinator
  Okra-sport
  Haachtsesteenweg 579
  B-1031 Brussel
  Ingrid.peeters@okrasport.be

- **OZ-fit**
  Onafhankelijk ziekenfonds
  www.oz-fit.be
  Ellen Moermans
  manager economy services
  OZ-fit
  Boomsesteenweg 5

B-2610 Wilrijk
Ellen.moermans@oz.be

- **Czech Republic**
  - **Intervention program for people with health impairment and population groups with internal civilization disorders**
    Kardio Klub Motol
    PaedDr. Miluše Matoušová
    Chair, instructor
    Klub Kardia,
    V Úvalu 84,
    150 18 Praha 5
    Czech Republic

  - **Yoga and Health**
    Yoga in Daily Life System, Vienna, Austria and Yoga in Daily Life System, Střílky, CZ
    MUDr. Vít Čajka
    Director, yoga instructor
    Nový Malín 43
    788 03
    Czech Republic
    joga.malin@seznam.cz

  - **Dance Classes For Seniors**
    Local council, Department of services for seniors and handicapped people
    PhDr. Jana Tomášková
    Local council, head of the department of services for seniors and handicapped people
    Kosmonautů 10
    779 00 Olomouc
    Czech Republic
    jana.tomaskova@mmol.cz

- **Denmark**
  - **Exercise on prescription (MPR)**
    Søndersø Fysioterapi and Region Syddanmark(Region of South Denmark)
    www.fysio-klinik.dk/soendersoe

Claus Sevel
Instructor in the project “motion as medicine”
Søndersø Fysioterapi I/S, Toftekær 7, 5471 Søndersø, Denmark.
fysio@saknet.dk

- **Nordic Walking**
  Danmarks idræts forbund/National Olympic committee and sport federation in Demark.
  www.dif.dk
  Henriette Boye Kyhl
  Health adviser
  House of Sport, 2605 Brøndby, Denmark
  Hbk@dif.dk

- **Boost the body, make everyday easier,- it is never too late.**
  ÆldreForum /AgeForum.
  www.aeldreforum.dk
  Lotte Philipson
  Head of the secretary
  Eldreforum. Skiphusvej 53,3 5000 Odense C
  lp@aeldreforum.dk

- **Get going where you live - " new energy to senior live".**
  County of Roskilde
  Elisabeth Bentsen
  Instructor
  Kirkebakken 42, 4621 Gadstup, Denmark
  beth@mail.dk

- **"Rely on sport" (Stol på idræt)**
  Esbjerg Commune
  www.esbjergkommune.dk
  Stine Stausholm
  Physiotherapist
  Ribegade 169A, 6700 Esbjerg.
  stis@esbjergkommune.dk

- **Physical activity according to legislation, Servicelov § 86**
  Odense Commune
  www.odense.dk
  Eva Hasselbalch

District leader
OKA- Aktivitet og Træning. Ørbækvej 100, 5220 Odense Sø, Denmark.
ehas@odense.dk

- **Training to prevent further lose of function**
  Esbjerg Commune
  www.esbjergkommune.dk
  Stine Stausholm
  Physiotherapist
  Ribegade 169A, 6700 Esbjerg.
  stis@esbjergkommune.dk

- **Finland**
  - **A Mobile gym for older adults in rural areas**
    Age Institute
    www.ikainst.fi
    Pirjo Kalmari
    Planner
    Kalevankatu 12 A
    00100 Helsinki, Finland
    pirjo.kalmari@ikainst.fi

  - **Senior gym**
    City of Jyväskylä, Cultural and Educational Affairs/Sport Centre
    www.jyvaskyla.fi/liikunta
    Marjukka Leino
    Physiotherapist
    City of Jyväskylä, AaltoAlvari, Pitkäkatu 2, 40700 Jyväskylä Finland
    Marjukka.Leino@jkl.fi

  - **Physical Activity Services for Older People in the City of Jyväskylä**
    www.jyvaskyla.fi/liikunta
    Pirjo Huovinen,
    Adapted Physical Educator
    City of Jyväskylä Cultural and Educational Affairs/Sport Centre, Kuntoportti 3, 40700 Jyväskylä, Finland,
    pirjo.huovinen@jkl.fi,
    Sirkka Kannas

Physical Activity Coordinator
City of Jyväskylä Centre for Social Welfare and Health Services, Kyllön terveysasema, PL 52, 40701 Jyväskylä, Finland
sirkka.kannas@jkl.fi

- **Rehabilitation Day Centre**
  Health Centre of the City of Joensuu
  www.jns.fi
  Leena Timonen
  Chief Physician
  Siilaisen terveysasema, Noljakantie 17, 80130 Joensuu
  leena.timonen@jns.fi

- **Winter Walk**
  Age Institute
  www.ikainst.fi
  Marja-Leena Virtanen
  Executive director
  Age Institute, Kalevankatu 12 A, 00100 Helsinki, Finland
  marjis.virtanen@paimio.fi

- **Liiku ja Liidä- Health enhancing physical activity for older people**
  Finnish Pensioners' Federation
  www.elakeliitto.fi
  Maaret Alaranta
  Project Secretary
  Eläkeliitto ry, Kalevankatu 61, 00180 Helsinki, Finland
  maaret.alaranta@elakeliitto.fi

- **Development of safe, supportive, and motivational environment (both outdoor and indoor) for physical Activity for the elderly**
  LIKES Research Center
  www.kki.likes.fi
  Liisamaria Kinnunen
  Producer
  LIKES Research Center, Fit for life program/ KKI-ohjelma, Heikkiläntie 7, FI-00210 Helsinki, Finland
  liisamaria.kinnunen@likes.fi

- **Exercise at home**

The city of Turku, Sports and Physical Activities Centre, Health Care Department
www.turku.fi
Päivi Vastamäki
Physical Activity Coordinator
Sports and physical activities service centre,
Blomberginaukio 4, FI-20720 Turku, Finland
paivi.vastamaki@turku.fi

- **Promotion of functional capacity among older home clients**
  National Public Health Institute, municipalities of Päijät-Häme regions (5)
  www.ktl.fi
  Heikki Heinonen
  Senior Researcher
  Health Promotion Unit, National Public Health Institute,
  Mannerheimintie 166, FI-00300 Helsinki, Finland
  heikki.heinonen@ktl.fi

- **The basics of elder exercise in social and health care, Instructor training (VALSSI)**
  Age Institute
  www.ikainst.fi
  Ulla Salminen
  Planner
  Kalevankatu 12 A, 00100 Helsinki, Finland
  ulla.salminen@ikainst.fi

- **Work in a suburb area for enjoyable ageing**
  Viitakodit ry
  www.viitakodit .fi
  Maarit Salonen
  Project leader
  Viitakoti, Viitaniementie 24, 40720 Jyväskylä, Finland
  salonen.maarit@suomi24.fi

- **France**
  - **Ateliers équilibre (work about balances)**
    Caisse régionale d'Assurance Maladie Bourgogne (CRAM)
    www.ffepgv.fr
    Dominique Gobillot (région)

Formatrice Fédération Française d'Education Physique et de Gymnastique Volontaire
Maison des sports, 13 rue Jean Moulin, BP 7001 54510 Tomblaine
gv.lorraine@wanadoo.fr

- **Programme prévention santé SIEL Bleu**
  Association SIEL Bleu
  www.sielbleu.org
  Jean-Michel Ricard
  Directeur Général
  SIEL Bleu 42 rue de la Krutenau 67000 Strasbourg
  jeanmichel.ricard@sielbleu.org

- **Programme Intégré d'Equilibre Dynamique (PIED)**
  Fédération Française d'Entraînement Physique dans le Monde Moderne (FFEPMM Sport Pour Tous)
  www.sportspourtous.org
  Thierry Fauchard
  Conseiller Technique National à la Fédération Française d' Entraînement Physique dans le Monde Moder
  153 rue Saint Martin, 75008 Paris
  thierry.fauchard@sportspourtous.org

- **Germany**
  - **Richtig Fit ab 50**
    Deutscher Olympischer Sportbund
    www.dosb.de
    www.richtigfitab50.de
    Ute Blessing Kapelke
    DOSB, Otto-Fleck-Schneise 12, 60528 Frankfurt am Main
    Blessing-kapelke@dosb.de

  - **SimA-Erhalt und Foerderung der Selbststandigkeit im hoeheren Alter SimA-Akademie e.V.**
    www.sima-akademie.de
    Univ.-Prof. Dr. W. D. Oswald
    SimA-Akademie e.V., Wallensteinstr. 61-63, 90431 Nuernberg
    ackermann@geronto.uni-erlangen.de

  - **"Fit bis ins hohe Alter"**

Deutscher Turner-Bund
www.dtb-online.de
Petra Regelin
Referentin fur Freizeit-und Gesundheitssport
Deutscher Turner-Bund, Otto-Flecke-Schneisse 8, 60528 Frankfurt am Main
petra.regelin@dtb-online.de

- **Standfest im Alter**
  Universitaet Erlangen-Nuernberg, Institute of Sport Science and Sport
  Dr. Ellen Freiberger
  Institute of Sports Science and Sport, Gebbertstrabe 123b, 91058 Erlangen
  ellen.freiberger@sport.uni-erlangen.de

- **Greece**
  - **"Exercise in postmemopausal women"**
    Youth and Sport Organization, Municipality of Athens
    www.oma.gr
    Tripolitsioti Alexandra
    Teacher of physical education
    Hatzi & Matsourani, Nimfothei, Athens

  - **"Exercise for old people"**
    Athletic Department in Municipality of Komotini,
    Ikonomidis Dimitrios
    Teacher of physical education
    G. Marasli 1, Komotini 69100
    donakom@otenet.gr

  - **"Exercise program for older people"**
    Psychogeriatric Organization "Nestor"
    www.gerontology.gr
    Douloumi Anna
    Physical therapist
    Patriarhou Konstantinou 16, N. Philadelphia 14341
    www.sotosgri@freemail.gr

  - **"Exercise in older individuals"**
    www.geocities.com/kalamariasports
    Mouzakidis Christos

Doctor of Physical Education
Kastritsiou 8, Thessaloniki 54623
cmouz@pe.auth.gr

- **"Exercise and old age (cardiac, osteoporotic patients, in Open Care Center for the Elderly)"**
  Gretsiou Eleni
  Teacher of physical education
  Korinthou 9-11, Komotini
  gretziou_eleni@yahoo.gr

- **Municipality of Neapoli**
  Cultural and Dance Club "Dionisos"
  Papaioannou Christina
  Teacher of physical education
  Georgiou Konstantinidi 18, 54640 Thessaloniki
  sterg28@otenet.gr

- **"Exercise for people with diabetes and heart problems"**
  Athletic center of Municipality of Thermi
  Kosmidou Kontantina
  Teacher of physical education
  Polytexneiou 12, Thessaloniki 54625
  nantiakosmidou@yahoo.gr

- **"Exercise for older adults"**
  Kalapotharakos Vassilis
  Doctor of Physical Education
  16 Diogenous street, Haidari, 12461 Athens
  vasikal@yahoo.com

- **"Physical education for the elderly"**
  "Traditional dances for the elderly"
  "Swimming and aqua aerobics"
  "Trekking"
  Municipality of Maroussi, Athens
  www.maroussi.gr
  Argyropoulou Evgenia-Christina
  Teacher of physical education, Director of the Athletic Dptm
  Kiprion Agoniston & Anaksagora, Maroussi, Athens
  e.c.argyropoulou@gmail.com
  akda@otenet.gr

- **Italy**
  - **Programma di attività motoria in un gruppo di anziani di un centro sociale in periferia di Milano**
    Facoltà di Scienze Motorie, Università Cattolica di Milano - www.unicatt.it
    Isabella Annoni
    Dottore in Scienze Motorie
    Via Mameli 25, 21020, Mornago (VA), Italy
    isaisy@interfree.it

  - **Servizio di attività fisica adattata**
    Casa di cura "Parco dei Tigli" Villa di Teolo (Pd)
    www.unipd.it
    Attilio Carraro
    Professore associato
    Via Beato Pellegrino 28, Padova, Italy
    attilio.carraro@unipd.it

