

**October 2007**

EUNAAPA – WP5

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

**National Report Greece**

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## ▪ INTRODUCTION

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

The first aim of EUNAAPA work package No. 5 (Identify Existing Programmes for Physical Activity and Physical Activity Promotion for Older People) was to identify and describe, with the help of national experts, Greek examples of physical activity (PA) programmes and PA promotion strategies for older people which were deemed to be 'successful'. The second aim was critically to compare these programmes and strategies with evidence based guidelines identified by a systematic search of the scientific literature.

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

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

The resulting data have been submitted to the leader of work package 5 (University of Edinburgh) for incorporation into a cross-national report. The present document is a national report on the data collected by and from the Greek Experts.

## ▪ THE EXPERTS

### ○ Methods

#### ▪ Selection of Experts

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

Five of the eight Greek Experts selected were known personally to the Greek Collaborating Partners. Selected Experts were contacted by the Collaborating Partners by telephone. Where necessary, e-mail or an answering service was used to arrange a mutually convenient appointment for the telephone conversation. The

purpose of the project was explained to the potential Expert by the Collaborating Partner and their support was requested.

- **Distribution and return of Experts' questionnaires**

In June 2007, each of the 14 Greek Experts contacted to participate was sent either an electronic copy or mailed a paper copy accompanied by an explanatory letter, depending on their request. The further distribution of the PA programme and PA promotion strategy questionnaires were made either by some of the Experts who were willing to distribute them themselves to the appropriate directors or by the Collaborating Partners. PA Experts were encouraged to complete and return the PA Expert questionnaires as soon as possible before August 10. However, due to the extended summer holidays in Greece, this deadline had to be extended until the 15<sup>th</sup> of September. Defaulters were reminded several times either electronically or by telephone.

- **Results**

- **Selection of Experts**

Fourteen potential Experts were selected and contacted out of which eight returned the filled out questionnaires, while two refused due to their perceived lack of knowledge in the area of physical activity. The remaining four never responded despite several reminders. When selecting the Experts, the Collaborating Partners judged that the fourteen Experts represented 9 out of the 11 primary matrix fields, with the exception of boxes 2 and 8, as there were no Experts in those areas (Table 1). Most of the Greek Experts could justifiably be identified with more than one field in the selection matrix (Table 2). Specifically, 8 Experts represented box 5, followed by 4 Experts that represented boxes 7, 10, and 11, respectively, and 2 Experts that represented box 3.

- **Return of Experts' questionnaires**

By mid September 2007, seven out of the eleven PA Expert questionnaires had been returned. By the 3<sup>rd</sup> of October, the eighth questionnaire was returned.

- **Experts' educational background**

In terms of their education, all but one Expert reported having a background in Exercise and Sport Sciences, while one indicated an additional background in other Health Professions, and one only in the latter (Table 3).

- **Experts' areas of practice**

All Experts reported physical activity programmes as their field of expertise, with one claiming both fields. Seven claimed the city, town or local neighbourhood as their organizational level while two experts claimed their program as regional. Seven experts referred to community-dwelling older adults as their target group, while two referred to institution-dwelling older adults. Five experts claimed the non government sector while three the government sector. Four experts reported having professional expertise in sport recreation and physical activity instruction/supervision as well as in research, followed by health promotion, and health-related exercise instruction (each reported by three experts). Two experts reported expertise in sport recreation and physical activity management as well as education, and one expert reported expertise in health care (Table 4).

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

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

	PA Expert										
	A	B	C	D	E	F	G	H	I	J	K
<b>Primary matrix field</b>	5,11	4	10	6,7	10	5	5,10	5			

*Table 2.* Primary matrix fields of the national Experts, as perceived by the national partners when selecting the Experts.

	PA Expert											Total
	A	B	C	D	E	F	G	H	I	J	K	
<b>Medicine</b>												
<b>Other Health Profession</b>	X	X										2
<b>Exercise/ Sport Science</b>	X		X	X	X	X	X	X				7
<b>Other</b>												1
<b>Missing data</b>												
<b>Total</b>	3	1	1	1	1	1	1	1				10

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

<b>Expert</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>F</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>K</b>
<b>FIELD</b>											
Physical activity programmes	X	X	X	X	X	X	X	X			
Physical activity (promotion) strategies				X							
<b>ORGANISATIONAL LEVEL</b>											
National											
Regional						X	X				
City, town or local neighbourhood	X	X	X	X	X	X		X			
<b>CLIENT GROUP</b>											
Community-dwelling older adults		X	X	X	X	X	X	X			
Institution-dwelling older adults	X	X									
<b>SECTOR</b>											
Government			X	X				X			
Non government organisation	X	X			X	X	X				
<b>PROFESSIONAL EXPERTISE</b>											
Health care		X									
Health promotion	X			X			X				
Sport/ recreation/ physical activity facility management			X	X							
Sport/recreation/ physical activity instruction/ supervision/guidance	X	X			X	X					
Health-related exercise facility management											
Health-related exercise instruction/ supervision/guidance		X			X	X					
Education		X						X			
Research	X					X	X	X			
Social services, social care or social welfare											
Socio-cultural organisation											

*Table 4 (XQ10).* The national Experts' areas of practice

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

- **Methods**

The questionnaire completed by the 8 national Experts also asked about the availability in their countries of national qualifications in the supervision or guidance of physical activity for adults in general and for older adults in particular. It asked whether such qualifications were optional or compulsory, and requested detailed information about assessment, validation and revalidation of the higher level, older-person-specific qualification. Finally, it asked about the existence in their country of a professional register of qualified instructors (*i.e.* a regulatory body that holds a current record of those qualified to guide or supervise physical activity and of their level of specialist qualification).

- **Results**

- **Basic level qualification**

Six PA Experts indicated that there is a basic level of qualification required to supervise and guide physical activity, however only two reported that it is properly implemented in Greece, while five reported that only sometimes it is. Most Experts did not know the estimates of the prevalence of the basic, entry level qualification, while two referred to 25% and one to 50% of instructors (Table 5 & 7).

- **Higher level qualification**

Only two Experts indicated that a higher level of qualification in supervising or guiding physical activity or exercise by older adults is required. None indicated however, that there is proper implementation, external validation, or that there is a percentage of instructors that have attained this level. In terms of the necessity of the higher level of qualification, six Experts reported affirmatively (Table 6 & 7).

- **Assessment, validation and revalidation**

Six Experts reported the necessity of proper implementation of higher level qualification (Table 6). Their responses concerning the components of the assessment for the higher level (older person specific) qualification were as follows: Four Experts referred to components such as the practical teaching competence assessed with participants of any age, as well as with older individuals. Four Experts also referred to a summative assessment of knowledge, while two referred to CPR certification (Table 8). Concerning the requirements for retention of the higher level (older person specific) qualification, two Experts referred to the evidence of current CPR certification, a practical test of teaching competence, and the evidence of continuing professional development (CPD) (Table 9).

- **Professional register**

None of the Experts referred to the existence of a professional register of qualified instructors in Greece, however one Expert referred to the requirement of basic entry level as well as higher level qualification for membership of the professional register (Table 10).

	Basic level qualification	
	Required	Implemented
<b>Yes</b>	6	2
<b>No</b>	1	0
<b>Don't know</b>	1	1
<b>Sometimes</b>	N/A	5
<b>Total</b>	8	8

*Table 5 (XQ11 & 13).* PA Experts' responses concerning the availability in Greece of a basic level qualification in supervising or guiding physical activity or exercise by adults in general.

	Higher level qualification			
	Required	Implemented	Necessary	External verification
<b>Yes</b>	2	0	6	0
<b>No</b>	4	1	0	2
<b>Sometimes</b>	N/A	1	0	N/A
<b>Don't know</b>	1	3	0	4
<b>N/A</b>	N/A	2	1	1
<b>Missing Data</b>	1	1	1	1
<b>Total</b>	8	8	8	8

*Table 6 (XQ 14 & 16-18).* PA Experts' responses concerning the availability in Greece of a higher level qualification in supervising or guiding physical activity or exercise by older adults.

	Entry level	Higher level
<b>0%</b>	0	0
<b>25%</b>	2	0
<b>50%</b>	1	0
<b>75%</b>	0	0
<b>100%</b>	0	0
<b>Don't know</b>	5	0
<b>Not applicable</b>	0	8
<b>Missing data</b>	0	0
<b>Total</b>	8	8

*Table 7 (XQ21 & 22).* PA Experts' estimates of the prevalence of the basic, entry level qualification and the higher level (older-person-specific) qualification among instructors guiding or supervising physical activity by older participants

	A	B	C	D	Not applicable	Don't know
<b>Yes</b>	2	4	4	4	1	0
<b>No</b>	5	3	3	3		
<b>Total</b>	7	7	7	7		

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

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

	A	B	C	D	E	F	Not applicable
<b>Yes</b>	0	2	2	2	0	0	0
<b>No</b>	7	5	5	5	7	7	
<b>Total</b>	7	7	7	7	7	7	

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

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

	Professional register		
	Exists	Membership requires	
		Entry level*	Higher level**
<b>Yes</b>	0	1	1
<b>No</b>	5	0	1
<b>Don't know</b>	3	2	3
<b>N/A</b>		4	2
<b>Missing data</b>	0	1	1
<b>Total</b>	8	8	8

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

- **‘SUCCESSFUL’ PA PROGRAMMES**

- **Methods**

- **Selection of programmes (including definitions)**

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

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

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

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

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

- **Distribution and return of programme questionnaires**

Twelve PA program directors were contacted either by the Experts or by the Collaborating Partners, however only nine directors responded. From the non-respondents, one Expert indicated himself as a program director but never returned a programme questionnaire. The remaining two program directors who never responded were two of the Experts who never responded.

