Evidence-based Guidelines on Health Promotion for Older People:

Social determinants, Inequality and Sustainability

Overview on health promotion for older people

European Report

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May 2008

Co-financed by the European Commission

Co-financed by Fund for a Healthy Austria

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1. Introduction

Charlotte Strümpel

Background

In the face of rapid demographic change including low birth rates and increasing. longetivity increasing population ageing is a challenge to be dealt with in the future. This will change disease patterns and put a burden on health care systems. Thus the demand for health care and at the same time health care spending will be increased. In this connection solutions are being sought after how people can live longer and stay healthy at the same time. Thus healthy ageing and specifically actively promoting the health of older people are becoming increasingly important in national as well as EU-policies.

While various individual projects and programmes exist in EU-member states that aim to promote health for older people, most of these projects are of local and national character and do not take the EU-wide context into account. Little is known about the scope of programmes and on the state of the art of health promotion activities for older people on a European level.

Aims of project

With a view to this background, the healthPROelderly project aims to gather information from the partner countries and identify best practices in the field of health promotion for older people. There is a focus on those models that have a sustainable approach and which regard socio-economic, environmental and life-style related determinants.

The project "healthPROelderly" has as its overall aim in contributing to the development of health promotion for older people through producing guidelines with recommendations for potential actors in this field on EU, national and local level.

The specific objectives of the healthPROelderly project are:

- to carry out a literature review concerning health promotion of older people in each of the participating countries.
- to develop a common vocabulary and a glossary in order to create a terminology and understanding for health promotion projects.
- to develop a set of criteria for the selection of models of good practices in the health promotion of older people as well as models of best practice.
- to identify models for health promotion for older people and make them available in the form of a database on the website.
- to develop a strategic approach to communicate and disseminate the findings of the project and the identified models of best practice for health promotion.
- to inform and raise the awareness amongst experts and authorities throughout the EU about the issue of ageing and the impact of the demographic change on our society

The project started in April 2006 and will be running until December 2008. 17 partners from 11 member states are involved in carrying out the healthPROelderly-project. They are partners from different sectors, such as universities, NGO's, Public Health networks, the WHO, etc.

Structure of report

This report contains the results of the first phase of the healthPROelderly project which was concerned with a literature overview on health promotion for older people with a focus on health determinants, policy issues as well as interventions. It also served to compile a glossary on terms that are relevant throughout the healthPROelderly project as well as identifying criteria that were used to choose models of best practice for the project database compiled in phase 2.

In the following this report outlines the research questions we have sought to answer in the first phase of our research as well as the methods used. A short chapter on the overall theoretical framework to put our work into context follows this as well as a chapter outlining key policy issues raised in the partner countries in this area. An overview on the main health determinants, especially with respect to older people precedes the chapters containing the main findings of our literature review: After a short quantitative overview, the main strands of information found are described by themes of health promotion and then by transversal themes that we have identified. The transversal themes are issues we have identified, which play a role over all types of health promotion activities, such as methodological aspects, settings they take place in or strategies of health promotion. The final chapter includes conclusions of our work, criteria for our further work resulting from the conclusions as well as references to other European projects on health ageing.

2. Research questions and methods

Eva Krizova

2.1. Research questions of the literature search

The research question of the WP4 (literature search) was determined by its objectives which were:

- to gain an overview of literature on: health promotion policies for older people, health promotion projects for older people, studies on health promotion for older people in each of the partner countries, health determinants,
- to elicit criteria for choosing projects and best practice,
- to harmonise (standardise) the terminology and concepts for an effective communication within the interdisciplinary and multinational team
- to identify gaps in (European) Literature
- and to compare the scientific and health promoting activities in each of the partner countries

The research questions that resulted from this are:

- Which health determinants have been found in the literature in different countries?
- Which policy trends on health promotion of older people can be found in your country?
- What is the state of the art of research on health promotion for older people in your country (e.g. how much literature is there on this, which terms are used, which are not used)?
- Which evidence-base on health promotion for older people can be found in your country?
- (How) is inequality addressed in literature on health promotion for older people?
- (How) are gender issues addressed in literature on health promotion for older people?
- (How) is sustainability addressed in literature on health promotion for older people?
- Which criteria for choosing (good practice) models/projects of health promotion of older people can be elicited from the literature?

The main questions were what was the state of the art of research on health promotion for older people in particular countries, which policy trends on health promotion for older people were found and which health determinants were found in the literature. A special attention was paid to the question whether health promotion based on scientific evidence and evaluation could be found.

Our research aimed not only at the comparison of the amount of literature found and its source, but also on the content, structure and quality of the literature. The content was analysed according to a list of themes some of which were subcategorised (mental health, social participation, lifestyle), according to a list of transversal themes and according to the keywords. The attention paid to inequality and diversity, to gender aspects, consumer involvement and sustainability was examined. Also the economic dimension as expressed by cost-effectiveness was considered and the availability of a multi-disciplinary approach monitored.

The main question was how these issues were addressed and what the differences among countries were. Also, the research method, social setting of the health promotion activity and a feed-back evaluation were taken into account. Geographical and age scope was also studied. The geographical scope distinguished between the international, EU, national, regional and local scope of the project/article.

Apart from creating a database another expected outcome of the literature analysis was to elicit criteria for choosing good practice models/projects of health promotion for older people. In order to harmonise (standardise) the terminology and concepts for an effective communication within the interdisciplinary and multinational team a common glossary has been developed by the team. Due to differences in concepts used in the participants countries a national report was compiled which described in a structured but qualitative way the context of the statistical database and served as a tool for appropriate interpretation of the national findings in the international perspective.

2.2. Methods and search strategy

In each country, partners searched for literature on health promotion for older people. An excel database was constructed to record the results of the literature search and guidelines on how to proceed with the literature search were formulated.

Every partner concentrated on the country specific scientific and other literature published both in the national and international periodicals and other sources. In most cases not only scientific articles, but also information on health promotion projects for older people were searched for. Only literature published in the last 10 years was included (1996-2006). The main focus of the search was on health promotion interventions explicitly targeted towards people who are 50+. However, many countries included projects or literature targeted also on younger populations which included the elderly apart form other population groups. In the search it was also recorded, whether there was some other target group mentioned apart from seniors (e.g. women, migrants, men, health professionals, poor people, people with disability or mental health problem, homeless people).

A hierarchy of search steps was prepared in advance (see Overview 1). The instructions were to proceed from the “highest level” of available literature to the “lowest”. Countries where the production of literature on health promotion for elderly was expected to be enormous (e.g. Netherlands, United Kingdom, Germany) were presumed to stop on a higher “search” level than those countries with small production rather on “lower” level.

The priority was given to the outcomes of the higher level and researchers selected the most relevant and scientifically based articles, in countries where large amount of literature were

available. Translations of foreign texts into national languages were not included into the database.

Overview 1: Overview of types of literature searched
1) International database of scientific literature (Embase, Medline, Current Contents, Web of Science, Proquest 5000, Eric, Cochrane, JStok, Psychinfo)
2) National scientific database (if available)
3) National database of health promotion projects (if available)
4) Professional journals and magazines
5) Grey literature, internet, contacting colleagues/experts

In most cases, the search started in each country with the international scientific databases where the national contributions of the highest scientific quality were likely to be included. Then the search continued using national databases of scientific literature and national databases of health promotion projects or other relevant databases. The "grey literature" was included if it addressed those issues mentioned above and these could not be found in scientific literature. Grey literature in this case means diploma and doctoral theses, final project reports, different information materials published by governmental, non-governmental and other bodies etc.

Literature with the following characteristics was left out:

- Focusing on on care (nursing/community/hospital) – unless there was an explicit mention of health promotion aims or activities
- Focusing on treating diseases
- Addressing only on screening or having a purely medical focus
- Not addressing the target group 50+ explicitly
- Articles not explicitly aiming at population 50+.

While the above mentioned search strategy was defined for use by all partners, there were country specific modifications due to the type and amount of information available. Some could rely on an advanced system of bibliographical information organised at the national level on existing databases of health promotion projects. In countries where less literature was found and which did not have national databases, partners had to rely more on informal information from colleagues and other experts.

The particular procedures which were conducted on the national levels are described in the national reports. Some countries followed the above-mentioned search in one process, some others used some additional procedures apart from the main search strategy.

Overview 2: Overview of themes and transversal issues	
Themes	Transversal issues
• Health determinants	• Research methods
• Quality of Life	• Settings
• Promoting mental health	• Consumer involvement/ voice of older people
• Empowerment	• Inequality
• Social participation	• Diversity
• Lifestyle	• Gender
	• Sustainability
	• Cost-effectiveness
	• Multidisciplinarity

After the literature was found using the above mentioned search strategy, information on each article was recorded in an excel database. The database served to document two types of information. On one hand it collected bibliographical information, and on the other it focused also on the content of the literature beyond the bibliographical standards. Partners recorded whether following themes and transversal issues were mentioned in the article or not.

The data collected in the excel data base are described by statistical frequencies and visualised by correspondence analysis as a method of multidimensional statistics in the following. Apart from that, the searched literature was analysed in detail by the research partners and results described in national reports according to the pre-defined themes and transversal issues. The results of the excel database and the national reports are the basis for all further chapters in this report.

3. Health promotion of older people: Theoretical background

Beata Tobiasz-Adamczyk

This chapter aims to give an overview of the theoretical discourse on which the issues of health promotion for older people has been based in the last years. The relevance of specific health promotion efforts for older people has been stated relatively early in the discussion on health promotion. Already the document "Targets for health for all" which was one of the pillars of the Ottawa Charter (WHO, 1986) mentions the following issues:

- the importance of being provided with the basic requirements for health and being effectively protected against disease and accidents;
- that older people should have an equal opportunity to live in a stimulating environment of social interaction, free from the risk of war, full of opportunities to fulfill satisfying economic and social roles and grow old in a society which supports the maintenance of their capacities, provide for secure and purposeful retirement, offers care when care is needed and, finally, allows them to die with dignity.

A number of dimensions related to health outcomes also involve actions closely associated with health promotion for older people. Such dimensions include ensuring equity in health by reducing the present gap in health status between countries or groups within countries, adding life to years by ensuring the full development and use of one's integral and residual physical and mental capacity to derive full benefit from and cope with life in a healthy way, and adding health to life by reducing disease and disability (WHO, 1986). This means that "all human rights and privileges must be reaffirmed in respect of aging people who have an evident claim to a fair share of the benefits flowing from the development to which they have contributed, and societies should explore to the full the possibilities of mobilizing and deriving benefit from the intellectual and cultural resources of the old" (WHO,1986).

In their article "Health Promotion among the elderly," Dean and Holstein (1991) cite that many people, especially the older people themselves, might question why older people receive special attention in relation to health promotion. They answer that the "older stage of life is perceived as characterized by chronic conditions, disability and many other health problems." For this reason, the aim of health promotion among older people tends to focus on the health potential of individuals and communities (Dean & Holstein, 1991). This is based on the definition of health promotion as "a unifying concept, a process enabling individuals and communities to increase control over the determinants of health and recognizing the basic needs for change in both the ways and conditions of living in order to promote health".

A new tendency in research and policy has named health-related quality of life as one of the most significant aspects of older age. This new tendency has resulted from demographic changes and an increasing life expectancy in most European countries connected with a rapidly increasing population of older people, including those in good health that function as active and independent members of the community. The health of older people is based on the health of the population of which they are a segment and is chiefly determined by the quality of their social environment.

The dynamic model of health (Noack, 1991), which perceives health in three stages: history of health, health balance and potential health, has since been applied to a new epidemiological concept, the so-called life course approach. Many concepts of health depend on social and cultural contexts and are age-group and gender specific. Epidemiological and socio-medical data confirm strong differences in health status and mortality patterns in the elderly, especially in relation to social and environmental conditions. With respect to chronic conditions, disability, and level of functional status, epidemiological data show considerable variation in the health status of elderly people.

Health-related quality of life constitutes a broader concept than health status. As developed in gerontology, it is defined in older age as "goodness of life, good life, successful ageing, satisfaction with life" (Bowling 1997). Quality of life of older people may also be defined as an individual's subjective satisfaction with life, in terms of his or her physical and psychosocial well-being and happiness. Social gerontologists extend this definition using such variables as physical capacity, mental health, freedom from pain, social activities in the family and during leisure time, financial independence, general life satisfaction, and social network. The concept of quality is equally important, specifically in terms of one's social interactions, living arrangements, spirituality, social support, continued learning, relationship with one's environment and the social position of older people in society.

The new concept of health in older age, supported by the model of positive physical and social health, has been used in this new approach to ageing (i.e. healthy, active ageing). At first, the functionalistic approach was used to describe healthy ageing as the ability to function in order to perform personal, social, and economic roles, that is, actively contribute to the maintenance of society. Later, the phenomenologistic model argued that health-related quality of life was dependent on an individual's interpretation and perception of health, putting a focus on the meaning and significance of health status to an individual (i.e. healthy ageing in their own words). The phenomenological approach is based on the paradigm that reality is multiple and socially constructed through the interactions of individuals who use symbols to interpret each other and assign meaning to perception and experience. This approach was initially used by the WHO Quality of Life (WHOQOL) Group (1995) to define quality of life as an "individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals." Quality of life research in gerontology overlaps with research on positive ageing, of which the key points are feelings of control, social interaction, quality of environmental setting and mental health, specifically in terms of cognitive efficacy, social competence and productivity, as well as personal control and life satisfaction (Bowling, 1997).

Antonovsky's model of coherence has been perceived as a key tool in health promotion practices for older people. The concept of positive health as the ability to cope with stressful situations is based on this model. The inverse association between socioeconomic status and Antonovsky's salutogenic model of coherence is based on three components: comprehensibility, manageability, and meaningfulness as coping strategies for stressful life events. According to a number of models, specific factors of health in older life are associated with:

1. A life course perspective, including characteristics of one's social environment, and social influences. These are social resources in earlier stages of the life-span which affect quality of life in older age.

2. Pathway effects through which the social environment sets individuals onto life trajectories which, in turn, affect health status over time.

3.Cumulative affects of health status, whereby intensity and duration of exposure to unfavourable environments may adversely affect health status. According to a dose-response relationship, the interaction between experiences and exposure influences one's ability to stay healthy or the risk to become sick.

The concept of positive health, as well as the concept of health-related quality of life in the elderly, gives special attention to the possession of social resources necessary for satisfying one's individual needs. Social capital and social support remain key issues in both of these concepts.

Analysis of epidemiological data describes the vital role of health promotion in assessing the health status of a population. Much discussion has taken place a about whom health promotion projects should be targeted towards. Considering their long life perspective, one group includes younger segments of the population. Also, wishing to enhance their health potential, another group may include older people interested in protecting and enhancing their remaining health. Differences in health status among older segments of the population also suggest the need for promotion activities specifically focused on specific subgroups of the elderly.

Dean and Holstein suggest three strategies for health promotion in older people: maintaining and increasing functional capacity, maintaining or improving self-care, and stimulating one's social network. These strategies are concentrated on different subgroups of older people and are based on their life situation: healthy older people, older people with special needs, and impaired or chronically ill older people. Projects tend to focus on improving functional capacity based on exercise projects, maintaining functional capacity during illness, and 24-hour domiciliary care. Behaviour projects designed to improve self-care among healthy older people aim to activate those living alone and stimulate social networks focused on building satisfying social interactions.

Although social inequalities in health status decrease in older age, Siegrist and Marmot (2006) describe social inequalities in health in older populations as defining the direction of future research in this field. The life course perspective confirms a strong relationship between health history and potential health in older stages of life, as well as the role of social position and social activities on quality of life in the elderly.

The relationship between the sociocultural environment (i.e. social networks) and health outcomes has been supported by the Covey Theory (formulated by Kahn and Antonucci). According to this theory, "the individual is seen in a life course perspective as travelling through life surrounded by members of his/her cohort, who share experiences and life history and who provide support to one another reciprocally over time" (Berkman 2000). The process of ageing is closely interrelated with psycho-social conditions. Numerous studies have addressed the relationship between mortality patterns in the elderly and various social

predictors, such as socio-economic conditions, marital status, living alone, loneliness, social ties, social support, and self-rated health.

Several definitions of social capital exist, such as “ties and norms linking individuals together across a variety of institutional and formal as well as informal associational realms or as a moral resource such as trust” (Berkman 2000). But perhaps a combination of these two, defining social capital as a “high level of social participation in formal and informal social networks and activities and a society characterized by general reciprocity” best reflects this new challenge for effective health promotion among older members of society.

4. Policy initiatives for older people in the context of health promotion

Ciril Klajnscek

Policy initiatives conducive to health of the elderly refer to any plan of action initiated and articulated by states and/or government or by associated civil society organizations and groups.that are directed at the promotion of health of older people. They include the *identification of different alternatives*, such as programs or spending priorities, *and choosing among them* on the basis of the impact they will have. They can be understood as political, financial, management, and administrative mechanisms arranged to reach explicit goals aiming at promoting older people's health. They encompass the wide range of social policy initiatives which should have substantial input to health promotion of elderly. More directly they express healthy public policy and health promotion policy.

Building **healthy public policy** is one of the five means of health promotion action to achieve Health For All by the year 2000 – along with creating supportive environments, strengthening community action, developing personal skills and reorienting health services. (Bunton, R. 1992) The concept "healthy public policy" should *anticipate a new culture of public policy* which looks beyond state administrative planning structures to develop and implement policy, calling for *multi-sectored*, *multilevel*, and *participative initiatives*. It refers to *collaborative processes* involving the participation of all groups and populations affected. It points to the need for analysis of broader beliefs and cultures as well as a detailed understanding of the nature of available policy advocates, areas or public support, the nature of key stakeholders and influencers of policy, as well as government and organizational structure.

Health promotion policy is neighbouring concept, which tends to refer to the development of specific health promotion programs such as the development of non-smoking policies or healthy diet policies, or even the establishment of health promotion organizations or structures. (Bunton, 1992)

Taking into the consideration that health promotion is a central pillar of new public health, policy initiatives should be examined in the context of the latter.

The policy initiatives for older people in ten EU countries as described in the healthPROelderly National Reports reflect not only actual policy differences between countries but also differences in the understanding of politics and indirectly also differences in the understanding of health promotion as such. As regard to this the following different topics were touched/discussed by different authors:

- constitutions, acts and codes;
- health as a basic right;
- health, public health and health for all;
- prevention and health promotion;
- health and health care systems;
- health, social and retirement insurance;

- health and social policy;
- policy for older people;
- legislation and the legal basis for health promotion;
- funds and funding;
- the political and organizational framework;
- individual and social responsibility for health;
- aims, goals, targets; of health promotion
- plans and strategies of health promotion policy
- provision of health and social services;
- usefulness and effectiveness of services
- social inclusion/exclusion and
- quality standards of projects

The countries represented in the healthPROelderly-project are extremely diverse in geography, amount of population), social structure, socio-economic situation and health status of the population. They differ in terms of social and political structure, social regulations, existing governmental policies, political culture, health and social care systems, provision of services, quality of services, community involvement, existing plans, programs and strategies etc.

In the chapters on policy issues in the country reports, much has been written on the issues just mentioned. However, there has been very little explicit mention on healthy public policy or health promotion policy. One of the conclusions could be that health promotion is still to much embedded in existing health systems and existing health policy. As such it is still more or less the domain of health professionals and consequently it could be said that we are still fare away from the real multi-sectoral concern and participative health promotion initiatives that are in-line with frequent health promotion rhetoric. It could also be said that health promotion professionals and stakeholders are not enough concerned with policy processes. To promote health they should be able to understand, analyze and influence policies. All in all it seems that health promotion policies are not an integral part of ageing policies in the examined countries.

Understanding political processes and health promotion in their context allows us better understanding of *the barriers and possibilities for achieving health promotion goals* and objectives. It also allows us to define and select among different possible approaches, models and strategies - according the selected criteria.

Some of the countries have gone through the process of changing welfare states and systems, others - so called post-socialist countries - have witnessed the complete social and political reconstruction of society, including health and social welfare. The transition from the socialist to the liberal capitalist system reflects on changing social policy and consequently health promotion has been seen as a means of directing individuals to take more

responsibility for their own health status and doing so, reducing the financial burden on health care services.

Apart from these, there are some countries where health promotion has explicitly entered into the existing political agenda, discourses and processes. But even there – authors say -. there is still no clear legal basis for health promotion and are still number of unanswered questions.

In *Austria* in 1992 health promotion was introduced into the General Social Insurance Act (abbreviated "ASVG"). In 1998 **the Health Promotion Act** (GfG, 1998) came into force which constituted the first national law on health promotion in Austria. Older people are specifically mentioned in the above mentioned law as a target group of health promotion apart from chronically ill people, children/youth and employees. **The Fund for A Healthy Austria** holds a special position within the Austrian Law as a player in health promotion. The Fund also promotes health promotion for older people and funds health promoting programmes and projects on a regular basis.

In *Germany* health care policy began to focus more on prevention and health promotion with the Health Reform Act in 2000, when aspects of salutogenesis and social responsibility were incorporated in the legislation. In addition to this, a national strategy to advance health prevention and health promotion was developed. This strategy also targets the reduction of social inequality in the health sector, takes older people into account and mainly consists of the following elements:

- the "German Forum for Prevention and Health Promotion"
- the Law for Prevention and Health Promotion;
- the German Prevention Award
- national health goals

The German Forum Prevention and Health Promotion is an initiative of 71 associations and organizations in the health sector, which was founded in July 2002 by the Minister of Health. It is organized into several working groups, one of them called AG 3 "Healthy ageing" guided by the Federal Association for Health It sees ageing as a chance and achievement, with a focus on an increase in quality of life. Age should be looked at not only through the economic lens but rather be seen as a chance for health, independence, mobility and competence. The working group has two main goals: to create positive messages for an awareness campaign and to establish a preventive doctoral home visit.

The prevention law is a general law concerning all populations and age groups, however, this law is of relevance since it is just being discussed and projects eligible for funding under this law will also concern demographic ageing. Its main focus is coordination and cooperation, quality assurance, environment-oriented measures and a new regulation of prevention within the social insurance.

With the German prevention Award the following criteria for the evaluation of projects have been introduced:: clearly defined, revisable objectives, clearly defined target group(s) for the project (within the 50-plus target group), active involvement of the target group(s) in planning and implementing the measure, documentation of the measure, proof of achievement of

objectives as originally defined; continued viability of the measure after start-up funding ceases, transferability of the measure, innovation, for instance of the measure as such, in the form of cooperation or in funding, accessibility for population groups

National health goals and their implementation have been initiated by the Ministry of Health and Social Security. Different sub-goals, strategies and measures especially address older people as a vulnerable target group

In **Slovakia** a key document on health promotion is the **National Health Promotion Programme** (first adopted in 1992 and last updated in 2004) with the main aim to initiate partnerships between particular components of society to provide support and improvement of public health in order to achieve continuous improvement in public health status. Its objectives are based on the Report on Public Health Status of the SR and the most recent survey of public health awareness and behaviour in the SR. Health promotion activities which are focused also on older people are covered mainly by the following objectives: healthy lifestyle; health care; healthy nutrition; reduction of damage due to alcohol, drugs and tobacco products; reduction of the incidence of infectious diseases; reduction of the incidence of non-infectious diseases and physical activity.

In 2005, the **Dutch** Cabinet listed the continuing health of elderly people as the first operational objective of its policy for the elderly in its memorandum **'Policy for the elderly in the context of the greying population'**. The government wants to stimulate activities aimed at keeping the elderly fit and healthy for as long as possible. According to the Cabinet, healthy old age begins with a healthy lifestyle at a younger age. People need to learn to pay attention to healthy nutrition, exercise, the moderation of alcohol use, and abstinence from smoking on a permanent basis. The Cabinet assumes that in the future, more older people will be confronted with the consequences of an unhealthy lifestyle than is the case now. But, it also acknowledges that many people are unable to live up to their own responsibility for their health, because they lack sufficient insight into the relationship between their health and their behaviour. For this reason, the Cabinet now acknowledges the government's responsibility for prevention.

The **Czech Republic** has been actively participating in two European projects funded by the PHEA, the Healthy Ageing project and in the Active Age project. **The national programme on preparation for ageing** for the period 2003-2007 was passed in 2002. Preparation for ageing is considered to be a life-long process which apart from the social and collective responsibility embraces also the individual contribution of each person. Ageing is perceived as a problem of the entire society, not only of the group of senior citizens. **The governmental advisory council for the senior population** and ageing was founded in 2006 at the Ministry of Labour and Social Affairs. In 1994 a governmental programme subsidizing "Health Promoting Projects" was started. In 2004 another state grant programme "Healthy Ageing Projects" was launched focusing on the population 55+ years old.