  - **Una città in salute – Attività motorie per la terza età / A healthy city – Motor activity for old people**
    Ufficio Attività creativa Terza Età – servizi sociali – comune di Padova
    www.padovanet.it
    Flavio Martinella
    Coordinatore attività motorie ASD Gymansium
    Via Magellano 18, 35030, Selvezzano Dentro, Padova, Italy
    a.s.d.gymnasium@alice.it

  - **Interventi per il miglioramento della qualità della vita nel comune di Badia Calavena. Programma di attività motoria per età adulta e terza età.**
    "La DEFAV" Associazione iplomati educazione fisica, associate Verona
    www.ladefav.it
    Doriana Rudi
    Diplomata ISEF
    Via Salieri 87, 37132, Verona, Italy
    doriana.rudi@univr.it

  - **Ginnastica per la terza età**
    Palestra Elisa
    www.palestraelisa.it

Vainer Lucchetta
Laurea in Scienze Motorie
Via Pulliere 19, 32035, Santa Giustina, Italy
lucchettavainer@libero.it

- **GinnasticAncora - Attività motoria di gruppo per la terza età / Still in movement - Group movement activity for the elderly**
  Gruppo Sportivo Audace – Commissione ginnasticAncora CSI Vicenza
  www.ginnasticaaudace.it
  www.csivicenza.it
  Sonia Giacomazzi
  Insegnante di educazione fisica/Operatore sportivo per la terza età
  Via Corbetta 24, 36100, Vicenza, Italy
  giacomazzisonia@libero.it

- **Programma di educazione motoria per la popolazione anziana.**
  CEBISM
  www.form.unitn.it/cebism
  Arianna Zandonai
  Specialista in Scienze Motorie preventive e adattate
  Via S. Antonio 26, 38060, Villalagarina, Trento, Italy
  ariannazando@hotmail.com

- **Progetti Benessere over 55**
  UISP MODENA
  www.uispmodena.it
  Grazia Baracchi
  Diplomata ISEF
  Via IV Novembre, 4/h, 41100, Modena, Italy
  grazia@uispmodena.it

- **Lo sportpertutti per la grande età**
  UISP
  www.uisp.it
  Beatrice Andalò
  Diplomata ISEF – Laurea in Scienze della Formazione
  Via Bellavista 21, 38100, Trento, Italy
  beatrice@corporea.net

- **Netherlands**
  - **ACTOR**
    Stichting In Beweging
    www.actormethode.nl,
    www.stichtinginbeweging.nl
    Marielle Tromp
    Director of Stichting In Beweging (Foundation)
    Dwazziewegen 11, 9301 ZR RODEN, The Netherlands
    m.tromp@stichtinginbeweging.nl

  - **Groningen Active Living Model (GALM)**
    Center for Human Movement Sciences, UMCG / University of Groningen
    www.rug.nl/www.galm.nl
    Dr. M.H.G. de Greef
    Associate professor
    P.O. Box 196, 9700 AD GRONINGEN, The Netherlands
    m.h.g.de.greef@rug.nl

  - **In Balans (In Balance)**
    Netherlands Institute for Sport and Physical Activity (NISB)
    www.nisb.nl
    Ger Kroes, projectmanager
    Postbus 64
    6720 AB Bennekom
    ger.kroes@nisb.nl

  - **COOL**
    Nursing home Driemaasstede
    www.argoszorggroep.nl
    Ellen de Bruin
    Physical therapist
    Locatie Driemaasstede, Postbus 4023, 3102 GA Schiedam
    edbruin@argoszorggroep.nl

  - **Gezond & Vitaal (Healthy & Vital)**
    TNO Quality of Life
    www.tno.nl
    Marijke Hopman-Rock
    Head of department Physical Activity & Health

P.O. Box 2215, 2301 CE Leiden
marijke.hopman@tno.nl

- **Meer Bewegen voor Ouderen, sectie Amsterdam - More exercise for Seniors- region Amsterdam**
  Stichting Meer Bewegen voor Ouderen - Foundation "More exercise for Seniors, Amsterdam"
  www.mbvo-amsterdam.nl
  Joke Kat
  Consultant
  Plein 40 - 45 nr. 5, 1063 KP Amsterdam
  mvbo_amsterdam@hotmail.com

- **Meer Bewegen voor Ouderen, sectie Noord Holland (More Exercise for Seniors – region Noord Holland)**
  SWO (Organisation for the Wellbeing of the Elderly) & Thuiszorg (Care at home)
  www.sportservicenoordholland.nl
  T. Kegel-Slop
  Consultant
  P.O. Box 338, 2000 AH Haarlem
  tkegel@sportservicenoordholland.nl

- **Bewegen is van iedereen (Exercise is (part) of Everyone)**
  Lectoraat Gerontology (Lectorship Gerontology)
  www.avans.nl
  Dr. Arno Rademaker
  Research and Education
  Hogeschoollaan 1, 4818 CR Breda
  achj.rademaker@avans.nl

- **Care programme for senior people**
  Praktijk voor oefentherapie Cesar "het Noorderbad" Groningen (Practice for Cesar Therapy "het Noorderbad" Groningen)
  www.oefentherapiecesarnoorderbad.nl
  Annemieke Uneken, Oefentherapeute Cesar (therapist Cesar)
  Oosterhamrikkade 66, 9714 BG Groningen
  otcesar-noorderbad@planet.nl

- **Vallen Verleden Tijd (Nijmegan Falls Prevention Program)**
  Sint Maartenskliniek

www.maartenskliniek.nl
Ellen Smulders
Physical therapist (MSc)
Hengstdal 3, 6522 JV Nijmegen
e.smulders@maartenskliniek.nl

- **Norway**
  - **Senior training NIMI**
    Norwegian Institute of Sportsd Medicine
    www.nimi.no
    Grete Stene Johannessen
    Advicer in Sport and Health
    Nimi,Sognsveien 75D, 805, Oslo, Norway
    Grete.s-j@nimi.no

  - **60+**
    Oslo Idrettskrets
    www.60+.Oslo.no
    Harald Skoglund
    Projectmanager
    Oslo Idrettskrets, 60+, Ekebergveien 101,1178, Oslo, Norway
    harald.skoglund@idrettsforbundet.no

  - **I harmony/ In harmony**
    Norwegian School of Physical Education
    www.swussnasau.no
    Anne Mette Rustaden
    Physiotherapist
    Swiss Masai Norge AS, Tvetenveien 30 N-0666, Oslo
    amr@masainorge.no

  - **Nevrologigruppen-Fana/ Group for Patients with Nevrological Disorders**
    Ergo og fysioterapitjenesten, Fana, Bergen
    www.bergen.kommune.no
    Birgit Gran
    Head of Department of occupational and physiotherapy
    Ergo og fysioterapitjenesten, Fana, Postboks 85, Nesttun, 5852, Bergen, Norway
    birgit.gran@bergen.kommune.no

- **Exercise to prevent functional decline and falls in communitydwelling older persons**
  Enhet for fysioterapitjenester, Trondheimkommune
  Municipality of Trondheim, Primary health care sector
  Elin Simonsen
  Physiotherapist
  Enhet for fysioterapitjenester v/ Elin Simonsen, Frostadveien 2C, 7004, Trondheim, Norway
  elin.simonsen@trondheim.kommune.no

- **Exercise for Seniors**
  Høgskolen i Tromsø, fysioterapeututdanningen, AFH,
  Tromsø University College, Faculty of health Sciences
  www.hitos.no
  Sissel Thraning and physiotherapy students
  Assistante Professor in Physiotherapy
  Fysioterapiutdanningen i Tromsø, MH-bygget, Breivika, 9092, Tromsø, Norway
  sissel.thraning@hitos.no

- **Opp av godstolen "Rise from your restchair"**
  Health and social and sports departement in Kristiansand muncipality, Central Agder Recreation
  www.midt-agderfriuft.no
  Ketil Fossheim
  Outdoor and PA counsultant
  Postbox207,4662, Kristiansand, Norway
  kjetil@midt-agderfriluft.no

- **Strength and balance Activity Groups**
  Physiotherapy section, Health service , Drammen city
  Ingrid Tellsgaard
  Speical physiotherapist
  Drammen, geriatriske kommpetansesenter, Landfalløya 80, 3023, Drammen, Norway
  ingrid.tellsgaard@drmk.no

- **Senior training**
  friskis&Svettis
  www.friskissvettis.no
  Maddan Yran
  Teacher in Exercise
  Elmholtveien 18, 0281, Oslo, Norway

m-yran@online.no

- **Group training for osteoporosis**
  Physiotherapy department of Stavanger, University Hospital
  Mari Ørstadvik Ånestad
  Physiotherapist
  Fysioterapiavdeling, Stavanger sykehus, Box 8100, 4068, Stavanger
  aamo@sus.no

- **Poland**
  - **5 "Lżejsi w jesieni życia"**
    Akademia Wychowania Fizycznego Józefa Piłsudskiego w Warszawie
    www.awf.edu.pl
    Ewa Kozdroń
    dr n. wych. Fiz
    Akademia Wychowania Fizycznego Józefa Piłsudskiego w Warszawie;
    ul. Marymoncka 34,
    00-968 Warszawa
    ewa.kodron@awf.edu.pl

- **Portugal**
  - **No Porto a vida é longa/ In Porto life goes on**
    Porto Municipalities
    www.portolazer.pt
    Armando Oliveira
    Executive administrator
    Rua Bartolomeu Telmo 648, 4150 Porto,
    geral@portolazer.pt

  - **Idade mais, mais saúde /More Age, More Health**
    Department of Sciences of Sport and Physical Education
    High School of Education, Polytechnic Institute
    www.ese.ipb.pt
    António Miguel de Barros Monteiro
    Graduate

Campus Santa Apolónia Apartado 1101-49, 5305- Bragança, mmonteiro@ipb.pt

- **Exercise for Seniors**
  Faculty of Human Motricity
  www.fmh.utl.pt
  Mª Margarida Marques Rebelo Espanha
  Associated Prof.
  Estrada da Costa Cruz Quebrada 1495-688 Cruz Quebrada-Dafundo, mespanha@fmh.utl.pt

- **Menopausa em forma/ Fit menopause**
  University of Trás os Montes & Portuguese Sport Institute,
  www.utad.pt/pt/eventos/menopausa_em_forma/programa.html
  Maria Helena Rodrigues Moreira
  Professor at university (UTAD)
  Rua Dr. Manuel Cardona Departamento de Desporto CIFOP 5000-558 Vila Real
  hmoreira@utad.pt

- **Actividade Física na 3ª idade/ Exercise in elderly**
  Faculty of Sport University of Porto
  www.fade.up.pt
  Maria Joana Carvalho
  Associated Prof.
  Rua Dr. Plácido Costa, 91 4200 Porto
  jcarvalho@fade.up.pt

- **Programa 50+/ Programme 50+**
  Faculty of Human Motricity
  www.labes.fmh.utl.pt
  Fátima Baptista
  Associated Prof.
  Estrada da Costa Cruz Quebrada 1495-688 Cruz Quebrada-Dafundo
  FBaptista@fmh.utl.pt

- **Exercício vibratório e prevenção de quedas na mulher pós-menopausa/ Vibratory exercise and falls prevention in menopause women**
  University of Evora -Department of Sport and health
  Armando Raimundo
  Associated Prof.
  Prolongamento Rua Regengos de Monçaraz, 14 7000-727 Évora
  ammr@uevora.pt

- **Clube Maia Sénior/ Maia Sénior Club**
  Maia municipalities
  desporto.maiadigital@cm-maia.pt
  José Francisco Pedrosa Simões Ferreira, Department Director
  Praça Dr. José Vieira de Carvalho 4470 Maia,
  dfd.pedrosa@cm-maia.pt

- **Sweden**
  - **Life style centre**
    Local health care services in the west of Östergötland,
    www.lio.se
    Ingrid Lagerqvist
    nurse/life style coach
    Jungfruvägen 5, SE-592 32 Vadstena, Sweden
    ingrid.lagerqvist@lio.se

  - **Preventive and health promoted activities for the elderly**
    Prevention and Promotion Unit within health care,
    www.goteborg.se/tynnered
    Gunilla Foltyn
    Head of Prevention and Promotion Unit within elderly care
    SDN Tynnered, SE-421 08 V. Frölunda, Sweden
    gunilla.foltyn@tynnered.goteborg.se