Four Experts willingly distributed themselves the program questionnaires to the appropriate PA directors, while the remaining five were distributed by the Collaborating Partners. One Expert although indicated a program director sent her questionnaire late, therefore the program director was not contacted. Although initially, PA Experts were requested to not select their own PA Programme, this regulation was not always followed.

As with the Experts, reminders were sent as appropriate to the PA program Directors.

- **Results**

- **Selection of programmes**

The Collaborating Partners did not encounter instances in which more than one Expert wanted to select the same programme (which was not permissible). Two Experts however, indicated themselves as Program Directors while only one returned the PA program questionnaire, meanwhile another Expert did not indicate any program

director. As indicated above, while twelve PA Program Directors were contacted, only nine responded.

- **Return of programme questionnaires**

By 23<sup>rd</sup> September 2007, nine PA Programme questionnaires had been returned.

- **Programme directors' educational backgrounds**

All but one of the respondents reported having a background in Exercise and Sport Science. The remaining one indicated having health profession background (Table 11).

- **Catchment areas of programmes**

Concerning the geographical classification of their programme, eight respondents classified it as limited to a city or town, whereas one classified it as national (Table 12).

- **Ages of programmes**

Regarding the length of time their programme has existed, four respondents indicated 1 to 5 years, three indicated 6 to 10 years, and the remaining two indicated 10+ years (Table 13).

- **Components of overall programmes**

Eight PA programme directors' responses indicated that "community based senior fitness programmes groups" was the most frequent component program included in their overall programmes, followed by "medical condition-specific" programmes and "arthritis" programs (5 respectively). Four responses referred to "falls prevention" and "cardiac rehabilitation" programs, while three responses referred to "pulmonary" rehabilitation programs. "Masters" programmes, "exercise and general referral" programs, and "other medical condition specific" programs (i.e., post menopause, neurological rehabilitation) each had two responses. Lastly, "community based senior chair-based" programs had one response (Table 14).

Overall programs were most frequently described as being a group activity (8 responses), followed by being indoors and land-based (6 and 5 responses, respectively). The descriptions of individual activity, water-based, and outdoors each had two responses (Table 15). Most facilities recorded as used by the overall programs were sport and physical recreation ones (7 responses), followed by day resources centres (6 responses) and community centres (5 responses). Sheltered housing and related living facilities, as well as participant's private dwelling received two and one response, respectively (Table 16).

- **Characteristics of programmes' clients**

The modal response for the average age of participant actually attending a typical session of the programme was 60 years of age, followed by 65 and 70 years, and then 75 years of age. The modal minimum age of participants attending a typical session of the programme was 45 (3 responses), followed by 50, 55, and 65 (2 responses each). The maximum ages of participants attending a typical session of the programme were 75, 80, and 90 years of age indicated by three respondents respectively (Figure 1).

Five respondents indicated that their overall program is aimed at community-dwelling older adults, while three indicated both groups (community and institution-dwelling older adults) in separate groups, and the remaining one indicated both groups in the same group (Table 17).

With regard to the gender of the participants in the overall program, two program directors indicated that all of them were women, four indicated that 75% were women, and one indicated that 50% and 25% (respectively) of program participants were women (Table 19).

#### ▪ **Characteristics of programmes' classes**

Most respondents (6) estimated the 'group' sizes used in their overall programmes to be 11-15 participants, followed by those (4 program directors) who estimated 6-10 participants (Table 20). The most frequent ratio of instructors to participants in a typical session of their programme was 1: 11-25 as reported by 6 programme directors, followed by ratios of 1:1 and 1: 2-10 reported by three program directors, respectively (Table 21).

In regard to the PA maximum possible frequency and the usual frequency with which individuals participate in their overall programme, most respondents estimated 3-4 times (eight and six reports, respectively) (Table 22). Concerning the proportion of current participants that have attended their overall programme for at least a year, six respondents estimated 75% while two estimated 50% and the remaining one 25% (Table 23).

#### ▪ **Objectives, outcomes, monitoring and feedback**

PA programme directors' responses concerning the most important overall aims of their programme, from the point of view of its sponsoring organisation were health promotion (8), followed by improved physical function (5) and disease prevention, improved mood and improved self esteem, each having four responses (Table 24).

With regard to the frequency (times per year) with which the satisfaction of participants in their programme is formally measured, the two most common estimates were "1-2" times (four responses) and "not at all" times (three responses) (Table 25).

Four respondents reported that participants are formally surveyed for the aims of their involvement in the program, and four also indicated that programmes are adjusted according to participants' aims, while five indicated that objective outcome measures are recorded for participants at regular intervals (Table 26).

With regard to recording objective outcome measures, four responses highlighted the sub maximal test of aerobic fitness and balance each, while three responses highlighted strength or explosive power, joint range of motion, and mood. Body composition and bone density each had two responses, followed by maximal oxygen uptake, and social support, which had one response each (Table 27).

#### ▪ **Pre-participation assessment**

All program directors responded affirmatively to the requirement of a health check for the potential participant prior to their eligibility for entry to their programme (Table

28). Concerning the form of health check required, seven referred to an assessment by a doctor, while three by a doctor who is a sports medicine doctor or programme doctor, and three referred to an assessment by some other healthcare professional. Four referred to an assessment by an exercise instructor, and two to a completion of a health screening tool (Table 28), whereas three program directors responded affirmatively to the requirement of the completion of a health screening tool by the potential participant (Table 30).

In regard to whether the health screening tool is internationally recognised and whether it had been adapted for their programme, two and three respondents, respectively, responded in the affirmative (Table 31). Concerning the dizziness, eyesight, and hearing questions included in the health screening tool, two program directors responded in the affirmative for each one (Table 32). Lastly, in response to what is done so that an applicant can be permitted to enter a programme after a potential problem has been identified by the health screening tool, one programme director indicated a necessary “approval” from their doctor, and one from any healthcare professional (Table 33).

#### ▪ Programme content

In response to the components or aspects of physical fitness which their PA programme aims to improve, nine respondents indicated coordination and balance, followed by seven who indicated endurance and joint range of motion. While six noted strength, four noted bone density. Lastly, one indicated explosive power, and one body composition (Table 34).

The most frequent modalities of physical activities offered in each programme were as follows: aqua exercises (aquatics; 4 responses), road/paths (cycling; 1 response), bowling (group sports/ball games; 1 response), exercise to music and movement to exercise (7 response each) followed by dance (recreational movement (5 responses), indoor running (running; 6 responses), indoor walking (6 responses) and outdoor walking (walking; 4 responses), and followed by dumbbells/free weights (machine based equipment; 8 responses). In the area of adapted exercise, back pain prevention (9 responses) was most common followed by osteoporosis prevention (7 responses), pelvic floor exercise (6 responses), fall prevention, chair-based exercise, as well as cardio rehabilitation (5 responses each), and lastly, pulmonary rehabilitation (4 responses) (Table 35).

All nine respondents indicated that ‘progression’ of participants is always part of their overall programme (Table 36). With regard to the length of a usual warm up at the beginning of a session, four responses indicated 16-20 minutes, while two indicated 6-10 and then 11-15 minutes. With regard to the length of a usual cool down at the end of a session in this programme, five responses pointed to 1-5 minutes, followed by three pointing to 6-10, and one to 11-15 minutes (Table 37).

Four respondents estimated the length of a usual workout component of a session to be 30 minutes, followed by two estimating 40 and 50 minutes, and lastly, one estimating 60 minutes (Table 38). In terms of how respondents cater for the exercise needs of older people with chronic medical conditions, five answered that they have “adapted exercise, with participants included in the mainstream older person’s group(s)”, followed by three who indicated that they have “adapted exercise, with

participants in disease-related groups”, and lastly, one reported that he/she has “adapted exercise, with participants in frailty-related or disability-related groups” (Table 39).

▪ **Instructors’ qualifications and training**

In response to the minimum level of qualification required for instructors delivering their programme to older participants, four respondents indicated that a basic qualification level is required, whereas five indicated that a higher qualification level is required (Table 40). When asked what proportion of instructors guiding/supervising older participants, in each programme, have the entry level qualification, four responses indicated 100%, and two indicated 75%.

Regarding the proportion of instructors having the higher level qualification, three responses indicated 100%, while one response indicated 75%, 50%, 25%, and 0%, respectively (Table 41). None of the respondents indicated that instructors for their programme have to be a member of a professional register (Table 42).

In terms of the number of hours in-service training provided each year for the instructors in each programme, two respondents reported 20 hours while one reported more than 30 hours (Table 43). Lastly, concerning the ways that unpaid volunteers contribute to each programme, three respondents indicated that volunteers are the instructor’s assistant, and three responded that volunteers ‘buddy’ a participant. One respondent indicated that volunteers are used for instruction, and one for transport (Table 44).

▪ **Client safety**

In regard to whether each programme has specific protocols to be followed in emergency situations or in respect to the use, storage and maintenance of equipment, three respondents answered yes, respectively (Table 45). In terms of the frequency of staff training in the protocols to be followed in emergency situations, one response indicated every six months and one annually. With respect to the frequency of staff training in the use, storage and maintenance of equipment, one response indicated every six months (Table 46).

▪ **Finance, transport and refreshments**

When asked about the total cost (per participant per session) of providing their programme (excluding transport and refreshments but including the cost of the room, lighting, heating, maintenance, instructor’s fee, administration), three respondents estimated between 5 and 10 Euros, and one estimated more than 10 Euros (Table 47). In terms of the proportion of cost paid by each participant in their programme, four program directors indicated 0%, while one indicated, 5%, one 10%, and one 25% (Table 48).