Other policy initiatives mentioned are related more or less to the general health and social policy initiatives aimed at social protection, social inclusion and the provision of different services.

In order to analyse health promotion strategies for older people it is important to understand the political context that they were developed and functions in. It is difficult to find a clear and

common basis for understanding the varied political contexts in the different countries and to place health promotion strategies into the existing political context in order to fully understand the "reality" of these approaches.

Davison, C. and Smith, G.D. (1995) provide a scheme showing different approaches to public health which are connected to certain political perspectives and visualize the consequences of this for health promotion interventions.

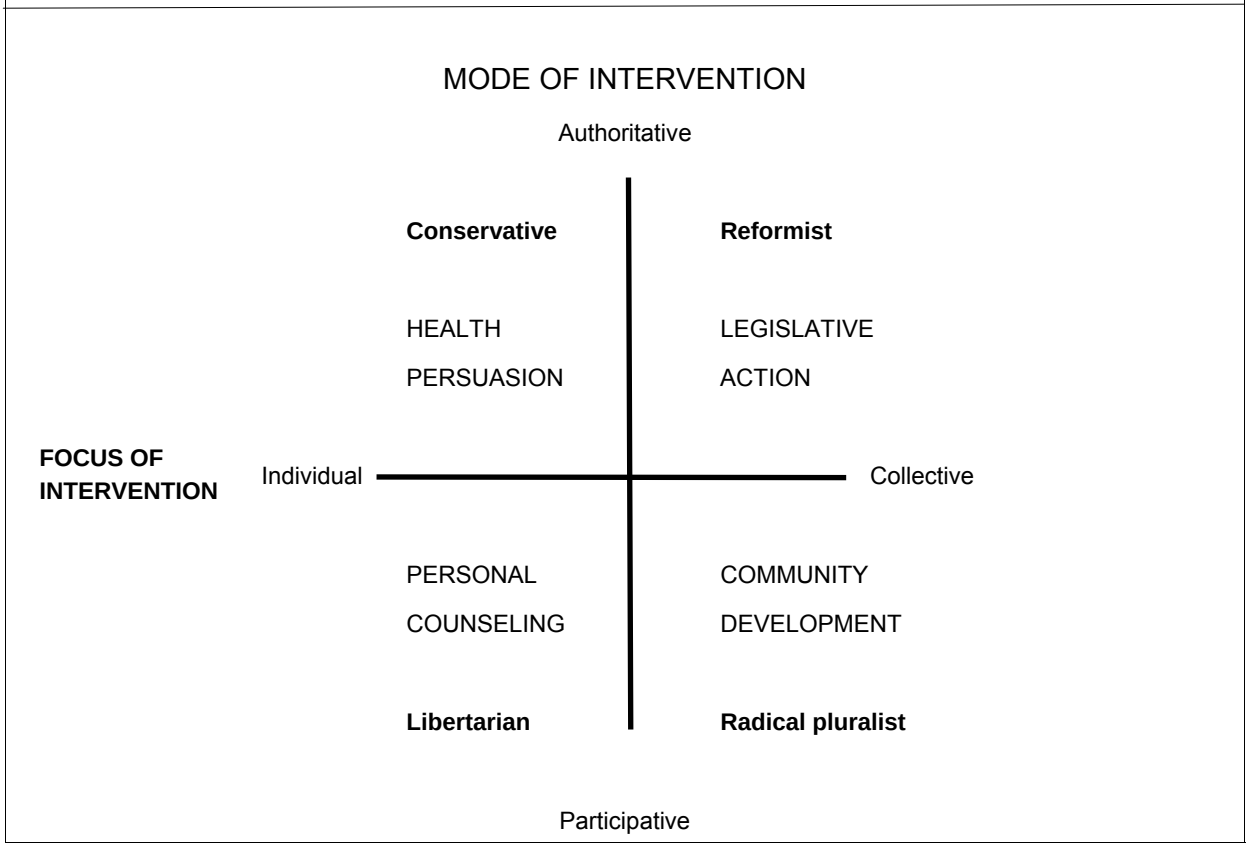
Overview 3:
Approaches to 2 basics of public health

	Collectivist ⟶ **Individualist**			
	"Fabian" or Marxist" perspective	**"New public health" perspective**	**"Health of the nation" perspective**	**"Free-market" perspective**
Production of disease	The distribution of illness is a function of the relationship between the economic and social spheres of collective action.	Many diseases are linked to personal behaviours and shared environments. These exist in a social and political context	Many of the major diseases of industrial society are rooted in personal behaviours which have a social and geographical distribution	If illness is caused by personal behaviour then individuals are free to choose health or illness from a range of lifestyle options
The design of health promotion interventions	Interventions should aim at social justice and material improvement – equity in health will follow	Sensitive attention to pathogenic lifestyle – empowerment of individuals and communities to choose health	Pathogenic lifestyle to be tackled at source – i.e. the individuals who do them should be identified and persuaded to change	The idea of an intervention involves the notion of collective conformity. Health can only be chosen by individuals, not by a "nanny" state on their behalf

Source: Davidson, C. and Smith, G.D. (1995)

Another framework for health promotion is offered by Beatie (1991) in the form of ***structural analysis of health promotion approaches.*** He links different political philosophies with different types of action (health promotion strategies). The political philosophies are defined by paternalistic versus participatory and individualist versus collectivist approaches. The types of health promotion strategies, are linked to **conservative** (health persuasion techniques), **reformist** (legislative action for health), **libertarian** (personal counselling for health) and **radical pluralist** (community development for health) concepts.

Overview 4:
Structural analysis of health promotion approaches



These models can help us to differentiate between different policy initiatives from the perspective of different approaches and strategies as well as from the perspective of different (expected) impact they can have. In the end we can conclude the following:

Health is primarily about politics, not in the traditional sense of class or ethnic power struggles, but as an issue – based matter. It is linked to power and domination or to socio-economic arrangements. It has been transformed from the neutral idea in the beginning, into a social and political value, loaded with moral connotations, it has become a basic human right as well as a commodity available in the marketplace.

Health promotion has become a political movement, without resolving the key philosophical problems at the heart of both rightward and leftward thinking, namely the reconciliation of free will and determinism in explaining human behaviour.

As ***policy*** is fundamental to health promotion, understanding the existing policies and policy environment is central to the development of political initiatives conducive to the models of best practices of health promotion of older people.

As all ***policy initiatives*** intend to effect our every day functioning, we have to pay attention to them and play an active role in policy processes, if possible from the beginning to the end - representing and advocating the needs and interests of older people all the time.

In the future, the function of the ***state*** as a tool of social and economic regulation is supposed to be smaller and state power diminished in favour of greater role of ***civil society*** and sub-state formations such as communities, cities and localities. Initiatives are expected to be more multi-sectoral, multi-level and participative and stronger voice of the elderly is expected in all policy processes.

5. Health determinants

Katharina Resch

Health determinants are enormously important for reducing burden of disease and for promoting health among European citizens. The European Union categorizes health determinants as follows: a) personal behaviour and lifestyles, b) influences within communities, c) living and working conditions as well as access to health services, and d) socio-economic, cultural and environmental conditions (European Commission, 2007). This categorization is used throughout this chapter.

5.1. Personal Behaviour and lifestyles

"Lifestyle is a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions, and socioeconomic and environmental living conditions […]. It is important to recognize, however, that there is no "optimal" lifestyle to be prescribed for all people. Culture, income, family structure, age, physical ability, home and work environment will make certain ways and conditions of living more attractive, feasible and appropriate" (WHO, 1998, p. 16).

Lifestyle related health determinants include alcohol, tobacco, nutritional habits, and the use of drugs and substances. Health problems are often linked to unhealthy lifestyles among older European citizens, but can also have their roots in the setting the person lives and works in. Still, addressing behavioural factors that influence health, is a strong focus in health promotion literature. Participation is one of the key factors of health promotion, which is why individual behaviour and habits should be addressed when discussing health promotion. Therefore the individual behaviour of older people has to be taken into account when describing the driving forces of health (Kuhlmann, Reichert, & Schäfer, 2007).

The main behavioural and lifestyle issues identified in the literature search were nutritional habits and physical activity, which were found in the UK, the Dutch, Slovakian, Austrian, Czech, Italian and German literature.[1] Several physical factors (nutrition, physical activity, degree of medication etc.) go hand in hand and influence the physical well-being of older people across Europe as well as the degree of physical impairment (obesity, hypertension, high cholesterol and diabetes). Only a few reports mentioned studies on the consumption of fruits and vegetables in their countries and their influence on health (see Czech, Italian and Slovakian HealthPROelderly reports). All of these lifestyle factors are rooted in the individual behaviour of older people in the respective countries and they require attention on a national and EU-level.

[1] The connection between mental and physical health determinants is also mentioned in some reports, but takes no dominating position in the literature.

Nutrition is one of the main health determinants, together with physical activity and smoking habits. The most common diseases connected to these health determinants are cardiovascular disease and cancer (European Commission, 2007).

The nutritional habits of older people in the *Netherlands* for example are far from optimal and a majority of the Dutch population exercises too little. Diseases like obesity and diabetes are rooted in unhealthy lifestyles like bad nutritional habits, smoking, lack of physical exercise and alcohol abuse leading to physical impairments like high blood pressure, high cholesterol levels and obesity according to the Dutch literature (Visser, 2005). Health promotion and prevention must aim at fostering behavioral change among the elderly in the Netherlands. In the near future the number of diabetics is likely to increase because people have become more obese and less physically active. A high number of older people in ethnic groups (Turkish, Moroccan and Surinam) in the Netherlands have to contend with severe physical limitations as well.

The highest risk factors among the elderly in *Slovakia* are obesity, high blood pressure, and diabetes, which can be led back to unhealthy eating habits and the lack of physical activity. In the field of nutrition the most significant risk factors are the low consumption of milk and cheese products, fresh fruits and vegetables, and too high consumption of salt and sweets.

In the *Austrian* literature physical activity such as sports and regular exercise are seen as being essential for health (Diketmüller, 1997; Lames & Kolb, 1997). Activity factors for health are often strongly related to life-style issues (nutrition, smoking, alcohol, drugs, etc.) and are sometimes only seen as a simple income-outcome determination of health (Elmadfa & Freisling, 2005; Kiefer, 2004a; Noack & Reis-Klingspiegl, 1999; Pils & Neumann, 2006; Rieder, 2003).

In *Italy* among the most important behavioural risk factors are cigarette smoking, excessive consumption of alcohol, and an unhealthy diet, although these statements have not been adequately investigated in the Italian literature. Among the biological risk factors, obesity and hypercholesterolemia are well known, but large scale data relative to the elderly are unfortunately scarce. As for nutritional factors, so far, only the consumption of fruits and vegetables has been investigated and results show that only a very low proportion of the elderly, 14% for males and 15% for females, eat two or more portions of fruit and/or vegetables per day. About 34% of the males and 27% of the females are overweight and 15% and 28% respectively are obese according to the WHO-definition. There is a statistically significant association between obesity and hypertension in the Italian literature.

In *Germany* Renteln-Kruse, et al.(Renteln-Kruse, J., Dapp, & Meier-Baumgartner, 2003) identified health impairments and risks among older people whose mobility is already restricted but who still live autonomously. The most pressing problems were found in the areas of malnutrition, and activities of everyday life. Some risk factors can be influenced directly like physical exercise, alcohol consumption and smoking, while other factors are subject to indirect influence, such as adiposity, hypertension and excessive cholesterol values. They do not derive only from personal behaviour and generally require extensive intervention.

In the *UK literature* physical health was often linked to nutrition, e.g. (Pearson, Taylor, & Masud, 2004), housing and winter deaths (Donaldson & Keatinge, 2003). Here it was

explicitly mentioned that mental and physical health or capacities reinforce one another (Bowling & Grundy, 1997).

Furthermore, the proportion of older obese people (65-74 years) in the *Czech Republic* is relatively high: 21% of males and 29% of females. After political changes in 1990 – going hand in hand with technological modernization and positive changes in lifestyles – a decrease in the consumption of meat and animal fat and an increase in the consumption of fruits and vegetables was reported.

The issue of **smoking** is not only an issue of personal habits but requires an integrated strategy on tobacco control at the level of the Member States in order to effectively combat smoking – and the linked diseases (European Commission, 2007).

Five national reports mention smoking as part of health determinants rooted in lifestyles (Dutch, Austrian, Italian, German, Slovakian).

The *Italian Report* mentions cigarette smoking as the main risk factor caused by individual behaviour. The Italian literature also states a notable increase in mortality from malignant neoplasms, above all, lung cancer which is undoubtedly due to cigarette smoking.

On the other hand the most important risk groups among older people in the *Netherlands* are: low educated older people (smoking and too little exercise), men (smoking, alcohol abuse), older women (too little exercise), and the chronically ill (also too little exercise). According to the Public Health Council, preventive policy should aim for behavioural change: to make people stop smoking, start with a healthier diet and do more exercise when they get older.

Conversely, in *Slovakia* smoking is seen as a decreasing issue among the elderly according to two longitudinal studies (Jurkovicova, 2005; NPPZ, 2005).

As far as **alcohol** is concerned, five countries (see Austrian, German, Italian, Dutch and UK reports) mentioned alcohol as a health determinant for older people's health. In Europe the consumption of alcohol per capita is the highest in the world (European Commission, 2007) which is the cause for major health strains and diseases.

Additionally in the *UK* literature links were found between anxiety and alcohol consumption (Hajat, Haines, Bulpitt, & Fletcher, 2004), and between alcohol and falls (Patton, 2002). Among the behavioural risk factors in *Italy,* the most important are cigarette smoking, excessive consumption of alcohol and diet, although these associations have not been adequately investigated. Among those who drink wine, however, only 3% of the women and 24% of the men state that they drink more than 50grams of alcohol (1/2 litres of wine) per day (Maggi S, Zucchetto M, & Grigoletto F, 1994)[2]. On the other hand 75% of older men and 91% of older women in *Germany* have claimed that they drink very little or no alcohol (Robert-Koch-Institut, 2004, p. 13).

[2] ILSA Study – The Italian Longitudinal Study on Aging

Lifestyle related factors are the originators of the most frequent causes of death in Europe. Four countries mention **mortality rates** in their description of health determinants (e.g. Czech Republic, Italy, Slovakia and Germany) and how they are linked to (un-)healthy behaviour.

In the *Czech Republic* the main causes of mortality in the long-term perspective are diseases of the circulatory system (52%), cancer (26%) as well as external injuries and poisonings. Even though cardiovascular mortality has remarkably decreased since 1990 due to technological modernisation of cardiosurgery care and positive changes in lifestyle. However, some positive trends have occurred in the stagnation and potential decrease of mortality due to malignant neoplasms.

The *German* literature states that mortality risks increase almost fivefold in persons with three or more risk factors (BMFSFJ, 2001, p. 89; Helmert, 2003, p. 547). Income is also seen as a predictor of morbidity and mortality (BMGS, 2005). Moreover, some risk factors can have multiple causes: for instance falls generally have a multiple origin and are often the result of a combination of risks (BMFSFJ, 2001, p. 90; Robert-Koch-Institut, 2002, p. 16). Cardiovascular diseases[3] also lead to a significant increase in mortality and are, for both men and women, the most frequent cause of death at an advanced age (Deutscher Bundestag, 2001, p. 94; Steinhagen-Thiessen & Borchelt, 1996; Walter & Schwartz, 2001, p. 197).

The *Italian* literature shows a twofold trend concerning mortality among older citizens. On the one hand mortality from cardio-circulatory diseases has declined in the last years, but on the other hand mortality from malignant neoplasms, above all lung cancers (which can be traced back to smoking habits of the population) and mortality from cancer among people aged 55+ has increased notably in the last years.

Moreover, the *Slovakian* literature also shows the trend towards reduced mortality from cardiovascular diseases, like in Italy. The incidence of myocardial infarction is decreasing for all age groups, especially for men in their professional life. The highest mortality rate for both sexes at the age of over 65 years due to cardiovascular diseases was noted in southern and southeastern regions of the Slovak Republic. A minimal improvement in age-specific mortality from cerebrovascular diseases was noted in all age groups, particularly for men in the last decade.

5.2. Mental health

“There is no health without mental health” (Jané-Llopis & Anderson, 2005). Mental health can be defined as “a dynamic process in which a person’s physical, cognitive, affective, behavioural and social dimensions interact functionally with one another and with the environment” (The Queensland Transcultural Mental Health Centre, 2000).

[3] Clinical pictures include hypertension, arteriosclerosis, myocardial infarction and apoplexy (Walter & Schwartz, 2001,197).

Mental health was not mentioned in connection with health determinants in most reports as often as physical variables were. However, it was stated that in *Slovenia*, for example, deficiencies in mental health are a growing problem. Currently there are about 21.000 patients in Slovakia with dementia and trends show that in 10 years this number is said to triple. According to the *UK* literature a low socio-economic-status (SES) can have a negative impact on mental health (Silveira & Ebrahim, 1998). Mental health is seen as central to healthy older life and its interaction and interdependence with physical wellness (e.g. Bowling & Grundy, 1997).

5.3. Living and working conditions

The effects of healthy or unhealthy working conditions on older people were mentioned in the Austrian, German, and Polish literature. Apart from the *Austrian* literature, which really puts a focus on healthy work in general, this issue is not covered thouroughly in the European literature. The importance of a stable work structure, work organisation, work process and work environment are focal points in the Austrian literature (e.g. Karazman, 1995; Meggeneder, 2002). Especially for low wage jobs involvement, rewarding, job satisfaction, communication and a social support structure as factors of social capital are mentioned as health determinants for the older workforce (e.g. Hilschner, 2004; Wolf, 2004; Wolf, 2005).

Living conditions are also rarely mentioned in the literature highlighted in the national reports. Some information of this issue will be covered by the factor “geographical scope” or setting.

5.4. Socio-economic, cultural and environmental conditions

The relevance of socio-economic status is mentioned in 6 of 11 country reports. Differences in the SES between citizens cause major health inequalities within countries and between the Member States. Health inequalities lower the person’s ability to achieve their full health potential (European Commission, 2007). There are a number of policies at EU level addressing this problem[4]. The WHO global strategy of achieving Health for All is fundamentally directed towards achieving greater equity in health between and within populations, and between countries. This implies that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health (WHO, 1998, p. 7). Higher income and social status are commonly linked to better health (WHO, 2007).

Socio-economic inequalities were a recurring theme within the *UK* literature, with deprivation likely to have a negative impact on both mental health, for example in helping explain differences in psychiatric morbidity between ethnic groups (Silveira & Ebrahim, 1998), as well as physical health.

[4] Public health action programme 2003-2008; Health and Consumer Protection Strategy and proposed action programme 2007-2013; regional policies etc.

Findings in the *German* literature indicate a connection between socio-economic status and state of health within the advanced age groups, with a special significance being ascribed to income as a predictor of morbidity and mortality (BMGS, 2005). However, the question whether the significance of social differences increases or decreases with age has not yet been fully answered by empirical studies. On the one hand, social differences seem to become more significant in old age, since the ageing process may involve financial burdens that require appropriate resources (double-jeopardy-theory). On the other hand, the literature assumes social differences being levelled out due to the fact that all older people are equally affected by the biological ageing process, regardless of their social status.This is seen as the ”age-as-a-leveller-theory” (Lampert, 2000, p. 165; Tesch-Römer, 2005, p. 45).[5]

The *Dutch* literature gives evidence about very old single women (in particular widows) who are especially vulnerable. But there is also an unequal life expectancy among older people in the Netherlands related to ethnicity. The causes of their poorer health are related to socio-economic factors like income, lower education, and a low degree of socio-cultural integration.

The most frequent health determinant mentioned in the *Austrian* literature is socio-economic status (SES) – mostly measured in terms of education, occupation and income. These factors are seen to be mainly responsible for the existing health inequalities in the country (GOe, 2003, 2005; Kiefer, 2004b; Pochobradsky, 1995).

Life expectancy in *Slovenia* differs between men and women. There are also regional differences in the country which have an effect on health – the economic situation and the consequential living conditions of older people differ between areas.

The *Polish* literature states changes in the SES after the transition of the Polish economy into a market economy bringing about various social consequences for older people such as changes in the distribution of income, increase of poverty for some groups of the population, unemployment and homelessness.

Environmental factors determining the health of older people were not mentioned as often as other factors in the countries‘ literature repots. The physical environment in which people live and work (e.g. clean water, air, healthy workplaces, safe houses, and communities) are not addressed in the countries‘ reports on health determinants. Factors from the environment can damage health and have a serious effect on the body (radiation, chemical exposures, pollution, noise – to just mention a few) leading to sleeping disorders, hearing problems, skin cancer, astma and many more problems (European Commission, 2007).

[5] These two theories were originally proposed by Dowd & Bengtson (1978), quoted from Lampert (2000, 165).

Surprisingly **gender** as a health determinant is only explicitly mentioned in seven of eleven country reports: Austria, Germany, Italy, Poland, Slovenia, Slovakia, and the UK. Most of the literature states statistical differences between men and women in morbidity or mortality rates. All other reports do not mention gender at all or refer to gaps in the literature. Some *German* figures show major differences in health between men and women: 32% of men and 71% of women aged over 65 are non-smokers (Robert-Koch-Institut, 2004, p. 13). Men and women's health differs in terms of genetics, outcomes, causes of death, disability rates, and behavioural aspects.

5.5. Conclusion

The health determinants mentioned most often in the countries' literature are risk factors (high blood pressure, smoking, inactive lifestyle, civilization diseases etc.), lifestyle issues (nutrition, physical activity, alcohol abuse etc.) and socio-economic factors determining health (income, poverty, inequalities). The literature states relevant statistical facts about mortality rates and causes of death.

Mental health, gender and genetic predispositions are rarely touched by the health promotion literature in European countries. Health and the body are in the foreground, while mental or spiritual health is neglected. Culture, ethical background and social support networks are also in large disregarded in the literature.

6. Overview of the literature search

Eva Krizova, Gert Lang, Piotr Brzyski

This chapter gives an overview of some of the main quantitative results of the literature search. A quantitative overview of the themes identified in the literature overview are presented as part of the thematic analysis and can be found under the respective headings in section 7. Here we present general themes relating to age groups, geographical scope and other target groups.

General Overview

Over all 11 European partner countries participating in the healthPROelderly project 1788 items were found which focused on health promotion and prevention in elderly projects in some way. The database containing these 1788 items covers a wide variety of publications and includes both articles in peer-reviewed scientific journals, monographs or articles in professional periodicals. A large proportion of items covers the documentation of health promotion projects.

Most of the countries collected 5-10% of all publications found each. Poland (37.9%), and Italy (14.4%) recorded substantially more items than most of the other partners. This is due to the fact, that the Polish team included more types of material, including magazine and newspaper articles and used these results for further national analysis. In Italy a wide focus was put on the literature entered in the database, including general topics on ageing. The smallest number articles concerning health promotion projectsfor older people was found in the Slovak Republic (about 1%) , in Slovenia and Spain (about 3%). This reflects the fact, that the issue has not been focused on in these countries until relatively lately.

Due to the quantitative prevalence of Polish items, the largest number of articles were written in Polish (35,1%), followed by English (17,8%) and Italian (13.1%). Apart from this, the percentages of items that are written in national languages correspond roughly with the amount of articles found in the respective countries.

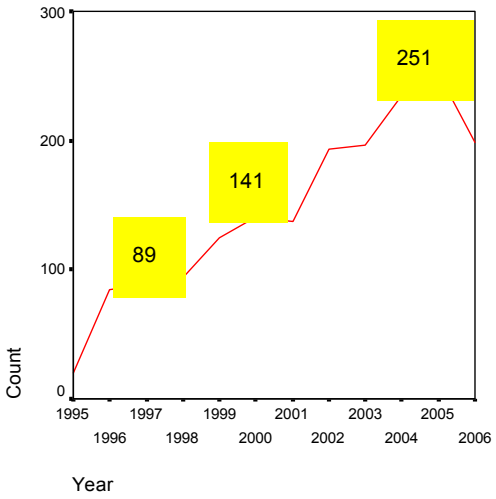
Table 1: Amount of items in the database by country		
Country	number	%
Austria	121	6,8
Czech republic	109	6,1
Germany	83	4,6
Greece	144	8,1
Italy	258	14,4
Netherlands	108	6,0
Poland	678	37,9
Slovak Republic	19	1,1
Slovenia	55	3,1
United Kingdom	153	8,6
Spain	59	3,3
Total	1.788	100

Trend between 1995-2005

The number of articles concerning health promotion issues aimed at older people distinctly increased during the period of observation[6]. The number of articles included in the project database which were published in 2005 was three times as high as those published in 1996. The total number of items in the first period reached 554 (31%) while in the following period it reached 1210 items (69%).

