



Evidence-based Guidelines on Health
Promotion for Older People:

Social determinants, Inequality and
Sustainability

National Evaluation Report – Austria

Katharina Resch

Gert Lang

Research Institute of the Viennese Red Cross

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1 The Evaluated Health Promotion Cases for Older People

1.1 National Selection Procedure

In Austria approximately 35 health promotion projects for older people were found. Two of the projects which were chosen for evaluation were selected because they ranked high in the national selection procedure. This procedure – which was carried out by two different researchers – was based on a points system in which points for 16 inclusion criteria were assigned to the projects in the Online-Database¹. “Aktiv ins Alter” and “LIMA” were among the five highest ranked projects in Austria and were therefore chosen for further investigation. “Anders Altern in Radenthein” was additionally chosen because of its focus on health promotion structures and its special focus on local communities and gender aspects. It is highly evidence-based (based on a process- and outcome evaluation) and involved many stakeholders of the local community.

“Aktiv ins Alter“: Two project reports² of “Aktiv ins Alter” were available (Publikumsbericht, Forschungsbericht). Both reports were studied with the healthPROelderly tool for document analysis (Reinprecht, Donat, & Kienzl-Plochberger, 2005; Reinprecht & Kienzl-Plochberger, 2005). After this analysis interviews with key persons of the project (project coordinator and project leader) were carried out in a second step³. In addition, the SWOT-analysis instrument was applied as a non-reactive summarizing method. Because of the lack of appropriate data (i.e. budget details) there are no results concerning cost-effectiveness of the project.

“LIMA“: Two reports were consulted for the evaluation phase (Dangl-Watko, 2004; Schaffer, 2002) and additionally one face-to-face interview was carried out with the

¹ cp. www.healthproelderly.com/database

² A still existing website was not available any more. Instead there were project leaflets, brochures and other information material (e.g. Brochure “Aktiv im Bezirk”, Grätzlwegweiser).

³ Both interviews were adopted in the persons’ office surroundings. The gross interviewing time for each interview was more than one hour (75 and 90 minutes) and the interviews were tape recorded. All interview partners gave their admission for tape recording. For the analysis both interviews were transcribed.

project manager⁴. The interview was transcribed according to established rules of transcription in the social sciences. The SWOT-analysis was applied as a summary.

The third selected health promotion project for older people, “Anders Altern in Radenthein”, is, concerning the applied methods, very comparable with the instruments used for the first project. There were also two official reports for the analysis (Buchinger, Gschwandtner, & Marchner, 2006; Burgstaller, Bauer, & Krenn, 2006), and two telephone interviews with the project manager and the project evaluator were carried out⁵. Also the SWOT analysis was adopted for this project. There was not enough information to carry out a cost-effectiveness-analysis.

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

“Aktiv ins Alter” [AT-16] is a WHO demonstration project (project duration was from December 2002 to June 2005) which combines the active and healthy ageing concept on the individual level with the idea of intersectional exchange of already existing services in the local context (environmental, network) in three significant living areas for older people (Austrians and major migrant groups) in the capital city of Austria (Vienna). By the method of visiting older people between an age of 55 and 80 (with critical life-events) at home, needs and resources of the older individuals were figured out and were linked to accessible health and social services by professionals.

The project has a strong theoretical foundation and also covers deprived and socially excluded “invisible” groups of older people (i.e. economic, social and cultural). These groups are very isolated and not easy to access for health promotion. The project tries to re-activate these older people with a very low threshold approach through personal home visits (“aufsuchende Aktivierung”) which is a very *innovative strategy* and also very effective. An extensive *quantitative scientific evaluation* was also applied.

Furthermore the project has advantages from a *multi-agency perspective* and it was aimed at improving local social and health services which have turned out to be *sustainable*. Interview partners also stated that the project idea is *transferable* to other urban and rural areas which was another justification for the selection of the project.

⁴ duration: 48 minutes

⁵ duration: 52 and 64 minutes

The *LIMA Project* [AT-40] (2001-ongoing) deals with quality of life, life-long learning and cognitive issues in old age. It involves people who are over the age of 55 years in four Federal States of Austria – Vienna, Styria (Steiermark), Lower Austria (Niederösterreich), and Burgenland⁶ – and older people who themselves work with older people (multiplicators). It offers training courses for older people involving four modules: memory training, psychomotor training, training of everyday competences and spiritual questions. The courses are offered in local churches.

It was chosen for evaluation because of its sustainability in Austria (it started in Lower Austria and has now spread to all other regions in Austria) and is still ongoing. It is considered *evidence-based* since in-depth interviews were carried out with the participants of the training courses, well-grounded since it has a *clear theoretical approach* and *holistic* due to the fact that it involves all features of health (physical, mental, social and spiritual health).

“*Anders Altern in Radenthein*” [AT-33] is a health promotion project in the rural area in the Austrian Province of Carinthia (Radenthein). It was carried out from 2003 to 2006 by an association called “Vitamin R”.

Because of the specific history of the geographic area, the main aims of the project were to create a model to develop and implement *sustainable rural structures* (services and infrastructures) for the promotion of health for older people (Note: and for people in professional or private contact with older people). Therefore a very *complex project structure* (project leader, five working groups, external experts and an advisory board) with an *extensive project evaluation* (process and outcome) was developed and carried out in the years 2003-2006.

In addition, the project can be characterised by its *diversity*, *gender sensitiveness*, *accessibility* and the attempt to include *invisible groups* of older people. Health promoting structures were developed in a geographical and physically reachable institution along several working groups for older women, men, professional carers and relatives who care for their own family members. This structural aspect in combination with the process of the project gives it an innovative character which has shown to be *sustainable* and possibly transferable to other contexts.

⁶ In all other Federal States it is called differently.

2 Results of the National Case Studies

2.1 In-depth Analysis of Case 1: “Aktiv ins Alter”



2.1.1 Structure Evaluation Results

Target group

The target group of the health promotion project “Active Ageing”⁷ were older people between the age of 55 to 80 years who live in three distinct areas of Vienna⁸ (see setting approach below). These older people were Austrians but also (socio-economically disadvantaged) migrants, especially people from Turkey or countries from former Yugoslavia who represent the two largest migration groups in Austria. It was also intended to concentrate on older people who experienced a critical life-event, the loss of one’s partner or retirement recently. All groups are in danger of social withdrawal and social isolation.

Theoretical foundation

The background of the project was two-fold: firstly the concept of active and healthy ageing was central as the main theoretical background whereas the WHO defines active ageing as a lifelong “(...) *process of optimising opportunities for health, participation and security in order to enhance quality of life as people age*” (WHO, 2002). The aim is to expand the number of years in which a person can live a healthy life and therefore “*the best investment in health of older people is the promotion of active ageing.*” (Reinprecht & Kienzl-Plochberger, 2005, pp. 3-4). Secondly the problem of local intersectional exchange as a practical phenomenon was dominant. Therefore the theoretical foundation was based on a model which respects two action contexts, the behavioural level of the actor (i.e. of older people) as well as the environmental (i.e. networking of already existing social and health institutions) on the local level. The theoretical premises for the implementation of the project were

⁷ The full project title is „Active Ageing. Investment in the Future of Older People” which is the English translation of the German project name “Aktiv ins Alter. Investition in die Zukunft älterer Menschen”.

⁸ The project was conducted in an international cooperation of three towns which represent three different city types: Vienna (as a metropolitan area) and the two German cities Hannover (as a large city) and Radevormwald (as a small city).

based on four central principles: activation approach⁹, holistic approach¹⁰, diversity approach¹¹ and the social-environment approach¹² (cp. Reinprecht, Donat, & Kienzl-Plochberger, 2005, pp. 5-7). Hence, the core principle is the activation on an individual level which is defined as: “Activation means the experience, sometimes in several steps, of knowing that it’s worthwhile to be active, of realizing that one can actually reach and influence something, and of knowing that you are not only a victim of a situation or a conflict, but an active contributor.” (Richers, 2003, cited by Reinprecht & Kienzl-Plochberger, 2005, p. 13) In addition the linking between (all) institutional actors on the local level – from district area to the political arena – was intended (see goals section).

All in all, the theoretical design of the project was to activate older people (who have experienced a critical life-event recently) by home visits (so called “*aufsuchende Aktivierung*”) by professionals, to survey individual resources of the aged and to bridge their specific health needs with local institutions.