Respondents were also asked whether transport is provided for participants in their programme. Two responded in the affirmative for some participants for some sessions, while one responded in the affirmative for everyone. With regard to whether refreshments are provided, two responded in the affirmative for everyone (Table 49).

In terms of the proportion of the cost of transport that is paid by each participant in their programme, three respondents indicated 0%, while one indicated 100%. In terms

of the proportion of the cost of refreshments that are paid by each participant, one program director indicated 0%, one indicated 5%, and one indicated 100% (Table 50).

▪ **Publicity, marketing and promotion**

The most frequent responses concerning the methods which have been used to publicise, market or promote each programme were as follows: advertising in local newspapers, leafleting in community centres for older people, and word of mouth, each indicated by six program directors, followed by sports hall and health premises leafleting, each indicated by four program directors. Lastly, advertising through elder-oriented organisations and on local radio, having features in local newspapers and neighbourhood leafleting, as well as talking to local groups, and websites, each received three responses (Table 51).

Only one respondent reported that his/her programme had found it useful (1) to capitalise on national or regional campaigns, and one respondent reported that his/her programme had found it useful (2) to build partnerships with local healthcare professionals or organisations (Table 52).

	PA Programme Director											Total
	A	B	C	D	E	F	G	H	I	J	K	
<b>Medicine</b>												
<b>Other Health Profession</b>			X									1
<b>Exercise/Sport Science</b>	X	X		X	X	X	X	X	X			8
<b>Other</b>												
<b>Missing data</b>												
<b>Total</b>	1	1	1	1	1	1	1	1	1			9

*Table 11 - Programme Questionnaire Question 4 (ProgQ4).* Educational backgrounds of PA Programme Directors selected by Greek national Experts

	Number
<b>National</b>	1
<b>Regional</b>	0
<b>Limited to a city/town</b>	8
<b>Limited to a local neighbourhood</b>	0
<b>Missing data</b>	0
<b>Total</b>	9

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

	<b>Number</b>
<b>Less than 1 year</b>	0
<b>1 to 5 years</b>	4
<b>6 to 10 years</b>	3
<b>More than 10 years</b>	2
<b>Missing data</b>	0
<b>Total</b>	9

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

	<b>Number</b>
<b>Masters (elite competitor) programme</b>	2
<b>Community based senior fitness programmes (groups)</b>	8
<b>Community based senior chair-based programmes</b>	1
<b>Home based exercise programmes (individual)</b>	0
<b>Exercise referral / General Practitioner referral programmes</b>	2
<b>Falls Prevention Programmes</b>	4
<b>Medical condition-specific programmes</b>	5
<b>Cardiac rehabilitation</b>	4
<b>Pulmonary rehabilitation</b>	3
<b>Arthritis programmes</b>	5
<b>Other medical condition-specific programmes</b>	2
<b>Other programmes</b>	0

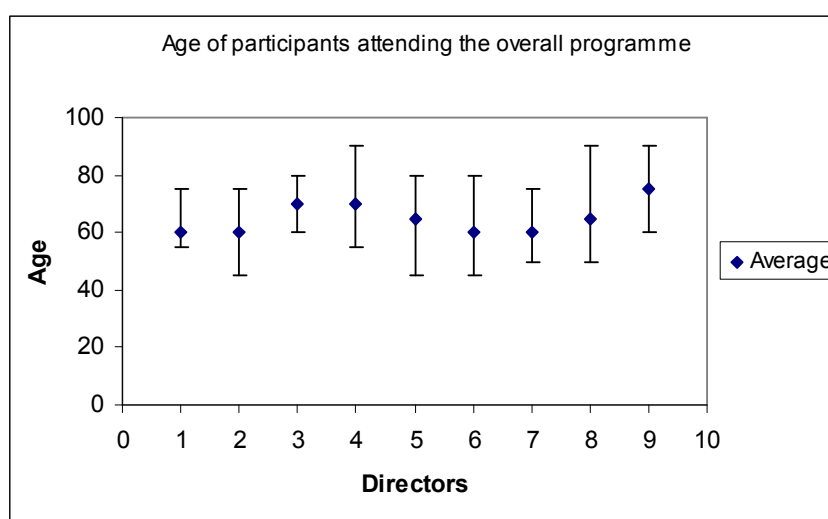
*Table 14 (ProgQ11).* PA Programme Directors' responses concerning which component programmes are included in their overall programmes

	<b>Number</b>
<b>Group activity</b>	8
<b>Individual activity</b>	2
<b>Indoors</b>	6
<b>Outdoors</b>	2
<b>Water-based</b>	2
<b>Land-based</b>	5

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

	Number
<b>Sport / physical recreation facility</b>	7
<b>Community centre</b>	5
<b>Day resources centre</b>	6
<b>Participant's private dwelling</b>	1
<b>Sheltered housing, assisted living facility, care home or nursing home</b>	2
<b>Other</b>	0

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



**Figure 1 (ProgQ14-15).** PA Programme Directors' responses concerning the age groups for whom their overall programme is intended and the average age of participant actually attending a typical session of the programme

	Number
<b>Community- dwelling older adults</b>	5
<b>Institution - dwelling older adults</b>	0
<b>Both, together (in the same group)</b>	1
<b>Both separately (in different groups)</b>	3
<b>Total</b>	9

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

	<b>Number</b>
<b>Frequently walks vigorously or runs</b>	7
<b>Walking outdoors with no walking aids and no assistance or supervision by another person</b>	6
<b>Walks outdoors with a walking aid but no assistance or supervision by another person</b>	2
<b>Walks outdoors only with assistance or supervision by another person</b>	3
<b>Never walks outdoors</b>	0

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

	<b>Number</b>
<b>0%</b>	0
<b>25%</b>	1
<b>50%</b>	1
<b>75%</b>	4
<b>100%</b>	2
<b>Don't know</b>	1
<b>Total</b>	9

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

	<b>Number</b>
<b>1</b>	1
<b>2 – 5</b>	2
<b>6 – 10</b>	4
<b>11 – 15</b>	6
<b>16 – 20</b>	2
<b>21 – 25</b>	0
<b>26 – 50</b>	1
<b>51+</b>	0
<b>Don't know</b>	0

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

	<b>Number</b>
<b>1 : 1</b>	3
<b>1 : 2 - 10</b>	3
<b>1 : 11 - 25</b>	6
<b>1 : 26 - 50</b>	0
<b>1 : 51+</b>	0
<b>Don't know</b>	0
<b>Total</b>	12

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

	<b>Maximum</b>	<b>Usual</b>
<b>&lt;1</b>	0	0
<b>1</b>	0	0
<b>2</b>	1	2
<b>3 – 4</b>	8	6
<b>5 – 7</b>	0	0
<b>8+</b>	0	0
<b>Don't know</b>	0	0
<b>Total</b>	9	8

**Table 22 (ProgQ21-22).** PA Programme Directors' estimates of the maximum possible frequency and the usual frequency with which individuals participate in their overall programme.

	<b>Number</b>
<b>0%</b>	0
<b>25%</b>	1
<b>50%</b>	2
<b>75%</b>	6
<b>100%</b>	0
<b>Don't know</b>	0
<b>Total</b>	9

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

	<b>Number</b>
<b>Health promotion</b>	8
<b>Improved competitive performance</b>	0
<b>Disease prevention</b>	4
<b>Improved physical function</b>	5
<b>Improved mood</b>	4
<b>Opportunities to socialise</b>	2
<b>Improved self esteem / confidence</b>	4
<b>Other</b>	0
<b>Don't know</b>	0
<b>Total</b>	27

**Table 24 (ProgQ24).** PA Programme Directors' responses concerning the two most important overall aims of their programme, from the point of view of its sponsoring organisation. (Some PAs marked more than 2 boxes).

	<b>Number</b>
<b>Not at all</b>	3
<b>1 – 2</b>	4
<b>3 – 6</b>	1
<b>More than 6</b>	1
<b>Don't know</b>	0
<b>Total</b>	9

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

	<b>survey of aims</b>	<b>prog. adjusted for aims</b>	<b>outcomes measured</b>
<b>Yes</b>	4	4	5
<b>No</b>	4	0	3
<b>Don't know</b>	1	0	0
<b>Not applicable</b>	N/A	4	0
<b>Total</b>	9	8	8

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

	<b>Number</b>
<b>Strength or explosive power</b>	3
<b>Maximal oxygen uptake (directly measured)</b>	1
<b>Sub maximal test of aerobic fitness</b>	4
<b>Balance</b>	4
<b>Joint range of motion</b>	3
<b>Body composition</b>	2
<b>Bone density</b>	2
<b>Mood / depression</b>	3
<b>Social support</b>	1
<b>Other</b>	1
<b>Not applicable</b>	3

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

	<b>Number</b>
<b>Yes</b>	9
<b>No</b>	0
<b>Don't know</b>	0
<b>Total</b>	9

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

	<b>Number</b>
<b>Completion of a health screening tool</b>	2
<b>Assessment by a doctor</b>	7
<b>Assessment by a doctor who is a sports medicine specialist or by the programme doctor</b>	3
<b>Assessment by some other healthcare professional</b>	3
<b>Assessment by an exercise instructor</b>	4
<b>Other</b>	1
<b>Total</b>	20

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

	<b>Number</b>
<b>Yes</b>	3
<b>No</b>	5
<b>Missing value</b>	0
<b>Total</b>	8

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

	<b>Internationally recognised</b>	<b>Adapted for the prog.</b>
<b>Yes</b>	2	3
<b>No</b>	1	0
<b>Not applicable</b>	5	5
<b>Total</b>	8	8