[6] A decrease in number of articles found in 2006 results from the fact that the search was performed only until October 2006. Therefore, not all articles printed in 2006 could be included in the project results.

Graph 1



For almost all countries, the trend is that the number of articles printed every year after 2000 is higher than that printed in the years before 2000. In all countries except Greece and Slovenia, the number of papers printed every year slightly increased. In Italy, Greece, and Slovenia, the number of papers printed concerning health promotion in elderly is relatively stable throughout the period of observation, with the exception of 1998-99 in Slovenia and 2000 and 2002 in Greece when the number of such papers was distinctly higher.

Types and sources of publications

The items taken into account in the healthPROelderly project were mostly published in scientific literature (over 36%) or printed as proceedings, monographs or professional journals (about 10% respectively). They were least often found in newspapers or grey literature (4% or less, respectively). Other sources, e.g., final reports, chapters in books, articles in magazines (or other sources) accounted for 5-8% of papers. The low amount of other sources included results from the fact that partners in those countries that revealed a large amount of scientific literature did not include these types of sources.

Papers found during the healthPROelderly-project represented a variety of literature across different countries. Scientific journals were the main source of papers in the UK (over 75% in this country), 50% in the Netherlands, 47% in Germany, about 40% in Poland and Italy as well as to a lower extent in Austria (22%). In Austria, entries concerning health promotion programmes were also found in a similar number of conference proceedings. Final project reports were the main source of entries in Slovakia and the Czech Republic, over 40%, respectively. The main source of articles in other countries included conferences proceedings in Greece (almost 60% of papers) and professional journals in Spain (almost 30%).

Table 2: Type of publication		
	Frequency	%
Scientific journal	647	36,2
Monograph/book	178	10,0
Book section/chapter	122	6,8
Proceedings	194	10,9
Final report	146	8,2
Grey literature	66	3,7
Newspaper	46	2,6
Magazines	93	5,2
Professionsl journal	167	9,3
Other	113	6,3
Total	1.788	100

Table 3: Source of literature		
	Frequency	%
International scientific database	284	15,9
National scientific database	473	26,5
National database of health promoting projects	325	18,2
Internet	369	20,6
Comibnations (not included above)	41	2,3
Total	1.788	100

Most papers were found in national scientific databases (more than 26%) and about 20% of papers where identified in national databases of health promotion projects or the internet (21%). About 16% of papers were found in international scientific databases or in other sources (see Table 3).

Similar to overall outcomes, the majority of the papers found during the search of literature were included in national scientific databases particularly in Austria, Germany, the Netherlands, and Poland (from 37 to 45%, respectively). No national scientific databases were used to find papers in Slovakia or Slovenia,. National databases of health promoting projects were the main source of papers in the Czech Republic (over 40%) and were very important in Poland (35% of papers found), but this source did not contribute any articles in Slovakia, Slovenia, the UK, Germany, and Greece. The internet was the main source of papers found the UK (over 56%) and Italy (43%). This source of papers was important also in Slovakia (40%), Germany (almost 25%), Austria, the Netherlands, and Poland (about 10%, respectively). “Other” sources of articles were the biggest source of papers in Slovenia (100%), Greece (90%)Slovakia (60%) and Austria (23%). Important sources of papers were international scientific databases in the UK (over 40%), the Netherlands, Italy (over 30%), and Germany and Austria (over 20%, respectively). International scientific databases did not contribute any entries in Greece, Slovakia, and Slovenia as well as the internet in Slovenia.

Owing to the fact that the search trajectory was designed to follow a vertical line from the most significant and valued sources like international scientific database through to the internet and “other” sources, we can draw the conclusion that United Kingdom, Netherlands and Italy were able to draw from the highest quality sources of literature, likely to be collected in the international scientific database. While United Kingdom and Italy combined this source with the internet, the Netherlands, Austria and Germany used a combination of international and national scientific databases. The Czech Republic and Poland tended to rely on national scientific databases. Finally, due to a missing bibliographical system or for other reasons, some countries like Slovakia, Slovenia and Greece had to rely upon “other” sources, like collegial contacts in case of Slovenia or the internet only (Slovakia).

Scientific disciplines

Most of the papers found in this project were concerned with the scientific discipline of ageing (26%) and community health (13%). Other more frequently touched upon scientific disciplines were gerontology and geriatrics (9%), education (almost 8%), and health promotion (over 6%). Only rarely, (less than 1%), were papers grouped with paramedical, physical science, and economic topics. Other disciplines such as epidemiology, social and preventive medicine, social policy, public health, sociology, nursing, and medical or nutritional sciences were mentioned in 2-4 % of gathered articles.

Table 4: Scientific disciplines		
	Frequency	%
Ageing	453	25,5
Community health	234	13,2
Education	139	7,8
Epidemiology	71	4,0
Gerontology, geriatrics	162	9,1
Health promotion	118	6,6
Social or Preventive Medicine	76	4,3
Paramedical	6	0,3
Psychology	66	3,7
Public health	59	3,3
Social Policy	74	4,2
Sociology	48	2,7
Nursing	68	3,8
Medicine	65	3,7
Nutritional Science	43	2,4
Physical Science	6	0,6
Economy	5	0,3
na/dk	61	3,4
Other	25	1,4
Total	1.779	100

Within countries, 46% of articles in Italy were written within the discipline “ageing” like 37% in Poland and in the Netherlands, Slovenia, and the UK (about 14% of articles). In Spain, 32% of articles were about ageing and community health, the latter being also a popular discipline in Poland (23% of articles), the Netherlands (13%) and the Czech Republic and the UK (about 10%). The most popular discipline in Slovakia (50%) and Greece (24%) was education, a topic also popular in the Netherlands (16%). The most often touched upon disciplines in Slovenia (38%) and Germany (20%) were gerontology and geriatrics. Literature on health promotion of older people was found within Greece, Italy, the Czech Republic, and Slovakia (about 10-15% of papers). The most often mentioned disciplines in the Netherlands were social or preventive medicine (19%), also frequent in the Czech Republic (10%). Similar to Germany (15%), public health was quite often mentioned in papers found in Slovakia (22%). A discipline dealing with health promotion of older peopl in Slovakia was psychology (11%). Sociology was the most often mentioned discipline in Austria (12%) as was nursing in the Czech Republic (18%) and nutritional sciences in the UK (20%). Other disciplines were health promotion in the Netherlands and Greece (almost 19%,) as well as public health in Slovakia (22%) and Germany (16%). Medicine was also a prominent discipline in the Czech Republic (12%) and the UK (15%).

Disciplines like nutritional science or medicine were mentioned in half of countries participating in the project. In some countries, health promotion projects mentioned only a few disciplines like education, gerontology and geriatrics, social or preventive medicine, psychology, and public health in Slovenia. Only gerontology and geriatrics, social and preventive medicine, and public health were found in papers included into project database in all countries participating in the project and only in Poland were articles found which mentioned all the disciplines of interest. Almost all disciplines were found in Austria, the Czech Republic, Germany, Italy, and the UK and almost in all countries were such topics like ageing, community health, education, and health promotion mentioned.

Age groups

Health promotion programmes were either directed towards seniors aged 65 years and over, reflecting over 30% of papers included in the project database, or to seniors aged over 60 years (14%). 60+ and 65+ are hence the most evident cut-off point that constitutes ‘older people’ within the health promotion literature. A large number (20%) of papers were not geared to a specific group of older people, in total 8% of participants were just generally described as seniors or older people (8%) without any mention of a specific age group. Some health promotion programmes (10% of articles) included also younger groups, some as young as 45 years. Only 7% of projects were targeted at population between 50-59 years and 6% projects at people aged 70+ (including following age groups 75 and 80).

Table 5: Age groups		
	Frequency	%
Seniors	57	3,2
Unspecified	375	21,0
50 +	80	4,5
55 +	42	2,3
60 +	254	14,2
65 +	573	32,0
70 +	33	1,8
75 +	40	2,2
80 +	30	1,7
85 +	4	0,2
Older employees	3	0,2
Including younger groups (up to 45)	180	10,1
Elderly, oder age, older people	95	5,3
Restricted (without the minimum age), eg. By 70	18	1,0
Centenary	4	0,2
Total	1.788	100

Programmes were rarely explicitly aimed at people over the age of 85, examples were found in Italy and Poland that dealt with centenarians. In the Czech Republic for example the exact age group was only rarely set specifically, rather the verbal concept “seniors” was prevailingly used. Concerning the verbal description of the target group “elderly” was used instead of seniors in UK, Poland and Austria. In Germany, the Netherlands, Italy, Greece and Spain mostly an explicit age limitation was set. In over half of the countries participating in the healthPROelderly-project, publications describing health promotion projects aimed at the elderly most often targeted those aged 65 years and over, especially in Slovenia, Greece,

Italy, and Slovakia. Other projects mostly addressed groups aged 60 years and over, especially in Poland, Austria, Germany, and Italy. Projects directed to those aged 50 years and over were also found in Slovakia, Spain, Germany, Austria, and Poland. In many health promotion projects, the target group was described as “the elderly” of “older people” (e.g., in the UK and Austria) or “seniors” in the Czech Republic. The most popular target age group in Spain and one of the most popular in the UK and Germany included younger individuals, some as young as 45 years. In many countries, a number of projects did not describe their target group (the Netherlands, Austria, the Czech Republic, Germany, and Poland).

Geographic scope

Many health promotion projects aimed at older people mainly take place on a national scale (45%). Other projects take place on a local (23%) or regional (11%) scale. A rather small number of projects were those taking place on an international or European (7% total) level.

Table 6:
Geographic scope

	Frequency	%
Local	409	22,9
Regional	203	11,4
National	815	45,6
EU	36	2,0
International	93	5,2
Other	127	7,1
Combinations	52	2,9
Total	1.788	100

A similar number of projects were described as “other” or as a combination of geographic locations. Most papers described health promotion projects aimed to the elderly which were enacted at national level. This included 100% of projects in Slovenia and over 30% in other countries. Exceptions included Slovakia, Greece, and the UK where this group of projects was less popular compared to projects enacted at a more local level. In Slovakia the highest number of projects was conducted at a “combined” level (almost 80%), in Greece at an “other” level (almost 70%) and in the UK, the most popular projects were held at a local level (over 40%).

Projects at this level were also popular in most of the other countries participating in the project, from 16% in Austria, increasing in the Czech Republic, Germany, Spain, Italy, the Netherlands, and Poland, up to 40% in the UK. More regional projects were also less popular in some countries, averaging 15-20% in the Netherlands, Italy, Greece, Austria, and the Czech Republic, respectively.

Other target groups

Target groups of more than half of literature found were not mentioned (58%). Such groups as women, the disabled, and people with mental health problems were specified in the case of 4-5% of papers. Target groups such as migrants, the poor, or men (no more than 2% of articles) were mentioned more rarely. A quite large group of authors specified the target group as “other” (over 15%) or as a combination of groups (7%).

Table 7:
Other target groups

	Frequency	%
No/not mentioned	1.030	57,6
Woman	70	3,9
Migrants	13	0,7
People with a disability	81	4,5
People with mental health problems	86	4,8
Poor	7	0,4
Men	28	1,6
Dk	38	2,1
Other	304	17,0
Combinations	129	7,2
Total	1.788	100

7. Areas of health promotion for older people

Jenny Billings, Charlotte Strümpel, Barbara Wozniak, Eva Krizova

7.1. Introduction

This section provides a thematic documentary analysis of the literature findings within each partner country's national reports. The analysis is grouped into the prearranged themes of promoting mental health, social participation, empowerment and lifestyle. Each of these main themes were further subdivided into categories agreed on in the first healthPROeldery-project meeting, grouping them into predominant areas. Some quantitative information about the frequency with which certain topics could be identified within the literature is provided, and some cross country comparison is made. The first section provides a general quantitative overview.

The themes and topics most often touched upon were quality of life (over 56%) and life style (almost 55%). Other topics included health determinants (almost 50%) and participation (over 40%). Approximately a third of papers dealt with empowerment and mental health respectively.

Comparing selected themes during the period 1996-2005 we may observe that only empowerment shows an increase, while health determinants, quality of life and life style are the traditional well-proven and rooted pillars of health promotion activities. Health determinants was the topic appearing most in published articles, increasing in number until 2000, then decreasing in each following year. Quality of life was most often mentioned in papers published before 2003. Empowerment was almost non existent in papers printed in 1995, then most often touched upon in 1996, 2001, and 2006.

Table 8:
Themes and Topics

	Yes (%)
Health determinants	49,6
Quality of life	56,7
Mental health	35,1
Empowerment	31,7
Participation	40,6
Lifestyle	54,5

7.2. Promoting Mental Health

Almost 30% of all literature found addressed mental health. This covered a combination of different topics, such as depression (21,7%), cognitive issues (e.g. memory training) or emotional support (over 10%), stress & burn-out or issues of self-respect and dignity (about 5%).

Table 9:
Mental Health

	Frequency	%
Yes (% of all papers)	627/1788	35,1
Addressing depression	136	21,7
Addressing stress & burn-out	38	6
Cognitive issues (e.g. memory training)	74	11,7
Self-respect, dignity	29	4,6
Emotional support	67	10,5
Do not know	61	9,7
Other	34	5,4
Combinations	188	29,9
Total	627	100

There were varying amounts of literature relating to promoting mental health, but articles were evident in all countries apart from Slovakia where none were found. Approximately a quarter to a third of all articles on health promotion were specifically targeting mental health issues in Austria, Germany, the Netherlands, Spain and the UK, less so in Greece and Poland. The majority of activity seemed to centre on the alleviation of depression in older age and measures to promote cognitive activity such as memory training. In Greece and Slovenia, issues relating to emotional support of carers seemed to be apparent. In Spain, it was noted that the body of scientific evidence on the promotion of mental health for older people was limited. Literature on this topic referred to effective empowerment strategies for such areas as controlling nutrition and drug consumption. It also refers to strengthening community networks, preventing violent situations in a number of different environments, facilitating social participation. In general however, health promotion activity in this area highlighted the interdependence between physical and mental issues, especially in the

Czech Republic, and that serious long-term mental disorders must be treated as both a health and a social problem.

The following sections will continue with a closer examination and comparison of what was found for the mental health topic areas of (i) depression, (ii) stress and burn out, (iii) cognitive issues and memory training, and (iv) emotional support. Some overlap exists between the categories.

7.2.1. Addressing Depression

Given that depression is seen to be a common, serious and persistent problem among older people and older women in particular, there was general agreement in the literature across the countries that its detection and prevention was of major importance as it is strongly associated with a decline in physical health.

The literature appeared to highlight the issues and activity through three main themes, namely policy, primary and secondary prevention:

A **policy connection** was evident in the literature of some countries. In Austria there has been a focus on raising awareness of depression and promoting tolerance of people with mental health disorders (Braunsteiner-Reidinger et al 2006). In Greece, there seems to be a policy deficit and a recognition that more should be done, particularly through occupational therapy. Dutch literature describes how activity to counter depression has been guided by focusing on different policy areas connected to social living environments, such as welfare and housing (Bohlmeijer 2005). Finally, in Poland promotion of psychological health in older people and their families was the topic of a programme sponsored by the Department of Psychiatry (Frenkiel-Zydek 2000).

Primary prevention to reduce the risk of depression among older people was apparent in some of the literature. Interventions focused on the importance of sport and exercise, as well as social activity. In Spain, good practices for dealing with depression were those which facilitated optimism, promoted the pursuit of hobbies and stimulated social and community participation. Even programmes to promote physical health resulted in an improvement of the individual's mood and reduced depression when present. Similarly in the UK, literature highlighted that exercise has been shown to have some positive effects especially when conducted in groups in local communities (Mather 2002). In addition, a project targeting the recently bereaved offered companionship with others who had gone through a recent experience (Heer 2002). In the Czech Republic, interventions included walking, dance therapy and encouraging attendance at internet cafes. In Germany, a project targeted older men in residential homes, involving them in activities that were more tuned to male interests, such as making models. This appeared to lessen withdrawal and inactivity (Stierle et al 2005). Also, a Polish study described a therapeutic intervention aimed at social workers to deliver to older people at risk (Gielas 2002).

There were also projects relating to **secondary prevention**. In the Netherlands for example, one extensive experimentally designed project was concerned with providing training to caregivers in residential homes on detecting and supporting depressed residents through a range of interventions, alongside giving information to all personnel, residents and relatives (Cuijpers 2001). This had a positive effect on influencing depressive symptoms. In addition,

studies describing screening activities for depression were evident in the literature. In Greece, two projects were carried out to increase the identification of depression among older people attending KAPIs and Health Centres, also raising awareness and sensitivity among professionals of the incidence. Research from the UK emphasised the importance of targeted screening towards at risk populations, such as ethnic elders who have been identified as being particularly at risk (Silveira 1998).

7.2.2. Addressing stress and burn-out

Literature addressing primarily stress and burn-out among older people was not widespread. It was not evident in Italy, the Netherlands or Slovakia and only to a minor extent in Greece, Slovenia, Spain and the UK. In general, literature was found that related to stress reduction projects in the workplace, that aimed to reduce stress experienced by carers, and that sought to target stress and anxiety (general and specific) experienced by older people. The Spanish literature emphasised the importance of social support once more acting as a buffer against situations of stress.

Most literature on **workplace** health promotion of older workers emanated from Austria and Germany. In Austria, it was recognised that older employees could often be exposed to stressful situations which required specific age-related interventions, often not available. This can be connected to difficulties adjusting to reorganisation, and cognitive abilities such as learning delays. A project aimed at reducing stress and improving work-life balance helped to increase motivation (Wolf 2005). In Germany, most of the literature concentrated on the workforce as a whole. However some interesting research focusing on older employee retention has been conducted, which identified factors such as a regular job rotation process, avoidance of health-related injuries such as repetitive strain injury and group work as being conducive to long-term employability of older workers (Huber 2002; Morschhäuser 2005).

Acknowledgement of the **stress experienced by carers** formed the main body of literature in the Czech Republic. In Germany, a project addressing carer stress was undertaken by Schmidt (2005), involving the provision of information and counselling, as well as health promotion advise such as relaxation techniques and personal competence in daily life. In addition, support groups for carers of people with dementia have been shown to reduce the physical and emotional strain associated with it. In Greece, an intervention included the provision of guidelines to prevent burn-out connected to caring.

Two countries reported interventions for **reducing stress and anxiety for older people**. In the Czech Republic, a specific project focusing on reducing stress related to issues of safety in the home has taken place, providing information about available services and installing ‘hot lines’ for emergencies. In the UK, a drama based project helped to reduce general anxiety among older people by raising awareness of mental health issues (Scottish Executive 2004).

7.2.3. Cognitive issues and memory training

Countries varied in the amount of literature found in this area, but where indicated, it mostly amounted to between 5 – 11%. No literature specific to cognitive issues was found in Italy, Slovakia, Spain and Slovenia. While some countries identified evaluated projects on the subject, others such as Austria noted a dearth of empirically well-founded studies on cognitive issues. Instead, the literature here appeared to promote memory training and life-long learning through suggestions such as 'brain jogging' (regular cognitive training), engaging in regular volunteer work and playing chess (Rind 1995; Bruck 2004). This was also the case in Poland, where publications recommended specific cognitive exercises such as reading and doing puzzles to improve memory function. On occasion, this would include a 'self-help' memory test to allow older people to measure improvement (eg Bialy 2005).

In other countries, projects and studies were found that focused on the primary and secondary prevention of declining cognitive states such as memory loss and dementia. There was recognition of the value in the dual approach of combining cognitive training with physical training in some of these studies, once more acknowledging the interdependence of these functions.

Primary preventive projects were found in Germany and the UK. In Germany, a SimA study, which was a longitudinal training programme to preserve autonomy in older age, indicated that some potential for improving cognitive performance and preventing dementia existed through a combined strategy of memory and physical training, stimulating cognitive and psychomotor functions (Oswald, Hagen & Rupprecht 2001). The Sing for your Life project in the UK has demonstrated that socially supportive, entertaining group-based activities can also be applied to promote cognitive capacity (Sing for your Life 2005). Songs are specifically created to engage and stretch cognitive and short-term memory.

Examples of **secondary preventive** projects were found in the Netherlands, Germany and the UK and centred on halting the deterioration of pre-existing mental health conditions. In the Netherlands, a study examined the effectiveness of two types of memory training (collective and individual) compared to control among older people who self-reported memory difficulties (Valentijn 2005). Findings indicated that the collective training group faired better, reporting improved recall and objective memory functioning, and had fewer feelings of anxiety and stress about their memories.

In Germany, the SimA study again implemented and evaluated a specific biography-oriented activation programme among nursing home residents suffering from dementia, alongside a physical training programme. Results indicated significant improvements in cognitive and functional abilities, also having an effect on activities of daily living and a reduction in falls (Oswald, Ackermann & Gunzelmann 2006).

The dual approach to health promotion in this area was also found in the UK. The Dundee Memory Clinic project stated the importance of recognising physical difficulties associated with forms of dementia (Thompson 1997). Aside from memory training, it provided a holistic service that included wider health promotion activity with multi-agency teams such as pharmacists, occupational therapists, social workers and community mental health teams.

7.2.4. Self-respect and dignity

As a category, very little literature oriented to health promotion projects was specifically found, and nothing at all in Germany, Italy, the Netherlands, Slovakia and the UK. There was general acknowledgement however that the concepts of self-respect and dignity would feature or be subsumed in other areas of health promotion as general aims or outcomes, rather than to be the specific focus.

Literature that was found highlighted non-specific issues, either as commentary or discussion from a theoretical level. For example, commentary from Austria and Spain focusing on employment suggested that self-respect and dignity are lost through retirement or unemployment, and that volunteer work may act as a possible solution. Low income was singled out as a particularly important factor related to dignity in Spain. Additionally, Polish commentary emphasised the need for older people to be respected, particularly in relation to chronic disorders; in Slovenia, the societal perspective is also highlighted, pointing out the need for support from society to ensure quality of life in old age. The issue of self-respect in patient care was discussed in relation to Orem's self-care theory in Greece, stressing the leading role of the nurse.

7.2.5. Emotional support

While Italy and Slovakia reported no specific literature on this subject, other countries identified between 5% – 20% of articles with emotional support as a key feature. Themes emerging from this literature included the role of emotional support in illness prevention, the value of social activity, interventions for individuals, emotional support in retirement, and the sense of coherence – building emotional resources for health.

With respect to **illness prevention** and linking with a previous section, the Greek and Polish literature particularly highlighted the value of emotional support in the prevention of depression. In Greece, the relationship between psycho-social support and depression was particularly stressed, with older people who have greater familial contact and an established social environment being less at risk. In Poland, articles were mostly geared towards professional education, especially for those working in rehabilitation and social work, and they tended to give advice on improving the health of those affected by depression and dementia. Current literature in Poland talks at great length about emotional support.

In the UK, the role of emotional support in illness prevention highlighted isolation (Cattan 2005), but recognised that it appeared in the literature in a much richer and wider context. For example, it was associated with a range of interventions and environments such as a falls prevention programme (Allen 1999), as a way to empower and engage participants in projects promoting healthy ageing (Secker 2005), and was a key component of quality of life (Bowling 2004).

In Austria, the Czech Republic, Germany, Poland, Slovenia, Spain and the UK, emotional support was operationalised through a range of **social activities** mostly involving groups. In Spain, there were specific social programmes aimed at the development of social skills and self sufficiency. In Austria, emotional support has been given through regular gatherings of older people in their favourite restaurants or bars where they were able to discuss their

health problems (Glabischnig 2005); and in the Czech Republic, group physical training, courses and pet therapy have been made available as health promoting strategies. To counter the effects of social isolation among Turkish and Yugoslav migrants, a German pilot project has set about organising multi-lingual and multi-disciplinary international teams and deploying native nursing staff. In Poland, professionals have been encouraged to provide group therapy combining a bio-physical approach; and Slovenian literature highlighted the value of family and friends. Evidence from the UK suggested that group activities were more effective than one-to-one interventions in countering social isolation (Cattan 2005).