Health determinants

Determined by the approach of healthy and active ageing health determinants were addressed to the fact that “activity” – *can be physical, mental or social* - fosters well-being and this supports different perceptions and promotes health and quality of life of individuals and older people. In the project logic this simultaneously includes two aspects: “activation” on the individual level (e.g. by information) as well as on the local level by networking activities.

⁹ This fosters the importance of “*the possibility of an active and self-determined way of living. Physical, social and mental activity is the basis for well-being and life satisfaction, at last for health*” (Reinprecht & Kienzl-Plochberger, 2005, p. 4).

¹⁰ “*It is a precondition for the promotion of active ageing to recognize and to overcome barriers and hindrances which block the fulfilment of individual needs*” (Ibid., p. 4). A holistic approach includes the individual (economic, social, cultural) as well as the systemic context (social and physical environment, network, system) here.

¹¹ “*When promoting active ageing it is important to accept older people in their variety of lifestyles and ways of life because these lifestyles also influence expectations and standards which are interrelated with ageing. Older people live in different material, social, and cultural circumstances*” (Ibid., p. 5).

¹² “*In old age accommodation and the living environment are a pivotal source for health, quality of life, and activity. The urban living environment is both a restricted area as well as an area with a lot of possibilities*” (Ibid., p. 5).

Setting

The project defined the region or community as its setting whereas three different districts (or areas within the 10th, 12th and 15th district of Vienna, so called “Grätzl”) were chosen. These areas are representative as typical or traditional Viennese residential areas. These areas are also typical “problem areas” with a structural mix of certain socioeconomic and demographic variables as well as different types of buildings: the three areas represent a compendium of migration, blue and white collar workers and areas for older people in Vienna with already existing supporting structures in terms of social and health institutions.

Stakeholders

The project was compiled in a national cooperation structure with local networking partners and in an international exchange: The national project “Active Aging” was a cooperation of the City of Vienna (Stadt Wien), Fonds Soziales Wien (FSW), Wiener Sozialdienste (WS) and the Department of Sociology of the University of Vienna.

In each selected region, local networking partners were involved in the project and were contacted from an early stage on for an intersectional interaction between already existing social and health offers for older people. These partners were the local councils: district representatives (Bezirksvertretung), representatives from senior organisations (Seniorenvertretung), area maintenance (Gebietsbetreuung), health services (e.g. general practitioners, geriatric care centres, pharmacies), social services (Beratungszentrum, Familienzentrum, Kolpinghaus), institutions for further/higher education (Volkshochschulen), cultural institutions, churches but also local coffee shops or restaurants.

In addition, there was also an intense collaboration with two German projects in Hannover (“Gesund alter werden”) and Radevormwald (“Aktiv55plus”)¹³.

Goals of the project

Based on the structural foundation of the project stated above two main goals with several sub-goals of the project can be described. The aims of the project were

1. Strengthening older individuals and improving their quality of life:

- to activate older people through home visits (“*aufsuchende Aktivierung*”)
- to evaluate the social and health needs of older people and to make individual resources visible by means of a standardised interview (including quality of life and active lifestyle)

¹³ See the German evaluation report: Reichert, M., Kuhlmann, A., Lis, A. & Cosack, A. (2008). National Evaluation Report, Germany. Dortmund: Research Institute of Gerontology in Dortmund, Germany.
healthPROelderly – National Report (Austria)

- to support and to empower individuals by regular professional counselling so that older people can use their resources on their own
- to bridge individual needs with local services and initiatives.

2. Enhancement of the social and health infrastructures and improvement of their accessibility:

- to make the concept of active ageing (better) known and to show the benefits of the concept
- to network and to improve the accessibility of already existing regional social and health services and initiatives.

Management structure and budgetary arrangements

The “Wiener Sozialdienste”¹⁴ was the executing organisation (project coordinator) and the Department of Sociology (University of Vienna) was the leading organisation of the project and was responsible for the scientific research and evaluation of “Active Ageing”. The national project team consisted of a project coordinator, seven female staff members (professional counsellors: the team was a mixture of psychologists, social workers, pedagogues with foreign language abilities) and one project administrator. The scientific research team consisted of two sociologists.

2.1.2 Process Evaluation Results

Involvement and activation of target groups

The core of “Active Ageing” is the activation of older people between 55 and 80 years with the method of home visits (“*aufsuchende Aktivierung*”). After contacting the target group¹⁵, there information giving followed as well as a face-to-face interview (Note: all interviews were conducted in the respondents’ mother tongue) with a standardised scientific questionnaire. The interview also touched the individual resources and needs which means special attention was given to their voice/opinion. In addition, counsellors had the aim to connect persons with individual needs with the local social and health institutions. Secondly, there were target group-oriented public relations activities. This was described as the approach on individual level.

¹⁴ Full name: “Wiener Sozialdienste Alten- und Pflegedienste GmbH” – facility offering nursing care at home with public subsidies.

¹⁵ The contact was in 73% of the cases achieved by a letter (contact database of the Wiener Sozialdienste) and in 14% of the cases by word-of-mouth recommendations.

Conversely on the local level the professionals' activities were to strengthen the already existing social and health services and initiatives in the three areas. This networking approach tried to support intersectional co-operations between the institutional actors.

Implementation of the theoretical foundation

With home visits and the questionnaire design¹⁶ it was possible to reach N=335 older people between 55 and 80 years. About 60% of them are Austrians (with relatively high SES, more women, more widowed people, many below 65 years of age) and migrants (with relatively low SES, younger older people, also many men, and married people). Professional counsellors (psychologists, social workers and one pedagogue) connected the individual needs, gathered from the interviews and in the consultation process¹⁷, with the local social and health services in the area.

On the local level several activities were put into practice: first of all there was public relations work (e.g. information material and PR activities (leaflets, brochures) in the mother tongue of the target groups and public events. Secondly, there were networking activities for the local social and health institutions (in each of the three regions according to their services). Thirdly, the project offered information events and consultations together with the local services and initiatives throughout the entire project duration.

Addressing health determinants

The health determinants were in principle addressed through the low threshold approach of the home visits and regular offers on the local level: From the interviews with the project experts it became obvious that the interview initiated a process in which older people reflected about their own situation, about their beliefs, social and health resources as well as their needs. Therefore this was a process that raised the awareness and first activation. After this the counselling of the professionals paved the way to give information about local social and health services which could cover their specific needs.

¹⁶ The theoretical foundation was operationalised through objective (e.g. living conditions, income, health and social relations) and subjective perceptions (e.g. life satisfaction, quality of life), possibilities and barriers for activity, subjective needs and wishes. (Note: the short scale of the WHOQOL World Health Organization Quality of Life was used)

¹⁷ It was intended to arrange an additional date for the next home visit to establish regularity and obligation. For each individual an average of more than one home visit was necessary: in 46% of the cases there were two, in 38% of the cases there were between three and ten, and in 16% of the cases there were eleven or more home visits.

To reach the activation aim several home visits were necessary due to the life circumstances of the target group: More visits were necessary in cases of mourning for a deceased person, individual crisis, family conflicts, ill health but also problems with authorities. But the activation process tried to make use of the strengths, not of the weaknesses, of the older individuals and it was very needs-oriented. It was possible to direct the activation process to social, physical but also to mental (health) needs of the older target group.

Accessibility of the setting

One strength of the project is the setting approach of three typical residential areas for older people in three Viennese districts. In order to link the individual with the local social and health services, offers for older people were designed. These offers were developed in the near environment around the residential areas and the physical and social accessibility was possible (with no or low thresholds).

The activation of older people was possible because of the proceeded instruments and participation possibilities¹⁸ such as: regular on-site consultation-hours (in regional intersection services without advance notification), regulars' table (in each of the three target areas), PR activities (information material, brochures), local events (lectures about retirement legislation, gymnastics, healthy nutrition, eye diseases and diabetes and the lecture series "Leben, laufen, lernen"), networking between the social and health organisations and, last but not least, the above mentioned home visits.

Involvement of stakeholders

Professional counsellors were responsible for the home visits of older people but also for regional networking. Their activities also focussed on networking with services and initiatives but it was not envisaged to create new local offers. It was aimed at reducing contact barriers for older people in their living region. In addition, it was aimed at creating synergies between these existing health and social services.