  - **Fall prevention for the elderly at risk for falls, living independently in their own homes.**
    Regionförbundet Örebro

www.regionorebro.se
Gunilla Fahlström
Social worker, PhD
Regionförbundet Örebro SE-701 83 Örebro, Sweden
gunilla.fahlstrom@regionorebro.se

- **Health projects**
  The Swedish school of sports and health sciences,
  www.gih.se
  Eva Andersson
  Physician, PhD, Lecturer
  Box 5626, S-114 86 Stockholm, Sweden
  eva.andersson@gih.se

- **Aerobics, moderate intensity**
  Friskvårdscentrum
  www.stockholm.se/hasselgarden
  Lena Markström
  Physiotherapist
  Friskvårdscentrum, Ormängsgatan 10, SE-165 56 Hässelby
  lena.markstrom@hasselby.stockholm.se

- **Pilates**
  Friskvårdscentrum
  www.stockholm.se/hasselgarden
  Lena Markström
  Physiotherapist
  Friskvårdscentrum, Ormängsgatan 10, SE-165 56 Hässelby
  lena.markstrom@hasselby.stockholm.se

- **Circuit training in gym**
  Friskvårdscentrum
  www.stockholm.se/hasselgarden
  Lena Markström
  Physiotherapist
  Friskvårdscentrum, Ormängsgatan 10, SE-165 56 Hässelby
  lena.markstrom@hasselby.stockholm.se

- **Senior activities**
  Korpen Göteborgs Pensionärsmotion,
  www.korpen.se/goteborg
  Viola Bodo
  Consultant in keep-fit activities

Korpen Göteborgs Pensionärsmotion, Kvibergsvägen 5,
SE-415 82 Göteborg, Sweden
viola.bodo@korpen.se

- **The High-Intensity Functional Exercise Program (the HIFE Program)**
  Luleå University of Technology
  www.ltu.se
  Erik Rosendahl
  Physiotherapist, PhD
  Luleå University of Technology, Dept. Health Sciences,
  Physiotherapy Unit, SE-971 87 Luleå, Sweden.
  erik.rosendahl@ltu.se

- **United Kingdom**
  - **Ageing Well Programme**
    Edinburgh Leisure
    www.edinburghleisure.co.uk
    Hannah Macrae/ Anita Jeffries
    Health Development Officer for Older People
    Edinburgh Leisure, Sport Development, 141 London Road,
    Edinburgh, EH7 6AE
    hannahmacrae@edinburghleisure.co.uk

  - **Practice Activity and Leisure Scheme (PALS)**
    Kirklees, Council in partnership with Kirklees Primary Care Trust
    Alison Morby
    Physical Activity Development Manager
    Culture and Leisure Service, Stadium Business and Leisure Complex, Stadium Way, Huddersfield, HD1 6PG
    Alison.morby@kirklees.gov.uk

  - **Walking the Way to Health**
    Natural England
    www.whi.org.uk
    Stella Goddard
    Healthy Walking Project Manager
    John Dower House, Crescent Place, Cheltenham, GL50 3RA
    Stella.goddard@naturalengland.org.uk

  - **Healthy Living Programme**

Central YMCA Club
www.centralymca.org.uk
Tina Albrecht
Community Programmes' Manager
112 Great Russell St, London, WC1B 3NQ
t.albrecht@centralymca.org.uk

- **Actively Ageing Well**
  Age Concern Northern Ireland and the Health Improvement Agency for Northern Ireland
  www.ageconcernni.org
  www.healthpromotionagency.org.uk
  Alan Herron
  Director of Community Services, Age Concern Northern Ireland, 3 Lower Crescent, Belfast, BT7 1NR
  a.herron@ageconcernni.org
  &
  Linda Barclay
  Director of Programme Development, The Health Promotion Agency
  18 Ormeau Avenue, Belfast, BT2 8HS
  l.barclay@hpani.org.uk

- **Extend**
  www.extend.org.uk
  Wendy Penny
  Director of Training
  60 Brooks Road, Sutton Coldfield, West Midlands, BY2 1HR
  Wendy.penny@extrain.org.uk

- **GO50**
  Age Concern Surrey
  www.acsurrey.org.uk
  Gill Walker
  Deputy Chief Executive
  Age Concern Surrey, Rex House, William Road, Guildford, Surrey, GN1 4Q2
  gill@acsurrey.org.uk

- **Ageing Well in Wales**
  Age Concern Cymru
  www.accymru.org.uk

Mark Allen
Ageing Well Manager
Ty John Pathy, 13/14 Neptune Court, Vanguard Way,
Cardiff, CF24 5PJ
Mark.allen@accymru.org.uk

- **Young@Heart**
  Nottinghamshire Rural Community Council
  www.nottsrcc.org.uk
  Rachel Hind
  Newstead Healthy Living Centre Project manager
  Newstead Healthy Living Centre, Cornerstone House,
  32 Tilford Road, Newstead Village, Nolts, NG15 0BU
  rhind@noltrscc.org.uk

- **West of Cornwall Leap Project**
  Cornwall Isle of Scilly Primary care Trust
  www.leapactive.org
  Christopher Cleator
  LEAP Activator
  Kernow Building, Wilson Way Pool, Redruth, Cornwall,
  TR15 3QE
  Christopher.Cleator@CIOSPCT.cornwall.nhs.uk

- **APPENDIX THREE - IDENTIFICATION DETAILS OF 'SUCCESSFUL' PA PROMOTION STRATEGIES**

  - **Austria**
    - **JUNG.ALT.WERDEN**
      Allgemeiner Sportverband Oesterreich (ASVOE)
      www.asvoewien.at
      www.jungaltwerden.at/de/
      Mag. Maria Lengauer
      Secretary general of ASVOE-Vienna
      A-1060 Wien, Gumpendorfer Straße 65/18
      maria.lengauer@asvoe.at

    - **'Minigolf kommt zu dir!'**
      engl. 'Miniature golf comes to you!'
      Minigolf Company
      www.minigolfcompany.com
      Christine Nestler
      President of the Minigolf Company
      A-1120 Wien, Tivoligasse 34/21
      christine.nestler@chello.at

    - **LeBe 'Lebensqualität erhalten - Bewegung erfahren'**
      engl. 'Quality of life receive - movement experience
      Land Niederoesterreich (engl. government of Lower Austria)
      www.sportlandnoe.at
      Stefan Grubhofer
      Coordinator of SPORT.LAND.NOE
      A-3109 St.Poelten, Niederoesterreichring 2, Haus C
      grubhofer@noe.co.at

    - **ALT.JUNG.SEIN. Lebensqualität im Alter**
      Katholisches Bildungswerk Vorarlberg and Caritas Vorarlberg
      www.altjungsein.at
      Dr. Hans A. Rapp
      Head of the Catholic Educational Institute
      A-6800 Feldkirch, Bahnhofstraße 13
      hans.rapp@kath-kirche-vorarlberg.at

    - **'Lebenswerte Lebenswelten für ältere Menschen'**

University of Graz, Austrian Public Health Association
(ÖGPH – Oesterreichische Gesellschaft für Public Health)
www.oeph.at
lebenswelten.meduni-graz.at/
Em.Univ.Prof. Dr. R. Horst Noack
A-8010 Graz, Universitätsstraße 6/1
horst.noack@meduni-graz.at

- **Ein Herz für Wien engl. 'A heart for Vienna'**
  Fonds Soziales Wien
  www.einherzfuerwien.at
  Mag. Michael Kowanz-Eichberger
  Programm Director
  A-1030 Wien, Guglgase 7 -9
  michael.kowanz-eichberger@fsw.at

- **Belgium**
  - **50+ Sportclub**
    City of Tienen
    www.tienen.be
    Michel Roskin
    sport functionary of the city of Tienen
    Reizigerstraat 81
    B-3300 Tienen
    Michel.roskin@tienen.be

  - **Fit en Fel; Senioretics**
    Seniorencentrum Brussel
    www.seniorencentrum-brussel.be
    Frank Lemahieu
    Responsible publications
    Seniorencentrum
    Leopoldstraat 25
    B-1000 Brussel
    publicaties@seniorencentrum-brussel.be

  - **BOEBS community based intervention to prevent falling among the elderly**
    Vlaams Instituut voor Gezondheidspromotie
    www.vig.be
    Mia Van Laeken
    staff member injury prevention

Vlaams Instituut voor Gezondheidspromotie
G. Schildknechtstraat 9
B-1020 Brussel
Mia.vanlaeken@vig.be

- **Allround Promotion FROS**
  FROS
  www.fros.be
  Anne-Marie Clerinx
  Coordination regional secretary
  Fros Vlaams Brabant
  Sint-Maartenstraat 55/3
  B-3000 Leuven
  vlaamsbrabant@fros.be

- **"Dans je fit"**
  Dance club Dans je fit
  www.dansjefit.bravehost.com
  Monique Demoor
  Director and teacht dance club
  Dr Demoorstraat 18
  B-9300 Aalst
  Demoor.monique@skynet.be

- **Allround promotion OOK**
  Vlaamse Ouderraad OOK
  www.vlaams.ook.be
  Mie Moerenhout
  Director
  Koningstraat 136
  B-1000 Brussel
  Mie.moerenhout@vlaamse-ouderenraad.be

- **Senior Sportief**
  Bloso
  www.bloso.be
  Ken Nys
  Regional inspector sports and outdoor recreation
  Bloso Insectiedienst
  Vorselaarsebaan 60
  B-2200 Herentals
  Ken.neys@bloso.be

- **Health and Sports service city of Ghent**
  City of Ghent
  www.gent.be
  Caroline Antonowicz
  Assistant-director
  Seniorenhuis
  Begijnhofdries 33
  B-9000 Gent
  Caroline.antonowicz@gent.be

- **Allround promotion through associations of the elderly**
  S-sport
  www.s-sport.be
  David De vlieger
  Administrative coordinator
  S-Sport
  Sint-Jansstraat 32
  B-1000 Brussel
  David.devlieger@socmut.be

- **Meer bewegen, beter leven** (lecture)
  Okrasport
  www.okrasport.be
  Ingrid Peeters
  Sports technical coordinator
  Haachtsesteenweg 579
  B-1031 Brussel
  ingridpeeters@okrasport.be

- **OZ-fit: info sessions related to physical activity and health**
  Onafhankelijk Ziekenfonds
  www.oz-fit.be
  Ellen Moermans
  manager economy services
  Boomsesteenweg 5
  B-2610 Wilrijk
  Ellen.moermans@oz.be

- **Czech Republic**
  - **Sustainability and development of services in clubs for seniors**

Local council, Department of services for seniors and handicapped people
Jana Tomášková
Local council, Head of the department of services for seniors and handicapped people
Kosmonautů 10,
Olomouc 779 00,
Czech Republic

- **Finland**
  - **Strength in old age- A health exercise programme for older adults 2005-2009**
    Age Institute
    www.ikainst.fi
    www.voimaavanhuuteen.fi
    Päivi Niemi
    Programme Coordinator
    Age Institute, Kalevankatu 12 A, 00100 Helsinki, Finland
    paivi.niemi@ikainst.fi

  - **Physical Activity Prescription by Physicians (Liikkumisresepti, www.liikumisresepti.net)**
    UKK-Institute
    www.ukkinstituutti.fi
    Minna Aittasalo and the research group
    The UKK Institute, PO Box 30, 33501 Tampere, Finland
    minna.aittasalo@uta.fi

  - **Walking Strategy 2005-2009 (Kävelyohjelma, www.kavely.fi)**
    UKK-Institute
    www.ukkinstituutti.fi
    Minna Aittasalo and the research group
    The UKK Institute, PO Box 30, 33501 Tampere, Finland
    minna.aittasalo@uta.fi

  - **Screening and counselling for physical activity in older people**
    GeroCenter Foundation
    www.gerocenter.fi, www.jyu.fi
    Taina Rantanen/ Raija Leinonen
    Professor/ Senior researcher

Taina Rantanen Dept. Health Sciences University of Jyväskylä FIN-40014 University of Jyväskylä,
Raija Leinonen Kinkomaan sairaala, 6krs. FIN 40930 Kinkomaa
taina.rantanen@sport.jyu.fi
raija.leinonen@gerocenter.fi