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

	<b>Dizziness</b>	<b>Eyesight</b>	<b>Hearing</b>	<b>Don't know</b>	<b>Not applicable</b>
<b>Yes</b>	2	2	2	0	5
<b>No</b>	6	6	6		
<b>Total</b>	8	8	8		

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

	Number
The applicant need only sign a liability waiver	0
Applicant must obtain 'approval' from any healthcare professional	1
Applicant must obtain 'approval' from their doctor	1
Applicant must obtain 'approval' from a doctor who is a sports medicine specialist or from the programme doctor	0
It is not possible for the applicant to be permitted to enter the programme	0
Other	6
Don't know	0
Not applicable	4
<b>Total</b>	<b>12</b>

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

	As in response to ....	Number
<b>Strength</b>	ProgQ40	6
<b>Explosive power</b>	ProgQ40	1
<b>Endurance</b>	ProgQ38	7
<b>Coordination – Balance</b>	ProgQ38	9
<b>Joint range of motion</b>	ProgQ40	7
<b>Body composition</b>	ProgQ40	1
<b>Bone density</b>	ProgQ40	4
<b>Other</b>	ProgQ40	1

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

**TABLE 35 (ProgQ39)**

Number	
<b>Aquatics</b>	
Swimming	2
Aqua exercises	4
<b>Cycling</b>	
On Road/ Paths	1
Off Road/ Track/ Hills	0

<b>Group Sports/ Ball Games</b>	
Badminton	0
Billiard Sports	0
Boules	0
Bowling	1
Golf	0
Minigolf	0
Short tennis	0
Tennis	0
<b>Recreational Movement</b>	
Dance	5
Movement to exercise	7
Exercise to music	7
Derived from Pilates	2
Derived from Tai Chi	0
Derived from Qigong	0
Derived from Yoga	1
<b>Running</b>	
Indoor running (not on treadmill)	6
Outdoor running/ Track	3
Orienteering	1
<b>Skiing</b>	
Cross Country Skiing	0
Downhill (Alpine Skiing)	0
Ski Touring	0
<b>Walking</b>	
Indoor Walking (not on treadmill)	6
Outdoor Walking on path/ track	1
Outdoor Walking groups	4
Rambling or Hill Walking	0
Trekking	1
Nordic Walking	0
<b>Machine based equipment</b>	
Circuits	1
Treadmill	1
Cycle	2
Rowing	0
Stepper	1
Cross – trainer	0
Cable machines/ fixed resistance	2
Dumbbells / Free weights	8
Physioballs (Swiss balls/ exercise balls) for balance	3
Resistance balls/ bands/ tubes	3
Balance disks/ wobbleboards	2
Other	2
<b>Competitive sport</b>	
<b>Adapted exercise</b>	
Back pain prevention	9

Osteoporosis prevention	7
Falls prevention	5
Pelvis Floor exercise	6
Chair-based exercise	5
Cardio rehab	5
Pulmonary rehab	4
Other	1

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

	Number
<b>Never</b>	0
<b>For the first few weeks only</b>	0
<b>For the first few months only</b>	0
<b>Always</b>	9
<b>Don't know</b>	0
<b>Total</b>	9

**Table 36 (ProgQ41).** PA Programme Directors' responses concerning the extent to which 'progression' of participants is part of their overall programme. ('Progression' defined as a systematic increase in the intensity or resistance, the frequency and/or duration of exercise.)

	Warm up	Cool down
<b>0 minutes</b>	0	0
<b>1 – 5 minutes</b>	0	5
<b>6 – 10 minutes</b>	2	3
<b>11 – 15 minutes</b>	2	1
<b>16 – 20 minutes</b>	4	0
<b>Don't know</b>	1	0
<b>Total</b>	9	9

**Table 37 (ProgQ42-43).** PA Programme Directors' estimates of the length of a usual warm up at the beginning of a session in this programme and of the length of a usual cool down (or 'wind down' or 'warm down') at the end of a session

	Number
<b>0 minutes</b>	0
<b>10 minutes</b>	0
<b>20 minutes</b>	0
<b>30 minutes</b>	4
<b>40 minutes</b>	2
<b>50 minutes</b>	2
<b>60 minutes</b>	1
<b>More than 60 minutes</b>	0
<b>Don't know</b>	0
<b>Total</b>	9

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

	<b>Number</b>
<b>This is not possible</b>	0
<b>Adapted exercise, with participants in disease-related groups</b>	3
<b>Adapted exercise, with participants in frailty-related or disability-related groups</b>	1
<b>Adapted exercise, with participants included in the mainstream older person's group(s)</b>	5
<b>Don't know</b>	0
<b>Total</b>	9

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

	<b>Number</b>
<b>A basic (entry level) qualification</b>	4
<b>A higher level (old age specific) qualification</b>	5
<b>Other</b>	0
<b>Don't know</b>	0

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

	<b>Entry level qualification</b>	<b>Higher level qualification</b>
<b>0%</b>	0	1
<b>25%</b>	0	1
<b>50%</b>	0	1
<b>75%</b>	2	1
<b>100%</b>	4	3
<b>Don't know</b>	2	2
<b>Total</b>	8	9

**Table 41 (ProgQ48 & ProgQ49).** PA Programme Directors' estimates of the proportion of instructors guiding/ supervising older participants, in this programme, that have the entry level qualification or the higher level qualification.

	<b>Number</b>
<b>Yes</b>	0
<b>No</b>	4
<b>Don't know</b>	5
<b>Total</b>	9

**Table 42 (ProgQ.47).** PA Programme Directors' responses concerning whether instructors for this programme have to be a member of a professional register

	<b>Number</b>
<b>0</b>	0
<b>1</b>	0
<b>3</b>	0
<b>5</b>	0
<b>10</b>	0
<b>15</b>	0
<b>20</b>	2
<b>30</b>	0
<b>More than 30</b>	1
<b>Don't know</b>	1
<b>Not applicable</b>	5
<b>Total</b>	9

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

	<b>Number</b>
<b>Not at all</b>	0
<b>Instruction</b>	1
<b>Instructor's assistant</b>	3
<b>'Buddying' a participant</b>	3
<b>Peer mentoring participants</b>	0
<b>Administration</b>	0
<b>Transport</b>	1
<b>Refreshments</b>	0
<b>Other</b>	0
<b>Don't know</b>	0
<b>Not applicable</b>	4

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

	<b>Emergency protocols</b>	<b>Equipment protocols</b>
<b>Yes</b>	3	3
<b>No</b>	3	5
<b>Don't know</b>	2	1
<b>Total</b>	8	9

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

	<b>Emergency protocols</b>	<b>Equipment protocols</b>
<b>3 monthly</b>	0	0
<b>6 monthly</b>	1	1
<b>Annually</b>	1	0
<b>Never</b>	0	0
<b>Don't know</b>	1	1
<b>Not applicable</b>	5	5
<b>Total</b>	8	7

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

	<b>Number</b>
<b>Up to € 2</b>	0
<b>More than € 2, up to € 5</b>	0
<b>More than € 5, up to € 10</b>	3
<b>More than € 10</b>	1
<b>Don't know</b>	5
<b>Total</b>	9

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

	<b>Number</b>
<b>0%</b>	4
<b>5%</b>	1
<b>10%</b>	1
<b>25%</b>	1
<b>50%</b>	0
<b>75%</b>	0
<b>100%</b>	0
<b>Don't know</b>	2
<b>Total</b>	9

*Table 48 (ProgQ 60).* PA Programme Directors' estimates of the proportion of cost paid by each participant in their programme

	<b>Transport</b>	<b>Refreshments</b>
<b>Yes, to everyone</b>	1	2
<b>Yes, selectively</b>	*2	**0
<b>No</b>	6	7
<b>Don't know</b>	0	0
<b>Total</b>	9	9

\*some participants, some sessions

\*\*some sessions

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

	<b>Transport</b>	<b>Refreshments</b>
<b>0%</b>	3	1
<b>5%</b>	0	1
<b>10%</b>	0	0
<b>25%</b>	0	0
<b>50%</b>	0	0
<b>75%</b>	0	0
<b>100%</b>	1	1
<b>Don't know</b>	1	1
<b>Not applicable</b>	4	5
<b>Total</b>	9	9

*Table 50 (ProgQ62 and 64).* PA Programme Directors' estimates of the proportion of the cost of transport and of refreshments that is paid by each participant in their programme.

	<b>Number</b>	<b>%</b>
<b>Advertising in local newspapers</b>	6	67
<b>Advertising in national/ regional newspapers</b>	0	
<b>Advertising in elder-oriented magazines</b>	2	22
<b>Advertising through elder-oriented organisations</b>	3	33
<b>Features in local newspapers</b>	3	33
<b>Features in national/ regional newspapers</b>	0	
<b>Features in elder-oriented magazines</b>	1	11
<b>Advertising on local radio</b>	3	33
<b>Advertising on national/ regional radio</b>	0	
<b>Advertising on local TV</b>	2	22
<b>Advertising on national/ regional TV</b>	1	11
<b>Features on local radio</b>	2	22
<b>Features on national/ regional TV</b>	0	
<b>Features on local TV</b>	1	11
<b>Features on national/ regional TV</b>	0	
<b>Neighbourhood leafleting</b>	3	33
<b>Sports hall leafleting</b>	4	44
<b>Health premises leafleting</b>	4	44

<b>Leafleting in community centres for older people</b>	6	67
<b>Talks to local groups</b>	3	33
<b>Word of mouth</b>	6	67
<b>Websites</b>	3	33
<b>Open days</b>	0	
<b>Bring a friend</b>	2	22
<b>Discounts</b>	0	
<b>Multiple session bookings</b>	0	
<b>Other</b>	0	

*Table 51 (ProgQ65).* PA Programme Directors' responses concerning the methods which have been used to publicise, market or promote their programme.