For Germany and the Netherlands, emotional **support for individuals** was identified through different interventions. In Germany, Walter (2005) stressed the need for suitable user-focused counselling and information for older people at critical events such as the loss of loved ones. In the context of successful ageing, the Dutch literature focused on strategies to enable effective adaptation, involving the development of coping strategies to optimise personal functioning and well-being (Slagen-de Kort 2001).

Issues of **retirement** were a feature of the Greek literature on this subject. It was reported that a significant factor enabling people to adjust to retirement was a strong psychosocial supportive network. In Open Care Centres, retired people participated in activities, shared the highs and lows of life, amused themselves and organised local festivals. Of interest was the gender divide regarding retirement, with men being more 'externally' active (excursions, meeting friends in cafes, and participation in local associations), and women's social activity being confined to the family and religion. Greek literature also highlighted that psychosocial support differs in different geographical areas. The implications of these findings are not discussed.

In the UK, retirement villages were reported as being a means of promoting networks of social support around older people. The benefit of this approach was that health and social services could converge more easily whilst still offering the older person a large degree of independence, combined with added security (Croucher 2006).

Austria and Germany identified strategies connected to Antonovsky's **sense of coherence.** This concerns the development of emotional strength and resources to promote health and well-being by building on positive attributes within a person. In Germany in particular, a study focused on 'healthy' older people and demonstrated an improvement in psychosocial resources, such as self-respect and personal initiative, and subjective well-being, through a programme of either physical activity or self-reflection. The freely selected courses and their positive assessment indicated that healthy older people will select measures for themselves to strengthen their resources (Wiesmann et al 2006).

7.3. Empowerment

All countries aside from Italy reported large numbers of publications referring to empowerment. In Poland, empowerment constituted over 50% of papers, 45% in Slovenia, Austria, and the Czech Republic, and about 30% of papers in Spain, Slovakia, and the UK. In most countries, information about empowerment was more likely to be found in professional publications than scientific ones, and as a consequence the messages from the

literature tended to be geared towards how care should be delivered. There were different orientations to these messages, but all concerned with the bolstering of autonomy.

In Austria and Germany for example, there was an emphasis on individual or personal responsibility and the use of motivation, alongside the promotion of self-determination in matters of personal health (Döhner 2001). In the Czech Republic, literature emphasised the importance of the active contribution of older people and participation in decision-making, rather than passive consumption of what professionals have to offer. In Spain, empowerment was mainly applied to communities – 'community empowerment'. Participation in community matters, in support networks, in the design and implementation of policies, and in activities and acts of intervention that directly affect the elderly, was articulated as a fundamental part of their empowerment.

The general impression was that its prominence indicates the priority given to this area of health promotion, still remaining a topical issue. Literature could be clustered into three main areas, namely a policy perspective, the importance of empowerment in terms of primary prevention, and actual projects that featured empowerment as a strong focus.

Regarding firstly the **policy connection**, in Poland and Slovakia, there seems to be a more evident policy connection that other countries. In Poland, empowerment is seen as a fundamental theme of health promotion and is embedded in policy dealing with issues such as patient rights and social welfare. From a Slovakian perspective, empowerment is visible mainly through the inclusion of older people in the process of policy and strategy preparation, as well as health and social care reforms.

In terms of **primary prevention**, empowerment is seen as a necessary pre-requisite to an enhanced health status. In Austria for example where there was a strong body of literature, in which empowerment was seen as a means to enable older people to adopt healthier lifestyles (Kurz 2003). Suggested activities included volunteer work, singing in a choir, and doing sport (Bruck 2004). Empowerment was also seen to be instrumental in preventing social isolation; in both Austria and the Netherlands, social participation was closely linked to empowerment and seen as key in keeping people as socially active as possible to reduce social isolation and loneliness, especially among those with lower incomes (Kocken 2000). In Greece, low levels of control and associated disempowerment in hospitalised older people was linked to high levels of stress and compliance with treatment; and in the UK, empowering strategies such as an inclusive approach in decision-making were seen to be important in combating low self-esteem (Woolhead 2004).

A few **projects** dealing with empowerment were also reported. In Greece, a project in Piraeus is currently addressing internal control issues, bringing to the fore older people's abilities and strengths. The project aims to help people communicate with each other and generate improved social support. In Germany, the project 'Active health promotion in older age' uses a multi-disciplinary team to individually counsel older people with the aim of strengthening personal responsibility for health care. The outcomes are that older people are able to initiate and carry out health promotion activity based on their own recommendations (Dapp et al 2002).

In the Netherlands, the programme 'Successful Ageing' is a health education course focusing on empowerment and social participation. Topics such as the use of medicines, memory problems and housing issues are discussed. Although the beneficial effects could not be fully demonstrated, the study showed that the course improved social support and subjective health (Kocken 2000). Finally in the UK, a project combining regular exercise with education on physical and mental wellbeing was effective in improving self-esteem and life satisfaction, two aspects associated with empowerment.

7.4. Social participation and inclusion

7.4.1. Introduction

A total of 44% of all papers included social participation in very diverse forms. Over 30% of papers touched on themes such as life-long learning, education of older people, social networking and social support, respectively. Over 20% of the literature found overall countries talked about a combination of these topics.

Table 10:
Social participation

	Frequency	%
Yes (% of all 1.788 papers)	784	43,8
Lifelong learning, education of older people	266	34
Social support, network	252	32,2
Self-help groups	16	2,1
Volunteering	12	1,6
Don´t know	32	4,1
Other	38	4,8
Combinations	168	21,5
Total	784	100

Themes like self-help groups or volunteering were mentioned in less than 3% of papers dealing with social participation. It was difficult to assess the topics and/or what problems were discussed in 4% of papers found.

Literature analysed within the healthPROelderly-project mentions social participation by older people as well as their inclusion into different forms of social activity to varying degrees,

dependent on the country. Certain countries such as Austria and the Czech Republic place a greater emphasis on the social participation of older people in connection with health promotion, devoting more publications to this topic. In other countries such as Poland, this topic is just beginning to be recognized and, as a result, is not widely found in literature.

The role social resources play for health and positive functioning of older people is just starting to be recognized. These resources include older people's social, emotional, cognitive, instrumental, and material (e.g., family, friends) support networks and enhance their self-respect and psychological well-being (BMFSFJ, 2001). In the Netherlands health promotion activities for older people addressing social support/networks are especially directed to the prevention of loneliness.

In most participating countries encouraging social participation of older people is at least beginning to be on the policy agenda. For example in Italy, social participation of older people plays an important role in the policies adopted at a regional level for the promotion of rehabilitation, recreation and socialisation, particularly for people who are not self-sufficient physically or suffering from disease.

The Spanish report mentions that prejudice and stereotypes are two barriers hindering the increased social participation of older people. They lead to marginalization and discrimination in this age group at various levels of social functioning, a fact painfully present in healthcare.

7.4.2. Life long learning

Life-long learning (LLL) appeared in over 20% of articles in Austria, the Czech Republic, Spain, Italy, the Netherlands, and Slovakia. This is a topic often encountered in relation to social participation for example in Austria, the Czech Republic and Greece. While in all participating countries a variety of educational offers for older people exist, it is of note that many of these activities are not discussed in relation to health promotion in older people as is the case in Spain and Poland.

Learning and development are significant elements of health promotion (Österreichischer Seniorenrat, 2003, p. 29). In the Czech Republic, Poland and Germany learning was discussed in relation to health-promotion such as health education and encouraging a healthy lifestyle. The role of education in preventing disease and risk factors commonly encountered in older age are explicitly mentioned in the Czech Republic and in the UK where health education and promotion among older people has already been seen to have significant health benefits and moreover is central to the National Service Framework (Biley 2002).

Several **health benefits** of participating in educational programmes have been identified with respect to older people:

Positive effects on the three dimensions of health, physical, psychological, and social health were mentioned in Austria, Netherlands and the United Kingdom. Austrian literature stated that education fosters empowerment and self-management, individual competence and autonomy (Kolb, 2003, p. 189) and that learning contributes to older people's happiness and support their health (Rosenmayr, 2004, p. 7). In the UK a health maintenance programme found that education, especially when combined with exercise in a group setting, was

effective in lowering blood pressure and improving flexibility, self-esteem and life satisfaction (Dungan 1996). In the “Healthy and Vital programme” in the Netherlands that also offers health education in combination with physical exercise the contribution to successful ageing, physical and mental resistance as well as increasing safety in and around the home was stressed (Hopman-Rock et al, 2002).

Health promotion activities use a variety of educational methods, from lectures, seminars, and courses, to informational brochures, mentioned in the Czech Republic and occupational therapy, mentioned in Greece.

In many countries, such as Czech Republic, Italy, Poland, Slovakia and Spain, **Third Age Universities** which target older people specifically were mentioned in connection with promoting older people’s health. They constitute a possible location for health education projects and offer, besides traditional academic courses, instruction on healthy dietary habits and leading a health-conscious lifestyle (Tirpáková, 2005; Hrapková, 2006; senior.sk, 2006). Education on health issues is usually one component of courses within Third Age Universities which offer a wide variety of themes for older people. In some countries Third Age Universities are not mentioned in the connection of improving older people’s health at all and no examples were mentioned where the health effects on attendance of Third Age Universities were explicitly measured.

General courses geared towards older people are another means for continuing education. Frequently, they offer participants the possibility to become acquainted with new technology (e.g., computer courses) and foreign languages. Such classes are organized by foundations and NGOs, such as The Fullness of Life Academy (Kraków, Poland), offering older people free lessons in three languages, art and computer classes, and publishing a textbook on computer use for seniors.

Two examples of **education based on art** were mentioned in the UK. These activities are aimed at promoting health among older people as well as encouraging social participation. Examples include the Bromley-by-Bow Centre in London or the *Sing for your life* project. The goals of this project, besides providing the opportunity for social interaction and singing, improve health, if only by improving cognitive functioning (Sing for your Life 2005). The health promotion value and sustainability of interpersonal projects is evident in the Bromley-by-Bow Centre, an arts based community centre in London. Arts were seen as useful means by which local older people can be brought in to the project and share in its wider programme of ‘health promotion, social entrepreneurship, active citizenship, integrated working and community regeneration’ (Frogett 2005).

The importance of education for improving the situation of **older workers** was mentioned in Austria and Germany. Continued education should allow them the opportunity improve their knowledge and develop new skills and qualifications, with the aim of improving their employment potential in older age (Tempel & Giesert (2005). Work-place intergenerational learning may serve to meet these goals (Dietscher & Nowak, 2005).

Several examples for projects involving health education were mentioned in the national reports. These included *Active health promotion in old age* and *Academy for senior citizens* in Germany, *Open Care Centres for the Elderly* (KAPI) in Greece, *Healthy and Vital* in the

Netherlands, the *Fullness of Life Academy* in Poland, and the Bromley-by-Bow Centre's Arts projects as well as the *Sing for your life* programme in the UK.

In Greece a health education program was implemented in two Open Care Centres for the Elderly (KAPI). It focused on training older people how to adopt healthier lifestyles with respect to cardiovascular risks. The results of this intervention were compared with those in a control group. A statistically significant decrease of body weight, salt intake, smoking, as well as an increase in the daily walking time was noted in the group of people who participated in the training programme. It was concluded that a well-designed health promotion program, based on integrated health education methodology and using existing community structures, shows positive effects on attitudes and behaviours of older participants (Velonakis E., 1999).

The *Active health promotion in old age* program (Dapp et al. 2002a) is based on the four characteristics of effective health education: (1) adopting a multidimensional approach (in this case: nutrition, physical activity, and social environment); (2) using teachers from diverse backgrounds, representatives from various specialities; adopting a (3) behavioral and (4) environmental approach.

In Germany it was mentioned that LLL is often interconnected with promoting volunteerism in older people (e.g., *Academy for senior citizens*) where these individuals have a chance to pass along their knowledge and skills to other older people. The concept of an "Academy for senior citizens" implemented in Heidelberg combines the approach of lifelong learning with the promotion of voluntary work. Senior citizens engaged in voluntary work pass on their knowledge and skills to other older people in training courses, lectures, sports groups and organized travel, and also benefit from the talents of others. Meanwhile, the Academy has grown to 3,744 members. In addition to an extension of sports programmes and cultural events, it is now planned to support younger families in future in keeping their careers compatible with family life (Stierle et al. 2005, p. 76ff).

7.4.3. Social support and networks

Articles mentioning social support were generally found less often than those dealing with issues of LLL. However, the consensus in literature found for example in Spain and Italy is that strengthening social support and social networks constitutes a fundamental element of social policy geared towards older people. Literature in Germany and Austria especially considers the effects social support and networks (or their lack) may have for the health and wellbeing of older people (Kruse, 2002; Tesch-Römer, 2005).

National reports from the Czech Republic, Greece, Netherlands, Poland and UK mention the that older people are at risk of **loneliness, isolation and marginalization** (Tokarz, 2006). It is widely recognized that social isolation and absent social participation have negative health consequences. For example in Austria it was found, that family support and marital status have an impact on older people's health condition (Abbassi-Nik, 2004). Thus, encouraging social support networks is a significant goal of health promotion campaigns as mentioned in the Czech Republic, Greece and Spain. Poverty is cited as one risk factor influencing the potential for isolation in the Greek report.

Many different **sources of social support** and social networks are mentioned, such as family-based social support (Przyklenk, 1996) or support of friends. Social support through

participation in the local community is mentioned. The Spanish report states that including older people in such activities should constitute a significant element of health promotion projects. Different ways of forming relationships and, as a result, increasing the social support of participants were cited. These included traveling, cohabitating, volunteering, exchanging grandmothers/grandfathers, and senior associations (Przyklenk, 1996).

Also, a wide variety of **settings** are mentioned where older people can find social contacts and support. Social centers, sports and recreation clubs (Lames & Kolb, 1997), Third Age Universities, culturals centers, and church clubs/institutions are named as potential sources of support for older people in Italy and Austria. In Slovakia specific NGOs work at local, regional and national levels to offer support for older people and promote health.

In Austria, a certain amount of attention is paid to supporting **older workers** going on retirement. Workshops, coaching, health panels, and seminars and discussions between employer and employees are recommended for this group (Schierl, 1995, pp. 147-148).

In the Italian report it was mentioned for, that **professional help and care** staff e.g., home helpers, etc. can be a source of support for older people, especially those living alone and needing care. As a result, they should be properly prepared for their role by training. In Germany a relevant issue is that social support is a vital element for **older migrants**, promoted especially by an approach of culturally sensitive care-giving, preventive home visits conducted in the person's native language (Wohlrab 2004) and events and materials passing on information about subjects connected with social assistance law and health care (Schnabel & Schopf 2006).With respect to migrants, in Italy it was mentioned that many migrants are employed for the help and care of older people. In these cases, one goal of social policy should be to ensure the quality of such services.

A variety of health promotion projects have been described that have the goal to encourage the social support of older people: *Active health promotion in old age*, *Cologne Senior Citizens Networks*, *Assisted living* (Germany), *Open Care Centres for the Elderly* (KAPIs), *Help at Home* (Greece), *Allowances for Treatment for the Elderly and Disabled* (Italy), *In Good Company* and *Loneliness* (Netherlands).

The goals of these projects include, above all else: establishing a social support network, stimulating older people (e.g., assisted living), improving social support in the context of health promotion, encouraging participation, autonomy, solidarity (e.g., *Cologne Senior Citizens Networks*), ensuring support for older and disabled individuals, and preventing loneliness and the social isolation of older people (*In Good Company*, *Loneliness*). The target groups of such projects are explicitly defined segments of society, such as older people living in specific local communities, older people who are long-term unemployed, older migrants, persons suffering from mental disease, elderly homosexuals, older women, or widow(er)s.

The **evidence of activities** to strengthen social isolation and improve inclusion of older people is not always conclusive. For example in the Dutch case some projects had no or limited effects in reducing loneliness and were were limited and size and location. Though social isolation and loneliness is a recognised phenomenon, Cattan and colleagues, in their systematic review of literature in the UK, note that educational and social activity groups can be effective in dealing with loneliness (2005). However in another study based on interviews

with older people and practitioners, it is suggested that many groups are understandably run with current participants in mind, meaning that those outside circles of the 'socially active' are not included (Cattan 2003).

In the Dutch project *In Good Company*, a friendship enrichment programme for older women, the needs assessment among older adults and intermediates showed that there was a demand for change of environmental determinants using meeting and recreational activities for older adults, instead of behaviour oriented support groups and skills courses which had been proven efficacious from research. It was concluded that the use of democratic linkage strategies, like needs assessments, local action plans and two way communication between program designers and users, is essential for successful dissemination of health promotion activities (Kocken, 2001).

In the Greek project 98 people who had participated in the program and services' providers (social workers, nurses, family helpers) were asked to evaluate the programme. Main areas where the participants asked for improvement was the collaboration with medical staff (23,03%), more home care visits (21,07%), first aid services (20,55%) and the collaboration with the health practitioner (7,05%).

7.4.4. Self-help groups

While self-help groups in general seem to be quite well developed in some countries, such as in Germany and Austria, other countries report that self-help groups in general are a new phenomenon. Self-help groups in connection with health promotion for older people were identified very rarely. 16 items of literature were found over all countries on this issue.

As the German report explains, the work of self-help groups, which exist beside and in addition to the professional health care system, focuses mainly on the promotion of independence and participation of the individuals involved. Additionally, occasional deficiencies in professional health care are dealt with and partly offset. A characteristic feature of such groups is that they go beyond professional counselling and information to provide in particular psychosocial support to persons affected by certain problems. Based on mutual understanding, assistance and exchange of experience with people in similar situations, self-help groups have a positive effect on the preservation of health and coping with problems (Robert-Koch-Institut, 2004).

Self-help groups are based on the idea of mutual support and volunteering and most often function as part of the third sector. They take the form of different associations, societies, and senior clubs, for example in Poland. Reports from Austria and Poland show that women more often than men choose to participate in self-help groups. Self-help groups targeting men require further development according to a report from Austria (Habl, 2004).

The fact that not much literature has been found on this subject can be related to the fact that self-help groups are a rather new phenomenon in some countries such as in Poland or are just starting to develop and require further study as mentioned in Italy.

In other countries, this sector is generally well developed. In Germany, for example, 70.000-100.000 self-help groups exist with an estimated membership of three million people. In Austria, self-help groups are also an integral part of health promotion activities.

In the context of health promotion and older people one prominent focus, e.g. in Germany and Czech Republic is support groups for family members of those suffering from dementia or other chronic diseases and disability. Examples of self-help groups involving seniors themselves were mentioned in Slovakia, Slovenia, where a long tradition in this area is mentioned.

Assistance takes on various forms. This can mean specific material support, psychosocial support, information support by providing information, sharing one's experience of dealing with a certain problem, and help in dealing with illness. Advantages arising from participation in self-help groups are encouraging social integration (Hadlicka, Pedich, 1997), promotion of independence and participation of the individuals involved, increased autonomy and confidence, and preservation of health .

A few examples of established self-help groups have been described. The Czech Alzheimer's Society and the dementia counseling office in Mannheim are institutions meant to help patients and their care-givers (v.d.Knesebeck et al., 2006). In a European research project that Germany was involved in, a handbook was developed for group leaders organising training courses/self-help groups for care-giving relatives of persons suffering from dementia. A prominent feature of this guidebook is its salutogenic approach. This programme is centred around the psychosocial needs of care-givers. The objective is to improve the self-help potential of care-giving relatives. Active involvement of the group members in planning and developing the group is a central element of this guidebook (Humbach & Apel, 1998[7]).

Certain projects also work to develop more social integrative attitudes among older people. One example is *The Senior Council*, Antoniuk, Białystok, Poland. The goal of this project, which was one of the first projects ever geared to those aged 60 years and over, was to organize and promote self-help principles and develop pro-social attitudes among seniors (Halicka, Pędich 1996).

7.4.5. Volunteering

While quite a number of health promotion projects work with volunteers, in the literature search not many items were found that dealt with volunteering in the context of health promotion of older people. As mentioned in the Czech report, this topic may be under-represented in literature due to the lag in time between the practical application of certain projects and their publication in literature.

In some countries such as Poland, volunteering by older people is a relatively new and unknown topic. In the Czech republic, it has begun to develop dynamically, especially at the level of NGOs in the last five years. In Austria and Germany older people as volunteers has

[7] http://www.uni-koeln.de/ew-fak/Klein/docs/ge_mod01.rtf; not included in the database

been high on the policy agenda for quite a while. However, this issue is seldom dealt with in the context of health promotion.

Encouraging volunteering among older people is a significant goal of social policy due to the fact that older age inevitably leads to retirement, or post-productivity, which may lead to decreased activity among older people. Volunteering allows older people to lead an active lifestyle during retirement (Kruse, 2002) and should be encouraged on a large scale (Gawrońska, 2006). A study in Poland, for example found that one in four volunteers was an older person. A decisive factor in choosing to become a volunteer was found to be free time and religious motivation (Kluzowa, 2000). Volunteering can for example take place in the area of social and cultural work, sports, politics, and religion.

Volunteering is discussed in two forms: volunteering for older people and volunteering where the older person is actively helping others (Vidal, 2004; Zaorska, 2004). Some of the advantages of volunteering are social contact, positive influence on mental and physical health, opportunity for personal development, and remaining mobile (Amann et al., 2005, Przyklenk, 1996). In other words, these advantages follow from leading an active lifestyle. Volunteering improves self-esteem and adds confidence (Kruse, 2002).

Social participation seems to be an integral element of volunteering, working against the marginalization and isolation of older people (Mazur 2006). This fact is exceptionally important especially in societies where marginalization of older people, with the connected problem of discrimination, presents as a pressing social concern.

The Pilot project for the promotion of social commitment and integration of female migrants and naturalised German citizens through voluntary work is a program meant to encourage volunteering and mutual cooperation between immigrants and older German citizens who live alone and seek support and help (Stierle et al. 2005). Integrating generations is a Polish program consisting of 23 subprojects aimed at preventing the isolation of older people by reducing the distance between generations by encouraging volunteering by older people for younger as well as older age groups.

7.5. Lifestyle

7.5.1. Introduction

The role of lifestyle in the health of the individual was confirmed in literature analyzed as part of the healthPROelderly program, where more than half (58.3%) of all literature touched on this topic. Among the lifestyle elements considered in this analysis, physical fitness and nutritional habits were the most often discussed topics, followed by prevention of disease (20.8%), physical fitness (18.2%), and nutritional habits (13.6%). Other topics included the prevention of falls and accidents (about 6%) or elder abuse, substance abuse or sexual activity (about 1% of papers). The two last mentioned were the least frequent in the literature. It was difficult to assess the topic in over 6% of papers and almost 4% concerned other topics. Almost 30% of papers described a combination of different topics concerning lifestyle.

Table 11: Lifestyle		
	Frequency	%
Yes (% of all 1.788 papers)	745	58,3
Nutrition	142	13,6
Physical activity	189	18,2
Sexual activity	11	1,0
Subtance abuse	8	0,7
Safety (e.g. prevention of falls, accidents, injuries)	61	5,8
Preventing abuse/violence against older people	16	1,5
Prevention of disease	216	20,8
Don´t know	68	6,5
Other	37	3,6
Combinations	295	28,3
Total	745	100

It is common knowledge that lifestyle significantly influences health. It is understood as the model of behavior, habits, and customs observed in all aspects of living by the individual, including physical fitness and nutritional habits as well as use of alcohol, tobacco, coffee, and/or tea (Last, 2001, p. 105-106) The influence of lifestyle on morbidity and mortality is well documented in literature. An active lifestyle is a significant predictor decreasing mortality risk and is an important factor influencing health. For these reasons, positive benefits of physical fitness in older age are repeatedly highlighted. Also, nutritional habits play a similarly important role in the health of older persons, who have nutritional needs unique from other age groups. In this group especially, poor nutritional habits may exert a detrimental effect. Promoting a healthy lifestyle is an important element in health education and, equally so, in health promotion.