- **Quality recommendations for guided health-enhancing physical activity for older people**
  Ministry of Social Affairs and Health
  www.stm.fi
  Mari Miettinen
  Senior officer
  Ministry of Social Affairs and Health, P.O. Box 33, 00023 Government, Finland
  mari.miettinen@stm.fi

- **Keep walking project 2002-2005. Outdoor exercise and activities of daily living as part of the everyday living of older adults**
  Age Institute
  www.ikainst.fi
  Elina Karvinen
  Sector Manager
  Age Institute, Kalevankatu 12 A, 00100 Helsinki, Finland
  elina.karvinen@ikainst.fi

- **Physical Activity Strategy of Finnish Pensioners' Federation**
  Finnish Pensioners' Federation
  www.elakeliitto.fi
  Maaret Alaranta
  Project Secretary
  Maaret Alaranta Eläkeliitto ry, Kalevankatu 61, 00180 Helsinki, Finland
  maaret.alaranta@elakeliitto.fi

- **Fit for Life Program**
  LIKES Research Center for Sport and Health Sciences
  www.kki.likes.fi
  Jyrki Komulainen
  Program director

LIKES, Research Center for Sport and Health Sciences,
Rautpohjankatu 8a, FI-40700 Jyväskylä, Finland
jyrki.komulainen@likes.fi

- **Routes for the Elderly with zimmer frame in Kuopio, Finland**
  The City of Kuopio
  www.kuopio.fi
  Aila Mäkelä
  Physiotherapist
  Kuopion kaupunki, sosiaali- ja terveyskeskus,
  Tullinportinkatu 31, FI-70100 Kuopio, Finland
  aila.makela@kuopio.fi

- **"NEVER"-falls prevention in older adults**
  National Public Health Institute
  www.ktl.fi
  Sanna Sihvonen
  Senior Researcher
  Injury Prevention Unit, National Public Health Institute,
  Mannerheimintie 166, FI-00300 Helsinki, Finland
  sanna.sihvonen@ktl.fi

- **Instructor training**
  Age Institute
  www.ikainst.fi
  Elina Karvinen
  Sector Manager
  Kalevankatu 12 A, 00100 Helsinki, Finland
  elina.karvinen@ikainst.fi

- **Greece**
  - **“Exercise in old age”**
    Municipality of Evosmos (Local authority)
    www.evosmos.gr
    Ganatsios Georgios
    Director of the Dptm of Education, Sport, and Youth.
    M. Aleksandrou 57, Evosmos, Thessaloniki 56224, Cultural Center of Evosmos
    Gganatsios@yahoo.gr

  - **“Sport for all”**

Athletic Department in Municipality of Komotini,
donakom@otenet.gr
Ikonomidis Dimitrios
Teacher of Physical Education
G. Maraoli 1, 69100 Komotini
donakom@otenet.gr

- **No name of promotion strategy specified**
  www.ona.gr
  www.cityofathens.gr
  Mantzoris Mihalis
  Teacher of Physical Education
  Satovriandou 20, Athens 10431

- **"Traditional (folk) dance for older people"**
  Likesas Georgios
  Professor of Physical Education and Folk Dance teacher
  Mitropolitou Kallidou 33, Kalamaria 55131, Thessaloniki
  likes@otenet.gr

- **No name of promotion strategy specified**
  www.gerontology.gr
  Mougia Maria
  Director of Psychogeriatric Organization "Nestor"
  Ioannou Drosopoulou 22, Kypseli 11257, Athens
  hagg@otenet.gr

- **"Sport for all"**
  Municipality of Thermi
  www.dimosthermis.gr
  Sanidas Georgios
  Director of Municipal Sport Development
  10 klm Thermis-Triadiou, 57001, P.O.Box 2917, Thessaloniki
  athlitiko@dimosthermis.gr

- **Italy**
  - **Physical activity promotion in the elderly**
    ASL
    www.villapiaggio.it
    Claudio Culotta
    Medical doctor
    Via Operai 80, 16149, Genova, Italy
    Claudio.Culotta@asl3.liguria.it

- **Schiena leggera in acqua / Soft back on the water**
  Rarinantes Marostica
  www.rarinantesmarostica.com
  Maurizio Bertollo
  Docente universitario
  Via Marini 58, 36055, Nove, Chieti, Italy
  m.bertollo@unich.it

- **BenATTIVI a Trieste – Promozione dell'attività fisica nell'anziano**
  Ceformed
  www.ceformed.it
  Luigi Canciani
  Direttore Scientifico Centro Regionale di Formazione per l'Area delle Cure Primarie Regione Friuli Venezia Giulia – Responsabile Nazionale Area Prevenzione SIMG
  Via Grassi, 14/1, 33033, Codroipo, Udine, Italy
  contact@ceformed.it
  gigidoc@tin.it

- **Promotion for adults and older people life**
  Comune di Badia Calavena
  www.badiacalavena.it
  Ermanno Anselmi
  Sindaco del comune di Badia Calavena
  P.zza Mercato 1, c/o Comune di Badia Calavena, (VR)
  ermanno.anselmi@libero.it

- **GINNASTICANCORA – Interventi di promozione della vita delle persone adulte e anziane**
  CSI
  Centro Sportivo Italiano
  Luisa Paiola
  Diplomata ISEF
  Via Lago d'Orta 8, Vicenza, Italy
  luisapaiola@hotmail.com

- **Progetto "OSAI ARGENTO"**
  Cooperativa Sociale CIVITABELLA ONLUS
  Roberto Sanzolini
  Presidente Cooperativa Sociale
  CIVITABELLA ONLUS

Via del Tiro a Segno, 00053, Civitavecchia, Roma, Italy
sandolini@arci.it

- **Università Età Libera – Corsi di attività motorie**
  Università Età Libera
  www.comune.rovereto.tn.it
  Ferruccio Fasanelli
  Assistente amministrativo
  Via Pasqui 10, 38040, Trento, Italy
  fasanelliferruccio@comune.rovereto.tn.it

- **Campagna sull'uso delle Scale – Counselling da parte del MMG**
  Azienda Provinciale Servizi Sanitari
  www.apss.tn.it
  Enrico Nava
  Medico direttore U.O. Assistenza territoriale distretto di Trento
  Centro Servizi Sanitari Palazzina D, Viale Verona, 38100, Trento, Italy
  enrico.nava@apss.tn.it

- **BenATTIVI**
  GlaxoSmithKline S.p.A.
  www.gsk.it
  Giuseppina Leardini
  Dirigente Settore Sociale GSK
  GlaxoSmithKline S.p.A. Via Fleming 2, 37135, Verona, Italy
  salutesocietà@gsk.com

- **Netherlands**
  - **De Methode Big!Move [Big!Move Method]**
    Big!Move institute
    www.bigmove.nu
    Marijn Aalders
    Director of content, Big!Move trainer and physical therapist
    Gezondheidscentrum Velserpolder, Alfred Doblinstraat 56, 1102 VL, Amsterdam, The Netherlands
    marijnaalders@gmail.com

- **FLASH Campagne bewegen met plezier 55+ [FLASH Campaign Exercise with pleasure 55+]**
  Nederlands Instituut voor Sport en Bewegen (NISB)
  [Netherlands Institute for Sport and Exercise]
  www.nisb.nl
  Jaap de Graaf (general mamager campaigns) en Ger Kroes (Campaign leader)
  NISB, P.O. 64, 6720 AB Bennekom
  jaap.degraaf@nisb.nl, ger.kroes@nisb.nl

- **Groningen Actif Leven Model GALM [Groningen Active Living Model GALM]**
  Center for Human Movement Sciences, UMCG / University of Groningen
  www.rug.nl/www.galm.nl
  Dr. M.H.G. de Greef
  P.O. Box 196, 9700 AD GRONINGEN, The Netherlands
  m.h.g.de.greef@rug.nl

- **Valpreventie voor ouderen: implementatie van het 'Vallen verleden tijd' programma [Fall prevention for elderly: simplementation of the 'Falls past time' program]**
  St. Maartenskliniek, Research
  Development & Education
  www.maartenskliniek.nl
  H. Rijken
  PO Box 9011, 6500 Nijmegen, the Netherlands
  h.rijken@maartenskliniek.nl

- **Looproutes voor mensen met hulpmiddelen [Walking routes for people with walking disabilities]**
  NIGZ [Netherlands Institute for Health Promotion and Disease Prevention]
  www.nigz.nl / www.woerdenactief.nl
  Maarten Stiggelbout
  Senior Advisor
  P.O. Box 500, 3440 AM, Woerden, The Netherlands
  mstiggelbout@nigz.nl

- **Norway**

- **Handlingsplan for fysisk aktivitet (2005-2009)-Sammen for fysisk aktivitet**
  www.shdir.no
  Olof Belander
  Advicer
  Directorate for Health and Social Affairs, Department for Physical Activity, P.O.7000, St. Olavs Plass, N-0130, Oslo
  olb@shdir.no

- **Looproutes voor mensen met hulpmiddelen [Walking routes for people with walking disabilities]**
  NIGZ
  wwww.ingrid-kristiansen.com
  Ingrid Kristiansen
  Nils Collets Vogts vei 51B, 0765, Oslo, Norway
  ebas@c2i.net

- **Oslo Idrettskrets 60+ (Oslo Sport Club 60+)**
  www.60+
  Harald Skoglund
  Project manager
  Oslo Idrettskrets 60+, Ekebergveien 101, 1178,Oslo, Norway
  harald.skoglund@idrettsforbundet.no

- **Adapted Physical Activity**
  www.bergen.kommune.no
  Birgit Gran
  Head of department of occupational and physiotherapists
  Ergo og fysioterapitjenesten Fana, BOx 85, Nesttun, 5852, Bregen, Norway
  birgit.gran@bergen.kommune.no

- **Physical activity and elderly people**
  www.hitos.no
  Sissel Thraning
  Assistant Professor in physiotherapy
  Tromsø University College, Faculty of Health Care
  Department of Physiotherapy, 9293, Tromsø, Norway
  sissl.Thraning@hitos.no

- **Strength and Balance Activity Group**
  Ingrid Tellsgaard

Special Physiotherapist
Drammen geriatriske kompetansesenter, Langfalløya 80,
3023, Drammen, Norway
Ingrid.Tellsgaard@drmk.no

- **Friskis& Svettis, Senior**
  www.friskissvettis.no
  Margareta Yran
  Teacher in Exercise
  Elmholtveien 18, 0281, Oslo, Norway
  m-yran@online.no

- **Wednesday exercise**
  Marit Ørstavik Aanestad
  Physiotherapist
  Fysioterapeutavdelingen Stavanger Sykehus, Box 8100,
  4068, Stavanger, Norway
  aamo@sus.no

- **Exercise to prevetn functional decline and falls in community-dwelling older persons**
  www.trondheim.kommune.no
  Anne Hansen
  Head of the Physiotherapy Section in the Primary Health Care in the municiplity of Trondheim, Norway
  Enhet for fysioterapitjeenester, trondheim kommune N-7000,
  Trondheim, Norway
  anne-elisabeth.hansen@trondheim.kommune.no

- **Poland**
  - **Aktywność sposobem na zdrowe życie, akademia ruchu, aktywna szkoła**
    www.aktywni.info
    Anna Majerkiewicz-Lenart
    mgr prawa, instruktor rekreacji, instruktor kinezogerontoprofilaktyki
    Fundacja Aktywni,
    ul. Leśna 17,
    05-420 Józefów
    anna.majerkiewicz@aktywni.info

  - **Rzeszowskie Stowarzyszenie "Ruch dla Zdrowia"**

www.ruchdlazdrowia.org
Piotr Latawiec
MD
ul. Św. Marcina,
35-330 Rzeszów
piotr.latawiec@post.harvard.edu

- **Programme of Recreational Activity for Aged People (PRAAP)**
  www.awf.edu.pl
  Ewa Kozdroń
  dr n. wych. Fizycznego (PhD)
  Akademia Wychowania Fizycznego Józefa Piłsudskiego w Warszawie
  ul. Marymoncka 34
  00-968 Warszawa
  ewa.kozdron@awf.edu.pl

- **Promocja aktywności fizycznej w profilaktyce otyłości osób starszych "Lżejsi w jesieni życia"**
  www.espar50.org
  Marta Gaworska, Anna Kozdroń
  MSc, MSc
  European 50+ Physical Activity Promotion Association (EPAPA 50+),
  ul. Millera 14m.
  24, 01-496 Warszawa
  espar@onet.eu