	<b>(1)</b>	<b>(2)</b>
<b>Yes</b>	1	1
<b>No</b>	2	3
<b>Have not tried</b>	4	3
<b>Don't know</b>	2	1
<b>Total</b>	9	8

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

- **‘SUCCESSFUL’ PA PROMOTION STRATEGIES**

- **Methods**

- **Selection of programmes (including definitions)**

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

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

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

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

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

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

Fourteen Experts were contacted by the Collaborating Partners, however only eight responded with filled out questionnaires. Out of the eight that responded, only four Experts indicated PA promotion strategy directors. Out of the remaining four, one Expert indicated himself as a promotion strategy director but never returned a promotion strategy questionnaire, while the other three were not aware of any promotion strategy directors. As a result, the Collaborating Partners ended up finding themselves two other promotion strategy directors.

- **Results**

- **Selection of promotion strategies**

Six PA promotion strategy questionnaires were received (Appendix 3). The Collaborating Partners did not encounter instances in which more than one Expert wanted to select the same promotion strategy (which was not permissible). Initially, PA Experts were requested to not select their own PA promotion strategy, however this regulation was not always followed as one Expert selected his own promotion strategy. As with the Experts, reminders were sent as appropriate to the PA promotion strategy directors.

- **Return of promotion strategy questionnaires**

By 23<sup>rd</sup> September 2007, six PA promotion strategy questionnaires had been returned.

- **Promotion strategy directors' educational backgrounds**

All but one director of the PA promotion strategies come from an exercise and sport science educational background (Table 53).

- **Prevailing national context**

Respondents were asked whether (1) there is a law or other regulations, in Greece, for promotion of physical activity, (2) there is a law or other regulations, in Greece, for the promotion of physical activity especially for older people, and (3) there are any national level recommendations, in Greece, for promotion of physical activity especially for older people. Three, two and one directors, respectively, responded in the affirmative (Table 54).

- **Description of promotion strategies**

The government sector as well as the non-government sector were equally represented both in terms of the sector in which each organization that developed each promotion strategy, as well as that in which the organization that delivers the promotion strategy. Most promotion strategies were developed in the national level and delivered in the local level, while in the non-governmental sector, most were developed and delivered in the welfare/community organization level (Table 55).

In terms of the levels at which each promotion strategy is aimed to deliver, most responses pointed to the city/town and local neighbourhood level, while fewer pointed to the national and regional level. Specifically, seven responses indicated the city/town and local neighbourhood level while three indicated the national and regional level (Table 56).

Concerning the settings in which respondents considered their promotion strategy encouraged physical activity, most (6) indicated the centre based and outdoor setting (4). As far as the exercise format, most (6) indicated the group exercise settings (Table 57). Concerning the settings/ organisations which respondents consider are taking part in their promotion strategy, most (5) reported community centres, while some (2) indicated social institutions and primary health care respectively, followed by one indicating welfare organizations and workplace, respectively (Table 58).

Most respondents reported that a theoretical basis was used to develop and/or deliver their promotion strategy. Specifically, four indicated the Health Belief Model, two the Protection Motivation Theory, and one the Theory of Reasoned Action and one ASE Model (Table 59).

In response to the length of time their promotion strategy has run, three respondents estimated more than 10 years and two from 6 to 10 years (Table 60). In response to whether it has run continually, periodically, or once only, three indicated continually, while two periodically (Table 61).

Lastly, regarding the intermediaries used to reach the intended population, respondents reported mostly exercise/ dance instructors and sports coaches, followed by nurses, physiotherapists, and community/social workers, and finally, medical practitioners and volunteers (Table 62).

### ▪ **Characteristics of strategies' target populations**

The modal estimates of the lower age limits of those for whom their strategy is intended was 45 years of age, followed by 50 and then 55. The modal estimates of the upper age limits of those for whom their strategy is intended was 75 years of age, followed by 80 (Figure 2). In terms of the 'category' of participants targeted by their promotion strategy, most (4) promotion strategies are intended for the general population. Fewer (3) promotion strategies are intended for either all older adults or institutionalised older adults. Only two promotion strategies are intended for older adults with chronic condition, followed by one respondent indicating that their promotion strategy is intended for community-dwelling older adults (Table 63). No promotion strategy directors responded in the affirmative when asked if specific cultural differences were catered for in their promotion strategy (Table 64).

In response to the 'category' of individual (by level of functional mobility) their promotion strategy aimed to include, most (4) respondents indicated the general population (people who have the ability to frequently walk vigorously or run, and to walk outdoors with no walking aids and no assistance or supervision, respectively). Two respondents reported the ability to walk outdoors only with assistance or supervision, and one indicated the ability to walk outdoors with a walking aid (Table 65).

### ▪ **Design of promotion strategies**

Respondents were asked to indicate approaches each used in their strategy to encourage behaviour change in relation to physical activity. Their responses in ranking order were as follows: improved knowledge (5 responses), improved safety, motivation, and skill (4 responses), improved access, time management skills, and reduction in misconceptions about aging (3 responses), and fear reduction (2 responses) (Table 66).

When asked whether the target population was screened for their readiness for behaviour change prior to implementing this promotion strategy, only one respondent answered yes (Table 67). With regard to the barriers each promotion strategy was designed to surmount, most (5) respondents answered in the affirmative (Table 68). Out of these, most (4) respondents referred to the symptoms associated with chronic conditions, followed by three respondents indicating perceived poor health, fear of injury, and misconceptions about aging, respectively. Fewer respondents (2) referred to lack of skill and energy, and environmental barriers, respectively. Acute exacerbation and lack of time were the barriers indicated the least (Table 69).

Respondents were asked to indicate which approaches their PA promotion strategy used. In terms of the information approaches tried, most (6) indicated the group-based health education focused on information provision, followed by community wide campaigns (5), mass media campaigns (2), and point of decision prompts (1). In terms of the behavioural and social approaches, most (3) indicated individually adapted behaviour change, non-family social support, and health professional social support, respectively. One respondent indicated family-based social support, and one indicated education with TV/video/DVD. In terms of the environmental and policy approaches, all (6) indicated the enhanced access to physical activity, followed by some (2) respondents also indicating outreach activities, infrastructure changes, respectively. Lastly, one respondent also indicated urban planning (Table 70).

Respondents were also asked to report on the message being used in their promotion strategy. Three indicated using a general message, and specific advice, respectively, while messages such as general advice as well as general and specific warnings each received one response (Table 71). In terms of the way each message was conveyed to the target population, the following were reported in ranking order: intermediaries (3 responses), media, model/opinion, and events (2 responses), and post, and personal contact (1 response each).

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

Regarding the proportion of the population that has been reached by their promotion strategy since its initiation, two respondents estimated 25%, while one reported 50% and one reported 75% (Table 73).

Respondents were asked to indicate which approaches they had found to be effective in achieving the aims of their promotion strategy. In terms of the information approaches tried, most indicated the community wide campaigns, followed by the group-based health education focused on information provision, and mass media campaigns. In terms of the behavioural and social approaches, most indicated individually adapted behaviour change and non-family social support, followed by family-based and health professional social support, and lastly education with TV/video/DVD. In terms of the environmental and policy approaches, most indicated the enhanced access to physical activity, followed by outreach activities. Lastly, transportation policy, infrastructure changes, and urban planning each received one response (Table 74).

When asked whether their promotion strategy had been evaluated since it was implemented, only two respondents responded in the affirmative (Table 75). One indicated specifically that the behaviour change and the population reached were the aspects evaluated, while the second one indicated the cost effectiveness of the promotion strategy (Table 76). When asked whether their promotion strategy included a specific plan or device to maintain the behaviour change achieved, most (4) respondents answered yes (Table 77).

Out of the four that responded in the affirmative, three respondents reported using positive reinforcement and feedback rewards, while two reported using the telephone, social support, and opportunities to socialize, respectively. Lastly, buddy groups was the tool least indicated (Table 78).

- **Finance**

When asked to report on the total cost of running each promotion strategy, only one respondent responded by indicating an actual amount (Table 79). The rest indicated that they did not know. In terms of the funding of each promotion strategy, four respondents pointed to the national/regional governmental sector. Specifically, three indicated the leisure/sport budget and one did not specify. Five respondents pointed to the city/local governmental sector, out of which all specified the leisure/sport budget, while one also indicated the contributions (10%) of each senior and another also indicated the social care budget (Table 80).