7.5.2. Prevention of disease

Research on lifestyle issue is very often addressed within the context of disease prevention over all countries. The theoretical basis for prevention is frequently encountered in literature as addressed in Austria and Germany, which differentiates between the different forms of prevention. The following table presents these differences:

Overview 5:
Four stages of intervention

Intervention	**Primordial**	**Primary**	**Secondary**	**Tertiary**
Timing	In good health	With recognizable risk factors for disease	In preliminary and early stages of disease	Following treatment of acute disease
Target group	Total population	Risk groups	(Potential) patients	Rehabilitation patients
Objective	Influencing environmental conditions and lifestyles	Influencing parameters related to specific risks	Influencing causes and consequences of disease	Prevention of secondary disorders and diseases

Source: Hurrelmann & Laaser (2006, p. 754)

Disease prevention is frequently discussed in the context of health promotion. While the idea of disease prevention is to intervene at an early stage in life to prevent disease in later life is quite common, the assumption that prevention (of disease) is important at any age, also in older age, is relatively new. Consequently, senior citizens are also increasingly taken into account as target groups for the prevention of disease (Kuhlmey, 2006, 10; Walter 2006, p. 537ff). The main goal of prevention is therefore to not only to increase life expectancy, but also to increase active disability-free life expectancy as the Spanish report states.

A wide variety of diseases were named in the context disease prevention and health promotion, especially cardiovascular disease, cancer, dementia and hypertension. Other diseases relevant in this connection were for example obesity, diabetes, hearing and sight impairment, chronic pain, osteoporosis musculoskeletal changes and urinary incontinence (Kruse, 2002. Halbwachs et al., 2000; Noack & Reis-Klingspiegl, 1999; Garbe, McLeod & Buettner, 2000, Rieder, 2001. Pils & Neumann, 2006).

Recommendations for prevention of the diseases mentioned are promoting a healthy lifestyle including physical activity a health diet and elimination risk factors (e.g. obesity, smoking, hypercholesterolemia). Furthermore, literature in Germany recommended environmental adaptations and preventive screening. Articles in Germany and the UK highlighted the importance of comprehensive geriatric assessment in this connection. Literature in Poland

and Spain mentioned the importance of education initiatives led by professionals to prevent for example hypertension and cardiovascular diseases. Preventive home visits were especially recommended for those living alone in German and UK articles. More details on interventions which aim at preventing diseases as one of several goals are highlighted in the following sections.

7.5.3. Nutrition

The importance of nutrition as an integral part of healthy ageing was undisputed in all countries. A variety of literature was found on this theme among all partner countries. It is widely accepted that the lifestyle factor nutrition is important for one's health and wellbeing, that an unhealthy diet raises risk factors for major diseases and that health promotion can be (and sometimes: has to be) a strategy to prevent them (see preceding section).

There was a body of literature found on the **role of poor nutrition as a risk factor** for diseases and improving dietary habits as an important pillar for disease prevention (see also health determinants). Literature described poor nutritional habits as a possible cause of disease. Mostly, attention was paid to poor nutrition as being a risk factor possibly increasing the incidence of a number of diseases encountered in old age. The possible consequences of poor dietary habits, such as obesity, hypertension, diabetes, coronary heart disease, including increases in oxidative stress (Fletcher 2003), decreased cognitive aptitude and osteoporosis were described (de Jong, 1999, Pelikan, Nowak & Dietscher, 2002, Sheiham 2001). (see preceeding section)

Health promotion programmes addressing nutritional habits of older people are many times addressed together with other lifestyle elements, especially physical activity as well as preventing substance abuse, and smoking for example in Austria, Germany and Poland.

Problems among older people result from **worsening dietary habits, malnutrition, and dietary deficiencies** as mentioned in UK, Poland and Spain. Polish literature highlighted the poor knowledge of older people on proper nutrition, how lower socioeconomic status influences nutritional choices, and nutritional deficiencies in general (Kołłajtis-Dołowy, Tyska 2004; Kraus 2002). UK literature mentioned the difficulties certain groups have in choosing and eating healthy food, due to frailty (Tolson 2002) and associated access problems (Wylie 1999) which were also linked to locality (McKie 1999), and made especially problematic due to 'decentralisation' of food stores (Wilson 2004). Here it was also noted that vulnerable groups, for example those experiencing dementia (Manthorpe 2003), were especially susceptible to poor dietary intake.

A well-balanced diet was widely seen as being a protective factor and aiding in the fight against a variety of diseases. It is indisputable that healthy nutritional habits play a role in physical health, quality of life, and general wellbeing, all key factors in healthy aging. Nutritional habits are discussed foremost in the context of health promotion, undertaken as part of **health education**, the goal of which is to encourage the acceptance of healthy nutritional habits by older people and supposedly leading to a generally more health-conscious lifestyle. Promoting healthy nutritional habits is foremost done by encouraging and motivating the individual as well as increasing their overall **knowledge on nutrition** as

mentioned in Austria and in Spain. A variety of educational projects and publications directed towards older people, both popular and scientific, were found in Poland.

A wide variety on **educational strategies** was found in Austria, Germany, Spain, Greece, Slovakia and the UK with the main goal to promote healthy eating habits in older people. Specifically, focus was put on changing existing, negative eating habits (Czech Republic, Slovenia), teaching new positive eating behavior (Czech Republic, Poland, Slovenia, UK) and correcting existing dietary strategies to support positive dietary intake (Germany and Slovakia).

Specific strategies mentioned were for example integrated awareness raising programs concerning life-style factors (Dietscher & Nowak, 2001; Kiefer, 2004b). A German example mentioned taking advantage of media for providing information on balanced diets in older age; a Polish example talked about dietary advice in magazines and an example from the UK reported on distributing publications on a healthy diet. Apart from this the UK report mentions one-day information events (Amber Valley PCT 2005) and combining empowerment and reminiscence to produce a nutritional leaflet (Robinson 2000). Several examples in Czech republic, Poland, Slovenia and UK were mentioned on teaching healthy cooking and/or providing healthy recipes. A review article in the UK stressed the importance of health care professionals encouraging older people to eat and drink independently, linking this problem to lack of effective staff training (Copeman 2000).

Several **projects** dealing with nutrition in the period from 1996-2005 were found: In Germany: the “DHP-project”, “Active health promotion in old age”, in Greece: Senior Health Mentors; in Slovakia. “I am 65+ and happy to live a healthy life“, „Programme for Nutritional Enhancement of the Slovak Population”; “House of Heart” and UK: “Get Cooking!”.

In the project “Active health promotion in old age” participants received an analysis based on a standardised one-day nutrition protocol made by the dietician with suggestions for individual measures, especially recommendations on fluid intake and the consumption of fruit and vegetables. About 60% of participants were advised to drink more and to eat more fruit and vegetables. Participants were given the nutrition protocol with the aim to implement the recommendations in their daily lives during the following 6 months. An increase in fluid intake was achieved by 77% of the 293 participants who had been advised to drink more; increased intake of fruit and vegetables was implemented by 46% (Dapp et al., 2002b, 5ff; Meier-Baumgartner et al., 2004, 56f).

An interesting example in Greece, was the participation in an European project about Alzheimer’s disease and nutrition. A survey was carried out with 456 older people from 26 Open Care Centres for the Elderly (KAPI). An information package was developed, including a booklet with practical information, a leaflet and a time table. This information package aimed to help carers of old people with Alzheimer’s disease to prevent, to diagnose and to control loss weight of the person they care for. (Μούγιας Α., 2000).

An intervention study in the Netherlands examined the effect of interventions concerning nutrition and exercise on the nutritional and health status of frail older people. Administering nutrient dense foods combined with exercise, led to improved blood nutrient levels in the frail older people. Also, the results cautiously suggest that nutrient dense foods may have a beneficial effect on several bone parameters (de Jong, 1999).

In Slovakia, special emphasis was paid to nutrition of older people in the project “I am 65+ and happy to live a healthy life“ (WHO SR, 2004; Public Health Authority of the SR, 2005; Morvicová, 2006). Also, in Slovakia Health Counselling Centres offer counselling services on health nutrition. Almost 50% of clients taking up these services were over 45 (Ochabe, 2003). Support for healthy nutrition among older people is also included in the “House of Heart” project (Farský, 2001).

In the UK, the Food Standards Agency, Wales ran a large campaign which distributed 50,000 booklets, targeted at over-65s, called ‘Eat Well This Winter’, including recipes and nutritional information. Though the content was well received by the focus groups in the evaluation, it was clear that the campaign had not achieved much awareness among its target audience. A more interactive, longer-term intervention was a ‘Get Cooking!’ course designed by Sustain and run by Age Concern (Sustain 2000). Small groups of older people and psycho-geriatric referrals were led through a 10 week course which encouraged cooking skills as well as providing knowledge about nutrition and value for money.

7.5.4. Physical activity

Next to prevention of disease, physical activity was the most commonly found theme concerning issues of lifestyle. A broad number of positive outcomes were linked to engaging in physical activity. This mainly included underlining the many advantages arising from the participation of older people in physical activities, such as positive impact on general health as well as quality of life in general (Harland, 1999, Wegscheidler, 2004; Kostičová, 2002).

Literature in Austria, Slovenia, the Netherlands and Spain found positive influence of physical activity on mental wellbeing and mental health in older age, for example in dealing with psychological problems, or preventing social isolation (Reijneveld, et al. 2003, Schildhammer, 1996) Specifically, literature in Austria, UK, Poland and Slovenia suggests that physical activities, especially those performed in groups, clubs, etc., stimulate older people in their social relations and contact with their local environment, which in turn again influences health and quality of life in older age. Thus group physical activities protect older people from social isolation and prevent marginalization (Schildhammer, 1996, Polish Program “More fall in spring”). Literature in UK, Spain, Slovakia and Austria suggests that physical activity helps maintain a good functional state, ensuring independence and self-reliance even in advanced older age; improves endurance, physical strength and improves coordination (Halbwachs et al., 2000). A study in Greece could highlight the effect of a 12-week exercise programme for older women on balance and muscular coordination (Ourania, 2003). An in Germany Becker et al. (2006) describe positive effects on balance, walking speed and length of steps in people over the age of 75 as a result of regular, systematic training.

Articles in Austria, Germany and UK highlight that physical activity is instrumental in allowing older people to remain mobile and thus independent (Halbwachs et al., 2000, Becker et al., 2006, Malbut, 2002). Specific effects of physical activity, such as exercise was found in the UK, where some positive effects on preventing insomnia were observed (Montgomery, 2002).

Physical activity is also seen as a means to prevent a variety of diseases that are common in old age, such as cardiovascular disease (due to its positive effect on the circulatory system) or osteoporosis (Halbwachs et al, 2000). Physical activity can also help prevent falls, support the rehabilitation of dementia patients (e.g. in the Czech Republic) or be used in rheumatoid arthritis therapy (Hammond, 2004).

Publications dealing with physical activity devote much space to the different forms of such activity and special recommendations for older people. Sports and physical activity in older age does not necessarily signify forceful activity, but can also be recreation connected with, for example, keeping a garden as mentioned in Austria, Slovakia and Slovenia. Regular physical activity is always recommended, appropriate to the physical condition and functional status of the older person. It is repeatedly mentioned, that even those in advanced older age should not avoid devoting at least some amount of time to physical activity. In the Czech Republic and Slovenia, individualized training is recommended for older people, but in the context of group-oriented activities, especially considering the positive social effect. The most often recommended forms of physical activity are walking and longer distance walking trips, mentioned in Austria, Czech Republic, Poland, Slovakia, Slovenia and the UK, which often assume an organized, group form. Swimming is also recommended to older people in literature from the Czech Republic, Italy, Slovakia and Slovenia, as is dancing which is mentioned in Austria, Czech Republic, Greece, and Slovakia. Less often named sports include skiing, volleyball, and basketball. Attention is also paid to weight training and stretching, especially in the context of rehabilitation projects meant to improve dexterity in older people, for example in Poland (Kostka 2002; Żak, Mika 1997).

The fact that many older people do not engage in physical activities is mentioned throughout the literature found. In Slovakia it was found that the majority of older people not living at home rarely take part in physical activities and that organizing physical activities for older people is dependent upon the functional status and health conditions commonly encountered in advanced age (Ozorovský, 2002; Suchanová, Tirpáková, 2006). Research into why people tend not to participate in exercise programmes in the UK found that attitudes and fears about the limited abilities of older people to participate in exercise were predominant, as were issues surrounding access (Crombie 2004). An Austrian article highlights that those of lower SES are less likely to be active than those of higher SES (Pochobradsky, 1995). Restrictions in physical activity or the lack of such activity in older people is connected to cultural norms related to how leisure time is spent. In certain countries such as Poland, sport is not a popular form of physical activity. Thus, the issue of regular take-up of health promotion programmes for older people is one key issue to keep in mind when planning and organizing such programmes.

Quite a variety of projects and programs were described in different countries, some in connection with preventing heart disease. Several projects that were carried out in partner countries between 1996-2005 were described: Active health promotion in old age (Germany); Promotion of health and physical activity for persons of advanced age (Germany); The Groningen Active Living Model (GALM) (The Netherlands); More Exercise for Seniors (MBvO in Dutch) (The Netherlands); Healthy and Vital (The Netherlands); Revitalize your heart (Poland); More fall in spring (Poland); I am 65+ and happy to live a

healthy life (Slovakia); Ask your heart to move (Slovakia); House of Heart (Slovakia); Newcastle Exercise Project (UK).

The Groningen Active Living Model in the Netherlands (GALM) (e.g. de Jong et al, 2006) was designed to recruit and stimulate leisure-time physical activity in sedentary and underactive older adults aged 55-65. Interesting aspects are the special strategy for recruitment of the elderly for this program and the tailoring of activities to participant's preferences and needs. All potential participants received a written invitation and were screened during a home visit. More Exercise for Seniors (MBvO) (e.g. Stiggelbout, et al., 2004) is a moderately intensive exercise programme specifically designed for people of 65 years and older, offered once a week, that was started on experimental basis in 1966 and has been implemented widely since 1980. The goal is to promote optimal physical, mental and social functioning in older adults. In 2004, more than 300.000 older people over 65 years of age participated weekly in different aspects of this programme. Another Dutch programme, the Healthy and Vital programme consisted of health education and physical exercises and was adapted for Turkish immigrants. Education was adapted to the culture and knowledge of older Turks and offered by a Turkish peer educator, in Turkish (Reijneveld, et al., 2003).

In the German project "Active health promotion in old age" individual recommendations were provided by a physiotherapist on the basis of a standardized "activity protocol". More than half of the participants implemented the recommendations increased their physical activity in training for endurance, strength and balance (Dapp et al., 2002b; Meier-Baumgartner et al., 2004).

The project "Promotion of health and physical activity for persons of advanced age" carried out by the German Association for Excercise offers systematic training of strength, mobility and coordination to help persons over the age of 80 to cope with their daily lives as autonomously as possible. These training programmes are carried out in both nursing homes and at local sports clubs (Reglin in Stierle et al., 2005).

The 'Newcastle Exercise Project' used a randomised controlled trial to assess the effectiveness of various means of promoting physical activity such as brief interviews, more intensive, twelve week programmes of motivational interviewing, with and without financial incentives towards leisure activities (Harland, 1999). Whilst none of the modes of intervention produced statistically significant behaviour to the control, the more intensive mode was more successful in terms of behavioural change. The Dutch programmes described above, that were evaluated using a control groups design, also reported that results of physical activity were not always conclusive in comparison to the control group.

7.5.5. Sexual activity

Almost no literature was found concerning sexual activity in connection with health promotion for older people. No information was found in Germany, Greece, Spain, Netherlands, Slovakia and the UK. Sexual activity in older people still seems to be a taboo in the societies of the countries involved in the healthPROelderly-project and continues to be surrounded by a cult of silence, a fact which is mentioned specifically in the Austrian, Slovak and Polish reports. A number of stereotypes exist concerning sexual activity in older age, where the

majority of people consider older age to be devoid of sexual activity as a result of a general tendency to infantilize older people (Parlak 2000).

Two studies concerning the sexuality of older people were mentioned explicitly: One is a representative quantitative survey on *Age and sexual activity of the population of the Czech Republic under taken from 1996-1998* (Weiss/ Zvěřina, 1998). The other one concerns qualitative research on homosexuality among the elderly in Italy. Published in 2000, it investigated the psycho-social processes of ageing among homosexuals and highlighted how homosexual orientation can add additional stress or an act as a resource for adapting to life in old age. Generally, the question of homosexuality among the older people is not considered in Italian society.

A few general articles on the themes were mentioned in Austria, Czech Republic, Italy and Poland. These articles, for example in Poland, stress the relevance of sexual activity in older age and encourage older people not to resign from this type of activity (Dobosiewicz 2006; Oniszk 2006; Krajewska 1998).

Austrian literature states that sexual activity in older age is influenced by both physical and psychological health. Specifically, it is stated that older age and the passage of time bring about physical changes in the body, which may alter sexual activity (Przyklenk, 1996). Resigning from sexual activity is also connected with psychological health, where depression and other psychological problems may negatively affect sexual health (Eurag - Österreich,--).

7.5.6. Substance abuse (e.g. smoking, alcohol, drugs)

The topic of substance abuse, in terms of smoking, alcohol and drugs was a theme that was addressed very rarely in literature found concerning the health promotion of older people. Generally, for example in Germany the subject of addiction in old age, referring mainly to **alcohol and drug dependence** has been neglected (Weidner et al. 2004). In Austria literature has stated that preventing risky behavior like smoking or drug abuse should be an important part of individual health promotion also in older people (Pelikan et al. 2002) and that one task of health promotion is to provide for healthy environments such as smoke free areas (Rieder, 2003). Various studies in the UK suggest that excessive alcohol consumption amongst older people may for a “silent epidemic” (O’Connell, 2003). Despite this, in most participating countries almost no interventions addressing alcohol and drug abuse of older people were found.

The **lack of interventions addressing substance** abuse seemed to be due to two issues. One is that older people tend to consume less alcohol, tobacco and other addictive substances than people of some younger age groups. In the “health monitor” study in Germany, the 74% of people aged 45 to 79 interviewed are non-smokers and 78% consume alcohol only moderately or not at all (Kruse, 2004, p. 75). The other issue seems to be that like sexual activity and elder abuse, addiction among older people is also a taboo topic, reported rarely and thus not visible. Another issue which was not visible in this literature search was the issue of excessive or wrong use of medicines by older people.

The most frequently mentioned area of substance abuse in connection with health promotion of older people concerned **smoking**. On one hand it was stated that in some cases old age marks an end to smoking. Studies in Czech Republic, Slovakia and Germany find that

smoking in older age is a rare occurrence (HIS 2002, Kruse 2004, Kontrošová et al, 2002). Compared to dealing with alcoholism and drug abuse, the great amount of attention paid to stopping smoking can be explained by the role it plays in mortality and morbidity (Robert-Koch-Institut, 2006). It is a significant risk factor for cancer, cardiovascular diseases, and Chronic Obstructive Pulmonary Disease (Helmert, 2003; Biskupska, Wysocki 2004). Mostly, interventions were mentioned that were directed at all age groups.

Literature in Austria and Germany addressed individual changes in behavior and other actions which may combat nicotine addiction, such as developing health environments for example smoke-free areas. The value of social support in remaining a non-smoker was mentioned specifically in Poland (Broszkiewicz, Szymańska, Pikala, Drygas 2004). General interventions concerning smoking were addressed in Germany, Poland and Slovakia. In Germany for example the national health target of reducing tobacco consumption 8 addresses the population as a whole and includes several partial goals. A program in Slovakia, “Quit and Win” (SK), was targeted to the general population, including older people as a sub-group. The goal of this program was to encourage a smoke free lifestyle.

Different methods used to promote a smoke-free lifestyle included, among others, developing a positive image on non-smokers, encouraging physicians and pharmacists not to smoke, and using mass media to broadcast the negative health effects of smoking. These interventions were found to be effective, especially due to the active participation of general practitioners. However, most interventions targeted the general population with a focus on young people and do not target older people specifically.

7.5.7. Safety (e.g. prevention of falls, accidents, injuries)

A substantial amount of literature over all countries addressed issues of safety, specifically the prevention of falls, accidents and injuries. Most of this literature concerned prevalence, risk factors of and measures to prevent falls. Apart from that, single issues are mentioned such as preventing bed sores (in Italy and Greece), preventing poisoning (in the Czech Republic) and the issue of older drivers and preventing car accidents in old age in Austria (Bukasa & Panosch, 2006).

Falls in older people were seen as a serious problem throughout the participating countries. The Dutch reports highlights the fact that many older persons are involved in falls each year which result in serious health problems: About 1700 persons in the age of 55 years and over die each year, 27.000 are hospitalised, 67.000 are treated at the emergency departments of hospitals and 48.000 are treated by the general practitioner for falls (de Boer 2006). Apart from mortality and costs for treatment the **consequences of falling** include bone fractures (especially in women with osteoporosis) (Wildner et al., 2005, Augustyniak, Szymanowicz

[8] http://www.gesundheitsziele.de/xpage/objects/tabak/docs/1/files/030214_bericht_final1_ag6.pdf dated 15.12.2006

2004), the negative influence of falls on identity and autonomy of the older person, loss of mobility and independence (Coll-Planas et al. 2006).

It is highlighted in different reports that falls are usually the result of **multiple risk factors**. The need to identify and modify these risk factors is mentioned in the Dutch, Spanish, German and UK reports. The most often cited causes of falling include excessive alcohol consumption (Patton, 2002) and economic deprivation (Pearson, 2004), cognitive impairment, declining mobility, and the, practice of taking large amounts of medication, which is often encountered among older people (Austrian Report). In a mass media campaign in the Netherlands on preventing falls in people 55+ women, frail older people, and individuals of low SES were identified as groups at the highest risk of falls in older age and targeted specifically (Wijlhuizen, 2005). A study in Germany involving a group of older people living at home, identified a history of previous falls and the need for assistance when taking a bath as important indicators for an increased risk of falls. The need for assistance with this activity can easily be identified by professional care-giving staff and is therefore a reliable indicator for an increased danger of falls (Coll-Planas et al., 2006). The Polish report highlights that the risk of falling occurs most often among people living in social welfare homes (Zak, 2002).

The importance of addressing interventions to specific **target groups** is highlighted with respect to the prevention of falls in several different reports. In this connection falls prevention for people suffering from dementia is mentioned in the German and Greek reports. In Germany a need for further research on falls prevention for senior citizens suffering from dementia and those targeting groups of blind and visually handicapped senior citizens was identified (Becker et al., 2006). The Greek report mentions that three out of nine articles on falls prevention address specific issues for people with Alzheimer's disease. In Germany, one intervention was reported that was targeted towards people with visual impairments (Deittert et al., 2000).

Also, in Germany gender differences were found in the way in which older men and women fall. Women had the tendency to fall during daily housekeeping, while men fell during leisure activities outside the home (Freiberger & Menz, 2006). Most falls do not require medical attention, especially if they happen to a physically fit individual. Women, more often than men, seek medical attention following a fall.

In the UK, two recent reviews note the importance of tailoring interventions to a precise group of older people (Skelton 2003; McInnes 2004). This was found to be important in terms of the likely participation of older people in such programmes, as well as the actual effectiveness of the programmes themselves: "It is clear that the target population must be at risk or already fallers, they must be "not too fit" and "not too frail". Supervised home-based exercise programs may be effective in those aged over 80 because they fall more frequently, injure more easily, and recover more slowly. In younger, community-dwelling, fallers multifactorial group interventions including targeting of balance, strength, power, gait, endurance, flexibility, co-ordination and reaction may be more effective" (Skelton 2003 p. 77).

A wide variety of **programmes to prevent falls** were mentioned in Germany, the Netherlands, Italy, Poland, Spain and UK. These usually used a combination of methods to prevent falls and addressed different target groups. Reports from Spain, Netherlands and UK found complex and multidimensional interventions which targeted the individual (e.g., muscular frailty, balance problems) and environmental (e.g., conditions of urban setting)

determinants of falling at the same time. Reducing architectural barriers and adapting the environment to meet the needs of older people with decreased mobility as a means of falls prevention were highlighted in Italy and Germany. Programs for walking and physical and strength training were carried out in Germany, UK and Poland.

The Ulm project in Germany aimed at improving mobility and preventing falls in older persons in need of assistance and nursing care living at home. The interventions in this pilot project included training sessions that took place in the participants' homes. As a next step, training continued in groups. Also, the home environment of some participants was adapted and participants were informed about devices to protect their hip bones. By means of mobility training, a significant reduction in the frequency of falls was achieved among the participants. The frequency of hip joint fractures and other fractures also fell below expectation for the test group (Becker et al., 2005, 3).