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- –
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  Jarosław Derejczyk
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  Szpital Geriatryczny im Jana Pawła II
  ul. Morawa 31;
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- **Promocja i animacja zdrowego stylu życia osób III wieku**
  Mieczysław Ziemnicki
  ul. Chęcińska 4/220;
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- **Regional Programme of Seniors Physical Activity**
  www.cm.umk.pl
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- **Aktywność fizyczna osób starszych i niepełnosprawnych**
  Teresa Rozmarynowska
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- **Portugal**
  - **No Porto a vida é longa/ In Porto life goes on**
    Porto Municipalities

www.portolazer.pt
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- **Clube Maia Sénior/ Maia Sénior Club**
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- **Exercise for Seniors**
  Faculty of Human Motricity
  www.fmh.utl.pt
  Mª Margarida Marques Rebelo Espanha
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- **Mexa-se - Programa Nacional de Promoção da Actividade Física e Desportiva/ Be in motion - National program of physical activity**
  http://mexa-se.idesporto.pt/
  Carla Ribeiro, Master on sports management
  Av. Tomás Ribeiro nº 75 1º A 2795-464 Carnaxide Oeiras,
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- **Idade mais, mais saúde /More Age, More Health**
  Department of Sciences of Sport and Physical Education
  High School of Education, Polytechnic Institute
  www.ese.ipb.pt
  António Miguel de Barros Monteiro
  Graduate

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mmonteiro@ipb.pt

- **Menopausa em forma/ Fit menopause**
  University of Trás os Montes & Portuguese Sport Institute
  http://www.utad.pt/pt/eventos/menopausa_em_forma/programa.html
  Maria Helena Rodrigues Moreira
  Professor at university (UTAD)
  Rua Dr. Manuel Cardona Departamento de Desporto CIFOP
  5000-558 Vila Real
  hmoreira@utad.pt

- **Exercício vibratório e prevenção de quedas na mulher pós-menopausa/ Vibratory exercise and falls prevention in menopause women**
  University of Evora -Department of Sport and health
  Armando Raimundo, Associated Prof.
  Prolongamento Rua Regengos de Monçaraz, 14 7000-727 Évora
  ammr@uevora.pt

- **Sweden**
  - **Long term prevention of osteoporosis fractures and falls in a local community structure**
    Local health care services in the west of Östergötland,
    www.lio.se
    Carina Blomberg, Reg. Nurse
    Jungfruvägen 5, SE-542 32 Vadstena, Sweden
    carina.blomberg@lio.se

  - **Culture and activity leaflet, "Best possible life all life"**
    Prevention and Promotion Unit within health care,
    www.goteborg.se/tynnered
    Gunilla Foltyn, Head of Prevention and Promotion Unit within elderly care
    SDN Tynnered, SE-421 08 V. Frölunda, Sweden
    gunilla.foltyn@tynnered.goteborg.se

- **The Norsjö project**
  Public Health Service in Norsjö
  Bengt Larsson,
  Dentist and Head of Public Health Service in Norsjö
  Storgatan 3, SE-935 32 Norsjö, Sweden
  bengt.larsson@vll.se

- **Let´s go for a walk**
  Kristiandstad Kommun, www.kristianstad.se
  Birgitta Brännström Forss, Strategic planning officer
  Kristiandstad Kommun, Kommunledningskontoret,
  SE-291 80 Kristianstad, Sweden
  birgitta.brannstrom.forss@kristianstad.se

- **United Kingdom**
  - **Lets make Scotland more active, city for all ages, Edinburgh Leisure Development Plan for Sport**
    NHS Health Scotland
    www.healthscotland.com
    www.edinburghleisure.co.uk
    Maureen Kidd
    Health Improvement Programme Manager
    NHS Health Scotland, Rosebury House, 9 Haymarket Terrace, Edinburgh, EH12 5EZ
    Maureen.kidd@health.scot.nhs.uk
    &
    Hannah Macrae
    Physical Activity Health Development Officer for Older People
    Edinburgh Leisure, Sport Development Department, 141 London Road, Edinburgh, EH7 6AE
    HannahMacrae@edinburghleisure.co.uk

  - **30 minutes a day, any way**
    British Heart Foundation
    Josh Bayly
    Campaigns Officer
    14 Fitzharding Street, London, WIH 6DH
    baylyj@bhf.org.uk

  - **The United Kingdom national Cycle Networks**
    Sustrans

www.sustrans.org.uk
Philip Insall
Director, Active Travel
2 Cathedral Square, Bristol, BS1 5DD
Philip.insall@sustrans.org.uk

- **Central YMCA Activity for Health**
  Central YMCA
  www.centralymca.org.uk
  Mark Harrod
  Executive Director, Health and Community
  112 Great Russell St, London, WC1B 3NQ
  m.harrod@centralymca.org.uk

- **Actively Ageing Well**
  Age Concern Northern Ireland and the Health Promotion Agency
  www.ageconcernni.org
  www.healthpromotionagency.org.uk
  Alan Herron
  Director of Community Services, Age Concern
  3 Lower Crescent, Belfast, BT7 1NR
  aherron@ageconcernni.org
  &
  Linda Barclay
  Director of Programme Development
  Health Promotion Agency
  18 Ormeau Avenue, Belfast, Bt2 8HS
  l.barclay@hpani.org.uk

- **Everyday Swim-Open Days**
  British Swimming
  www.britishswimming.org
  www.everydayswim.org
  Kate Seargant
  Swimming Activity Manager
  ASA, 2nd Floor, Hampton House, St Michaels Hill, Cotham, Bristol, BS6 6AU
  Kate.seargant@swimming.org

- **Active for life in Kirklees**
  Kirklees Culture and Leisure Services
  www.kirklees.gov.uk

Helen Heaton
Marketing Manager for Kirklees and Leisure Services
The Stadium Business and Leisure Complex, Stadium Way, HD1 6PG
Helen.heaton@kirklees.gov.uk

- **Free Swimming 60+**
  Sports Council for Wales
  www.sportscouncilforwales.org
  Lowri Bunn
  National Free Swimming Coordinator
  Sports Council for Wales, Sophia Gardens, Cardiff, CF11
  Lowri.bunn@scw.co.uk

- **The Peoples Movement**
  Sheffield City Council
  www.thepeoplesmovement.co.uk
  Paul Billington
  Head of Sport and Physical Activity
  Sheffield City Council, 2-10 Carbrook hall Road, Sheffield, S92DB
  Paul.billington@sheffield.gov.uk

- **Get Moving Nottingham**
  Health Promotion Specialist Service
  www.getmovingnottingham.nhs.uk
  Paul Dodsley
  Health Promotion Specialist Physical Activity
  Linden House, 261 Beechdale Road, Notts Aspley, NG8 3EY
  Paul.dodsley@nottinghamcity.pct.nhs.uk

- **APPENDIX FOUR - INVENTORY OF EVIDENCE-BASED BEST-PRACTICE GUIDELINES**

Habitual Physical Activity and PA Promotion

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Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). JAMA 2001;285:2486-2497.

Diabetes

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Osteoporosis

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Falls

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for the prevention of falls in older persons. J Amer Geriat Soc. 2001;49:664-672.

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Osteoarthritis

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Chronic pain

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- **APPENDIX FIVE – THE QUESTIONNAIRES**
  - **PA expert questionnaire**
  - **PA programme questionnaire**
  - **PA promotion strategy questionnaire**

EUNAAPA

WORK PACKAGE 5

(WP5)

PHYSICAL ACTIVITY EXPERT

QUESTIONNAIRE

Dear Physical Activity Expert,

EUNAAPA (European Network for Action on Ageing and Physical Activity) is a Europe-wide project funded by a grant from the European Commission. Its objective is to improve the health, wellbeing and independence of older people throughout Europe by the promotion of evidence-based physical activity (PA).

EUNAAPA invites you to participate in Work Package 5 of the project, identifying and evaluating existing physical activity programmes and physical activity promotion strategies for older people throughout Europe. The objective is to compile a collection of successful PA programmes and a collection of successful PA promotion strategies, each with a critical analysis of the extent to which the chosen programmes and strategies conform to current best practice guidelines.

As you are a recognised authority on PA for older people, EUNAAPA would value your collaboration. Your roles would be:

- to complete a short questionnaire,
- to identify a successful PA programme in your country and assist its director to complete a second (longer) questionnaire, and
- to identify a successful PA promotion strategy in your country and assist its director to complete a third questionnaire.

Unless you request otherwise, your contribution will be acknowledged by name in the national and international reports which will be released in the public domain in 2008.

The EUNAAPA Partners hope that you share our belief in the importance of this project and that we can count on your involvement.

Yours sincerely

Archie Young
Leader of EUNAAPA Work Package 5
&
Professor of Geriatric Medicine,
University of Edinburgh

DEFINITIONS

Physical activity (or PA) – Any bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure *e.g.* running, walking, swimming, lifting or carrying a heavy weight.

PA programme – A schedule of selected physical activities in which individuals can choose to engage *e.g.* An overall programme of activities and PA opportunities for older people OR the components of such a programme, such as a programme of old time dancing classes, supervised resistance training, supervised, seated exercise classes, hill walking groups or aqua classes etc.

PA promotion strategy – An intervention, device or plan which it is intended will increase the PA of a community *e.g.* Improved street lighting or an educational TV advertising campaign.

A successful PA programme – A PA programme is 'successful' if a PA expert in that country considers it to be successful. This judgment may be based on some or all of a wide range of possible effects of the programme. These might include, for example, demonstrable improvements in physical fitness or quality of life, growing membership, client loyalty, etc.

To be eligible for consideration a successful PA Programme must have been **running for at least 6 months** and **if ceased, this must have occurred no longer than 2 years ago.**

A successful PA promotion strategy – A PA promotion strategy is 'successful' if a PA expert in that country considers it to be successful. This judgment may be based on some or all of a wide range of possible effects of the strategy. These might include, for example, demonstrable improvements in swimming pool use, in self-reported physical activity, increasing bicycle sales, high inclusivity, etc.

To be eligible for consideration a successful PA Promotion Strategy must have been **running for at least 6 months** and **if ceased, this must have occurred no longer than 2 years ago.**

INSTRUCTIONS

Please give details below of:

1. **One** example of a **physical activity programme** for older people in your country which you consider to be particularly "successful".

AND

2. **One** example of a **physical activity promotion strategy** for older people in your country which you consider to be particularly "successful".

IMPORTANT:

- You cannot select your own PA Programme or PA Promotion Strategy.
- A PA Programme and PA Promotion Strategy can be selected only if it has been running for at least 6 months and if ceased that this occurred no longer than 2 years ago.
- If a director of a PA Programme or PA Promotion Strategy has already been approached by another PA Expert in your country, then you will need to select another PA Programme or PA Promotion Strategy to avoid duplication.

1. Physical Activity Programme:.....

.....

Program Directors Name:.....

.....

2. Physical Activity Promotion Strategy:.....

.....

Promotion Strategy Directors Name: .....

.....

INSTRUCTIONS - CONTINUED

Step 1: Once you have selected one successful physical activity programme and one successful physical activity promotion strategy please contact the relevant directors and send them an invitation letter. If the director agrees to participate, then send them the appropriate questionnaire. Once they have received the questionnaire they will have 2 weeks to complete and return the questionnaire to you.

Step 2: You are required to fill in the questionnaire that follows these instructions. If you need to consult with you colleagues in order to complete the questionnaire then please do so.

IMPORTANT: Before returning the questionnaire to your EUNAAPA Partner, please take a photocopy of the questionnaire. You can return the questionnaire either electronically or via the post, as long as it is addressed to a named individual.

Step 3: Please contact the PA Programme Director and PA Promotion Strategy Director at the end of week 1 so as to give any assistance that is required. Directors need to be reminded that the questionnaire is due at the end of the next week.

Step 4: Please call again at the end of week 2 to offer any further assistance and remind directors to return the questionnaire. Please request that directors take a copy of the questionnaire before sending it to you either electronically or via the stamped addressed envelope.

Step 5: Once you have received the completed questionnaires, please review them for any blanks and possible errors. You will need to contact the director if this is the case and make appropriate amendments to the questionnaire.