	PA Promotion Strategy Directors											Total
	A	B	C	D	E	F	G	H	I	J	K	
<b>Medicine</b>												
<b>Other Health Profession</b>												
<b>Exercise/ Sport Science</b>	X	X	X	X		X						5
<b>Other</b>					X							1
<b>Missing data</b>												
<b>Total</b>	1	1	1	1	1	1						6

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

	(1)	(2)	(3)
<b>Yes</b>	3	2	1
<b>No</b>	1	1	0
<b>Don't know</b>	2	3	5
<b>Total</b>	6	6	6

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

	Developed	Delivered
<b>Government</b>	3	3
<b>National</b>	2	1
<b>Regional</b>	0	0
<b>Local</b>	1	2
<b>Non Governmental</b>	3	3
<b>Commercial</b>	0	0
<b>Welfare/community organisation</b>	2	2
<b>Research organisation</b>	0	0
<b>Other</b>	1	1

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

	<b>Number</b>
<b>National</b>	2
<b>Regional</b>	1
<b>Limited to a city/ town</b>	4
<b>Limited to a local neighbourhood</b>	3

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

	<b>Number</b>
<b>Centre based</b>	6
<b>Home based</b>	1
<b>Outdoors</b>	4
<b>Other</b>	0
<b>Group exercise</b>	6
<b>Independent exercise</b>	1
<b>Other</b>	0

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

	<b>Number</b>
<b>Social institutions</b>	2
<b>Primary health care</b>	2
<b>Community centres</b>	5
<b>Welfare organisations</b>	1
<b>Work place</b>	1
<b>Other</b>	0
<b>Don't know</b>	0

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

	<b>Number</b>
<b>Theoretical basis was used</b>	4
<b>Health Belief Model</b>	4
<b>Protection Motivation Theory</b>	2
<b>Theory of Reasoned Action</b>	1
<b>Theory of Planned Behaviour</b>	0
<b>ASE* – Model</b>	1
<b>Transtheoretical Model</b>	0
<b>Other</b>	1

\* Attitude, Social influence and self-Efficacy

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

	<b>Number</b>
<b>Less than 1 year</b>	0
<b>1 to 5 years</b>	0
<b>6 to 10 years</b>	2
<b>More than 10 years</b>	3
<b>Don't know</b>	0
<b>Total</b>	5

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

	<b>Number</b>
<b>Once only</b>	0
<b>Periodically</b>	2
<b>Continually</b>	3
<b>Other</b>	0
<b>Don't know</b>	0
<b>Total</b>	5

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

	<b>Number</b>
<b>Medical Practitioners</b>	2
<b>Nurses</b>	3
<b>Physiotherapists</b>	3
<b>Occupational therapists</b>	0
<b>Physiotherapy/ OT Assistants</b>	0
<b>Other Allied Health Care Professionals</b>	2
<b>Exercise/ dance instructors</b>	4
<b>Sports coaches</b>	4
<b>Community/Social Workers</b>	3
<b>Volunteers</b>	2
<b>Other</b>	0
<b>None</b>	0
<b>Don't know</b>	0

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



**Figure 2 (PSQ21).** PA Promotion Strategy Directors’ estimates of the upper and lower age limits of those for whom their strategy is intended

	<b>Number</b>
<b>General population (including older adults)</b>	4
<b>All older adults</b>	3
<b>Community – dwelling older adults</b>	1
<b>Institution – dwelling older adults</b>	3
<b>Older adults with chronic conditions</b>	2
<b>Ethnic minority older adults</b>	0
<b>Other</b>	0

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

	<b>Number</b>
<b>None</b>	0
<b>Different language</b>	0
<b>Different cultural perceptions</b>	0
<b>Different education levels</b>	0
<b>Different income levels</b>	0
<b>Other</b>	0
<b>Don’t know</b>	0

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

	<b>Number</b>
<b>Frequently walks vigorously or runs</b>	4
<b>Walks outdoors with no walking aids and no assistance or supervision by another person</b>	4
<b>Walks outdoors with a walking aid but no assistance or supervision by another person</b>	1
<b>Walks outdoors only with assistance or supervision by another person</b>	2
<b>Never walks outdoors</b>	0

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

	<b>Number</b>
<b>Improved knowledge</b>	5
<b>Improved access</b>	3
<b>improved safety</b>	4
<b>improved time management skills</b>	3
<b>Improved motivation</b>	4
<b>Fear reduction</b>	2
<b>Improved skill</b>	4
<b>Reduction in misconceptions about ageing</b>	3
<b>Don't know</b>	0

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

	<b>Number</b>
<b>Yes</b>	1
<b>No</b>	3
<b>Don't know</b>	1
<b>Total</b>	5

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

	<b>Number</b>
<b>Yes</b>	5
<b>No</b>	0
<b>Don't know</b>	0
<b>Total</b>	5

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

	<b>Number</b>
<b>Perceived poor health</b>	3
<b>Symptoms associated with chronic conditions</b>	4
<b>Fear of injury</b>	3
<b>Acute exacerbation of chronic conditions</b>	1
<b>Lack of skill</b>	2
<b>Lack of time</b>	1
<b>Lack of energy / motivation</b>	2
<b>Environmental barriers</b>	2
<b>Misconceptions about ageing</b>	3
<b>Other</b>	0

<b>Don't know</b>	0
<b>Not applicable</b>	0
<b>Total</b>	21

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

	<b>Number</b>
<b>INFORMATION APPROACHES</b>	
<b>Community wide campaigns</b>	5
<b>Group-based health education focused on info provision</b>	6
<b>Mass media campaigns</b>	2
<b>Point of decision prompts</b>	1
<b>Other</b>	0
<b>BEHAVIOURAL AND SOCIAL APPROACHES</b>	
<b>Individually-adapted behaviour change</b>	3
<b>Education with TV/video/DVD</b>	1
<b>Family-based social support</b>	1
<b>Health professionals social sup</b>	3
<b>Non-family social support</b>	3
<b>Other</b>	0
<b>ENVIRONMENTAL AND POLICY APPROACHES</b>	
<b>Enhanced access to physical activity</b>	6
<b>Outreach activities</b>	2
<b>Transportation policy</b>	0
<b>Infrastructure changes to promote non-motorised transit</b>	2
<b>Urban planning approaches</b>	1
<b>Other</b>	0
<b>Don't know</b>	0

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

	<b>Number</b>
<b>General message</b>	3
<b>General advice</b>	1
<b>General warning</b>	1
<b>Specific advice</b>	3
<b>Specific warning</b>	1
<b>Other</b>	1

<b>Don't know</b>	0
<b>Total</b>	10

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

	<b>Number</b>
<b>Media</b>	2
<b>Post</b>	1
<b>Internet / e-mail</b>	0
<b>Intermediates, healthcare professionals</b>	3
<b>Models / opinion</b>	2
<b>Events (e.g. Falls Awareness Day)</b>	2
<b>Other</b>	1
<b>Don't know</b>	0

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

	<b>Number</b>
<b>0%</b>	0
<b>25%</b>	2
<b>50%</b>	1
<b>75%</b>	1
<b>100%</b>	0
<b>Don't know</b>	1
<b>Total</b>	5

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

	<b>Number</b>
<b>INFORMATION APPROACHES</b>	
<b>Community wide campaigns</b>	5
<b>Group-based health education focused on info provision</b>	4
<b>Mass media campaigns</b>	2
<b>Point of decision prompts</b>	0
<b>Other</b>	0
<b>BEHAVIOURAL AND SOCIAL APPROACHES</b>	
<b>Individually-adapted behaviour change</b>	3
<b>Education with TV/video/DVD</b>	1
<b>Family-based social support</b>	2
<b>Health professionals social sup</b>	2
<b>Non-family social support</b>	3

Other	0
<b>ENVIRONMENTAL AND POLICY APPROACHES</b>	
Enhanced access to physical activity	4
Outreach activities	3
Transportation policy	1
Infrastructure changes to promote non-motorised transit	1
Urban planning approaches	1
Other	0
<b>Don't know</b>	0

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

	<b>Number</b>
<b>Yes</b>	2
<b>No</b>	2
<b>Don't know</b>	1
<b>Total</b>	5

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

	<b>Number</b>
<b>Behaviour change</b>	1
<b>Population reached</b>	1
<b>Cost effectiveness (e.g. total costs)</b>	1
<b>Other</b>	0
<b>Don't know</b>	1
<b>Not applicable</b>	0

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

	<b>Number</b>
<b>Yes</b>	4
<b>No</b>	0
<b>Don't know</b>	1
<b>Total</b>	5

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

	Number
<b>Printed material posted</b>	0
<b>Telephone</b>	2
<b>Positive reinforcement / feedback rewards</b>	3
<b>Financial incentives</b>	0
<b>Social support</b>	2
<b>Buddy groups</b>	1
<b>Opportunities to socialise</b>	2
<b>Promotion days</b>	0
<b>Other</b>	1
<b>Don't know</b>	1
<b>Not applicable</b>	0

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

<b>Median</b>	N/A
<b>Least</b>	N/A
<b>Most</b>	N/A
<b>N (1)</b>	120000

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

	Number
<b>NATIONAL / REGIONAL GOVERNMENT</b>	
<b>Health budget</b>	0
<b>Social care budget</b>	0
<b>Leisure / sport budget</b>	3
<b>Other</b>	1
<b>CITY / LOCAL GOVERNMENT</b>	
<b>Health budget</b>	0
<b>Social care budget</b>	1
<b>Leisure / sport budget</b>	5
<b>Other</b>	1
<b>OTHER SOURCES</b>	
<b>Lottery</b>	0
<b>Charity</b>	0
<b>Other</b>	0

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

▪ **SYSTEMATIC SEARCH FOR EVIDENCE BASED GUIDELINES**

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

The UK EUNAAPA collaborating partners searched the following electronic databases:

Ovid Medline (1950 to June Wk 4 2007)

CINAHL (1982 to June Wk 5 2007)

EMBASE (1996 to 2007 Wk 26)

SPORTDiscus (1830 to May 2007)

AARP Ageline (1978 to June 2007)

Cochrane Review Library

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

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

**Search 1 – Provision of physical activity for older people**

- 1 exp exercise/
- 2 (exercise\$ or physical activity or exercise prescription).mp
- 3 1 or 2
- 4 exp aged/ or exp "aged, 80 and over"/
- 5 (aged or elderly or senior\$ or older adult or older person\$ or older people).mp
- 6 4 or 5
- 7 guideline.pt
- 8 practice guideline.pt
- 9 exp guidelines/
- 10 exp health planning guidelines/
- 11 7 or 8 or 9 or 10
- 12 exp consensus/
- 13 (guideline\$ or consensus or position stand or standard\$ or recommendations\$).ti
- 14 11 or 12 or 13
- 15 3 and 6 and 14