In Italy, a project in Calabria has been designed to reduce the number of accidents in the home over a period of three years, giving incentives for the installation of security measures, initiating programmes for adapting home environments, starting a publicity campaign and introducing an epidemiological surveillance system to monitor the issues of home accidents. Also in Italy, the Public Health Agency of the region of Lazio has established guidelines for general practitioners to help prevent accidents in the home.

In the Netherlands several thoroughly evaluated programmes in the area of falls prevention have taken place, amongst others a mass media campaign on prevention of injury among older people which was launched in 2006 (see above). Another interesting research project focused on the preventive effects of house calls to older people living independently in their own homes; a high risk section of the population with regard to falling or mobility impairments (Haastrecht, 2002). In this experiment, 316 people of the age of seventy and older were randomly allotted to either an intervention or control group. The intervention group was visited by the district nurse 5 times throughout the course of one year. Risk factors with respect to falling and mobility impairments were determined and measures were taken to decrease these risks. The research showed that these house calls did lower the risk of falling and of mobility impairments.

The "Stop Falls" programme in Poland (Augustyniak, Szymanowicz 2004), was aimed at safely and effectively mobilizing seniors and at the same time minimizing motor imbalances (Rajewska – Twardowska 2006). The main goals were to prevent falls and prevent femur fractures (the most often encountered fracture among older people), educating older people how to prevent falls, how to fall safely, and how to prevent osteoporosis.

The Coventry City Council "Keeping Active" Programme in the UK combined information booklets on falls prevention with free-vouchers to encourage older people to take part in exercise sessions as well as address the difficulty of accessing sports centres experienced by older people, especially ethnic minorities (Chartered Institute of Environmental Health 2006).

7.5.8. Preventing abuse against older people

The issue of preventing abuse against older people is practically not addressed in literature on health promotion for older people. Germany, Greece, Slovakia and UK reported not finding any literature on this topic within a health promotion context, the Netherlands reported one article in this connection.

Generally the topic of abuse against older people is considered taboo and is not visible in public debate. Some reports, such as those on the Czech Republic, Slovakia and Slovenia reported the growing relevance and starting debates in their country on this issue in general.

Abuse against older people takes place in different contexts, e.g. within the family or in institutions. Regardless of the context of abuse, the role of professionals in preventing and recognizing abuse is crucial. This is mentioned in reports from the Czech Republic, Italy and Spain. The Spanish report also mentions that violence against older people can emanate in the context of difficult care situations and that supporting care-takers should be included as a vital element of any measure to prevent abuse against older people.

7.5.9. Other issues

Other issues that were mentioned in the frame work of lifestyle concerned work place health promotion for older people and adapting an older persons environment to improve independence and autonomy.

Changes in working conditions: for example, the *ABI Project* (Tempel & Giesert, 2005,) is a health management system taking account of the ageing process, it was established in three medium-sized enterprises in North Rhine-Westphalia.

Adaptations of home and environment were mentioned in two interesting project: “Enabling Autonomy, Participation and Well-Being in Old-Age: The Home Environment as a Determinant for Healthy Aging“ (ENABLE-AGE). This EU- project studied the effect of the home environment on healthy ageing of persons at a well-advanced age living alone in urban areas. It was shown that in Germany, as well as in the other countries participating (Sweden, Latvia, Hungary, UK), the adaptation of the environment to the individual is significant for healthy ageing (Oswald, Naumann, Schilling & Wahl (2005). “Prevention in Old Age” assists elderly and disabled persons with remodelling their homes into barrier-free residences (Kreuter in Stierle et al., 2005).

8. Transversal issues

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This section focuses on emergent issues that tended to cut across the main themes analysed in the previous section. These were research methods, health promotion strategies, settings, inequality and diversity, sustainability, cost effectiveness and consumer involvement. Some of these themes were also amenable to subdivision as before, and quantitative information is also provided giving frequency distributions.

8.1. Overview

When we look at the different countries there are some interesting comparisons between the relative visibility of the transversal themes. The voice of older people was the most often mentioned transversal issue in papers found in the UK (45%), Austria and the Czech Republic (about 30%), and Greece (20%). Gender was the most often described transversal issue in Slovenia (found in 100% of papers) and Germany (almost 50%). Sustainability was the most often described issue in Poland (40%).

The voice of older people was the second highest in Germany (40%-), the Netherlands (34%), Italy (30% -), Slovakia, and Slovenia (about 30%,). In other countries, this issue was mentioned in at least 14% of papers. Diversity was often mentioned in Slovenia (almost 50%) and in Germany and the Netherlands (over 30% of papers). Gender was a transversal issue, popular in Austria, Spain, the Netherlands, and Poland (over 20%,). Multidisciplinarity was touched upon in 60% of papers in Slovenia and in about 20% of papers, respectively, in the Czech Republic, Germany and Austria. In all countries, health promotion projects were described in at least 10% of papers. Inequality was often mentioned in Slovenia (over 40%) and Germany (33%), Austria, Poland, Slovakia, and the UK (over 20%). Sustainability was a popular issue in Slovenia (over 65% of papers), Slovakia, Germany, and Spain (about 40%, respectively). In almost all countries, with the exception of the Czech Republic, this issue was mentioned in at least 10% of papers. Cost effectiveness was mentioned in some form in about 30% of papers, respectively, in Germany, Spain, and Italy. In other countries, this issue was described in no more than 13% of entries. Sustainability, diversity, inequality and consumer involvement (voice of older people) show an increasing tendency during the researched period, while gender, multidisciplinarity and cost-effectiveness display are constantly present over time.

8.2. Research methods

This section attempts to identify different research approaches used in the literature in relation to health promotion of older people. This focused mainly on two areas, methods that evaluated health promotion projects that had or were in the process of being implemented, and methods used to identify the evidence-base for interventions or justify their need. As with other sections, a quantitative breakdown will be provided, followed by a more descriptive thematic account detailing with country specific findings and examples.

Overall, quantitative analysis highlights the general lack of identifiable research approaches used in the field of health promotion activity. 19% of papers described health promotion projects using qualitative research methods and 29% using quantitative methods. Only about 5% of papers described health promotion projects evaluated using both methods. It was difficult to assess the research method used in the case of 10% of papers. 10% of papers mentioned other research methods and 16% did not list any method.

Table 12:
Research method

	Frequency	%
None	290	16,2
Qualitative	342	19,1
Quantitative	517	28,9
Qualitative and quantitative	82	4,6
Don´t know	363	20,3
Other	193	10,8
Total	1788	100

Qualitative methods of research were mostly used in Slovakia (over 70% of papers described projects using this method), Germany and Italy (about 50%, respectively), the UK, Greece, Spain, Austria, and Poland (20% of papers, respectively). Quantitative approaches were more evident in the Czech Republic (40%), the Netherlands (35%), and Slovakia (30%). It must however be pointed out that the content of the concept “qualitative methods” was probably not uniquely defined and differed from what is usually considered as qualitative research in psychology and/or sociology.

Project Evaluation

With reference to project evaluation, quantitative analysis shows us that over 60% of the entries included in the literature database were not formally evaluated. This was very probably affected by the diverse type of the final database which gathered both the practical implementation of health promoting activities (described in a project) and scientific as well as mass media articles. However, it is clear that the database reflects the general difficulties experienced by the research community in identifying valid and reliable health-enhancing indicators directly related to health promotion project outcomes. In the case of 10% of articles or other items, outcome evaluation was available and surprisingly, only 3% of papers were listed as process evaluation. In the case of almost 10% of papers, quantitative evaluation was used and, in the case of only 3% of articles, qualitative evaluation. In the case of over 7% of papers, a combined evaluation was applied.

Table 13:
Project evaluation

	Frequency	%
No evaluation	1.080	60,4
Qualitative evaluation	55	3,1
Quantitative evaluation	176	9,8
Outcome evaluation	180	10,1
Process evaluation	41	2,3
Dk	117	6,5
Other	2	0,1
Combinations	137	7,7
Total	1.788	100

The highest number of papers without a formal evaluation was found in Poland (over 96%), Spain, Austria, and Greece (over 70%, respectively). In the case of Poland the result is caused by the high rate of magazine articles. There was no mention of evaluations in a large number of articles concerning health promotion projects conducted in Germany (almost 65%), and Italy (over 45%). All articles found in Slovakia contained evaluations of the described projects. All but one program used an evaluation in the UK. Also in Netherlands the number of entries without the evaluation is relatively low (23%).

With reference to the research methods used in the evaluations, quantitative evaluations were found mainly in the UK (almost 50% of papers) and in Austria, Czech, Italy and Slovenia (13-17%, respectively). In the Netherlands (50% of papers) and the UK (over 40%), mainly the program outcome was evaluated. This method of evaluation was also conducted in Italy (almost 20%) and the Czech Republic (10%). Process evaluations were more frequently conducted in the Netherlands (described in 15% of papers) and Slovenia (almost 10%). Combined evaluation were also mainly done in the Czech Republic (30%), Germany and Greece (about 25%, respectively), and Spain (10%). Qualitative evaluations were found in papers gathered mainly in Slovenia (over 66%). In other countries, qualitative evaluations were mentioned in no more than 7% of papers. In 8% of items it was not possible to describe the form of evaluation, though it was evident there was some.

A closer examination of the literature supports the quantitative analysis and reveals that for most countries rigorous scientific research aimed at the measurement of health promoting effects was not prevalent. In Austria for example, more than half of their project literature was not evaluated and a quarter failed to mention evaluation methods or intention at all. In Slovenia, most of the literature contained theoretical papers or the results of case studies. The nature of health promoting interventions does appear to militate against this and unless the projects are amenable to physical or cognitive measurement using randomised controlled trials, there are considerable difficulties proving health-enhancing benefits. Health promotion projects address a number of issues in different contexts, and the range of influential variables at play can thwart an accurate evaluation.

Despite this, evaluation has been conducted in some countries and the following gives examples of those using purely quantitative or qualitative approaches, and examples using mixed methods. It is clear however that in some countries where the database indicates the presence of evaluation, the actual quality of this evaluation is under question in the descriptive account and examples are not explicit.

The use of randomised controlled trials (RCTs) or quasi-experimental design was evident in the Netherlands, the UK, Greece and Germany, but this approach can only be suitable for focused interventions usually looking at one or two physical indicators. In the Netherlands for example, quasi-experimental designs were most evident for the evaluation of exercise programmes. Here, the effect on the experimental group of a health course in exercise was compared to those on the waiting list, receiving no exercise. Measurement of effectiveness was dependent upon self-report questionnaire given at stages throughout the course. Outcomes have been inconclusive, and one explanation for this is that older people may need longer to adapt to the programmes than the project duration allows for (Stiggelbout et al 2006). However, analysis in Italy concludes that research methods that rely on self-report or self-assessment cannot always be viewed as reliable and may be of limited value.

In Germany, RCTs were also used to evaluate exercise initiatives and general prevention programmes focusing on aspects such as nutrition and counselling within home visits. Evaluation techniques used a variety of methods such as psychometric tests, self and professional assessments and analysis of documentation. Such a range of techniques has the potential to provide a more comprehensive outcome picture. In the UK, the majority of interventions focusing on mental ill health used evaluation methods such as depression scales. It was noted that, while these methods have been rigorously validated, there remains

the possibility that aspects of the experience of people with mental illness can be overlooked if only quantitative measures are used, resulting in an incomplete evaluation of potential health enhancing effects.

Other health promotion project evaluations using quantitative methods (not RCTs) were evident. In the Czech Republic a project was conducted by medical staff and consisted of before and after measures of health status. Satisfaction surveys were also used here and are in evidence elsewhere, but their reliability, validity and representativeness was considered to be low which subsequently reflected on the plausibility of the results.

Qualitative approaches to evaluation were used to reveal more about the experience and process of the intervention rather than tangible health effects. In Spain, this approach is put forward as an important means of not only evaluating but designing programmes according to the realities that exist. In this respect, in the UK, these methods were often used to research an issue around the topic of health promotion rather than in the evaluation of an intervention. Ballinger's (2002) study for example looked at the construction of risk of falling by older people. In other countries, qualitative methods were used mostly within interventions concerned with cognition, such as reminiscence (The Czech Republic), and counselling (Austria). Across the countries, a range of qualitative methods were used to extract information, such as reflective journals, focus groups, health panels, and expert interviews to reveal personal benefits and progress attached to particular treatments or approaches to problems.

There was less mention of combined qualitative and quantitative approaches to evaluation. This is despite the fact that this is increasingly considered the method of choice in order to capture the different angles of potential health benefits, given the multi-faceted dimensions of health promotion projects. In the UK for example, questionnaire type approaches were combined with more open-ended questions administered through interviews or written responses. The most multi-method and detailed analysis of an intervention found in the UK was offered by Caiels (2005). By implementing a quantitative assessment based on falls data and changes in physical capacity, combined with qualitative responses from service users, an effective insight was offered both of what works and why.

Evidence-based Projects

These difficulties experienced regarding evaluation are connected to the extent to which projects that were implemented were found to be based on evidence of effectiveness, thus intimating that there is a 'circle of deficit' in this area. In Germany, authors such as Hurrel & Laaser (2006) note a lack of foundation upon which health promotion activity is based, stating that in most cases systematic empirical verification of approaches and programmes has not yet taken place. Our investigation seems to verify this statement.

In the Czech Republic and Austria for example, rationalising health promoting activities relied on well-known WHO concepts or other established theoretical frameworks. Increasingly, given the difficulties with ascertaining evidence of effectiveness in this area however, there was a demand for evidence of cost-effectiveness to justify project implementation.

8.3. Health Promotion Strategies

Within this section there appeared to be a range of different factors that constituted health promotion 'strategy', influencing the project plan, composition and direction. These could be clustered under the following headings: *policy imperatives; goals of the project; provider strategies; target population; and techniques/interventions.*

Policy imperatives

Both Austria and Germany cited the Ottawa Charter as being influential in underpinning direction in health promotion strategies. Particularly in Austria, strategies of advocacy, enablement and (to a lesser extent) mediation were evident in the national health promotion literature on older people (Dorner & Rieder 2004). In the Netherlands, the main focus of government policy is centred on the responsibility of the individual for their own health behaviour, hence some strategies have a tendency towards motivating people to choose a healthy lifestyle. In other countries such as Slovenia and the UK, health promotion programmes are oriented towards specific disease-focused public health trends such as cardiac disease, cancer prevention, diabetes and osteoporosis. In Slovakia there is increasing emphasis on improving older people's living situation, and as a consequence the emphasis is put on achieving their self-sufficiency, and increasing social participation, integration and autonomy through changes in social policy, as well as in society. For this reason various campaigns (one day, weekly or monthly each year) or competitions are also used to focus societal attention on the elderly population.

Goals of the project

This section covers a range of intended health outcomes focusing largely on potential personal health and social benefits (including the accumulation of skills), but also includes some environmental benefits.

With reference firstly to personal benefits, these centred in all countries on the acquisition of a range of skills to promote behavioural change towards a healthy lifestyle. Goals would include physical, psychological and social improvements and the emphasis on the different aspects varied between countries. In Germany for example, projects were found that targeted mostly physical health, and at a secondary level aimed to empower and enable older people. In other countries such as Austria and Poland, there was more of an emphasis on the goals of enabling or empowering older people, through for example helping them to learn practical skills (e.g. Halbwachs et al 2000) or promoting health through the medium of social groups in Third Generation Universities. Environmental benefits were mentioned infrequently, but were located in Italy through a regional project that aimed to reduce hardship caused by unpredictable climate changes.

Provider strategies

There were two strands to this section. A number of countries highlighted the organisational importance of having a clear strategy for who would deliver the project; and others outlined

strategies for the provision of training to providers with the aim of improving the delivery of health promotion interventions.

With reference to **personnel delivering the project**, there were a range of individuals and organisations involved. Some projects were interdisciplinary and holistic and others uni-professional; some used informal carers and volunteers, and others religious organisations. In many countries (e.g. the Czech Republic, UK, Italy the Netherlands) health promoting activities are delivered by physicians, community nurses and social workers, sometimes individually and other times collectively in a multi-disciplinary approach. A singular finding in the UK was that more effective, holistic strategies of health promotion tended to originate in multi-agency working (Parle 2002). In Greece, there are alternative delivery agents, as health promotion is mainly supported by the Ministries of Education, Health and Welfare or by associations such as the Hellenic Association of Gerontology and Geriatrics. A number of initiatives in Poland are organised and delivered by local churches. Parishes, priests and pastors organise support groups, informal education centres, clubs, pilgrimages, and holidays for older people.

Selecting properly trained individuals to deliver interventions is closely connected to successful outcomes. In the UK, a study indicated that a community team was not significantly effective in improving depression scores (Arthur 2002), perhaps due to a lack of training amongst the professionals in dealing with older people (ibid). This hypothesis is given weight by the positive results of another randomised control trial, this time involving a psycho-geriatric team (Banerjee 1996). Another intervention, through community nurses who regularly work with older age groups, also seemed to be effective in relieving depressive symptoms, especially in long-standing cases (Blanchard 1995). From the UK literature therefore, a 'fit for purpose' strategy seems to be key, ensuring that as far as possible staff have the necessary skills for the job.

In recognition of this and with reference now to the **training of those delivering health promotion**, advanced training of staff members in various medical and nursing professions can also be seen as a health promotion strategy. Many countries organise training courses and workshops to keep staff up-to-date with health promoting practices. In Germany for example, health promoting, rehabilitative and palliative aspects are becoming more prominent in professional education (Apitz & Winter 2004) and in Slovenia, gerontology is part of undergraduate and postgraduate programmes for many professionals. In the Czech Republic, courses are organised not only for health professionals, but also for informal carers such as family members, either to improve the quality of care, to prevent 'burn-out' and to prevent elderly abuse. Polish literature has an emphasis on educative articles that discuss techniques for working with older people and imparting rehabilitative methods for people with disease-specific conditions. In addition, here too is advice for carers on disease specific conditions, how to encourage physical activity among older people and how to guard against social isolation.

Target population

Most countries acknowledged that health promotion strategies needed to be accommodated to the recipients and differed between healthy citizens and those with degrees of ill health, social incapacity or pathology. There were a wide range of recipients of health promotion that

could be categorised into different groups and geographical locations. Aside from healthy population groups, target populations were grouped socio-culturally (e.g. socio-economically, ethnically, gender-based), within disease groupings (e.g. cardio-vascular, dementia), according to size (e.g. individually, within groups or communities) or within a specific or general geographical location (e.g. nursing homes, local area, region, city or nationally).

Techniques/interventions

This section outlines and provides examples of the vast range of approaches used as part of health promotion strategies. In summary, the large majority of countries used health education (or health communication) techniques as a primary instrument for health promotion through the distribution of verbal or written information within a counselling or educative forum, media campaigns or the more novel use of competitions (in Slovakia). The Czech Republic sums up the general view that the traditional use of health education by the means of lectures, exhibitions and seminars is wide spread, and health education in the sense of providing relevant health promoting information to the recipients is remarkably high. However, health education is more likely to be the techniques of choice in those projects which are organised by medical and health staff while the non-medical providers are more often using the practical teaching of new skills and competencies.

This Polish literature offers a number of published examples of health education topics aimed at older people. Authors of publications marketed to older people often provide practical advice on how to exercise, how much time to devote to physical activity, and how to prepare healthy food (including recipes). Articles on cognitive activity include memory tests and memory exercises. In general, older people are encouraged to learn and try new things. Also, articles generally directed to anyone wanting to live a long and healthy life discussed smoking and alcohol specifically in the context of potential health complications resulting from use.

In the UK, in terms of health education, interactive approaches were preferred over simply providing information. Only two interventions were implemented which relied solely on promotional material, one by a local council to encourage exercise and active lifestyle (Chartered Institute of Environmental Health 2006), the other to encourage wellness during winter, focusing on healthy eating (Food Standards Agency – Wales, 2001). All other health education was done through interaction with older people, occasionally through one-off events (e.g. Amber Valley PCT 2005), though usually over longer timeframes.

Despite this prevalent use of health education, literature from the Netherlands comments on its efficacy as a health promotion strategy. Research shows for example that there is reason to doubt the effectiveness of these strategies. Kok (1997) conducted a meta analysis on the health education programmes and indicated that, while these interventions generally have substantial effects for primary and secondary prevention, and patient education, learning principles such as rewards and feedback, that have been shown to increase effectiveness, are often not or not adequately applied. Also, too few interventions focus on possibilities to facilitate the desired behaviour (such as reminders, financial stimuli, and skills improvement). The potential effectiveness of interventions in practice may be increased by systematic development of adoption and implementation strategies, including the creation of 'linkage

systems' between intervention developers and representatives of the target and user systems.

Aside from health education, interventions directed at physical or psycho-social improvement used forms of specific therapy, such as exercise, strengthening, reminiscence, music, occupational, rehabilitative and recreational. The Greek literature identifies that physical activity, occupational therapy, music therapy and speech therapy were the main strategies of health promotion, in which older people actively participated.

In addition, other strategies focused on preventive techniques such as screening, falls prevention, the use of spas, and developing coping skills. With respect to the latter, recent research in the Netherlands studied the relationship between proactive coping and successful ageing (Ouwehand, 2005). The results showed that people between the ages of 50 and 70 can prepare themselves for the difficult aspects of growing older, and possess the problem-solving and analytical skills to take proactive coping measures and that particular groups of people benefit more from receiving information on or getting trained for coping with their old age.

From a primary and secondary preventive perspective in Poland, popular media and web-pages often devoted a number of articles to diseases affecting older people, describing their symptoms, giving advice on observing one's own body, and the necessity of visiting a physician should any symptoms arise. These media give lifestyle advice and advice on how to deal with diseases already affecting a person (e.g. exercises for those diagnosed with Parkinsons disease). The analysed literature also gave advice on prophylactic health tests, such as which tests should be done at what age, which medical specialty to turn to, what a given test looks like, and so on.

8.4. Settings

Overall most health promotion activities by far took place in the community setting, the next frequent setting was people's own homes and then residential homes.

From the whole sample, over 25% of projects were held in a community setting (i.e., city, region). Almost 23% of papers did not mention the setting in which health promotion projects take place and assessing the setting was difficult in the case of further 20% of papers.

Health promotion projects described in these papers were held in a community setting mostly in the UK (almost 80% of papers), Italy and Slovakia (over 50%), Slovenia and the Netherlands (over 30%), and Spain (over 25%). In Poland and Austria the proportion of health promotion projects implemented in a community reached more than 12%, respectively. Only in the Czech Republic were people's homes the most often described setting (30%), which might have been caused by a different classification approach. Similarly, in the Czech Republic in a relatively high number of projects the setting was classified as residential homes for older people (20%). "Other" settings were often mentioned in Greece, constituting the most often used category, the Netherlands and Spain (over 20%), as well as Slovakia and Poland (over 10%).

However, there were several variations by countries with respect to the settings that are relevant to health promotion of older people. In Italy it was mentioned that most of the

literature on health promotion of older people focused on small local areas and that other settings were generally less relevant. Quite a large number of health promotion activities took place in nursing homes in Poland, Slovenia and Czech Republic, while less activities in residential homes were reported in the UK. A specific focus on work place health promotion for older workers was found in Austria and Germany, that was not present in any other of the other participating countries.

Table 14:
Settings

	Frequency	%
Not mentioned	408	22,8
Workplace	36	2,0
Residential homes for the elderly	98	5,5
Community (e.g. city, region)	496	27,7
Neighbourhood	1	0,1
School	8	0,4
People´s own house	112	6,3
Don´t know	357	20,0
Combinations	88	4,9
Other	184	10,3
Total	1.788	100

Community settings

While the community is a broad term, it can be said that for example in the Netherlands, many health promotion projects for older people are organized and take place in municipalities. In Germany, the municipal setting has proved particularly effective for older people. In addition to the possibility of implementing behavioural as well as environmental preventive measures, it is easier to reach vulnerable target groups (such as older persons living alone or migrants) as well as the relevant actors (such as companies or welfare organisations) here. However, there is still the need to include older people in as a target group for municipal health promotion more frequently in Germany (Naegele, 2004).

In Austria a number of health promotion projects with a community setting approach was found (Amann et al., 2005; Bukasa & Panosch, 2006; Diketmüller & Kolb, 2003; Dorner & Rieder, 2004; A. Rieder, 2003; J. M. Rieder, 1999; Sprenger, 2005). Their overall goal is on the one hand the enhancement of independence and individual responsibility for one's health and on the other hand the making available of social support and respective contexts (e.g. telephone hotlines, rooms, brochures, walking miles, cookery books, practical activities etc.) for promoting older people's health. One Austrian health promotion project aimed at empowering older people in the community setting (Amann et al., 2005). It contributed to a positive reception of elderly people in society, reduced the feeling of social isolation and increased the number of social contacts of older people in an urban setting.