Therefore, there was a lot of networking activity which led to a large regional compendium of social and health services and initiatives in all three target regions (cp. Reinprecht & Kienzl-Plochberger, 2005, pp. 25-30).

¹⁸ An initial principle was the use of existing services and initiatives, but not all realised offers were planned in advance. A certain flexibility was necessary to design these activation and participation structures (e.g. the regulars' tables are an example for this).

Strategies and methods

A raised awareness of one's own problems of the older citizens was intended. This was conducted by the very innovative strategy of home visits which also has the possibility and function to reach target groups who are completely isolated. Furthermore, it was envisaged to survey the needs of these target groups and to link them to the existing professional services which could cover their needs and look for a problem solution. In total the idea is to link and to bridge individual needs with structural offers. The approach is designed on the basis of low threshold and geographical, physical and social accessibility for the older target group (*also see above*).

Changes and contingencies within the project

It was intended to reach deprived and isolated older people on the individual intervention level. The interview¹⁹ results showed that this aim was not reached completely. In fact the project activated many people with a high SES within the Austrian (cp. Reinprecht, Donat, & Kienzl-Plochberger, 2005, p. 16 and 20). But the method used (activation through home visits) was not efficient enough to reach younger older people. One interview partner stated that there was a semantic problem of the project title "Active Ageing": It was not easy to attract "older" people by the word "ageing".

The personnel recruitment is also very crucial because home visits and local networking need very competent and experienced people, with practical experiences and skills. This prerequisite was not fully given: It would need slightly "(...) *older counsellors with social competences*" (Int. 3, 199-200). Another notable aspect to reach the project aim is that activation needs time (more than one home visit) and trust of the (older) individual. "*In the beginning the 'home visit' was very sluggish and stressful for the counsellors*" (Int. 4, 222-224). It was necessary "(...) *to establish trust and then to work on the individuals' needs*" (Int. 4, 147). About the corporation with important social and health actors: "*It is difficult to get important actors into such a project structure (...) this approaches a limit (...) the limits of the system*" (Int. 3, 182-184).

Another contingency came up due to the metropolitan structure of Vienna. There are a lot of services and initiatives available but it is nearly impossible to make contact to all older people who were really in need.

In addition on the structural level the cooperation with some of the local network partners (services, initiatives) did not work very well, some intended co-operations

¹⁹ One interviewee critically noted: „*The scientifically guided questionnaire was too long but it turned out to be good to have results like this*" (Int.: 3, 206-207).

were frozen and some started their involvement but stopped it again during the project^{20,21}.

2.1.3 Outcome Evaluation Results

Evaluation methods and results

The core of the evaluation was a quantitative questionnaire design in two waves. The standardised face-to-face interviews were carried out with older people during the home visits. It was the method to survey the (objective and subjective factors of) the quality of life of the target group and to start a process of self-reflection in the counselling interaction. In total $N_{t1}=335$ interviews with older people between 55 and 80 years were carried out. A second questionnaire wave was carried out at the end of the project. It was possible to sample $N_{t2}=149$ older people from the first sample again (45 per cent of the first wave), which makes the results of both questionnaire waves comparable.

Cost-effectiveness

It was not possible to receive in-depth details about the financial structure of the project from the reports or from the interviews. Therefore it is not possible to make statements about the cost-effectiveness of the project.

Effects on health (physical, mental, social health)

Both interviewees, who are key persons in the project, stated that the home visits and the scientific survey started to get people thinking about needs, wishes and future plans. The evaluation results (gained from the two questionnaire waves), moreover, showed several important results: There was a raised recognition of information offers and there was an intensification of participation in social activities with significant others. This was mostly the case because there was the possibility “to get support in challenging situations” (as a central coping function). Approximately every

²⁰ Two facts were responsible: (i) the staff got no “access” to the local services and initiatives for the project ideas due to feelings of reservation, fear, and business competition and (ii) it was not possible to have constant cooperation to certain stakeholders which are central for health promotion (e.g. general practitioners).

²¹ Both problems areas, the individual and structural ones, were intensively discussed in the project team in order to cover these problems in an adequate way. There was also a problem exchange on a regional and local level in a reflection group (Reflexionsgruppe) which worked as an “*internal quality circle*” (cp. Int. 3, 222).

other person (48%) has “new social contacts” (*participation*) and many possess “knowledge and raised awareness” (*information*) about important personal issues²². Furthermore, 30% have taken some kind of action for their individual health which increased well-being. Subjective quality of life has increased in many (life) domains (satisfaction, leisure time, health, living and global quality of life)²³.

“Additionally, relatively many requirements were there in terms of mental needs but people feared to be pushed into the ‘mental corner’ due to stigmatisation” (Int. 4., 274-275). But this interviewee also added that there were less services which were able to cover these mental health needs.

Sustainable effects

It is sustainable that *“there are better co-operations on-site now in the areas and between the services and initiatives”* (Int. 4, 284-285). Better communication is now established and competition-thinking among services has now reduced. *“There is a much better perception of immigration groups now (...) and who have special needs which have to be encountered in their mother tongue”* (Int. 4, 286-288). *“The discourse has been enforced and changed”* (Int. 3, 290).

In addition there are some hints of achieved sustainable effects because the second questionnaire wave covered some aspects referring to this: 73% stated that they “want to stay active” after the end of the project and that they “feel well informed”. In addition, 77% stated that their “direct social environment supports their ‘new’ activities” which could be an indicator for social acceptance and control. Furthermore, many people articulated “plans for additional activities” in the (near) future.

Transferable effects

“It could certainly be possible to conduct the project with the idea of ‘activating home visits’ and the networking approach in other regions” (Int. 4, 296-298). The approach is transferable because *“the visiting aspect contains a face-to-face interaction and applies a personal relationship which can automatically in an informal way establish a social obligation”* (Int. 3, 307-309).

In addition, interviewees stated that it is necessary to look at already existing health and social infrastructure in the region where the project is implemented. Therefore the project developed a list of hindering factors on a regional level which can be used

²² More information about personal assistance and financial allowances (48%), own health (needs) (37%), leisure time possibilities (29%), possibilities in living area (24%).

²³ One interviewee stated that the health effects were more visible within the migrant groups because they *“are more ill (...) and have more the tendency to withdraw from social life.”* But the project showed them that *“(...) activities, contact etc. can produce well-being”* (Int. 3, 269-271).

for the transferability of the project if there is the intention to implement it in another context²⁴. It is a list which describes the main barriers to get “access” to and to use social and health services: no service in other languages (84%), not knowing a person (82%), not knowing who is responsible (61%), not feeling understood (36%), service is too far away (27%), and fear of discrimination (23%). Most of the percentages have reduced through the participation in the project.

Public recognition and awards

“Active Ageing” was a demonstration project of the World Health Organization and was carried out in three different cities. In Vienna, in all three settings a lot of PR activities – which all contributed to the public recognition of the project (e.g. through brochures and leaflets) – were conducted and several publications, most built the basis of this report, were published (Reinprecht, Donat, & Kienzl-Plochberger, 2005; Reinprecht & Kienzl-Plochberger, 2005; Wiener Sozialdienste, 2003a, 2003b, 2003c, 2003d, 2003e). Furthermore, there was a public closing event together with the City of Vienna. In addition, there were several project presentations which were held also after the end of the project in the (scientific) community.

Consumer satisfaction

In general, if it was possible to involve older people of the target group, they reported high satisfaction with the project in a positive and friendly way: “*Participants were very satisfied. (...) some were enthusiastic and flourished*” (Int. 4, 319-320). The very positive reaction was especially rooted in the local approach of the project because everything “was not too far away”. Another very strong positive feedback was given about the fact that many things were translated and available in people’s mother tongue.

But there were also some negative responses but only from the younger aged groups (about 55 years). They did not feel attracted by the project which named itself “Active Aging” because they did not see themselves as “old” or “aged”. “*It is difficult to find the right language. (...) it is necessary especially for younger groups because they are important in a special manner*”²⁵ (Int. 3, 328-329). Project officials in the interviews explained that there was a semantic problem with the project title. For the future one has to be more sensitive to the effects of the project (name).

²⁴ Note: The questionnaire was the same across countries which also showed that the survey is transferable.