**Search 2 – Promotion of physical activity for older people**

- 1 exp exercise/
- 2 (exercise\$ or physical activity).mp
- 3 1 or 2
- 4 exp health promotion/
- 5 (health promotion\$ or promotion strategy or promotion strategies or health behaviour\$ or campaign\$).mp
- 6 4 or 5
- 7 exp aged/ or exp "aged, 80 and over"/

- 8 (aged or elderly or senior\$ or older person\$ or older people or older adult\$).mp
- 9 7 or 8
- 10 guideline.pt.
- 11 practice guideline.pt
- 12 exp guidelines/ (61574)
- 13 exp health planning guidelines/
- 14 exp consensus/
- 15 (guideline\$ or consensus or position stand or recommendation\$ or standard\$).ti
- 16 10 or 11 or 12 or 13 or 14 or 15
- 17 3 and 6 and 9 and 16

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

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

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

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

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

**RESULTS**

Approximately 5120 titles were considered. Of these, over 650 abstracts were reviewed and, from them, 325 full publications were reviewed. Fifty-five publications met all 5 criteria for inclusion in the inventory, where they have been listed under the following subheadings: habitual physical activity and PA promotion, resistance training, exercise referral, cardiovascular conditions, exercise testing and screening, hypertension, stroke, hypercholesterolemia, diabetes, obesity, osteoporosis, falls, osteoarthritis and chronic pain (1).

▪ **CONCORDANCE OF PROGRAMMES WITH GUIDELINES**

### ○ **Discussion of experts' findings**

Based on the descriptive results concerning the general profile of the Greek experts, it is revealed that they only partially represent the whole matrix of fields, with a higher prevalence in the education governmental sector. In relation to areas of their practice, all but one claims the local neighbourhood as their organizational level and the community-dwelling older adults as their target group. These findings are expected since most physical activity experts -if not all- come from the University sector and specifically from the sport sciences departments in Greece. These departments are the only ones specialising in the training of those who deliver recreational, competitive or health related physical activity, not only for older people but for the whole population as well. Only one of the two experts who represent the governmental health sector is also a physical educator and a physiotherapist at the University level. However, while most represent the education governmental sector, they practice on a local neighbourhood level and mostly with healthy older adults.

In relation to qualification level, the findings reveal that although most experts are aware of the required level of qualification and the necessity of the higher level qualification, they cannot estimate the ranking prevalence of them, but do believe these qualifications are not always properly implemented or externally validated as they ought to. Additionally, with concern to the assessment and validation of qualifications, the most frequently addressed components are the practical teaching competence assessed with participants of any age, as well as with older individuals, and also a summative assessment of knowledge. Concerning the requirements for retention of the higher level (older person specific) qualification, only two experts referred to the evidence of current CPR certification, a practical test of teaching competence, and the evidence of continuing professional development (CPD). The above findings suggest that in Greece currently, there has not yet been any ranking qualification procedure for physical activity professionals, since Greek Sport Sciences departments offer only a basic level qualification. This situation is more pronounced when looking at the qualifications required for working with older people, since most University Sports departments offer only limited physical activity specialization tailored to older adults.

### **Discussion of physical activity programs findings**

The descriptive findings concerning the profile of physical activity program directors reveal many similarities with the experts' profile. Specifically, as with the experts' profile, all but one director have an Exercise and Sport Sciences background while the remaining one has a health background. Most programs are classified as being limited to the local neighbourhood and have lasted one to 10 years. This finding is expected since physical activity programs, the so called "Sport for All" programs, although in most cases are funded by the Governmental General Secretariat of Sport, are exclusively delivered and implemented through local authorities by the Physical education specialists, all over Greece. This is also the reason why it was impossible to derive PA experts, directors and/or promoters from all recommended sectors of the matrix.

The results reveal that the most common components of the overall programs are “community based senior fitness”, “falls prevention”, and “medical condition-specific” programmes such as “arthritis”, and “cardiac and pulmonary rehabilitation” programs. Most programs are characterized as having a group modality, being undertaken indoors and on land. Furthermore, most common facilities used seem to be sport and physical recreation ones, followed by community centres and institutional or private settings. Commenting on the common components of PA programs, they all seem to follow the professionally recommended ones, such as “senior fitness” for healthy population, and “fall prevention”, while less often they seem to follow the specific therapeutic ones which require personnel with specialized training (Nelson et al., 2007). Social support is also provided since community based programs more often use a group modality, which gives many opportunities for socializing (ACSM, 2004). Most programs are also undertaken indoors, as seniors do not feel at ease to expose themselves in the open environment, as well as on land, which are more convenient than travelling to the nearest swimming pools.

The findings show that the most frequent modalities of physical activity offered, are machine based, recreational type, and indoor running and walking, while back pain, osteoporosis and fall prevention, as well as pelvic floor, and chair-based exercise, and lastly cardio and pulmonary rehabilitation are less frequent. Additionally, the most common characteristics of a program class size appear to be 11 to 15 participants, with a ratio of 1:11-25 and a weekly frequency of 3 to 4 times. Furthermore, 75% of current participants seem to follow a program all year round. The modalities of the PA programs offered seem to be in accord with the multidimensional activity programs that are professionally recommended and include endurance, strength, balance, and flexibility training, which is optimal for health and functional benefits (ACSM, 2004). As for the size and ratio of the programs, although it might be effective for healthy active adults, it seems rather large for older less active individuals. The percentage (75%) of adherence to year round participation of older participants seems quite satisfactory, since regularity in PA participation is one of the most effective ways for older adults, including those with disabilities, to help prevent chronic disease, promote independence, and increase quality of life in old (Cleroux et al., 1999; ACSM, 2004; AHA, 2007).

The findings regarding clients’ ages range from that of 45 to 90 (common age of 60). Most clients in the overall programs are either all or mostly females and community-dwelling older adults. This is quite a common finding in community fitness programs in Greece, as is it elsewhere, where most participants are females. Although the reasons vary, women seem to be more concerned about their health and body appearance, as well as about social contacts, and therefore more often prefer to participate in organised community fitness groups.

The most frequent program aims are found to be health oriented, such as health promotion, physical functioning improvement and disease prevention, followed by improved mood and self esteem. Additionally, results show that most programs seem to be tailored towards their participants’ needs and that outcome measures are taken at regular intervals. These output measures are mostly related to aerobic fitness, followed by muscular fitness, and social support. In contrast, the components which most physical activity programs aim to improve follow a different ranking order, since all directors indicated first muscular fitness components and then aerobic

fitness, as well as body composition. This finding is probably explained by the different priorities some directors give regarding the aim and the output measures of their programs, which are often influenced by the availability of the measuring instruments, as well as the appropriate setting for these measurements. Lastly, participant satisfaction is measured 1 to 2 times per year. The above health oriented aim, including physical functioning, disease prevention, and behavioural change identified in the Greek PA programs seems to be universal in PA and public health programs, since the impact of a certain type and amount of physical activity is well established for improving and maintaining health in older adults (UK: Department of Health, 2004; ACSM/AHA, 2007).

The results related to a pre-participation assessment show that all programs require a health check prior to entry eligibility, mostly in the form of a doctor's assessment, less so by a sports medicine or program doctor, or by an exercise instructor, and lastly in the form of a health screening tool. This finding is very encouraging and is in accord with the recommended standards by the (AHA/ACSM, 1998; ACSM, 2004).

The findings regarding the most common length of a typical workout indicate a 30 minute duration with less frequent longer durations. As for older people with chronic medical conditions, most programs offer adapted exercises with participants included in the mainstream older groups, while less programs offer in more health specialized groups. When commenting on this finding, it seems that the basic length of at least 30 minutes of exercise – recommended by most experts (Briffa et al., 2006) even for individuals with clinically established cardiovascular disease - seem to have been met in most Greek programs delivered to older adults, while the opportunities for individualized health programs seem to be rare. Therefore, in view of the potential legal risks assumed by more specialized health programs, most qualified personnel and/or medical practitioners are needed for supervision and health screening.

The findings concerning the instructors' qualifications and training reveal that the directors' responses are almost divided between the high and basic qualification level. This probably occurs because some program directors consider those with a post graduate degree as highly qualified. This also explains the discrepancy of responses among directors concerning the instructors' proportion of having the entry or the high level qualification for these programs. As for the professional register, both experts and directors agree that there has not yet been a professional register for physical activity professionals. Finally, regarding the in-service training, most directors seem not to be aware of this possibility, since only few report the existence of 20 to 30 hours in-serving training yearly. There are, however, volunteers that help directors either as assistants or as buddies of the participants. Comparing the above findings with the international standards, it seems that the qualifications, training, as well as in service-training, are not adequately established and therefore not properly implemented in Greece. This is also apparent by the absence of a professional register, which would establish nationally recognised guidelines.

In relation to issues of client safety, results do not seem satisfactory, since only few directors indicate the existence of protocols followed in emergency situations or in respect to the use, storage and maintenance of equipment. This neglected safety requirement seems to be the result of the limited staff training availability in the exercise settings that is also followed by the absence of training concerning use,

storage and maintenance of the equipments. The above results reveal a limitation in client safety in most senior PA programs, the existence of which contrasts the professional standards recommended (AHA/ACSM, 1998). Client safety is an important issue in implementing health and exercise programs for all ages, especially for older adults, and requires serious consideration by all professionals involved.