Step 6:

IMPORTANT: Before returning the questionnaires to your EUNAAPA Partner, please take a photocopy of the questionnaires. Please return both the Physical Activity Programme and Physical Activity Promotion Strategy Questionnaire to your EUNAAPA Partner, either electronically or via the post. It must be addressed to a named individual.

PHYSICAL ACTIVITY EXPERT QUESTIONNAIRE

Country

1	country	

Physical Activity Expert's personal details

2	name	
3	job title	
4	organisation	
5	e-mail address	
6	postal address	
7	work telephone number (with international code)	
8	homepage of organisation	www.

9	What is your educational background? (Please tick as many as apply)	**Education** ☐ Medicine ☐ Other Health Professions ☐ Exercise/ Sport Science ☐ Other Please state…….. ……
10	For which areas are you answering as an expert? (Please mark <u>at least</u> one box for each subgroup.) ♦ Government means working in a ministry or municipal office.	**Field** ☐ Physical activity programmes ☐ Physical activity (promotion) campaigns **Organisational level** ☐ National ☐ Regional ☐ City, town or local neighbourhood **Client group** ☐ Community-dwelling older adults ☐ Institution-dwelling older adults **Sector** ☐ Government ♦ ☐ Non Government Organisation **Professional Expertise** ☐ Health care ☐ Health promotion ☐ Sport/recreation/physical activity facility management ☐ Sport/recreation/physical activity instruction/supervision/guidance ☐ Health-related exercise facility management ☐ Health-related exercise instruction/supervision/guidance ☐ Education ☐ Research ☐ Social services, social care or social welfare ☐ Socio-cultural organisation

National Qualification Requirements

11	In your country, is there a basic level qualification available to those supervising/guiding physical activity/exercise?	☐ Yes ☐ No ☐ Don't know
12	What is the name of the basic level qualification? *	☐ Not applicable
13	Is this basic level requirement implemented properly in your country? i.e. one can only supervise/guide physical activity/exercise if they have this qualification.	☐ Yes ☐ No ☐ Sometimes ☐ Don't know ☐ Not applicable
14	In your country, is an older person specific higher level qualification available to those supervising/guiding physical activity/exercise for older people?	☐ Yes ☐ No ☐ Don't know
15	If yes, what is the name of the higher level qualification for supervising/guiding older people? *	☐ Not applicable
16	Is this higher level requirement implemented properly in your country? i.e. one can only supervise/guide physical activity/exercise for older people if have qualification.	☐ Yes ☐ No ☐ Sometimes ☐ Don't know ☐ Not applicable
17	Do you think it is necessary that this higher level qualification is implemented properly?	☐ Yes ☐ No ☐ Don't know ☐ Not applicable
18	Is the higher level qualification externally validated/ verified?	☐Yes ☐No ☐ Don't know ☐Not applicable

* Please give name in your native language and in English if possible.

19	What does the assessment for the older person specific higher level qualification involve?	Verification of current cardiopulmonary resuscitation certification? ☐ Yes ☐ No Summative assessment of knowledge? ☐ Yes ☐ No Practical teaching competence assessed with participants of any age? ☐ Yes ☐ No Practical teaching competence assessed with older participants? ☐ Yes ☐ No ☐ Not applicable ☐ Don't know

20	On what does retention of the older person specific higher level qualification depend? (Please tick as many boxes as apply.)	☐ Not applicable ☐ Nothing ☐ Payment of a fee ☐ Evidence of current cardiopulmonary resuscitation certification ☐ Evidence of continuing professional development (CPD) ☐ A test of knowledge ☐ A practical test of teaching competence ☐ Other (Specify) ....

21	In your country, approximately what proportion of instructors guiding/ supervising older participants have the entry level qualification?	☐ 0% ☐ Don't know ☐ 25% ☐Not applicable ☐ 50% ☐ 75% ☐ 100%
22	In your country, approximately what proportion of instructors guiding/ supervising older participants have the higher level qualification?	☐ 0% ☐Don't know ☐ 25% ☐Not applicable ☐ 50% ☐ 75% ☐ 100%
23	Does your country have a professional register of qualified instructors (i.e. a regulatory body that holds a current record/ registration of those qualified to supervise/ guide physical activity)?	☐ Yes ☐ No ☐ Don't know
24	If yes, what is the name of the register? *	☐Not applicable …… ……
25	Is the entry level qualification required for membership of the professional register?	☐Yes ☐No ☐Not applicable ☐ Don't know
26	Does the professional register require a higher level qualification to supervise/guide physical activity/exercise by older people?	☐Yes ☐No ☐Not applicable ☐ Don't know
27	Is there a fixed remuneration for instructors	☐ Yes ☐ No ☐ Don't know

* Please give name in your native language and in English if possible.

EUNAAPA

WORK PACKAGE 5

(WP5)

PHYSICAL ACTIVITY PROGRAMME

QUESTIONNAIRE

Dear Director

EUNAAPA (European Network for Action on Ageing and Physical Activity) is a Europe-wide project funded by a grant from the European Commission. Its objective is to improve the health, wellbeing and independence of older people throughout Europe by improving the promotion and provision of evidence-based physical activity (PA).

EUNAAPA invites you to participate in Work Package 5 of the project. This Work Package will identify and evaluate existing physical activity programmes and physical activity promotion strategies for older people throughout Europe. The objective is to compile a collection of successful PA Programmes and a collection of successful PA Promotion Strategies.

Your physical activity programme for older people has been identified as successful and EUNAAPA would greatly value your contribution. Your role would be:

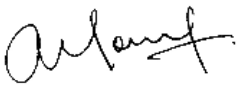
- to complete a questionnaire

Unless you request otherwise, your contribution will be acknowledged by name in the national and international reports which will be in the public domain in 2008.

If you have already been invited to participate in this project then please accept only your first invitation.

The EUNAAPA Partners hope that you share our belief in the importance of this project and that we can count on your involvement and expertise.

Yours sincerely



Archie Young
Leader of EUNAAPA Work Package 5
&
Professor of Geriatric Medicine,
University of Edinburgh

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

This questionnaire is designed to gather information about your **overall programme** for the older person. It is not intended that you focus on one aspect (i.e. falls prevention) but rather give information about the breadth and depth of the programmes and instructors.

Schedule

- After receiving the questionnaire, the Physical Activity Expert that identified your Programme will telephone you at the end of **week 1**. This is to ensure that everything is in order and to give any support at a local level.

- The Physical Activity Expert will call again **towards the end of Week 2** to discuss any questions you may have so that you can return the questionnaire.

- It is intended that you return the questionnaire to the Physical Activity Expert by the end of week 2.

IMPORTANT: Please keep a photocopy of the questionnaire before returning the original questionnaire either electronically or via the post. The questionnaire must be addressed to a named individual.

DEFINITIONS

Physical activity (or PA) – Any bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure *e.g.* running, walking, swimming, lifting or carrying a heavy weight.

PA programme – A schedule of selected physical activities in which individuals can choose to engage *e.g.* An overall of activities and PA opportunities for older people OR the components of such a programme, such as a programme of old time dancing classes, supervised resistance training, supervised, seated exercise classes, hill walking groups or aqua classes etc.

A successful PA programme – A PA programme is 'successful' if a PA expert in that country considers it to be successful. This judgment may be based on some or all of a wide range of possible effects of the programme. These might include, for example, demonstrable improvements in physical fitness or quality of life, growing membership, client loyalty, etc.

To be eligible for consideration a successful PA programme must have been **running for at least 6 months** and **if ceased, this must have occurred no longer than 2 years ago.**

Name of Physical Activity Programme

1	Name of Programme *	

Physical Activity Program Director Personal Details

2	name	
3	job title	
4	Education	☐ Medicine ☐ Other Health Professions ☐ Exercise/ Sport Science ☐ Other (please specify) ……
5	e-mail address	
6	postal address	
7	homepage of organisation	www.

* Please give name in your native language and in English if possible.

Programme description

8	What is the name of the organisation which delivers the programme? *	
9	Is the programme classified as?	☐ National ☐ Regional ☐ Limited to a city/town ☐ Limited to a local neighbourhood
10	How long has the programme existed?	☐ Less than 1 year ☐ 1 to 5 years ☐ 6 to 10 years ☐ More than 10 years

* Please give name in your native language and in English if possible.

11	Which of the following programmes are included in the overall programme? (Please tick as many as apply) ◊ GP also known as physician, primary care practitioner. A 'referral' is when a health professional sends a patient to a specific programme chosen for its therapeutic effect.	☐ Masters (elite competitor) programme ☐ Community based senior fitness programmes (groups) ☐ Community based senior chair based programmes ☐ Home based exercise programmes (individual) ☐ Exercise referral / General Practitioner (GP) referral programmes ◊ ☐ Falls Prevention programmes ☐ Medical condition-specific programmes ☐ cardiac rehabilitation ☐ pulmonary rehabilitation ☐ arthritis programmes ☐ other (please specify) …… …… ☐ Other (please specify) …….. …….. …….. ……..

12	Which of the following best describe the overall programme? (Choose at least one box in each subgroup.)	☐ Group activity ☐ Individual activity ☐ Indoors ☐ Outdoors ☐ Water-based ☐ Land-based
13	Which facilities does the programme use? (Please tick as many boxes as apply) ♦ Also known as Elder-specific Day Centre, Day Care Centre, Resource Centre.	☐ Sport/ physical recreation facility ☐ Community centre (e.g. church hall, school hall, or village hall) ☐ Day resources centre ♦ ☐ Participant's private dwelling ☐ Sheltered housing, assisted living facility, care home or nursing home ☐ Other (please specify) ……

Participants

14	For what age group is this overall programme intended? (Tick the boxes that most closely represent the intended lower and upper age limits.)	Age	Minimum Maximum
		45	☐☐
		50	☐☐
		55	☐☐
		60	☐☐
		65	☐☐
		70	☐☐
		75	☐☐
		80	☐☐
		90	☐☐
		100	☐☐

15	What is the average age of participants attending this overall programme? (Indicate the average age of participants actually attending a typical session of this programme.)	Age 45 50 55 60 65 70 75 80 90 100	Average ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

16	For what 'category' of participant is this overall programme intended?	☐ Community-dwelling older adults ☐ Institution-dwelling older adults ☐ Both, together (in the same group) ☐ Both, separately (in different groups)
17	For participants with what level of functional mobility is this overall programme intended? (Tick as many as apply)	☐ Frequently walks vigorously or runs ☐ Walks outdoors with no walking aids and no assistance or supervision by another person ☐ Walks outdoors with a walking aid (e.g. stick, cane or walking frame) but no assistance or supervision by another person ☐ Walks outdoors only with assistance or supervision by another person ☐ Never walks outdoors

18	What proportion of the participants in this overall programme are women?	☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ Don't know
19	What 'group' sizes are used in this overall programme? (Tick all that apply.)	☐ 1 ☐ 2-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 21-25 ☐ 26-50 ☐ 51+ ☐ Don't know
20	In a typical session of this overall programme what is the ratio of instructors to participants?	instructors : participants ☐ 1 : 1 ☐ 1 : 2-10 ☐ 1 : 11-25 ☐ 1 : 26-50 ☐ 1 : 51+ ☐ Don't know
21	What is the greatest number of times per week that it is possible for an individual to participate in this overall programme?	☐<1 ☐ 1 ☐ 2 ☐ 3-4 ☐ 5-7 ☐ 8+ ☐ Don't know
22	How many times per week is it usual for an individual to participate in this overall programme?	☐<1 ☐ 1 ☐ 2 ☐ 3-4 ☐ 5-7 ☐ 8+ ☐ Don't know
23	What proportion of current participants has attended this overall programme for at least one year?	☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ Don't know

Aims and objectives

24	What are the 2 most important overall aim(s) of the overall programme, from the point of view of the sponsoring organisation? (Tick 2 boxes)	☐ Health promotion ☐ Improved competitive performance ☐ Disease prevention ☐ Improved physical function ☐ Improved mood ☐ Opportunities to socialise ☐ Improved self esteem / confidence ☐ Other (please specify) .... ☐ Don't know
25	How many times per year is participant satisfaction formally measured?	☐ Not at all ☐1-2 ☐ 3-6 ☐ More than 6 ☐ Don't know
26	Are participants formally surveyed as to what their aims of being involved in the overall program are?	☐ Yes ☐ No ☐ Don't know
27	If you answered yes to the above question, do you adjust the programme according to the participants' aims?	☐ Yes ☐ No ☐ Not applicable