²⁵ For instance because of the transition from “working life” to “retirement”.

Empowerment of older people

It was possible to start an empowerment process from the beginning when it was possible to get an access to older peoples' homes. Surprisingly also the questionnaire started an activation process where people started thinking about themselves and about their own living situation. The process was facilitated because the home visits and interviews were with a professional counsellor²⁶ (psychologist, social worker, pedagogue). In many cases it was necessary to visit the older person again and again but like this it was possible to win the trust of the target group, to motivate and activate them on the basis of their strengths and resources and to link their specific needs to local offers, to local health and social services and initiatives.

2.2 In-depth Analysis of Case 2: “LIMA²⁷”



When talking about the LIMA project, which is carried out in all dioceses, this report takes into account the original project in Lower Austria (2001-2002) which is especially interesting because of its evaluation. Additionally, it is of special interest to look at the current situation in Austria – for this purpose the diocese of Vienna was chosen. This means that two subprojects of LIMA have been analysed which are characteristic for the developments in Austria (the original evaluated project in Lower Austria and one of the current projects in Vienna). The LIMA projects are still on-going in all dioceses (and Federal States) in Austria²⁸.

2.2.1 Structure Evaluation Results

Target groups

The target groups of LIMA are older people (55+) who on the one hand want to be trained as LIMA trainers and on the other hand those who participate in the LIMA training courses. Trainers, who are in two-thirds of all cases over 60 years old (Int. 1, 35), are educated and equipped with material in order to offer a four module course to older people in the community. Trainers are people from visible groups (mostly

²⁶ Note: the home visits and interviews were in the mother tongue of the older person. There was a professional atmosphere in which it was possible to reflect about personal circumstances.

²⁷ Original title: “Lebensqualität im Alter”.

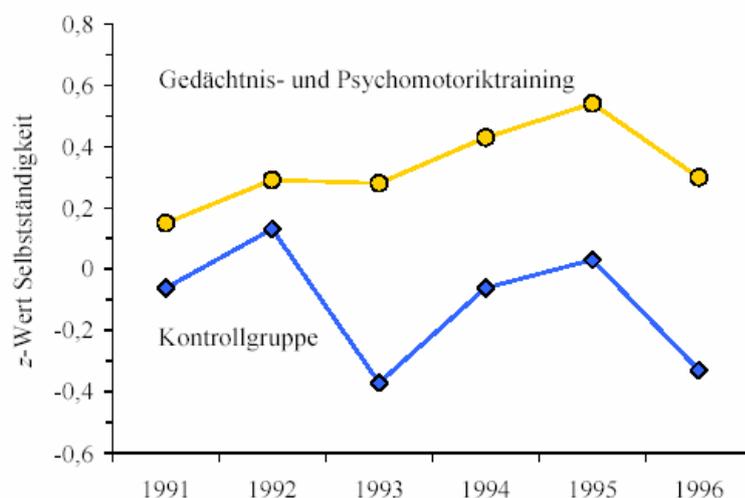
²⁸ The boundaries between the single LIMA projects in Austria are not based on the Federal States' boundaries but on the dioceses' boundaries. One project does therefore not take place in **one** Federal State, but in **one** diocese which can overlap with two Federal States.

female) – gatekeepers and people who work at interfaces in senior centres, in mobile care institutions, or who are responsible for older people in e.g. a day-care-centre. The groups of participants in the LIMA courses are people from invisible groups (remote areas, small villages, very old age). The groups are described as very diverse. Participants are reached through the LIMA trainers who go to a certain place, church or community and start a LIMA course there or directly through people from the community who call at the LIMA office and ask for a course in a certain town or village (Int. 1, 10-20).

Theoretical foundation

LIMA is based on a longitudinal study (N=375) from a German University in Erlangen-Nürnberg, called SIMA²⁹ (Independence in Old Age) which started in 1991. The results of the study (in 1998, N=340) showed that through combining memory training and psychomotor training, the best possible results for being independent in old age could be reached (cp. Oswald, Rupprecht, & Hagen, 2007). The table below shows that those older people who participated in both memory and psychomotor training show a significantly higher rate of independence than those in the control group (Ibid.).

The graph below from the SIMA study shows the degree of autonomy on the vertical scale and the time frame on the x-axis. The control group (blue curve) shows a lower degree of autonomy and independence over the course of the study than those who participated in the psychomotor and memory training of SIMA (yellow curve).



Eine regressionsanalytische Kurvenanpassung erwies als nicht erfolgreich
 $p_{global} = .028$, Wilcoxon-Mann-Whitney-Test zweiseitig, fallende Fallzahlen

(Source: Oswald, Rupprecht, & Hagen, 2007, p. 9)

²⁹ "Selbstständigkeit im Alter" (SIMA)

After the study a training concept for older people was developed and published in the form of a book (including training materials), which is also used by the Austrian LIMA project. LIMA can therefore be seen as evidence-based.

Health determinants

In the project health determinants were addressed on all levels. The physical variable is taken into account in the psychomotor trainings and some consideration is taken of healthy nutrition. Still, the psychological variable is more crucially covered in the LIMA courses: quality of life, well-being, motivation, happiness, independence and autonomy. Cognitive issues and life-long learning play a major role in LIMA, since trainers (60+) are being motivated to stay mentally fit and also participants are trained in mental health with the help of the training of everyday competences and the memory training. Additionally spiritual questions are addressed in terms of meaning of life, religious questions, death and illness (cp. Schaffer, 2002). Some social determinants of health are also addressed: socio-economic differences between the participants (Int. 1, 122-123). Geographical factors also play a major role: older people from urban areas are easier to activate than people from remote areas who have worked their whole life without indulging in anything for themselves (Int. 1, 113-121).

Setting

The general setting of LIMA is the community setting. Older people from the community (rural or urban areas) are to be reached with LIMA. Since the project is coordinated by a subdivision of the Catholic church, churches and locations rented by or dedicated to churches (monasteries, Don-Bosco Houses, Hippolyt Houses) are the explicit setting of the LIMA courses (cp. Schaffer, 2002). These settings were chosen because of the practical benefit (no rents) to LIMA and because there are many churches, even in remote areas. This way LIMA was able to be close to people's homes (in their towns, in their districts etc.) and therefore accessible. There is also the possibility for institutions of (higher) education to integrate a LIMA course into their existing course programmes, e.g. adult education centres (*Volkshochschulen*).

Stakeholders

LIMA does not involve many stakeholders except for sponsors and stakeholders who have a close relationship to the lead organisation (the Catholic Church). Mainly the LIMA courses can only be carried out through the lead organisation (Int. 1, 203-204) due to quality assurance standards. All those who want to implement a LIMA course naturally become partners.

Goals of the project

The goals of the pilot LIMA project in Lower Austria (2001-2002) were:

- to carry out six LIMA training courses
- with 20 participants (future trainers) (= 100% efficiency),
- to apply a regional approach,
- to receive positive feedback from participants (*consumer satisfaction*),
- to make sure that two-thirds of all participants would still use their know-how one year after the end of the training course.

Management structure and budgetary arrangements

The project is centrally organised and managed, meaning that the lead organisation (Catholic Educational Institute)³⁰ in each diocese 'pulls all the strings' (Int. 1, 54-56). In the project there is a project manager per diocese, referees and speakers, one leader of the training courses, and a secretary. Additionally there was a responsible person at the funding institution (e.g. Funds for a Healthy Austria).

The budget is centrally organised, trainers are paid with remunerations after the courses and participants have to pay a contribution to participate. No profits or losses are supposed to be generated by the project. The original project in Lower Austria (2001-2002) was approved with a budget³¹ of 24,200 € personnel costs, 35,610 € material costs, and 8,358 € preparation costs, which sums up to 68,168 € total costs. 31,976 € were taken in by funding and course contributions. This makes a deficit of 36,192 € (cp. Schaffer, 2002).

In general one training course was calculated with 5.167 € per year. 2.907 € can be taken in by course contributions per year, which means that each course makes a minus of 2.260 € per year. The deficit was carried by the Catholic Church.

2.2.2 Process Evaluation Results

Activation and involvement of target groups

Potential trainers are activated through information events and trial evenings/lessons (cp. Schaffer, 2002). Brochures and information material are distributed there by the project manager and others. From 52 participants in the first information event in

³⁰ Katholisches Bildungswerk www.bildungswerk.at.