In some countries, specific organizations are involved in health promotion for older people within the community. For example, in Greece most health promotion activities for older people are carried out within the KAPI's: "open care centre's for the elderly" as it is considered that most Greek older people visit them at some point in their lives. In Slovakia Regional Public Health Institutes, clubs and civic associations are engaged in this field, while Slovenia reports day centres that offer several different programmes for older people. In the UK, interventions targeting those living in the community are channelled through a number of contact settings. These range from pharmacies (Bellingham 2001), to community centres (Froggett 2005).

Some health promotion activities in the community focus on certain **professional groups.** In Germany, GP-oriented approaches to health promotion are based on the idea that the family doctor is an important and generally accepted contact person for the elderly. Therefore projects such as "Active health promotion in old age" (Dapp et al. 2002) or "Preventive home visits" (Meier-Baumgartner et al. 2004; v. Renteln-Kruse et al., 2003) are frequently based on cooperation with local general practitioners. Moreover, such measures were often implemented in the context of municipal settings, as was, for instance, the case with the DHP project one of the best-known examples of municipality-related measures of prevention and health promotion (DHP, 1998, 287ff). In Slovenia, community nurses visit the elderly at their homes regularly on the basis of a plan prepared for the elderly as a preventive measure and as support for their independence. The basic health promotion related principles of community nursing are: a holistic approach, assessment of the health needs of individuals, families and local as well as health education and support to healthy life style.

People's own homes

A setting which is closely connected to the community concerns people's own homes.

One aspect of people's own homes as a setting of health promotion for older people concerns **addressing those older people who are not likely to take part in community-based programmes** of their own accord.

In UK literature, the effectiveness of using the home as a setting for health promotion activity has been questioned, especially in terms of mental health where the evidence for individual focused interventions remains unclear (Cattan 2005). However, it is clear that more effort needs to be made to engage those who are not reached by such activities. Accessibility of community-based health promotion activities would seem to be important in this sense, both

in terms of physically getting into the building (Caiels 2005) and having available transport for those who may live some distance away, especially rural dwellers (O'Hara, 2005).

Another aspect of the home as a setting is the need to adapt the home **environment** in order to prevent accidents and support independent living. This is mentioned in Germany as well as Austria where it is stated that Homes of older people need to be in a secure condition (e.g. no cables across the floor, secure bathrooms, safe carpets etc.) in order to prevent falls or other injuries due to constructional failures (Österreichischer Seniorenrat, 2003).

The home environment of older persons is a suitable setting for behavioural as well as environmental preventive measures. Preventive home visits were mentioned in Germany as an example in this context, since they generally address both aspects mentioned. The community nurses, who visit older people in their own homes as a preventive measure in Slovakia are also relevant in this context.

Nursing home settings / Hospital

There seem to be some differences in countries in the extent to which health promotion for older people takes place in nursing homes and in hospitals.

In Poland encouraging an active life-style in older people most often takes place in social welfare homes and day-centres for older people. There are also rehabilitation interventions which take place in hospitals. Apart from Poland, Slovenia Czech republic and Germany reported health promotion interventions for older people in nursing homes.

In Germany several interventions were carried out in nursing homes. In addition to measures to prevent falls and promote mobility, measures to improve nutrition, cognitive performance and dental health were also implemented. (Oswald & Ackermann, 2006) criticise the fact that despite the availability of relevant knowledge and proven rehabilitative therapeutic approaches for residents of nursing homes, no general implementation of such measures takes place, although this would be desirable as an activating nursing care concept. The Spanish report also mentions that including activating care and pets should form an essential part of their philosophy, policy and action in the future. Austrian research also mentions that health promotion in hospitals and nursing homes is strongly linked with empowerment, well-being and quality of life, especially of the elderly (Dietscher et al., 2001a).

While a few studies found in the UK involved people in long-term care homes (Caiels, 2005; Sing for your life, 2005), it would seem that the many residents living in almost 14,000 care homes across the United Kingdom are largely ignored by health promotion strategies.

Work place health promotion

An overriding theme in Austria and Germany is work place health promotion. This is less relevant in other countries, such as Poland and Slovenia that have not found any literature referring to this issues.

In Germany, health promotion at the workplace addresses questions relating to an ageing workforce (such as employability of older employees with and in spite of health handicaps), but also questions of reinstatement into employment of (older) employees with (long-term) illnesses. In the Federal Republic of Germany, policy relating to health at the workplace is

based in particular on statutory health protection and legislation governing health promotion at the workplace (§20 SGB V)[9]. The Labour Protection Law (ArbSchG) and statutory accident insurance obligate employers to put certain measures into effect. Health insurance organisations and employers' liability insurance associations started to support health promotion measures at the workplace in the 1990s. Specifically, a project called ABI was run that was aimed at building up a system of health management, taking into account the age and ageing of workers, in medium-sized enterprises, where such measures are rather rare (Tempel & Giesert, 2005).

In Austria, health promotion measures for older people at the workplace mostly target at improving the health and working conditions of the target group. The literature stresses that organizations benefit from healthy employees in more than one way (increased efficiency and performance, motivated employees, improved working atmosphere etc.) (Meggeneder, 2005, p. 5). Still the number of days older employees report sick increases over the age of 50. Organizations can react with health promotion projects specifically aimed at older employees.

Internet as a setting

For the sake of completeness it must be added that the Internet can seen as a "setting" frequented by all target groups and without limits set by distance.

In Germany, for instance, as part of the federal government's pilot project "Richtig fit ab 50" (really fit from 50 onward), a website module (www.richtigfit-ab50.de) was installed. This homepage offers extensive information to older people about suitable sports and sports organisations (such as clubs/associations). It also includes hints on fitness, sports and nutrition, with specific instructions for actual training. The objective is to counteract prejudice and to increase the motivation of older persons to engage in sports and physical activity by means of detailed, specific information (Stiehr & Ritter, 2005).

In Poland, there are also a wide range of internet sites concerning health promotion marketed to seniors. These sites provide a vast amount of information and are developed in form and content to cater to the needs of older people. However, the differences which exist in Polish society in accessing digital media suggest a large number of older persons may not be able to benefit from this medium. Nonetheless, considering every tenth person aged 55 years and over uses the internet, one may conclude this medium stands to significantly influence the quality of health-related information. While other countries do not report explicitly on the internet as a setting, it is surely relevant in other countries. In the future, internet as a setting of health promotion for older people will gain in importance.

[9] Oppolzer (2005, 57f) mentions quality management (for instance integrated management) as a further necessity. Since the 1980s, the health of the workforce is also increasingly being discussed in connection with the introduction of quality management systems.

8.5. Inequality and Diversity

The subjects of social inequality/inequality in health, diversity and gender are closely connected with each other. Overcoming inequality in health due to socio-economic factors is an essential challenge for future health promotion and prevention.

Literature in most countries referred to issues of inequalities in some sense. The only countries that did not report any findings with respect to this theme were Greece and Slovakia. In the Czech Republic it is reported that official efforts are being made to support vulnerable seniors, while at the same time it is recognized that some activities of health promotion for older people are more accessible for healthy, well-off educated seniors living in big cities. While inequalities are not explicitly addressed in most practical health promotion projects, the need to address them is evident in the background. Also in Italian literature it is rare to find the transversal issue of inequality and or diversity discussed. Italian research tends to concentrate on poverty in old age or on ethnic minorities, while the general underlying problems are hardly ever taken into consideration. In the Netherlands, studies do not differentiate much according to inequality, gender and ethnicity, but there are some practical health promotion activities that address specific groups of older people.

In Germany, a very interesting approach to **overcoming inequalities in matters of health** is found in the project “Health promotion for the socially disadvantaged” staged by the Federal Centre for Health Education (BZgA). Measures in this area are an annual conference on the subject of “Poverty and Health”, the establishment and administration of a database containing approximately 2,700 health promotion projects targeting the socially disadvantaged, regional committees on this topic in each federal state as well as initiating the European model project “Closing the gap – Strategies to tackle health inequalities in Europe”. Issues of health inequalities among older people are also dealt with in the framework of this project (Lehmann et al. 2005).

In general much is said on inequalities in health due to one’s **social economic status** (e.g. education, occupation, income) (GOe, 2005; Meggeneder, 2003; Pochobradsky, 1995; Pochobradsky, Habl, & Schleicher, 2002). Especially in Austria, but also in the Czech republic lower take up of health promoting activities among those with lower SES was reported. One point that was made pertained to the lower participating in creative activities. The other is the readiness to finance health-promoting measures privately. One study states that in the upper classes it is just under 60%, in the middle class 43% and in the lower classes approximately 24%. The overall proportion of persons who have never participated in any health-promoting measures, however, was extremely high (83% of men, 75% of women) (Richter, Brand & Rössler, 2002).

The issue of **inequalities due to physical and geographical factors** is mentioned in Italy and Slovenia. An Italian study conducted by the Instituto Superiore di Sanità (the Italian Government’s Health Research Institute) shows an enormous difference between the North and South of the country in both the state of the health of the population aged over 65 and in their health needs. In the North, the elderly state that their health is better, the coverage of vaccination is higher and they suffer fewer cognitive deficits and disturbances. In the South, there is an increase in the incidence of pathologies and hospital admissions and a higher

number of older people who are not self-sufficient, but to their advantage, they are better integrated in society which, especially for women is a grave problem at this age.

In Slovenia physical inequality is seen as an inequality caused primarily by the place where people live and it is stated that only a complete network of necessary institutions and support systems can eliminate this.

Some work has been around health promotion for older people from **ethnic minorities** and migrants, for example in Austria (Brockmann, 2002; Haider-Koumansky & Özsoy, 2005; Reinprecht, 2003a, 2003b, 2003c; Wimmer-Puchinger & Baldaszti, 2001). One issue is that communication problems may qualify as a risk factor, for example language barriers in the case of older immigrants. In the UK, Grewal (2001) points out that the experiences of ethnic older people are often overlooked and that assumptions of family support help explain this lack of provision. There is correspondingly great value in explicitly targeting ethnically diverse areas, especially where these are also under-privileged, and an account of a project that has done so describes an increased need to promote healthy lifestyles in order to overcome social and economic inequalities (Patel 1999). In the Netherlands, for example a special health education and physical exercise programme for Turkish first generation elderly immigrants (Reijneveld, 2003) has been carried out. While health promotion projects in the Czech Republic have rarely addressed seniors from ethnic minorities, one recent project has focused on offering older people within the Prague Jewish community the opportunity to participate in a “healthy club”. In Spain it is mentioned that immigrants who now have employment should be the target of policies and actions of health promotion. Health promotion for older people from ethnic minorities should take into account their specific life situation and cultural reality. Spanish literature suggests that professionals dealing with health care and health promotion should adapt to the cultural peculiarities of the immigrant population, as contributing to setting up social support networks.

Some **gender aspects** are found in all participating countries. While some findings are more of a general nature, some countries report concrete health promotion projects, mostly focussing on older women.

With respect to findings of a general nature, literature in Slovenia deals with specificities caused by biological and sociological differences between men and women. All in all in Slovenia, men and women are seen as having a balanced social status, because about 46% of working population were and are women, which means that they are for the most part financially independent and equally educated. Polish literature tends to stress the overrepresentation of women in older age groups, which adequately reflects the current demographic profile of Polish seniors (Tobiasz-Adamczyk, Brzyski, Bajka 2004). Like in Slovenia, the social situation of older Polish women, concerning the large percentage remaining active in the workplace, should influence the analysis of those conditions affecting quality of life in older age (Tobiasz-Adamczyk, Brzyski 2005). Older Polish women show greater social activity than men. In Poland it was noted that one may noted typically male health problems e.g. andropause, prostatic hypertrophy and female problems health problems such as osteoporosis, cervical cancer and breast cancer.

In Germany, **gender-specific differences** play a part, resulting from the general income situation that places especially older women at a disadvantage during the ageing process. Currently older women, in particular women of an advanced age living alone, are affected

more frequently than men by socio-economically unfavourable conditions of life that can have an adverse effect on the health of women in old age (Kruse, 2002, 169).

Further variations also exist between men and women in terms of morbidity patterns and different health-related lifestyles. Apart from bio-physical and genetic factors, the lower life expectancy of men is also due to gender-specific differences in health-promoting lifestyles, so there is a need for action to promote health-consciousness and health-oriented behaviour among men (Kruse, 2002, 169).

There is also a marked difference in taking up offers for health promotion in Germany: like in Poland, women participate more frequently in health-promotion measures than men (Dapp et al. 2002b, 3ff; Kahl, Hölling & Kamtsiuris, 1999; Wiesemann et al. 2004). Also, a significant connection between participation in health promotion measures and social background for women was found: only 4% of women from the lower classes compared to just under 17% of women from the upper classes take part in such measures (Richter, Brand & Rössler, 2002).

One of the few studies surrounding gender in the UK found that men were more likely to drink in excess (Hajat, 2004), the rest of the studies mentioning gender differentials focused on women. The literature suggests older women are more prone to experiencing mental illness. One sociological article argued this was due in some degree to long-term and age-based inequalities as well as the inability of mental health services to account for gendered oppression and its negative affect on mental well-being (Milne, 2000). Older women's poorer mental health was also linked to their disproportionate experience of loneliness, though this is more affected by marital status, age and living arrangement than gender itself (Victor, 2006). Hence there would seem to be a clear difference in experience of health inequalities due to gender (Bowling, 2004) which, as already mentioned, is further compounded by poorer women's greater vulnerability to winter cold (Wilkinson, 2004; Donaldson, 2003) and a more general increased tendency towards cognitive and functional impairment suggested in a UK study (Jagger, 2001).

These findings on differences in older men and women with respect to health and health promotion are also reflected in several **projects and programmes**.

In the UK a few programmes are being run that are specifically tailored towards older women's needs, for example offering exercise (McMurdo, 1997; Ebrahim, 1997) to help overcome increased propensity for fractures linked to osteoporosis, or a wider programme which had a specific goal of reaching out to older Asian women (Chartered Institute of Environmental Health, 2006). Another study suggests that women may also be more likely to benefit from aerobic training than men (Malbut, 2002). In the Czech Republic, a few projects for older women are being carried out, especially by women's organisations. Apart from that health promotion projects for older people in the Czech Republic practically take into account the needs of their target groups and tailor the activities to their needs, even if the gender dimension is not explicitly articulated. In the Netherlands a loneliness intervention programme for older women was carried out addressing the problem that older women tend to be widowed and live alone more often than men (Stevens, 2001). In Austria there are a few projects addressing health promotion for older women, such as the community oriented project "Reife Äpfel" (Ripe Apples) or the Catholic Women's Movements' groups for older women "Frauenherbst" (Women's Autumn).

Poland, as one of three countries, took part in the Women II project, aimed at improving the effectiveness of clinical and continuous care of women around the time of menopause. The project website is accessible in a number of languages and ensures high-quality medical information as well as online consultations and the opportunity to chat with other patients (Bolanowski, Jędrzejczuk, Milewicz 2003; www.termedia.pl). The main goal of the international WOMAN II project was to improve everyday clinical practices in centres dealing with menopause. This improvement is reached by optimizing effectiveness, quality, and continuity of health care by offering information services to women and physicians. The goal is to create and promote a functional, multilingual European network for maintaining a homogenous data base for both patients and doctors.

8.6. Sustainability

Among the countries finding this issues in the publications, sustainability referred to the ability of a project to be continued beyond the project life-time and was dependent upon the engagement and support of the organisations and stakeholders – including the participants – involved in the project. The issue of sustainability was evident explicitly or implicitly in about a quarter or more of articles in Italy, Austria, the UK, Germany and Greece, less so in the Netherlands, and minimal or absent in the Czech Republic, Poland, Spain and Slovakia.

In Italy, a large part of the research projects demonstrated a high degree of sustainability, some of which have been transferred to other regions. This sustainability and transferability was successful due to meeting short, medium and long term goals and providing evaluation. Some projects improving the health include those improving the health of immigrants. In Greece, a further example of a sustainable project was the Volunteer Senior Health Mentors training in Health Nutrition, a project rendered equally transferable and hence sustainable through the development of a training package.

In Austria, Germany and the UK there was a mix of explicit and implicit examples where sustainability was well or less clearly articulated. With respect to the latter, in Austria for example a project was concerned with engaging older people in a sports club for health promotion activities that continued once the project had formally ended (Lames & Kolb 1997). There was an assumption that strategies had been put in place, however details were not made evident. In the UK, the literature referred to the importance of not overburdening professionals but to encourage volunteering or peer mentoring in order to facilitate sustainability (Allen 2003), putting forward suggestions rather than evidence. However, it is clear that multi-agency approaches are one means of lessening the burden on any one organisation or profession and improving the chances of sustainability (London Older People's Service Development Programme 2003). In Germany, research was conducted that looked at incentives for promoting sustainability. It was established that sustainability of an 'Active health promotion in old age' pilot approach could be connected to acceptance of the approach by older people, alongside the addition of a stable financial contribution. The subsequent extension of the project is now consolidating organisational and networking structures to increase the potential for sustainability even more (Meier-Baumgartner et al 2006).

The nature of how health promotion projects are funded is intrinsic to sustainability. In the Czech Republic, state grant agencies intentionally shortened the duration of funding to one

year, which arguably militates against opportunities for achieving goals, establishing evidence of effectiveness, attracting further funding streams, and thus becoming sustainable. In Poland, a system for multi-agency working in health promotion for older people has as yet not been established, thus rendering sustainability challenging. In Spain, publications on the subject provided guidance to implementation only.

8.7. Cost-effectiveness

While cost-effectiveness is gaining in importance concerning policy issues, little empirical evidence could be found on cost-effectiveness of health promotion interventions for older people in most of the European countries participating in the healthPROelderly project.

In Spain, Slovakia, Netherlands, Italy and the Czech Republic no concrete findings on cost-effectiveness could be reported. Greece reports that research in this area is confined to masters and doctoral theses'. In Poland, a lack of experience is noted when it comes to optimizing cost-effectiveness of programmes on health promotion for older people, since this topic is only noted in 1,8% of located Polish literature. In Slovenia cost effectiveness is also represented very modestly.

The cost-benefit assessment of preventive measures presents a number of problems, one of which being the fact that the effect of such measures is not immediate, but lies in the future. In the absence of long-term studies, the cost-benefit ratio of such measures is often estimated by model calculations. In Germany, standardised measurements of results of preventive measures are an exception, economic evaluations are only rarely carried out (Plamper, Stock & Lauterbach, 2004).

Some **anecdotal accounts** of cost-effectiveness have been reported:

In the Czech Republic, the projects and programmes in this area need to operated effectively and have a transparent financial plan, since resources for health promotion interventions for older people are very limited.

In Italy it is reported that some health promotion projects for older people at regional or local level have lead to a partial re-orientation of health and social services, giving increased attention to the needs of the elderly. These projects are seen to have a great positive balance in terms of cost-effectiveness in the sense that the health of the elderly population is actively supported and promoted.

In Slovenia a survey has been carried out on the contribution of health and active older people to society. This refers to their contribution as consumers, child carers, volunteers etc.

Austrian literature mentions that older people who live independently at home tend to have a higher quality of life and "*they are less likely to experience functional decline than those living in residential care. Additionally, it is a much cheaper option and hence more cost-effective to enable elderly people to live at home*." (Sprenger, 2005, p. 33)

The only participating countries that report some **evidence of cost-effectiveness** in health promotion activities are Austria, Germany and UK, although the scarcity of available information is also mentioned there.

Some articles cover cost-effectiveness in relation to physical activation and sports for older people. For instance, Lames and Kolb state that health promotion in sport clubs is practicable, efficient and economical (Lames & Kolb, 1997). Additionally, Halbwachs and colleagues (2000) discuss the development of a health-economic based cost-benefit-analysis, the costs of sport injuries and the societal benefit of sport. This study and other studies as well have shown that it is a myth that a bad health status is highly correlated with age. Nevertheless, since falls are more dominant in the higher age groups the medical costs for falls are high (Schwendimann, 2003; Ziere, van der Cammen, Pols, & Stricker, 2003). Also, in Austria the cost factor of security for older people was discussed in an own meeting on political level in 2002 (Österreichischer Seniorenrat, 2003).

In the German literature examined, 26 texts address cost-effectiveness to a varying extent, with one study including a health-economic evaluation. In connection with a feasibility study for geriatric home visits to older persons, Manstetten & Wildner (2002) carried out a comparative cost analysis which included the actual costs and possible savings, as well as the nursing care cases that could be prevented by this method (cost-effectiveness analysis). This health-economic evaluation, however, is not based on data collected in this particular study, but is also derived from model calculations. In addition, the state of health was recorded, and the assessment, the home visits and the criteria for access judged by the participants.

The UK literature stresses the importance of engaging participants for the sustainability (Caiels, 2005) and cost-effectiveness (Stevens, 1998) of any health promotion project. Greater numbers of participants usually mean greater numbers of people reached per £ which is vital in convincing those allocating finance to continue investing in projects. Specifically, equipping peer mentors to lead health promotion/education interventions is both financially efficient as well as empowering and sustainable. Even where such volunteers are not forthcoming or the level of required expertise is too high, there is a also cost-effectiveness case for using professionals in health promotion activities due to the fact that prevention is usually cheaper than cure (Munro, 2004; Parle, 2002).

8.8. Consumer involvement

In general consumer involvement is an issue that is becoming increasingly important concerning health promotion for older people. However, it has many different variations and in some countries there is very little evidence that it is already being put into practice.

For example in the Czech Republic the view of recipients or consumers is considered be highly important and attention is being paid to their feedback, in about 30% of the Czech literature found. However, there is little evidence of actively involving older people in practice. A similar phenomenon is reported in Italy where many different actors emphasise the importance of listening to the voices of the elderly, of considering their subjective experiences and their own opinions about their situation, but studies and projects on health promotion of older people, rarely take account of this. Thus, the involvement of the older people seems rather infrequent, especially considering the absence of participatory research and action research. Poland reports a lack of data concerning feedback by programme participants, but there is an increasing interest on the part of geriatric specialists to include feedback from older people.

In Slovakia, changing health and social policy for older people elicits positive changes in the attitude towards consumer involvement. The voice of users is starting to be important not only at the end of a programme but in the beginning, when health promotion activities are planned. Although it is generally considered important and necessary in Germany to involve the target groups in the development of health promotion measures, the actual development**,** planning and implementation is usually carried out by experts (Scheuermann, et al., 2000,1594; Walter & Schwartz, 2001). Scheuermann, et al. (2000, 1594) point out that exclusive involvement of experts in the development of projects can also have a negative influence on their sustainability. However, it is possible to win the participation of elderly persons as "co-producers" of health by a wide-spread application of empowerment strategies.

Principally, involving older people in research and interventions concerning their own health promotion is multi-faceted. Different methods allow the involvement of older people to a different extent. The simplest and most straight forward way of involving older people in research on health promotion is using **quantitative measures** such as surveys, questionnaires etc. This is reported in Austria, Czech Republic, Italy, Poland and UK. Involving the voice of older people using **qualitative methods** such as interviews and focus groups is mentioned in Austria and UK. Involving older peoples in **programme planning and delivery** is an issue that is being mentioned more and more. However, concrete activities in this direction are still very rare.

In the Netherlands, consumer involvement is seen as an important characteristic of the projects addressing empowerment and/or social participation. For example, in the programme "Successful Aging" the peer educators ("senior health educators") aged 55 and over were involved extensively in the planning and guidance of the course (Kocken, 2000). It was concluded that the use of strategies, like needs assessments, local action plans and two way communication between program designers and users, is essential for successful dissemination of health promotion activities (Kocken, 2001). In the UK a number of studies were reported which encouraged open feedback, from focus groups (Caiels, 2005; Food Standards Agency Wales 2001), through innovative means of eliciting views from dementia sufferers (Killick, 1999), even as far as training older people to do evaluative work themselves (Dorset County Council, 2005). An interesting project was carried out in Greece involving the training of older people as Senior Health Mentors. The Senior Health Mentors presented and discussed the basic principles of healthy diets with their peers. Both mentors and mentees were enthusiastic about the project and showed interest in health education and disseminating information on health and nutrition. Another example of a project actively involving older people is "Plan60" that was carried out in Austria. Here older people were trained and empowered to plan and implement their own initiatives for and with other older people.