28	Do you record objective outcome measures for participants at regular intervals (e.g. physiological, psychological measures – see question 29)?	☐ Yes ☐ No ☐ Don't know
29	If you answered yes to recording objective outcome measurements, then what are these measures (Tick as many boxes as apply.)	☐ Strength or explosive power ☐ Maximal oxygen uptake (directly measured) ☐ A sub maximal test of aerobic fitness ☐ Balance ☐ Joint range of motion ☐ Body composition ☐ Bone density ☐ Mood/ depression ☐ Social support ☐ Other (please specify) .... ☐ Not applicable

Pre –Participation Assessment

30	Does eligibility for entry to this programme require the potential participant to have a health check?	☐Yes ☐No ☐ Don't know
31	If yes, then what form does the health check take?	☐ Completion of a health screening tool ☐ Assessment by a doctor ☐ Assessment by a doctor who is a sports medicine specialist or by the programme doctor ☐ Assessment by some other healthcare professional ☐ Assessment by an exercise instructor ☐ Other (please specify) …….. …….. …….. ……..
32	Does eligibility for entry to this programme require completion of a health screening tool by the potential participant?	☐Yes ☐No ☐ Don't know
33	Is this health screening tool internationally recognised?	☐ Yes ☐ No ☐ Not applicable
34	What is the name of the health screening tool? *	
35	Has this screening tool been adapted for this programme?	☐ Yes ☐ No ☐ Not applicable

36	Does this health screening tool include questions regarding: Dizziness ♠ Eyesight Hearing	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Don't know ☐ Not applicable
37	If the health screening tool identifies the presence of a potential problem, what must be done before the applicant is permitted to enter the programme? (Tick one box only)	☐ The applicant need only sign a liability waiver ☐ Applicant must obtain 'approval' from any healthcare professional ☐ Applicant must obtain 'approval' from their doctor ☐ Applicant must obtain 'approval' from a doctor who is a sports medicine specialist or from the programme doctor ☐ It is not possible for the applicant to be permitted to enter the programme ☐ Other (please specify) …….. ..... ☐ Don't know ☐ Not applicable

* Please give name in your native language and in English if possible.
♠ Unsteadiness, poor balance, giddiness.

Programme Design

38	Which component(s) of physical fitness does this PA Programme aim to improve? (Tick as many as apply.)	☐ Endurance ☐ Strength ☐ Coordination - Balance ☐ Flexibility - Mobility ☐ Other (please specify)…… ……	
39	Which modalities of physical activity are offered in this programme? (Tick as many as apply.)	Aquatics	☐ Swimming ☐ Aqua exercise
		Cycling	☐ On Road/ Paths ☐ Off Road/ Track/Hills
		Group Sports/ Ball Games	☐ Badminton ☐ Billiard Sports ☐ Boules ☐ Bowling ☐ Golf ☐ Minigolf ☐ Short tennis ☐ Tennis
		Recreational Movement	☐ Dance ☐ Movement ☐ Exercise to music ☐ Derived from Pilates ☐ Derived from Tai Chi ☐ Derived from Qigong ☐ Derived from Yoga
		Running	☐ Indoor running (not on treadmill) ☐ Outdoor running/ Track ☐ Orienteering

		Skiing	☐ Cross Country Skiing ☐ Downhill (Alpine) Skiing ☐ Ski Touring
		Walking	☐ Indoor Walking (not on treadmill) ☐ Outdoor Walking on path/track ☐ Outdoor Walking Groups ☐ Rambling or Hill Walking ☐ Trekking ☐ Nordic Walking

	Question 39 Continued Which modalities of physical activity are offered in this programme? (Tick as many as apply.)	Machine based equipment (aerobic endurance training/ strength/ balance/ co-ordination training)	☐ Circuits ☐ Treadmill ☐ Cycle ☐ Rowing ☐ Stepper ☐ Cross - trainer ☐ Cable machines/ Fixed resistance ☐ Dumbells/ Free weights ☐ Physioballs (Swiss balls/ exercise balls) for balance ☐ Resistance balls/ bands/tubes ☐ Balance disks/ Wobbleboards ☐ Other (please specify) ……

		Competitive Sport	Which type of sport? ……. …….
		Adapted Exercise	☐ Back pain prevention ☐ Osteoporosis prevention ☐ Fall prevention ☐ Pelvic floor exercise ☐ Chair-based exercise ☐ Cardio rehab ☐ Pulmonary rehab ☐ Other (please specify) ……. ……..

40	Which aspect(s) of fitness is/are targeted in this programme? (Tick as many as apply.)	☐ Strength ☐ Explosive power ☐ Maximal oxygen uptake ☐ Balance ☐ Joint range of motion ☐ Body composition ☐ Bone density ☐ Other (specify) ..... …….. ……..
41	'Progression' can be defined as a systematic increase in the intensity or resistance, the frequency and/or the duration of exercise. Is progression of participant's part of your overall programme? (Tick one only.)	☐ Never ☐ For the first few weeks only ☐ For the first few months only ☐ Always ☐ Don't know

42	How long is the usual warm up at the beginning of a session in this programme? (Tick one only.)	☐ 0 minutes ☐ Don't know ☐ 1 – 5 minutes ☐ 6 – 10 minutes ☐ 11 – 15 minutes ☐ 16 – 20 minutes

43	How long is the usual cool down (wind down, warm down) at the end of a session in this programme? (Tick one only.)	☐ 0 minutes ☐ 1 – 5 minutes ☐ 6 – 10 minutes ☐ 11 – 15 minutes ☐ 16 - 20 minutes ☐ Don't know

44	How long is the usual workout component of a session in this programme? (Tick one only.)	☐ 0 minutes ☐ 10 minutes ☐ 20 minutes ☐ 30 minutes ☐ 40 minutes ☐ 50 minutes ☐ 60 minutes ☐ More than 1 hour ☐ Don't know
45	Within this programme, how do you cater for the exercise needs of older people with chronic medical conditions (e.g. osteoporosis, ischaemic heart disease, arthritis, Parkinson's disease, stroke)? (Tick one only.)	☐ This is not possible ☐ Adapted exercise, with participants in disease-related groups ☐ Adapted exercise, with participants in frailty-related or disability – related groups ☐ Adapted exercise, with participants included in the mainstream older person's group(s) ☐ Don't know

Instructors´ qualifications & training

46	What is the minimum level of qualification required for instructors delivering this programme to older participants? (Tick as many as apply.)	☐ A higher level ('old age specific') qualification ☐ A basic ('entry level') qualification ☐ Other (please specify) …… …… ☐ Don't know

47	Do the instructors for this programme have to be a member of a professional register?	☐ Yes ☐ No ☐ Don't know
48	In your programme, approximately what proportion of instructors guiding/ supervising older participants have the entry level qualification?	☐ 0% ☐ Don't know ☐ 25% ☐ 50% ☐ 75% ☐ 100%
49	In your programme, approximately what proportion of instructors guiding/ supervising older participants have the higher level qualification?	☐ 0% ☐ Don't know ☐ 25% ☐ 50% ☐ 75% ☐ 100%
50	Does this programme provide ongoing in-service training for the instructors? (e.g. Exercise adaptations for medical conditions, Communication with Older People, Causes of Falls in Old Age.)	☐ Yes ☐ No ☐ Don't know

51	How many hours per year of in-service training takes place?	☐ 0 ☐ 1 ☐ 3 ☐ 5 ☐10 ☐15 ☐ 20 ☐ 30 ☐ More than 30 ☐ Don't know ☐ Not applicable
52	Give 3 examples of topics recently covered in in-service training for this programme's instructors	1..... ..... 2..... ..... 3.....

53	Do unpaid volunteers contribute to this programme?	☐ Yes ☐ No ☐ Don't know
54	In what ways do unpaid volunteers contribute to the programme? (Tick as many as apply.)	☐ Not at all ☐ Instruction ☐ Instructor's assistant ☐ 'Buddying' a participant ☐ Peer mentoring participants ☐ Administration ☐ Transport ☐ Refreshments ☐ Other (please specify) .... ☐ Don't know ☐ Not applicable

Client Safety

55	Does this programme have specific protocols to be followed in emergency situations?	☐ Yes ☐ No ☐ Don't know
56	If yes, are all staff trained in emergency protocols? If yes, how often?	☐ Yes ☐ No ☐ Don't know ☐ 3 monthly ☐ 6 monthly ☐ Annually ☐ Don't know ☐ Not applicable

57	Does this programme have specific protocols and/or procedures to be followed in respect of equipment use, storage or maintenance?	☐ Yes ☐ No ☐ Don't know
58	If yes, then are all staff trained in equipment, storage, maintenance protocols? If yes, how often are they trained?	☐ Yes ☐ No ☐ Don't know ☐ 3 monthly ☐ 6 monthly ☐ Annually ☐ Don't know ☐ Not applicable

Finance

59	What is the total cost of providing this programme (per participant, per attendance), excluding transport and refreshments but including the cost of the room, lighting, heating, maintenance, instructor's fee, administration?	☐ Up to €2 ☐ More than €2, up to €5 ☐ More than €5, up to €10 ☐ More than €10 ☐ Don't know
60	What proportion of this cost is paid by each participant?	☐ 0% ☐ 5% ☐ 10% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ Don't know

61	Is transport provided?	☐ Yes, to everyone ☐ Yes, selectively (some participants, some sessions) ☐ No ☐ Don't know
62	If yes, what proportion of the cost of transport is paid by each participant?	☐ 0% ☐5% ☐10% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ Don't know
63	Are refreshments offered?	☐ yes ☐ no ☐ at some sessions ☐ Don't know
64	If yes, what proportion of the cost of refreshments is paid by each participant?	☐ 0% ☐5% ☐10% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ Don't know

Publicity, marketing and promotion

65	Which of these methods have been used to publicise, market or promote this programme? (Tick as many 'Yes' boxes as apply.)	**Yes** ☐ Advertising in local newspapers ☐ Advertising in national/regional newspapers ☐ Advertising in elder-oriented magazines ☐ Advertising through elder-oriented organisations ☐ Features in local newspapers ☐ Features in national/regional newspapers ☐ Features in elder-oriented magazines ☐ Advertising on local radio ☐ Advertising on national/regional radio ☐ Advertising on local TV ☐ Advertising on national/regional TV ☐ Features on local radio ☐ Features on national/regional radio ☐ Features on local TV ☐ Features on national/regional TV ☐ Neighbourhood leafleting ☐ Sports hall leafleting ☐ Health premises leafleting ☐ Leafleting in community centres for older people ☐ Talks to local groups ☐ Word of mouth ☐ Website ☐ Open days ☐ Bring a friend ☐ Discounts ☐ Multiple session bookings ☐ Other (please specify) ....

66	Has this programme found it useful to capitalise on national or regional campaigns related to aspects of ageing and health in order to improve recruitment of new participants and/or motivation of existing participants (e.g. Happy Hearts Day, Falls Awareness Day, the European Year of Older People, Osteoporosis Week, Walk for Life etc.)? If 'yes', give up to 3 successful examples.	☐Yes ☐No ☐Have not tried ☐ Don't know 1..... ..... 2..... ..... 3..... .....
67	Has this programme found it useful to build partnerships with local healthcare professionals or organisations? If 'yes', give up to 3 successful examples.	☐Yes ☐No ☐Have not tried ☐ Don't know 1..... ..... 2..... ..... 3..... .....

EUNAAPA

WORK PACKAGE 5

(WP5)

PHYSICAL ACTIVITY PROMOTION STRATEGY

QUESTIONNAIRE

Dear Director,

EUNAAPA (European Network for Action on Ageing and Physical Activity) is a Europe-wide project funded by a grant from the European Commission. Its objective is to improve the health, wellbeing and independence of older people throughout Europe by improving the promotion and provision of evidence-based physical activity (PA).

EUNAAPA invites you to participate in Work Package 5 of the project. This Work Package will identify and evaluate existing physical activity programmes and physical activity promotion strategies for older people throughout Europe. The objective is to compile a collection of successful PA Programmes and a collection of successful PA Promotion Strategies.