³¹ The project was calculated in Austrian Shillings (ATS). The numbers have been converted into Euros with a conversion rate of 13,76 ATS per Euro.

Lower Austria 32 signed up for a LIMA course the same evening (among them two men). Information about LIMA is delivered and distributed on a regional level. If no one is interested and signs up, the project “does not give up”, but tries – up to three semesters – to implement groups in certain regions. “*You need stamina and you must not give up and you must not be discouraged or demoralized because it’s just not that simple.*” (Int. 1, 252-254) Participants (*invisible groups*) are reached through the trainers (*visible groups*) or they themselves call the head organisation to be put in touch with LIMA.

Implementation of the theoretical foundation

The longitudinal study SIMA produced handbooks in three volumes (Baumann & Leye, 1995; Oswald, 1998; Oswald & Gunzelmann, 1995) on memory training, psychomotor training and competence training which are used in every LIMA lesson. Depending on the theme of the LIMA lesson, e.g. a competence theme, the competence handbook is studied and a lesson is creatively framed around the main theme. This is one of the characteristics of the project: that it is scientifically founded. The most important issue is to combine memory, competence and psychomotor training since it is evidence-based that this particular combination positively affects independence in old age (Int. 1, 76-79). Without the theoretical background of the SIMA study, LIMA would not be possible.

Addressing health determinants

Several factors which determine older people’s health were addressed in the course of the project, some directly some indirectly: socio-economic status – LIMA was also implemented in rural areas where income is low, culture – older people’s understanding of and access to learning and education were crucial determinants for entering the LIMA project, family structure – many older people living alone had no driver to the LIMA courses, living condition – major differences were observed between geographic regions, and social support issues – networking and personal relationships were addressed as a major health determinant (Int. 1, 101-141).

Accessibility of the setting

One of LIMA’s main strengths lies in the fact that it takes place in rural and remote areas in Austria. Granting geographical accessibility to LIMA courses in rural areas is however hard due to a lack of financial means and a missing network of “drivers”. Older people who are not mobile enough to drive hardly get access to the project. Therefore several solutions have been developed which are put into action in case of need: trainers pick up older frail people, one participant who is still mobile picks up older frail people, or young persons carrying out alternative service (*Zivildienst*) pick up older people and drive them home again.

Accessibility to buildings in LIMA is also hard, since many churches are “old” and certainly not handicapped accessible (Int. 1, 172-173). “*The majority are definitely not equipped.*” (Int. 1, 175), the project manager admits. But the head organisation is conscious about granting accessibility to transport and buildings, the main problem is of a financial nature – many churches would have to be renovated.

Involvement and activation of stakeholders

Other organisations or partners are not involved in the project. It does not follow a multi-agency approach because it is subject to strict quality standards which are monitored by the head organisation (Int. 1, 206).

Strategies and methods used

The project used the LIMA training courses to equip older people from visible groups and LIMA courses with four training modules to activate older people from the community. In these courses many different strategies were combined, like making available social support, developing personal skills, learning practical abilities etc. An example for a practical ability is a kinesiology training which was carried out in 2003 in Lower Austria: exercises for eyes and ears, relaxation of the neck and many others. Enabling and advocacy – two strategies from the Ottawa Charta (cp. WHO, 1986) – were put into practice. Other strategies were increasing social networking (Int. 1, 265-266), the exchange of material between older people (Int. 1, 242), and activating one’s neighbour (Int. 1, 261-262). Life-long learning strategies are also used throughout the project.

Changes and contingencies within the project

The main mission or request of LIMA is to reach older people in the community with their combined memory and psychomotor training. Because it has sometimes been hard in the course of the project to activate people, a further development of the project might be necessary, e.g. LIMA at home. Older people who do not leave their homes often should be activated and empowered. The strategies for this “new” project are still in discussion (Int. 1, 259-260).

The biggest barrier is to reach participants – older people in the community setting. The most meaningful solution is to keep motivating the LIMA trainers to promote the project. Other changes or contingencies were not documented.

2.2.3 Outcome Evaluation Results

Evaluation methods and results

In Lower Austria an outcome evaluation took place with participants of the first training course (with six participants in total) with interviews and questionnaires

(Schaffer, 2002). In other dioceses evaluations are still outstanding (Int. 1, 294-295). The evaluation in Lower Austria showed high expectations of the participants and high consumer satisfaction with the meaningfulness and practicability of LIMA courses. About 50% of the trainers were able to use the psychomotor and memory training for themselves as well as for their clients and participants. It was requested to extend questions on spirituality and beliefs in the courses. Courses were positively evaluated and strengthened older people's motivation (Dangl-Watko, 2004). Balance between practical training and theoretical input was valued as "good" from four out of six interviewed persons (Schaffer, 2002).

Cost-effectiveness of the project

Financial gains for the Federal States and the government were stated as major outcomes of the project. LIMA makes an active and evidence-based contribution to promoting independence in old age, which keeps risks of falls and hospitalisation costs down (Int. 1, 340-345). LIMA is financed through the Catholic church (and its sponsors) as well as (partly) through church taxes. Information events are free, marketing material for the LIMA trainers are free as well, and it is possible to get a discount on the course fee (Dangl-Watko, 2004).

Gains and benefits from LIMA can therefore be described as social and financial gains for active prevention work in the community.

Effects on health (physical, mental, social health)

Effects on health can be separated between the effects for the trainers and the effects for the participants.

The trainers' health was affected through the practical know-how they gained in the LIMA training courses on psychomotor training and memory training, which they used also for themselves: *"Memory training is also very useful for myself."* (Schaffer, 2002, p. 29), *"I gained most from the memory training – for my personal health"* (Ibid., p. 29). By 2004 84 people had been trained and empowered to be LIMA trainers, most of them over 60 years old (cp. Dangl-Watko, 2004).

One interviewee summarized the effects on health for the participants with the following statements: more quality of life and happiness was monitored by the trainers, muscles were built up and joints were kept moveable, easy exercises for everyday life were communicated, healthy nutrition was discussed, concentration was constantly trained, social capital was enhanced and increased, and spiritual questions were answered (Int. 1, 296ff.). This can be seen as descriptive evidence.

Sustainable effects

The question on why and how LIMA was – compared to other health promoting projects – so sustainable was answered with the following statements from one of the interviewees (Int. 1, 357-377):

- *“we have a trainers network”*
- *“trainers are surrounded by the LIMA family”*
- *“they feel well”*
- *“they are supervised well”*
- *“they are not left alone”*
- *“without the trainers this project would not exist”*
- *“they [the participants] are really looking forward to the day it [the course] begins”*
- *“it wouldn’t be that easy if the surroundings/structures were different”.*

Generally speaking the main strengths of LIMA are a functioning network of trainers, good supervision by the lead organisation, and appreciation and recognition of the trainers’ work and motivation by the head organisation.

Additionally, LIMA has spread to all other dioceses and is currently carried out in the whole country: *“In the diocese of Graz the project LIMA was launched and is currently also very successful there”* (Dangl-Watko, 2004, p. 3). The church as a setting can be seen as a booster to sustainability.

Transferable effects

The project documentation showed some interesting transferable effects. Here two examples: *“I will pass on very much in our residence [Note: for older people]”* (Schaffer, 2002, p. 31) and *“I received practical instruments to work with seniors in this area”* (Schaffer, 2002, p. 29).

Also the project was piloted in another country. A diocese in the Czech Republic was equipped with a training course. In 2006 a training course was held there and 15 older people were educated as trainers (Int. 1, 388-392). This is evidence of the transferability of LIMA which can be implemented anywhere. The prerequisite is: an “appropriate” partner in the respective country.

The project itself is a transferred project since it was piloted in Germany and has now been adapted to Austria. This is a clear indicator for the fact that LIMA is indeed transferable.

Public recognition and awards

LIMA received an award in 2005 in the category “adult education” of the “Danube University of the City of Krems (Donau-Universität-Krems, 2005; Schaffer, 2002, p. 29). Unfortunately it was not widely published and results about the project are hardly

made accessible to the public or the scientific (health promotion) community (except for internal print material of the Catholic church).