As far as finance, and the provision of transport and refreshments is concerned, findings show that few directors mention the participant cost to be 5 to 10 Euros per session, and the proportion of cost paid is distributed between 0% and 25% for most participants. Additionally, few directors report the availability of transportation which in most cases happens sporadically, while the proportion of cost of transport and refreshment paid by each participant ranges from 0% to 100%. The above findings reveal that most older adults participate at no cost or at least at low cost in the community programs that are offered locally, and the same situation exists in the provision of their transportation and refreshments. Therefore, considering the availability of the above parameters, it could be said that many measures so far have been in effect in Greece, that intend to minimize obstacles and facilitate greater PA participation of older people. Nevertheless many more measures should be taken to make a neighbourhood more conducive to active living. Among them are those recommended by WHO (2006), which assist a neighbourhood to become walkable, such as by having walking paths, street connectivity, aesthetics, road safety, security from crime, etc.

In relation to program publicity, marketing and promotion, the findings reveal that the most common methods used are by advertising print material, using word of mouth and/or talking to local groups locally in community centres for older people, as well as in sports halls and health premises. Less common methods used are advertising through elder-oriented organisations, and the local radio, as well as through the internet. As with marketing and promotion, only one director in each case reports finding it useful to capitalize on national or regional campaigns as well as to make and built partnerships with local healthcare and professional organizations. This finding is an indication of the poor communication network that exists not only locally but also nationally among various organizations dealing with older people and specifically with older people and physical activity. As a result, the poor communication does not facilitate the necessary information needed for older adults to be involved in PA programs. Therefore issues of publicity, marketing and promotion of PA programs should be in the agenda of all organizations involved by employing qualified health and recreation managers.

- **CONCORDANCE OF PROMOTION STRATEGIES WITH GUIDELINES**
  - **Discussion of findings related to physical activity promotion strategies**

The descriptive findings concerning the directors of PA promotion strategies reveal a similar profile to that of PA experts and PA program directors. Specifically, all but one director of PA promotion strategies come from an exercise and sport science educational background. Few of them are aware of the existence of Greek laws and regulations for the promotion of physical activity for adults and older adults, and only one is aware of the national level recommendations for the promotion of physical activity for older people. This finding shows the lack of an existing Greek law or

regulations regarding physical activity that is tailored toward the older population. Comparing the profiles and qualifications of Greek experts, directors of programs, as well as promoters of physical activity strategies, with those officially recommended by the academia, it is evident that all have the necessary knowledge to meet the professional standards established by the ACSM for the basic level of specialization required to deliver physical activity programs for the general population, as well as for the older population. However, with the exception of those with postgraduate degrees in exercise physiology, most of them lack a higher qualification certificate. But even among those better qualified, there seems not to be proper implementation or external validation regarding the qualifications, as is professionally recommended (AHA/ACSM, 1998).

The findings regarding the sectors in which organizations developed the promotion strategies, reveal that both the governmental and non-governmental sector is equally represented by the promoting organizations. Specifically, most promotion strategies are developed at the national level and delivered at the local level, while in the non-governmental sector most are developed and delivered at the welfare/community organization level. Furthermore, most promotion strategies aim to deliver at the city/town and local neighbourhood level, while encourage mostly centre based, outdoor, and group settings physical activity. Results also show that community centres are the most frequent settings for implementing promotion strategies, and in terms of their duration, most are estimated to have been running either continually or periodically for at least six years. Furthermore, most promotion strategies are described as using a theoretical basis and specifically the Health Belief Model. This is a finding that is in accordance with the aims of PA program development explained above, where the health oriented objectives are most common. Moreover, the intermediaries most commonly used by each strategy to reach the intended population are exercise/dance instructors and sports coaches, followed by healthcare professionals and volunteers.

The findings regarding the characteristics of the targeting populations show that most promotion strategies are intended for the general population including older adults, while half of the strategies are intended for all older adults as well as institutionalized ones. As anticipated therefore, with regard to the functional mobility level aimed at, the results point to those individuals who walk outdoors with no walking aid or assistance, and those who are able to walk vigorously or run. In terms of the modal estimates of lower and upper age limits, the responses indicate them as being 45 and 75 years of age, respectively. Responses lastly indicate that promotion strategies in Greece do not seem to cater to cultural differences.

With regard to the most frequently used factors encouraging behaviour change in physical activity, these seem to be improved knowledge, safety, motivation, and skill, without however, screening the target populations for their readiness to change prior to the implementation of each promotion strategy. These factors suggest that effective physical activity interventions are used to encourage and establish behavior change, which is in accord with to the recommended guidelines (ACSM, 2006). Additionally, the findings reveal that most promotion strategies are designed to overcome common barriers such as, symptoms associated with chronic conditions, perceived poor health, fear of injury, and misconceptions about aging. Overall, the results indicate that physical activity promotion strategies use a variety of approaches of which the most

common ones appear to be: a) community wide campaigns and group-based health education (information approaches), b) individually tailored behaviour change and non-family social support (behavioural and social approaches), and c) enhanced access to physical activity and outreach activities (environmental and policy approaches). The above strategies seem to be in agreement with the recommended ones by Nelson and colleagues (2007), where both community-level and individual-level approaches should compliment each other in order to promote effective PA programs. The findings also reveal that either a general message or specific advice is most commonly used, and this message is commonly conveyed through intermediaries and health care professionals.

In relation to the proportion of population reached by each strategy since its initiation, results reveal that this ranges between 25% and 75%. Furthermore, only two of the strategies had been evaluated since implementation for their specific population targets reached, their cost effectiveness, and their behaviour change. Most responses highlight that certain tools, such as positive reinforcement and feedback rewards, are used to maintain behaviour change. Regarding funding of promotion strategies, the findings reveal that these seem to be equally divided between the national/regional and city/local government level. In both cases, though, the leisure/sport budget is the funding source most commonly used.

#### ▪ **CONCLUSIONS & RECOMMENDATIONS**

Greece among other European countries has used many effective governmental and non-governmental promotion strategies for encouraging participation in physical activity of the general population, and less so for older population. Most promotion strategies are developed at the national level and delivered at the local level, but do not cater to cultural differences. Strategies encourage centre based, outdoor, and group settings physical activity. The Health Belief model is used as a theoretical basis for PA promotion. A combination of approaches is used for encouraging behaviour change and designed to overcome common barriers. The population reached for behaviour change is quite high by using effective tools such as positive reinforcement and feedback rewards.

Many physical activity programs have been implemented with the aim to improve health, physical functioning and disease prevention. They are based on the community level catering mostly to healthy older community-dwellers. Most programs include program components such as “senior fitness”, and “falls prevention”, while less include program components such as “arthritis”, and “cardiac and pulmonary rehabilitation”. Programs are machine based, indoor, and of recreational type, while fewer are of a health therapeutic type. Keeping in mind the restricted fitness settings in Greek cities, the program sizes of 11-15 participants and ratios of 1:11-25, as well as the mixed groups in terms of ability, physical activity programs do not allow the possibility of a variant exercise program for older adults. All programs require a health check prior to entry eligibility by a physician’s assessment, but they do not have the necessary protocols in emergency situations. Physical activity professionals with a basic level of qualification are employed in various exercise settings to deliver health and fitness community programs, but most lack in-service training. Moreover, they do not have a professional registry to adhere to for professional guidelines. Finance, transport and refreshment are available for most participants usually at low

cost, and make PA programs more accessible to older population. These accessibility measures would be more effective if facilitated through more thorough publication, marketing, and promotion measures.

In conclusion, it can be safely stated that the promotion and implementation of PA programs in Greece, in general terms, follows the ones that exist internationally, however adhere to a limited number of internationally recommended guidelines. Therefore, the following recommendations are suggested:

- Effective physical activity programs should be undertaken in all health-care related sectors and settings, as well as in seniors' voluntary organizations.
- Effective publicity and marketing should be established in all senior settings, including shopping malls, in order to facilitate communication and the dissemination of information.
- Effective measures should be taken to make a neighbourhood more conducive to active living, by establishing walking paths, street connectivity, aesthetics, road safety, safety and security from crime, etc.
- Pre-participation screening and health assessment by qualified personnel should be established in all fitness facilities.
- Effective safety measures for older participants should be taken in all fitness facilities, with specific protocols for emergency situations
- PA settings should be properly equipped with the more advanced fitness technology followed by available training, maintenance and storing possibilities.
- More emphasis should be given on individualized PA programs, as well as on health therapeutic programs with the necessary medical attention.
- Less crowded PA programs with more privacy and better ratios should be established that will facilitate accessibility and adherence to the programs.
- Behavior change seminars should be integrated in PA programs to enhance adherence by educating older participants on issues of social support, self-efficacy, and active choices, as well as health contracts, assurances of safety, and positive reinforcement.
- A professional registry should be established that will officially authorise professional qualification levels in the PA field according to international standards.

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#### ▪ ACKNOWLEDGMENTS

The present study could not be made possible without the help of the physical activity experts, directors and promoters that took part in this research. Therefore special thanks go to all of them who highlighted important issues regarding physical promotion strategies and programs undertaken in Greece with their valuable knowledge and expertise. Special appreciation is also extended to the Democritus University of Thrace and the European Committee for co-financing this project for without their support this project would not have been completed.

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▪ **APPENDIX TWO - IDENTIFICATION DETAILS OF ‘SUCCESSFUL’ PA PROGRAMMES**

○ **Name of programme I**

“Exercise in postmenopausal women”

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○ **Name of programme II**

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○ **Name of programme IV**

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○ **Name of programme IX**

“Physical education for the elderly”

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“Swimming and aqua aerobics”

“Trekking”

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▪ **APPENDIX THREE - IDENTIFICATION DETAILS OF ‘SUCCESSFUL’  
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