Your physical activity promotion strategy for older people has been identified as successful and EUNAAPA would greatly value your contribution. Your role would be:

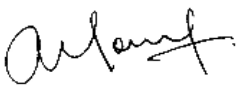
- to complete a questionnaire

Unless you request otherwise, your contribution will be acknowledged by name in the national and international reports which will be in the public domain in 2008.

If you have already been invited to participate in this project then please accept only your first invitation.

The EUNAAPA Partners hope that you share our belief in the importance of this project and that we can count on your involvement and expertise.

Yours sincerely



Archie Young
Leader of EUNAAPA Work Package 5
&
Professor of Geriatric Medicine,
University of Edinburgh

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Schedule

- The Physical Activity Expert who identified your Promotion Strategy will telephone you **one week** after sending you this questionnaire. This is to ensure that everything is in order and to give any support at a local level.

- The Physical Activity Expert will call again **towards the end of Week 2** to discuss any questions you may have so that you can complete the questionnaire.

- It is intended that you return the questionnaire to the Physical Activity Expert by the end of week 2.

IMPORTANT: Please keep a photocopy of the questionnaire before returning the original questionnaire either electronically or via the post. The questionnaire must be addressed to a named individual.

DEFINITIONS

Physical activity (or PA) – Any bodily movement that is produced by the contraction of skeletal muscle and that substantially increases energy expenditure *e.g.* running, walking, swimming, lifting or carrying a heavy weight.

PA promotion strategy – An intervention, device or plan which it is intended will increase the PA of a community *e.g.* Improved street lighting or an educational TV advertising campaign.

A successful PA promotion strategy – A PA promotion strategy is 'successful' if a PA expert in that country considers it to be successful.
This judgment may be based on some or all of a wide range of possible effects of the strategy. These might include, for example, demonstrable improvements in swimming pool use, in self-reported physical activity, increasing bicycle sales etc.

To be eligible for consideration a successful PA Promotion Strategy must have been **running for at least 6 months** and **if ceased, this must have occurred no longer than 2 years ago.**

Name of Physical Activity Promotion Strategy

1	Name of Promotion Strategy *	

Physical Activity Promotion Strategy Director Personal Details

2	name	
3	job title	
4	Education	☐ Medicine ☐ Other Health Professions ☐ Exercise/ Sport Science ☐ Other ……
5	e-mail address	
6	postal address	
7	homepage of organisation	www.

* Please give name in your native language and in English if possible.

Laws, regulations, national level recommendations

	Law or regulation	
8	In your country, is there a law or other regulations for promotion of physical activity?	☐ Yes ☐ No ☐ Don't know ☐ If Yes, give the name of the law or the regulation …… …… …… ☐ Don't know
9	In your country, is there a law or other regulations for promotion of physical activity especially for older people?	☐ Yes ☐ No ☐ Don't know ☐ If Yes, give the name of the law or the regulation …… …… …… ☐ Don't know
	Recommendation	
10	In your country, are there any national level recommendations for promotion of physical activity, especially for older people?	☐ Yes ☐ No ☐ Don't know ☐ If Yes, give the name of the recommendation …… …… …… ☐ Don't know

Promotion Strategy Description

11	In which sector is the organisation that developed the promotion strategy? (Please tick as many as apply)	☐ Governmental □ National □ Regional □ Local ☐ Non Governmental □ Commercial □ Welfare/community organisation □ Research organisation □ Other (please specify) …… ……
12	In which sector is the organisation that delivers the promotion strategy? (Please tick as many as apply)	☐ Governmental □ National □ Regional □ Local ☐ Non Governmental □ Commercial □ Welfare/community organisation □ Research organisation □ Other (please specify) …… ……
13	What is the name of the organisation(s) that delivers the promotion strategy? *	…… …… ……
14	At what level does the promotion strategy aim to deliver? (Please tick as many as apply)	☐ National ☐ Regional ☐ Limited to a city/town ☐ Limited to a local neighbourhood

* Please give name in your native language and in English if possible.

15	In which settings does this promotion strategy encourage physical activity? (Please tick at least one in each subgroup)	☐ Centre based ☐ Home based ☐ Outdoors ☐ Other (please specify)…….. ……. ☐ Group exercise ☐ Independent exercise ☐ Other (please specify)…….. …….
16	Which settings/ organisations are taking part in this promotion strategy? (Please tick as many as apply.)	☐ Social institutions ☐ Primary health care ☐ Community centres ☐ Welfare organisations ☐ Work place ☐ Other (please specify) ……. ……. ☐ Don't know
17	Was any theoretical basis used to develop and/or deliver this promotion strategy?	☐ Yes ☐ No ☐ Don't know

18	If yes, which theory or model was used? (Please tick as many as apply)	☐ Health Belief Model ☐ Protection Motivation Theory ☐ Theory of Reasoned Action ☐ Theory of Planned Behavior ☐ ASE-Model (Attitude, Social Influence and Self-Efficacy ☐ Transtheoretical Model ☐ Other (specify) …… ……

19	How long has the promotion strategy run?	☐ Less than 1 year ☐ 1 to 5 years ☐ 6 to 10 years ☐ More than 10 years ☐ Don't know
20	Does the promotion strategy run continually, periodically or once only?	☐ Once only ☐ Periodically ☐ Continually ☐ Other (please specify) …… …… ☐ Don't know

Target population

21	For what age is this promotion strategy intended? (Tick the boxes that most closely represent the intended lower and upper age limits.)	**Age**	**Minimum Maximum**
		45	☐☐
		50	☐☐
		55	☐☐
		60	☐☐
		65	☐☐
		70	☐☐
		75	☐☐
		80	☐☐
		90	☐☐
		100	☐☐
		Comments	
		.....	
		.....	

22	What 'category' of participants is this promotion strategy targeting? (Please tick as many as apply)	☐ General population (including older adults) ☐ All older adults ☐ Community-dwelling older adults ☐ Institution-dwelling older adults ☐ Older adults with chronic conditions ☐ Ethnic minority older adults ☐ Other (please specify) ....

23	Does this promotion strategy consider and cater for cultural differences e.g. language, education, income?	☐ Yes ☐ No ☐Don't know
24	If yes, which specific aspects does it cater for? (Please tick as many as apply)	☐ Different language ☐ Different cultural perceptions ☐ Different education levels ☐ Different income levels ☐ Other (please specify) .... ☐ Don't know

25	What level of functional mobility does this promotional strategy aim to include? (Please tick as many as apply)	☐ Frequently walks vigorously or runs ☐ General population Walks outdoors with no walking aids and no assistance or supervision by another person ☐ Walks outdoors with a walking aid (e.g. stick, cane or walking frame) but no assistance or supervision by another person ☐ Walks outdoors only with assistance or supervision by another person ☐ Never walks outdoors

26	What intermediaries, if any, are used to reach the intended population? (Please tick as many as apply.)	☐ Medical Practitioners ☐ Nurses ☐ Physiotherapists ☐ Occupational Therapists (OT) ☐ Physiotherapy/ OT Assistants ☐ Other Allied Health Care Professionals ☐ Exercise/ dance instructors ☐ Sports Coaches ☐ Community/ Social Workers ☐ Volunteers ☐ Other, specify …… …… ☐ None ☐ Don't know
27	What proportion of the target population has been reached by your promotion strategy overall since it has been running?	☐ 0% ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ Don't know

Promotion Strategy Design

28	In this promotion strategy, which of the following are used to encourage behaviour change in relation to physical activity? (Please tick as many as apply)	☐ Improved knowledge ☐ Improved access ☐ Improved safety ☐ Improved time management skills ☐ Improved motivation ☐ Fear reduction ☐ Improved skill ☐ Reduction in misconceptions about ageing ☐ Don't know

29	Was the target population screened for their readiness for behaviour change prior to implementing this promotion strategy?	☐ Yes ☐ No ☐ Don't know
30	Was this promotion strategy designed to surmount barriers to physical activity?	☐ Yes ☐ No ☐ Don't know
31	If yes, which particular barriers did it address?	☐ Perceived poor health ☐ Symptoms associated with chronic conditions ☐ Fear of injury ☐ Acute exacerbation of chronic conditions ☐ Lack of skill ☐ Lack of time ☐Lack of energy/motivation ☐ Environmental barriers (e.g. weather, extreme temperatures, uneven ground) ☐ Misconceptions about ageing ☐ Other (please specify) …… ☐ Don't know ☐ Not applicable

32	Which approaches does this physical activity promotion strategy use? (Please tick as many as apply.)	• Information approaches ☐ community wide campaigns ☐ group-based health education focused on information provision ☐ mass media campaigns ☐ point of decision prompts ☐ other (please specify) …… …… • Behavioural and social approaches ☐ individually-adapted behaviour change ☐ education with TV/video/DVD ☐ family-based social support ☐ health professionals social support ☐ non-family social support (e.g. friends) ☐ other (please specify) …… …… • Environmental and policy approaches ☐ Enhanced access to physical activity (excluding outreach activities) ☐ outreach activities ☐ transportation policy ☐ infrastructure changes to promote non-motorised transit e.g. cycle paths ☐ urban planning approaches – zoning and land use ☐ other (please specify) …… …… ☐ Don't know

33	Which approaches did you find effective in achieving the aims of your promotion strategy? (Please tick as many as apply.)	• Information approaches ☐ community wide campaigns ☐ group-based health education focused on information provision ☐ mass media campaigns ☐ point of decision prompts ☐ other (please specify) …… …… • Behavioural and social approaches ☐ individually-adapted behaviour change ☐ education with TV/video/DVD ☐ family-based social support ☐ health professionals social support ☐ non-family social support (e.g. friends) ☐ other (please specify) …… …… • Environmental and policy approaches ☐ Enhanced access to physical activity (excluding outreach activities) ☐ outreach activities ☐ transportation policy ☐ infrastructure changes to promote non-motorised transit e.g. cycle paths ☐ urban planning approaches – zoning and land use ☐ other (please specify) ☐ Don't know

34	What message is being used in this promotion strategy? (Please tick as many as apply.)	☐ General message (e.g. Exercise/PA is good for you, is fun) ☐ General Advice (e.g. If you exercise, you…..) ☐ General Warning (e.g. If you don't exercise….) ☐ Specific advice (e.g. If you exercise 5 times a week for 30 minutes a Day at moderate intensity, then….) ☐ Specific warning (e.g. If you don't exercise enough, your risk of getting CHD increases…..) ☐ Other (please specify) ……. ……. ……. ……. ☐ Don't know

35	In what way was the message conveyed to the target population? (Please tick as many as apply.)	☐ Media (TV, radio, papers, films) ☐ Post ☐ Internet / e-mail ☐ Intermediates, health care professionals ☐ Models/opinion ☐ Events e.g. Year of the Older Person, Falls Awareness Day ☐ Other (please specify)……. ……. ☐ Don't know

36	Having been implemented has this promotion strategy been evaluated?	☐ Yes ☐ No ☐ Don't know
37	If yes, which aspects of this promotion strategy are evaluated? (Please tick as many as apply)	☐ Behaviour change ☐ Population reached ☐ Cost effectiveness (e.g. total costs) ☐ Other (specify) ..... …… …… ☐ Don't know ☐ Not applicable
38	Does this promotion strategy include a specific plan or device to maintain the behaviour change achieved?	☐ Yes ☐ No ☐ Don't know

39	If yes, what tools do you use to maintain behaviour change? (Please tick as many as apply)	☐ Printed material posted ☐ Telephone ☐ Positive reinforcement/ feedback rewards ☐ Financial incentives ☐ Social support ☐ Buddy groups ☐ Opportunities to socialise ☐ Promotion days ☐ Other (please specify) …… ☐ Don't know ☐ Not applicable

Finance

40	What is the <u>total</u> cost of running this promotion strategy (including development)?	€ per annum ☐ Don't know
41	Who funds this promotion strategy? (Tick as many boxes as apply.)	National/regional government ☐ health budget ☐ social care budget ☐ leisure/sport budget ☐ other (please specify) ……. City/local government ☐ health budget ☐ social care budget ☐ leisure/sport budget ☐ other (please specify) ……. ☐ Lottery ☐ Charity (e.g. churches) ☐ Other (please specify) .....