Consumer satisfaction

100% of the interviewed persons in Lower Austria (N=6) would recommend the LIMA training courses. All criticism was considered as an input for future courses and so served as a quality assuring method in the project (Schaffer, 2002).

Empowerment of older people

Trainers were equipped and empowered with practical know-how in four modules: memory training, psychomotor training, training of everyday competences and spiritual questions and are now capable of promoting the health of other older people (Schaffer, 2002).

2.3 In-depth Analysis of Case 3: “Anders Altern in Radenthein”³²

2.3.1 Structure Evaluation Results



Target groups

There were four major target groups of “Anders Altern in Radenthein” (Burgstaller, Bauer, & Krenn, 2006):

- older men in middle age (“Lebensmitte”)
- older women in middle age (“Lebensmitte”)
- people who care for one/more of their relatives
- frail older people.

The targeted groups were very heterogeneous: They differed in age, former careers, and educational background (cp. Buchinger, Gschwandtner, & Marchner, 2006, p. 8). The differentiation between older men and older women was planned from the beginning, since the gender aspect was pivotal in the project. Visible groups, like general practitioners and pharmacists, were accessed by the project (Int. 6, 46) and

³² Translated: “Ageing differently in Radenthein”
healthPROelderly – National Report (Austria)

as a consequence it was possible to reach older people from the community (invisible groups). The municipality also supported the project.

It was essential that the association Vitamin R was known in the region of Millstätter See/Radenthein and that its work was generally appreciated and highly valued by the population. With this good reputation the foundation of the project was laid (Int. 6, 45-47).

Theoretical foundation

There was no single theoretical foundation of “Anders Altern”. However a literature review was carried out in the beginning of the project and the quality criteria of health promotion (sustainability, participation, empowerment, gender) and the Ottawa Charta were used as a scientific foundation of the project (cp. Burgstaller, Bauer, & Krenn, 2006). *“We work according to theoretical principles”* (Int. 6, 14). The specific and practical needs of older people in the community of Radenthein still remained the cornerstone of the project.

The project dealt with health promotion on a micro and macro level: it enclosed the needs of individuals but also aimed at influencing structures and political life.

Health determinants

The project mainly addressed structural determinants which influence health and social factors of health – social support, individual and group empowerment, living conditions, singularisation in society, and gender.

In the working groups (“Arbeitskreise”) also psychosocial factors and determinants were addressed, e.g. self-respect, self-care, psychosocial support, and emotional wellbeing.



Setting

The setting of the project was the local community of Radenthein in which the association Vitamin R had been working already for seven years when the project started. The rural region of Radenthein/Millstätter See is special in Austria due to its population characteristics: the higher-than-average rate of older people and the poor economic conditions in the region (Int. 6, 24-25). The high rate of older people can be explained by two factors: the downsizing of employees at Veitsch-Radex GmbH, and the mobility of younger people into larger cities away from Radenthein because of the poor economic situation and the consequential “leaving behind” of older people there. Because of the conditions and characteristics of the region, projects for older people might be more valuable than in other Austrian regions.

Stakeholders

The project took the multi-agency approach seriously – many governmental, non-governmental and professional organisations were involved in the project. Also co-operation was established with other health promotion projects in the Federal State (e.g. “Geh ma” and “Lebenswerte Lebenswelten”). Because of the constant motivation to involve other organisations the project was *very* sustainable in the end: *“Follow-up projects, like the pilot project for the development of a visiting service (Note: ‘Besuchsdienst’) in Radenthein with the Red Cross Spittal, are last but not least direct results of our networking work”* (Burgstaller, Bauer, & Krenn, 2006, p. 66). Networking activities were taken seriously because Vitamin R wanted to make health promotion for older people an issue in people’s personal and political life in the region. Existing structures for older people were therefore used to spread the news about the project.

Goals of the project

The main goal of the project was to develop structures and offers for older people in a sustainable way and to link this factor with the evolvement of personal competences of older people. Thus the goal was to apply individual and environmental strategies in the project in order for health promotion to be sustainable. The other goal was social activation of older men and women in Radenthein (Int. 6, 30-32).

Management structure and budgetary arrangements

The management structures of the project were very complex. There were explicit communication structures and time to communicate problems was given in different steering groups and retreats. Different instruments, e.g. an instrument for self-evaluation, assured the quality of the project's work. *“The internal project structure appointed responsibilities, roles and functions and with clear communication structures controls the information flow in the project.”*

In the two analysed reports there were no hints at budgetary arrangements of the total project. One interviewee was asked about cost-effectiveness of the project (see below).

2.3.2 Process Evaluation Results

Involvement and activation of target groups

Older people were reached by using existing structures in the region, e.g. day-care-centres (Tagesstätten), or other places older people would be at in their daily living activities (Int. 6, 48-49). Existing groups of older people from the Catholic women’s movement, the protestant women’s table, and several seniors’ associations were

visited and the project was presented there (cp. Burgstaller, Bauer, & Krenn, 2006, p. 60). Also, existing social networks of friends, neighbours, and relatives were used to reach older people. Information was also passed on to important authorities, like general practitioners or churches (Ibid.).

It was important that the target groups had a voice in the working groups (“Arbeitskreise”) and that their needs were addressed. The target groups themselves raised the issues they wanted to address in the course of the working groups.

Again, it was crucial that the association “Vitamin R” was well known in the region of Radenthein. Due to that fact projects carried out by Vitamin R were positively connoted from the beginning, as also “Anders Altern in Radenthein”.

Implementation of the theoretical foundation

Addressing the question how the theoretical foundation benefited the project during its life time, one interview partner answered that it was the foundation for the project team. Many competencies which were worked out in the beginning of the project were carried on to team members and there were a lot of workshops and advanced and continuing training throughout the project (cp. Int. 6, 60-63).

Additionally there were several (nine) retreats (“Klausuren”): each retreat was for the entire project team (a half-day) and for each key emphasis. The project leader, evaluator and health promotion experts plus the key persons were present.

Addressing health determinants

Some social determinants were predetermined by the project structure: On the one hand older people from disadvantaged backgrounds were not addressed. On the other hand gender was a determinant which was constantly responded to throughout the project (cp. Int. 6, 68-70).

The working groups dealt with different determinants of health. The women’s working group dealt with psychosocial determinants of health, like one’s own perception of the body, women and their free time, changes occurring in different phases of life, and emotional support by social networks (cp. Burgstaller, Bauer, & Krenn, 2006). The men’s working group addressed specific social issues like performance and accomplishments and social roles. The male experts who were invited at the first meetings of the group were highly valued in comparison to the experts’ status in the women’s group.

Accessibility of the setting

Most of the project activities were carried out in a central building used and developed by Vitamin R called “Anderes Haus des Alterns (AHA)”³³ in Radenthein. It was seen as important that the majority of activities were performed in the same place because it became a local setting of wellbeing and a significant point and reference centre for older people in the region. The building is specially designed for older people – it is suitable for disabled people as well. Water and fruit were always available in the AHA.

As also in “LIMA” (see above), transportation to the AHA was often problematic. A missing network of “drivers” made free access to the project difficult, although sometimes relatives, who were still mobile, took over the transportation of participants and sometimes volunteers took over this task. For some older people the House was accessible by foot since it is in the centre of Radenthein (Int. 6, 81-85).

Involvement of stakeholders

There were several roles other partners and stakeholders took over throughout the project (Burgstaller, Bauer, & Krenn, 2006, p. 11ff):

- There was an advisory board to the project which consisted of five external experts. These experts were people from the public health context, health promotion context, project funding or management, and experts with specific knowledge in ageing and gender.
- There were also meetings with different platforms (health promotion, ageing, etc.).
- Experts who were invited in the actual working groups were also actively involved in the project.
- Networking activities with other health promotion projects in the region were sought, e.g. the project “Geh ma”³⁴ or “Lebenswerte Lebenswelten”³⁵.

Summarized, regional and local platforms were well used and experiences from other projects were taken seriously and lessons learned were transferred to one’s own project.

³³ Which means „Different House of Ageing“, constructed by the Federal State of Carinthia and co-financed by the Gemeinde Radenthein.

³⁴ Carried out by the Familienforum Mölltal.

³⁵ Carried out by the Institute for Social Medicine Graz.