9. Key points of thematic findings and review of methods

Jenny Billings, Eva Křížová, Charlotte Strümpel

9.1. Key points

The theme most often touched upon was life style (almost 55%). Social participation reached over 40% of all literature and thereafter approximately a third of papers dealt with empowerment and mental health respectively.

Promoting mental health

Although there was variation between the countries, overall a third of the literature addressed mental health issues, most of which was about depression. Health promotion activity in this area highlighted the interdependence between physical and mental issues.

- Regarding **depression** there appeared to be three main themes from the literature. Firstly, there was a policy connection which focused on raising awareness on depression as a health promotion activity. Secondly, a primary prevention theme focussed on interventions concerning sport, exercise and social activity. Thirdly, a secondary prevention theme highlighted interventions regarding training and screening for depression.
- There was much less literature concerning **stress and burnout** among older people. What little there was focused on the work place (predominantly in Austria and Germany), stress experienced by carers and reducing stress and anxiety for older people.
- Literature relating to **cognitive issues and memory training** could be separated into primary preventive projects and secondary preventive projects. Primary preventive strategies focused on activities that could be applied to promote cognitive capacity through singing or memory training. Secondary prevention often combined physical with cognitive training for people with existing mental health problems.
- A range of themes emerged from **emotional support** literature. This included the role of emotional support in illness prevention, the value of social activity, interventions for individuals, emotional support in retirement, and the sense of coherence – building emotional resources for health.
- **Empowerment** literature was generally drawn from professional publications and was mostly geared towards how care should be delivered in an empowering way. Many projects promoted empowerment as a necessary prerequisite to an enhanced health status, especially in Austria.

Social participation and inclusion

A total of 44% of all papers included social participation in very diverse forms. Over 30% of papers touched on themes such as life-long learning, education of older people, social networking and social support, respectively. Themes like self-help groups or volunteering were mentioned but this was seldom.

- **Life long learning** was apparent in all countries. Most articles focused on health education and encouraging a healthy lifestyle. Positive effects on the three dimensions of health, physical, psychological, and social health were evident. Some links were made between volunteering and life-long learning in older people. In many countries Third Age Universities were mentioned in connection with promoting older people's health. Also, general courses were identified, which were geared specifically to older people such as art, singing and new technology. Education for improving the situation of older workers was highlighted in Austria and Germany.
- There was a broad consensus that strengthening **social support and social networks** constituted a fundamental element of social policy geared towards older people. The literature highlighted formal and informal sources of social support and indicated the most appropriate settings where older people could find social contacts. A variety of health promotion projects were found whose goal it was to encourage the social support of older people, for example establishing networks, preventing loneliness and enriching friendships, some focused on older migrants or women. However, evidence of effectiveness was difficult to establish within these projects.
- While **self-help groups** in general seem to be quite well developed in some countries, such as in Germany and Austria, other countries reported that self-help groups in general were a new phenomenon. Self-help groups in connection with health promotion for older people were identified very rarely. Even where self-help group memberships were high, for example in Germany, the focus was on carers and less on older people themselves.
- In some countries such as Poland, **volunteering** by older people is a relatively new and unknown topic. In other countries such as Austria and Germany older people as volunteers were more established. However, this issue is seldom dealt with in the context of health promotion. Some advantages of volunteering included social contact and positive influence on mental and physical health as well as opportunities for personal development.

Lifestyle

The role of lifestyle in the health of the individual was confirmed in literature analyzed as part of the healthPROelderly project, where more than half (58.3%) of all literature touched on this topic. Among the lifestyle elements considered in this analysis, physical fitness and nutritional habits were the most often discussed topics, followed by prevention of disease (20.8%), physical fitness (18.2%), and nutritional habits (13.6%). Other topics included the prevention of falls and accidents (about 6%) or elder abuse, substance abuse or sexual activity (about 1% of papers).

- The importance of **nutrition** as an integral part of healthy ageing was undisputed in all countries. Hence, variety of literature was found on this theme among all partner countries. It is widely accepted that the lifestyle factor nutrition is important for one's health and wellbeing, that an unhealthy diet raises risk factors for major diseases and that health promotion can be a strategy to prevent them.
- Like nutrition, **physical activity** was also prominent in the literature found, many times also in combination with issues of nutrition. Effects of physical activity on disease prevention, functional capacity, mental health and preventing social isolation were highlighted. Publications dealing with physical activity devote much space to the different forms of such activity and special recommendations for older people. A variety of intervention programmes were described. Thoroughly evaluated programmes in the UK and Netherlands reported inconclusive evidence of the effects of physical activity.
- Not many articles for found on **sexual activity** of older people in connection with health promotion. Apart from general remarks on the connection between sexual activity and ageing, a study was found in Italy looking t homosexuality among the elderly. In general, it can be said that sexual activity of older people is a taboo in the societies of the participating countries.
- Preventing **drug abuse and alcohol consumption** was very rarely addressed in the literature on health promotion for older people. On the one hand, prevalence decreases with older age due to mortality. On the other hand this seems to be a taboo topic. The issue addressed most frequently was preventing **smoking**. However, interventions in this area are mostly addressed to the general population with little specific focus on older people.
- A substantial amount of literature over all countries addressed issues of **safety, specifically the prevention of falls, accidents and injuries**. Most of this literature concerned prevalence, risk factors of and measures to prevent falls. A wide variety of programmes to prevent falls were mentioned in Germany, the Netherlands, Italy, Poland, Spain and UK. These usually used a combination of methods to prevent falls and addressed different target groups. The importance of tailoring specific interventions to certain target groups was highlighted specifically with respect to this topic.
- The issue of preventing **abuse against older people** is practically not addressed in literature on health promotion for older people. However, a general growing interest in the topic and starting public debates were reported.

Transversal issues

Transversal issues covered emergent issues that tended to cut across the main themes previously analysed. Transversal issues included research methods, health promotion strategies, settings, inequality and diversity, sustainability, cost effectiveness and consumer involvement.

- **Research approaches** used in health promotion projects focused mainly on two areas, methods that evaluated projects that had or were in the process of being implemented, and methods used to identify the evidence-base for interventions or justify their need. Generally, the literature highlighted the lack of identifiable research approaches used in this field. Despite this, evaluation has been conducted in some countries using purely quantitative or qualitative approaches, and a few using mixed methods, the actually quality of these evaluations is however, under question. RCTs were used rarely and only for focused interventions on one or two physical indicators.
- There appeared to be a range of different factors that constituted **health promotion strategy** that could be clustered under policy imperatives; goals of the project; provider strategies; target population; and techniques/interventions. The policy imperatives were concerned with motivating individuals to maintain a healthy lifestyle. Goals of the project focused on intended health outcomes such as potential personal health and social benefits.
- Provider strategies looked at the type of personnel required to deliver a health promotion project for older people and their training. As health promotion activity was often **holistic** in nature (tackling health and social aspects), an emphasis was placed on the importance of a **multi-disciplinary** team necessary to deliver this holistic approach.
- **Techniques and interventions** to deliver health promotion focused on health education techniques through verbal or written information. Aside from health education some **innovative strategies** were directed at physical or psycho-social improvement which used forms of specific therapy, such as exercise, reminiscence or occupational and recreational therapy. Other strategies focused on preventive techniques such as screening, falls prevention and developing coping skills.
- With respect to **settings**, most health promotion activities by far took place in the community setting, the next frequent setting was people's own homes and then residential homes. In the community it was easier to reach more vulnerable groups as well as relevant agencies, to boost the multi-disciplinary approach. Projects here focused on enhancing social support and on promoting health in general and empowering older people. People's own homes were chosen for those older people unlikely to take part in community-based programmes. Further settings included nursing homes and the hospital, the work place and the internet as a setting.

- There was a large amount of literature which highlighted, **social inequality and diversity**, stressing the importance of socio-economic variation in order to promote the health of older people. Some work has been done around health promotion for older people from ethnic minorities and migrants in several countries such as UK, Austria, Czech Republic, Spain (e.g. Turkish and Jewish communities).
- **Gender aspects** were found in all participating countries. Some countries discussed general gender issues that would be expected such as biological, sociological and economic differences between men and women. However, there were only a few gender specific projects and these only targeted women. Examples include projects that attempted to reach out to older Asian women, that tried to combat loneliness of older women and health promotion around the time of menopause.
- **Sustainability** referred to the ability of a project to be continued beyond the project lifetime and was dependent upon the engagement and support of the organisations and stakeholders involved in the project, including the participants. Sustainability was largely connected to funding issues, the acceptance of the project by older people and the firmness of organizational networking structures.
- While **cost-effectiveness** is gaining in importance, little empirical evidence was found on it. Mostly anecdotal accounts were evident. The only participating countries that report some evidence of cost-effectiveness in health promotion activities were Austria, Germany and UK, although the scarcity of available information was also mentioned there. The cost-benefit assessment of preventive measures presented a number of problems, one of which being the fact that the effect of such measures is not immediate, but lies in the future.
- In general **consumer involvement** is an issue that is becoming increasingly important concerning health promotion for older people. However, it has many different variations and in some countries there is very little evidence that it is already being put into practice. Some of the ways of involving older people were in research on health promotion using quantitative measures such as surveys and questionnaires and using qualitative methods such as interviews and focus groups. In addition, older people were involved in programme planning and delivery. However, concrete activities in this direction are still very seldom.

9.2. Review of methods

This process permitted a thorough search of health promotion literature geared at older people across a number of countries in their native languages hitherto not conducted. This provided a range of interesting, illuminating and comparative findings that could be synthesised into common themes to provide a European perspective.

The creation of a database to facilitate the collection of data enabled detailed and varied categorisation of leading ideas and concepts connected to contemporary health promotion understanding and policy. In addition, specific issues in respective countries have been revealed which has given a comparative insight into health promotion trends in the participating countries over the last ten years. However, due to the broad range of data

collected, a description of the individual subjects could only be made in the form of an overview, due to the wide range of subjects covered.

With respect to the actual categories selected for analysis, there were initial difficulties in clearly defining them. Not only is health promotion notoriously difficult to define consensually, but there were additional language and translation challenges. To overcome this, a glossary was developed early in the project with partners, alongside the development of clear literature review guidelines to overcome these problems.

Due to the nature of the project phases and hence development of categories there are some inconsistencies between the quantitative database categorisation and that used for the more qualitative thematic analysis, particularly for the transversal themes. This was due to the dynamic evolutionary logic and consensual underpinning of the project structure, alongside the need to refine and focus topic areas according to emerging policy and practice imperatives.

It was noteworthy that as the data collection progressed, many of the topic areas interrelated. Although there was not much in the way of literature focusing on mental health for example, it was implicit within or connected to papers on social participation and interventions countering social isolation. Empowerment also did not appear as a direct focus very frequently, more as a potential side effect of a project. Projecting this finding into health promotion practice, the importance of multi-faceted interventions becomes clear.

This study of the literature makes no claim to completeness due to the fact that only texts under the heading of ‘health promotion and prevention’ were considered. This means that positive health effects contained in other scientific studies were possibly missed as they make no direct reference to the theme of health promotion for older people and were therefore not captured. Moreover, older people with dependency problems and disabilities were not particularly evident as target groups for health promotion and preventive measures, perhaps because they appeared elsewhere in the literature.

In addition, the completeness of data was affected by the ease of access to published material which varied between the partner countries. For example, in Poland, mass media articles were most easily accessible; in the Czech Republic, there were on-line restrictions to health promotion literature which created considerable practical access problems; and in the Netherlands there were so many published articles only scientifically evaluated interventions were selected. The inherent bias in some reporting impacted therefore on the comparability aspects of the study. However, this does not detract from the overall impressions obtained on this scoping exercise and this is in itself an interesting result.

Overall, using the general keywords of ‘health promotion and prevention’ provided the opportunity to demonstrate the many facets of health promotion for older people and enabled a thematic analysis to be made.

10. Conclusions

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In general the literature searches revealed a body of information to support the potential generation of evidence-based criteria for health promotion for older people. Some publications described the importance of health promotion and detailed the negative effects of certain conditions, like bio-physical, social or environmental factors. In addition, many espoused other important features of health promotion such as consumer involvement, empowerment, cost effectiveness and sustainability. Other publications captured health promotion projects involving older people, which was more the focus of this phase, and the amount of published projects was connected to the degree to which health promotion practice was established in the respective countries. An overarching feature however was that, while there was general agreement about what constituted the best features of health promotion, the nature of many of the projects discovered did not match up to the rhetoric of what should be included. This 'rhetoric and reality' paradox was a strong feature of the analysis and has provided the project with a strong steer for the development of analytical criteria for health promotion projects for the ensuing phases. This conclusion will continue by a commentary on some main themes that emerge, namely the influence of health determinants, the role of policy, approaches to health promotion, the issue of evaluation, and multi-disciplinarity. It will also highlight the strengths and weaknesses of this phase and outline the criteria for the next phase of HealthPROelderly.

The influence of health determinants

There were a vast number of projects of varying complexity, but there was a high emphasis on bio-physical determinants and corresponding lifestyle and behavioural change. For example, measures relating to nutrition, physical activity, safety (especially prevention of falls) and prevention of disease predominated. Social factors were also recognised as important, but addressing social issues was seen as a side effect rather than the main focus of the project. Social participation and the promotion of mental health, including treatment of dependence syndromes (e.g. drug and alcohol abuse) were not mentioned so frequently in a health promotion context. This is perhaps not surprising, as an analysis of health determinants across the partner countries indicated a focus on risk factors related to blood pressure, inactivity, nutrition and alcohol abuse, clearly connected to the epidemiological profiles of all countries. What the major killers are in turn influences policy directives, which consequently guides health promotion activity for some of the partner countries.

The role of policy

The role of health promotion policy for older people would appear to be a key influential variable in the nature of health promotion activity. There seemed to be unison within policy aims that older people should remain as independent as possible, retaining their autonomy ideally in their own homes and avoiding admission to hospital or nursing homes. Health promotion was seen as an important vehicle to realise this. In addition, it has the ability to

tackle policy imperatives such as health inequalities and diversity by focusing on invisible target groups, such as isolated older people and ethnic elders.

It could be seen that policies directly geared towards older people varied between the countries with subsequent impact upon the nature and type of activity encountered in the published literature. In the UK for example, there were a number of strategies led by policy (e.g. National Service Framework), but in other countries policy was less strident, and here projects were organised at a local level with no real overall national co-ordinating strategy (e.g. the Netherlands, Greece).

Recent health changes in Slovakia have augmented health promotion in policy, but it is as yet to be rendered visible and health care systems continue to be oriented towards disease prevention. Similarly in other countries, interventions and strategies within public health are focused foremost on the prevention of illness and not upon effective health promotion, due in part to a lack of trained staff and an inadequate body of theoretical knowledge. However when health promotion is firmly embedded in policy such as the UK, sustainable co-joined activity is still problematic. Overall, these results would appear to contribute towards the tendency for small-scale, poorly funded projects, where there is lack of cohesion and structural planning between organisations and other stakeholders. Such projects are difficult to sustain and attract funding.

In accordance with what is understood by active aging, many countries agreed that health promotion is a right that all older people have to exercise and enjoy. Applying health promotion programmes effectively remains incomplete without the public policy to enforce these ends. So the most effective way of promoting the health of older people involves implementing the ideas outlined in this report on an individual, psychological, and group level and this requires public authorities to put forward appropriate policies of inclusion and integration.

Approaches to health promotion

With the predominance of lifestyle issues in mind, it was of interest that there was a corresponding emphasis on personal and individual responsibility for health and the development of a range of lifestyle interventions (sometimes including social and environmental factors) that people could choose (or not) to take up. The emphasis on the bio-physical meant that professionals took the lead in a ‘top down’ approach using more traditional health education methods. This was despite the fact that there was an acknowledgement that health education techniques are not always the most successful in establishing long-term health change, focusing as they do on physical issues and ignoring the wider social context that may act as strong barriers to behaviour modification.

So the health education models appeared to predominate, even though all countries have embraced the wider definitions of health promotion, enriching their strategies with WHO health promotion definitions (see Glossary). It could be argued that there may not be a good fit between the concepts of consumer involvement and empowerment, and the health education model of health promotion. This may explain why these concepts are not particularly evident in the projects revealed by the literature searches, but continue to be emphasised in health promotion dialogue.

Without doubt there is the growing recognition and inclusion of strategies in countries such as Austria, Germany, and the UK that tackle social problems of old age, propelled in part by the consequences of demographic change. In view of the increasing lifespan, health promotion and prevention of disease are gaining social as well as individual significance which can be gathered from the increasing numbers of publications and policy initiatives in these and other partner countries. As yet, however, appropriate statutory provision besides those for curative therapy, rehabilitation and nursing do not seem to be widely in place for many countries.

A theoretical approach seemed to provide some projects with an important framework through which to channel health promotion strategies. For example, an emerging concept in some countries (e.g. Germany, Austria, Netherlands) relates to a salutogenic approach which connects well to the underlying principles of health promotion, focusing as they do on the maximisation of resources for health and social capital to sustain a healthy old age, thus neatly linking together health and social issues. These concepts are realised through the emergence of programmes such as 'Active health promotion in old age' (Ger) and 'Healthy and Vital' (N). But even with these programmes there is a focus on nutrition and physical activity and mental health aspects are rarely considered.

When considering approaches to health promotion, issues relating to the target population with respect to inherent and unequal population differences, health promotion settings and access to projects was evident. The importance of having a specific focus on older people is clear. Health promotion directed at the general population is less likely to affect specific target groups than health promotion in specific settings with particular tools and goals. In Poland for example, most health promotion initiatives were target at younger people, or were aimed at the population at large and not exclusively older people. The extreme heterogeneity of the subjects in the older population must be remembered. Older people, older migrants, older women, older men, and older employees have special needs which need to be met during health promoting activities. To this must be added the variability between individuals, associated with ageing.

Most projects acknowledged the importance of specific targeting with these factors in mind, however, this did not happen frequently. Generally in those countries where there was more health promotion activity there appeared to be more projects geared towards the specific needs of older people in different settings. In countries where there was less activity, the focus was more general. Because of the previously mentioned diversity and differing needs of people as they age, health promotion activity will inevitably miss certain important target groups. This could be exacerbated by a lack of information about projects and how to get involved, alongside a motivational factor. For older people, easy access is important: depending on the persons' state of health, structures that encourage active participation such as organisational teams coming to participants' homes is important. In relation to inequality and diversity, overcoming language barriers for older migrants was also seen as a prerequisite for utilisation. With gender, differences were acknowledged in some examples of literature but there were only a few programmes specifically focused on this issue.

The issue of evaluation

It was of concern that convincing evaluation of projects was not widely found, but it must be recognised that there are well-known difficulties establishing health benefits that relate directly to health promotion projects. In spite of this, even basic evaluation such as participant feedback or satisfaction surveys were missing in many countries, or conducted in such a way as to render the findings inconsequential.

More formally evaluated projects were evident in the Netherlands and the UK, but these were sometimes restricted by their focus on single interventions employed in the institutional setting. These interventions were often analysed quantitatively with little or no opinion being sought from the older people themselves. Interventions organised in nursing settings or by social scientists tended to focus on more educational interventions aimed at changing behaviour. Many of these sought opinions of older people but typically through a highly structured questionnaire, thus allowing little expression of individual opinions, understandings or meanings given to behavioural responses to interventions.

With reference to multi-faceted projects (elaborated on below), evaluations were more problematic in terms of generating clear health benefits due to the difficulties controlling variables and demonstrating cause and effect, unlike those focusing on single issues. Multi-faceted projects were more likely to use qualitative methods and include the perceptions and views of older people, though these were not always reported in significant or meaningful depth. Qualitative methods are often criticised and using such methods are not seen as producing scientific evidence for practice, although this is increasingly disputed. Moreover, evaluations that give a voice to, and thus empower older people are seemingly less common due to their lack of scientific generalisability and assumed validity.

This lack of proper evaluation clearly reflects on the ability of stakeholders to demonstrate real health benefits and to improve on service delivery. In addition it makes transferability of projects to other settings more difficult.

Multi-disciplinarity

There is a growing recognition that projects that are most successful in achieving positive participant and service outcomes are those that adopt a multi-agency approach and are able to address a range of factors surrounding the complex issue of lifestyle change. Indeed, older people often have multi-pathology and need a holistic approach that requires the input of different expertise. There is support for the fact that health interventions in isolation are insufficient; the whole community needs to intervene on the specific socio-economic and environmental aspects of health improvement for older people. Professional expertise was seen to be a crucial ingredient to a multi-agency approach. The importance of ensuring that professionals have the correct and appropriate expertise to conduct this type of work is essential but often overlooked.

However in spite of evidence suggesting that health promotion is more effective through multi-dimensional approaches, such interventions are in the distinct minority.

There is also an associated problematic paradox by which the approaches that are most successful are equally seen as less scientific as outlined above. In addition, the

organisational and communicative difficulties that hinder multi-agency co-operation indirectly encourage projects that focus on only one aspect of health promotion – typically based on a bio-medical, physiological model which cannot take into account the complex emotionalities and sensitivities which affect and determine the health status and quality of life of older people.

In **conclusion** literature review has indicated a number of ways forward in the determination of criteria for best practice. Health in older people is affected by many interacting factors, culminating in the need for a holistic perspective which should be applied to health promotion interventions. These interventions should be supported by policy and consider the social factors of integration, inclusion, and the participation of the elderly. An important recurring theme however concerned the paradox between the rhetoric and reality of current health promotion activity, where pathways to health promotion were idealised but not generally applied to practice.

Criteria for the further development of the project

In order to ensure the appropriateness of criteria for further work in the project a combination of approaches has been applied. One approach has been the thematic analysis as reported in this document. In the other one project partners discussed potential criteria from the standpoint of their national reports during project meetings and by electronic communication. The intensive discussions and revisions resulted in a harmonisation of agreement from a European perspective about what should constitute the most strident criteria for health promotion projects for older people. Following criteria for choosing projects for the database that was compiled in the second project phase were elicited:

Multi-agency approach

More than one type of professional, governmental, non-governmental agency is involved with the project/programme.

Evaluation

The model has been evaluated in some form, either in a multi- or single-method format. That means there are evidence-based results concerning the process and/or outcome of the model. Quality management methods which produce such results can also be considered.

Multi-faceted, holistic

The project seeks to tackle more than one health promotion issue and intervenes in terms of both bio-medical and psycho-social factors.

Sustainability

The project displays a proven capacity for long-term implementation due to the continuing availability of social and economic resources as well as the enduring effectiveness of the project. And /or: it is or will be implemented within mainstream health policy for older people.

Voice of older people

The model shows an active involvement of older people in at least one of five areas: participation, involvement in project design, responding to older people's feed back in project design, feed back, contribution to the model (volunteers, project designers, project monitoring, management), as multiplicators and trainers.

Involving visible and invisible target groups

The project is successful at involving visible (older people in general) and invisible (ethnic groups, social isolated, low socio economic, cognitive impairment) members of the older population.

Diversity

The project addresses diversity and inequality in terms of gender, age, ethnic background, social-economic differences and thus is capable of dealing with issues of social accessibility, cultural differences in communication and financial hardship.

Geographical and physical accessibility

The project addresses issues of transport and infrastructure in order to be accessible to those living in remote areas or who are frail/physically impaired.

Well-grounded theoretical approach

The project methodology is based on a recognised theoretical framework which has been rigourously applied.

Gender sensitivity

The project recognises the importance of gender in affecting health and addresses this issue actively.

Cost effectiveness

The project demonstrates cost effectiveness, health, social and economic gains for government on a local, regional and/or national level.

Projects that include empowerment

The project addresses issues surrounding independence, autonomy, knowledge-promotion, self-esteem, dignity and/or motivation of the target groups.

Transferability

There is evidence that the project was successfully transferred, or at least displays the potential for transferability to another health, social care setting and/or another region or country.

Consumer satisfaction

The project is positively perceived by consumers in its ability due to meet their needs.

Innovative strategy

The project uses innovative strategies for encouraging behavioural change through an understanding of interactions within an environment, rather than simply offering health education.

In addition to the more clearly extracted criteria it is important to include on related to public recognition, as this is clearly and indicator of best practice in health promotion.

Public recognition/award

The project has achieved public recognition as indicated through receipt of awards or being widely publicised in recognised journals. Information regarding the project was widely disseminated and has reached the various target groups.

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