Strategies and methods used

Concerning health promotion strategies the project first of all aimed at changing and influencing existing structures (systemic level), which means that behavioural aspects of health promotion were definitely not in the foreground of the project. All behavioural health promotion strategies used were resource-oriented – all activities meant to strengthen the personal resources of older people and to equip them with tools to see their own resources and to be able to use them for their own health benefit, e.g. development of personal competences (Int. 6, 101-103).

The main health promotion strategies were empowerment and participation, social activation for more quality of life, and health information.

Changes and contingencies within the project

Two of the working groups had difficulties with acquiring participants. The working group for carers was only visited by professionals, not by older people themselves³⁶. The working group for older people in general was not suitable for the region since there were already many offers for this target group which were well established (cp. Burgstaller, Bauer, & Krenn, 2006). The project management and steering committee discussed the re-organisation of these working groups and changed/adapted the goals of the working groups to the existing structures in the area.

Changes and contingencies were also regularly addressed at the retreats (“Klausuren”). It was therefore possible to adapt (missing) quality standards and to adjust behaviour and goal setting to existing problems. The retreats were an essential reflection time for the whole project team.

2.3.3 Outcome Evaluation Results

Evaluation methods and results

The evaluation characteristic of the project is that it was an external formative evaluation which accompanied the development and implementation of the project³⁷. Therefore the core principles of the evaluation were to analyse and verify all relevant project dimensions (i.e. structures and individuals, concept and content, processes

³⁶ It was intentionalized that the working groups are visited by professionals and older people themselves in the first project year but after that the groups were supposed to function on their own without experts.

³⁷ The evaluation aimed to support the responsible persons to reflect the concept, the framework, possibilities and constraints. The evaluation was also conceptualised to offer a basis for orientation and decisions.

and results), to reflect and verify central quality criteria (working principles) and to take the relevant target groups (see *above*) into account. The methods for the evaluation were the analysis of all relevant and available documents, the performing of project retreats (*Klausuren*), and realisation of focus group interviews and the development of instruments for self-reflection (cp. Buchinger, Gschwandtner, & Marchner, 2006, pp. 12-13). In total, the evaluation can be characterised as a qualitative process evaluation (e.g. quarterly retreats with responsible persons) containing a small qualitative outcome evaluation (through ex-post-evaluation discussions and interviews with local officials at the end of the project)³⁸.

In addition, an important strength of the evaluation was the evaluating organisation. Solution & Helix are experts in evaluation but also in important content aspects of the project (i.e. health promotion, gender, social ageing, etc.) which eased the project development (cp. Int. 5, 194-198).

Moreover an important characteristic of the entire project (evaluation) was the development of aims, criteria, instruments, measures and indicators. They were developed to control the project aims in the very complex project which was “(...) a very work intensive but also very productive and meaningful process. Especially for the continuation of the project and the entire project idea“ (Int. 5, 174-178). In addition, for each of the working groups (*Arbeitskreise*) an expert was responsible³⁹.

Cost-effectiveness of the project

An analysis of the cost-effectiveness of the project was not possible. None of the reports included financial statements. Just one interviewee made a very significant statement about it: She/he stated that there was a high cost-effectiveness of the project but this was only possible “(...) because of the unpaid extra work of all project employees (...). Only like this it was possible to achieve a huge benefit from the project” (Int. 5, 215-216).

Effects on health (physical, mental, social health)

One interviewee stated a significant example which describes the “health effects” which were reached. The example was made concerning the established groups (*Arbeitskreise*) of older men and women in the project: “Discussions came up about

³⁸ The authors of the evaluation report about all evaluation characteristics of the project in three main sections: evaluation of the entire project, the key emphasis of the projects, and the effects (ex-post-interviews, focus group discussions). The evaluation report documents all phases and milestones of the evaluation in a very detailed and critical way (cp. Buchinger et al., 2006).

³⁹ He/she took over the moderation of his/her working group and also produced protocols/minutes of the working sessions which described and documented the process and contributed to the results.

different approaches (...) which were extremely efficient and somehow 'healing'. This marked the beginning of collective processes and structures which supported integration and communication, which was the actual revolutionary act in this process. Especially at the men's group a came into motion" (Int. 5, 225-229).

Furthermore the outcome evaluation concentrated on several aims of the focus group discussions⁴⁰: The main results demonstrate the high meaningfulness of the established group activities⁴¹ with important behavioural changes⁴². There were strong personal requests for the sustainability of structures and an increased diversification of issues. Also the external moderation was mentioned positively and the homogeneity of gender groups (cp. Buchinger, Gschwandtner, & Marchner, 2006, pp. 71-80).

Interviews with local officials (e.g. general practitioners, pharmacists, and clerics) enriched the results of the project. In their opinion the project increased the awareness and the recognition of important health issues through high-quality activities of the project actors and organisations. Also the necessity of sustainable structures was noted (Ibid., pp. 81-90).

Sustainable effects

Sustainability was a central quality criterion of the project through (i) raised long-term awareness of health promotion for different groups of older people and (ii) the future organisational covering of services and structures.

To which degree the sustainability of the project was reached is not totally clear. But some regional organisations now have the control over certain, still existing, (service) structures which were developed within the project. Furthermore there is a detailed description of standards for health promotion with quality criteria and indicators for older people in different dimensions now. There was also a certain political anchorage of health promotion for older people on the local and (not only through this project, but) also on the regional level: *"Criteria for health promotion and general prevention were developed for the Federal State of Carinthia for the allocation of subventions in health promotion projects"* (Int. 5, 277-278) which demonstrates the sustainable effects of good health promotion or promotion projects and which is –

⁴⁰ In total, 31 persons (26 women and 7 men) participated in four focus group discussions which had an average duration of two to three hours.

⁴¹ Persons in the focus group described the importance with: to have (new) personal contact and support, to have a certain structure and time frame, to talk freely in a secure and creative setting, to debate about one's own body and sexuality, a changed exposure to certain issues which led to a changed awareness.

⁴² Such as: gained security, new social contacts and companionship, more sensitive towards one's own body and health; to think about important issues in life, to have PR and success.

incidentally – also a result on the structural level⁴³ (cp. Buchinger, Gschwandtner, & Marchner, 2006, p. 97).

Transferable effects

There are not many markers which can show the transferability of the project to other health promotion contexts. But it is important to mention the availability of quality criteria and the indicators which are necessary to evaluate the successfulness of the implementation of the project. *“It was possible to create an important framework through the description of qualities: aims and indicators mirror these qualities. It was possible to put much into practice.”* (Minutes of the evaluation retreat in February 2006 cited by Buchinger, Gschwandtner, & Marchner, 2006, p. 40). *“In general the transferability of the quality criteria (...) is seen to be possible on this basis”* (Ibid.).

Public recognition and awards

The project reached public recognition, first of all mainly on a regional level. There were continuing reports and announcements of the project in local newspapers (e.g. Kleine Zeitung, Kärntner Woche, Kärntner Tageszeitung, Gemeindezeitung Radenthein) as well as national newspapers (Kronen Zeitung, Salzburger Nachrichten, Gesundes Österreich). Additionally, there was a press conference in the beginning of the project with all funding organisations. Two radio interviews were carried out in November 2003 and November 2004 with a regional radio station.

Also there were different project events where older people themselves also organized and framed the programme.

Consumer satisfaction

From the outcome evaluation of the project it became clear – as already stated above – that most of the older people were very happy with the project. A significant summarizing statement is: *“The participants of the evaluation workshops said that the project was very valuable for them, for instance due to the social contacts there”* (Int. 5, 259-261).

⁴³ This statement was made as a reaction of a central critique. In the own words of the interviewee: *„There is a lot going on disguised as health promotion – projects which amongst others, are financed by the Funds for a Healthy Austria. Most of them do not apply any kind of structural health promotion, which is very difficult to handle in my opinion”* (Int. 5, 273-275).

Empowerment of older people

It was intended to develop and to communicate health promoting competences through the project. The project also sought to promote the handling of people's own ageing as well as with the different target groups of the project.

Empowerment was achieved amongst the people taking part in the project. It was possible for them to gain additional knowledge but *“the collective discussions and reflexions during group meetings or in the working groups could be identified as the central element of empowerment”* (Buchinger, Gschwandtner, & Marchner, 2006, p. 95) with the important aspect of qualitative leadership and moderation of the group processes as an essential framework condition.

3 Conclusions

3.1 Recommendations for Successful Health Promotion for Older People

Structure

Generally a lack of information can be described in Austrian projects. Processes and outcomes of health promotion projects need to be made accessible and need to be published/documentated more in the future. The Austrian projects mainly document structures and goals, but hardly ever do project descriptions contain specific results or details about the developments and changes throughout the project. Sometimes final reports are not even available. Also there is hardly any information on gender, theoretical foundation, and cost-effectiveness of the health promotion initiatives in Austria. This calls for immediate action for the future.

Funding institutions need to make *documentation and evaluation* possible for projects. Concrete funds have to be dedicated to documentation from the very beginning of the project. Otherwise transferability and sustainability are adversely affected. One result supporting this argument is that an evidence-based theoretical approach and the respective materials (LIMA) can be seen as a strength for a sustainable project. The LIMA project could never have been carried out without solid material and documentation of the SIMA study.

As far as the structure and the first planning of health promotion projects for older people is concerned, there are several recommendations which can be deduced for the *target groups*: Clearly defined target groups from the beginning are a strength (e.g. older people in general as opposed to older migrants from Turkey in the 3rd district of Vienna). If a project aims at involving disadvantaged groups this needs to be made clear from the beginning and they need to be defined very specifically. It is also helpful to use visible groups of older people – those at interfaces – to reach out to invisible groups of older people – those at home, with health problems etc. Contribution fees for participating in courses or the like are mostly detrimental to involving disadvantaged target groups. Also, it was seen as a strength, when older people were activated by older people themselves.

Projects need to consider gender and ethnics from the beginning. Men, women, and different ethnic groups have completely different goals in health; men and women deal differently with health issues and migrants have other needs than natives.

Concerning the *setting*, it is essential to be c l o s e to the target group and to define what that means. The closest setting can be a sports club in the centre of town, but it can also be one's own home. It just has to be in the very near living environment of older people – a place where they would be anyway. It is therefore seen as essential to offer local health promotion activities in Austria. Also, these locations have to be

looked at in the conception phase of a health promotion project: Do older people live here? What does the exact living situation in this setting look like (unemployment, downsizing of older employees in the town's largest organisation etc.)? The executing organisation should be well-known in the setting and people should trust its services.

A *multi-professional team* was also seen as a vital recommendation for future projects. Ageing and health involve many diverse professional groups and for a health promotion project to be holistic it should have a multi-professional team. The personal motivation of key promoters or key managers is also essential for the functioning of the project. The embedding in an international project context (like "Aktiv ins Alter") and the respective networking activities are also recommended. If an international context is not possible, linking to other regional projects is positive ("Anders Altern in Radenthein"). It is important to not invent everything again, but to work together. Health promotion projects should not be isolated from each other.

Process

In the course of a project it is important to distinguish between:

- projects which are actively developing new material/strategies etc., and
- projects which are using material from former or other projects.

If *material* from other or former projects is used, it is important that your materials are dependable. If so, health outcomes can be increased (LIMA).

It is seen as a strength of the process in health promotion projects if an *executing organisation* has already been working with older people on a regular basis. This guarantees the access to the target group and an experienced team. A combination of individual and structural, behavioural and environmental, health promotion is also positive.

Projects have to be made public. There are manifold ways of raising *public awareness* about health promotion (radio interviews, folders, posters, native language flyers etc.). If it is not made public – apart from the executing institution – it is hard to reach the target group after a while (LIMA). A good PR-strategy will guarantee access to older people and will raise awareness about the topic of health promotion. Media have to be specifically chosen (regional newspapers as opposed to an organisation's internal newsletter) and be able to reach the target groups, the setting, and the enablers of the project.

Closeness to the target group is also essential during the process of the project. *Accountability and reliability* have to be established between the project team and older people, and also between networks of trainers. Accountability has to be created also for older people – their health has to become a value in their life. This can sometimes be reached with a contribution fee. Services and strategies have to differ

between men and women. Services have to be conceptualized as broadly as possible so that all interested older people will find “their core interest”. If a project is holistic, the chance rises that it is interesting for many people. This does not mean that health promotion becomes general and diffuse.

Health promotion projects with a *process evaluation* are stronger projects because a process evaluation helps to constantly reflect the process and address contingencies. Health promotion projects should have more than one evaluation (in the end) but maybe some interim evaluation. This might guarantee sustainability as well.

Outcomes

Concerning the outcomes of health promotion projects for older people it is clear that some evaluations do not differ between target groups in the evaluation. Evaluations of the outcomes have to be *target-group specific*, divided up between men, women, migrants, participants and trainers etc. Otherwise outcomes cannot be differentiated between e.g. the trainers in a course and the participants of a course.

In general outcome evaluations are not possible if no indicators for measurement are available. Clear goals lead to specific measures and these in return lead to specific outcomes. Clear indicators of the goals are needed for measuring outcomes.

Sustainability is guaranteed when structures and environmental issues (Verhältnisse) are taken into account. Structures need to be built up and developed if they are not there. Also, *functioning social networks and social capital* (in the team) guarantees sustainability. Similar value and belief systems of team members and between facilitators or trainers keeps motivation in the project strong. Older people feel the motivation of the project team and are very sensitive towards this form of motivation.

A prerequisite for *transferability* is good and solid documentation of structures, goals, personnel, costs, and the like. The project has to be comprehensible and transparent otherwise it cannot be transferred to another context. The project has to document its indicators for good quality. There should not be complicated certificates or competences which trainers or facilitators have to achieve, otherwise it is not possible for others to transfer the project.

Proven, tested and standardized *instruments for self-evaluation* are obviously still missing in health promotion in Austria. If no external evaluation is provided then self evaluation tools could be of use. At the moment they are re-invented by every project and not well distributed.

3.2 Specific Recommendations for Project Aims

Inequality

Out of the three analysed health promotion projects in Austria “Active Ageing” was the project which addressed social inequality of older people the most. This is mainly the fact because of the clear theoretical and practical standpoint and because it tries to reach the most vulnerable groups in society with a very low-threshold visiting approach. Nevertheless, it is not enough to define “older people” as the target group. A clear definition and the characteristics of the target group are essential.

In addition, the recommendation here is to have a solid *theoretical foundation* of the project first which clearly addresses older (disadvantaged) target groups and which builds the basis for the practical implementation. The methods for reaching the groups must therefore be adequate, innovative and must be proved to be able to fulfil the intended project aims in the intended beneficiary groups. To reach the inequality aim it is also essential to have project partners which are well-known at all levels of interest: the older people themselves and all networking partners at the local or community level.

Social determinants

Social determinants are very closely related to inequalities. Therefore social determinants cannot be seen separately from the recommendations above. But it is worthy noting that social determinants are closely related to *structural effects* and to the *social environment*. In this sense projects which not only deal with healthy behaviour of participants are in favour. Too many projects only consider the individual level.

Instead of this it is necessary to always take the structures of the individuals into account. Good health promoting projects should try to create a healthier “environment” and should think in a top-down-approach. All aspects of health – whether they are physical, social or mental – all aspects are embedded in a wider social and changing structure which needs to be addressed in the logic of social determinants of health and in health promotion practice.

Sustainability

As already denoted above, sustainability is in a close relationship with the degree of holistic thinking. Therefore it is difficult to deduce general recommendations. Nevertheless the three projects analysed showed that several aspects can be seen as the core for a sustainable (project) development. First of all the importance of the *visibility*, publicity and experience of the executing organisation of such projects for older people is crucial. In addition, a *functioning network* of older people themselves, and an already *existing structure of offers* and services could be a solid basis to build

on and are – in return – a guarantee for sustainability. Especially in terms of transferability, sustainability is only possible if there is a detailed documentation, transparency and plausibility of the project, its structures, processes and outcomes for which – in return (again) – rarely enough resources are available.

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5 Annex

Table of interviewed persons

Interview No.	Project affiliation	Position of interview partner	Date of interview	Duration
1	Case 1	Regional project manager	13.12.2007	48 minutes
3	Case 2	Project evaluator	13.12.2007	75 minutes
4	Case 2	Project manager	18.12.2007	89 minutes
5	Case 3	Project evaluator	15.1.2008	52 minutes
6	Case 3	Project manager	10.1.2008	64 minutes