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EUNAAPA – Work Package 5

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

National Report Italy

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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, Italian 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 Italian Experts.

▪ **THE EXPERTS**

○ **Methods**

▪ **Selection of Experts**

As requested by the leader of Work Package 5, eleven 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.

All of the Italian Experts selected were known personally to the Italian Collaborating Partner. Selected Experts were contacted by the Collaborating Partner by telephone, 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**

Starting from mid June 2007, each of the 11 Italian Experts who had agreed to participate was sent an electronic and a bound, paper copy of the PA Expert Questionnaire, accompanied by an explanatory letter. Also included were a template of a further explanatory letter and electronic and paper copies of the other two questionnaires for distribution, in due course, to the directors of their chosen PA programme and PA promotion strategy.

PA experts were encouraged to complete and return the PA Expert questionnaires as soon as possible before 10 August. By e-mail and telephone, defaulters were reminded in mid-July, mid August, late August, early September and mid September. The last reminder included a warning that if questionnaires were not returned by 30 September, it might not be possible for their data to be included in the final analysis and in the national and cross-national reports.

- **Results**

- **Selection of Experts**

Eleven potential Experts were selected and eleven agreed to participate.

When selecting the Experts, the WP5 Leader and the Collaborating Partner judged that the eleven represented all of the primary matrix fields (Table 1).

Most of the Italian Experts, however, could justifiably be identified with more than one field in the selection matrix.

Two experts who had agreed to participate did never send the questionnaire back. Therefore, the final number of participating experts is nine. The Experts who had not returned their questionnaires belong to sector 3 and 4 of matrix (see, Table 1 and Table 2).

- **Return of Experts' questionnaires**

By 31 July 2007, three of the eleven PA Expert questionnaires had been returned. By 30 August, other four questionnaires had been returned, while, despite several reminders, the 4 defaulters had still to return their Experts' questionnaires. By mid September, eight of the eleven questionnaires had been returned. The last questionnaire returned by late September. Finally, two Experts never returned their questionnaires.

- **Experts' educational background**

Seven experts cover the field of exercise/sports medicine, two of medicine, one of sociology and one of social welfare (XQ9, Table 3).

- **Experts' areas of practice**

FIELD: four participants stated they are experts in the field of PA programs only, one in the field of PA promotion only, and the remaining three on both fields. **LEVEL:** Four experts work with national level organizations, one with a regional level organization, three with local level organization and one with an organization covering national, regional and local levels. **TYPOLGY:** as regards older adult typology, six experts declared they deal with community-dwelling people, two with both community-dwelling and institutionalised people, None was dealing with institutionalised people only, while one stated that his organisation does not deal primarily with older people. **SECTOR:** three experts belong to governmental organisations, the other six to non-governmental organizations. **PROFESSIONAL EXPERTISE:** two experts stated their experience is in the field of health promotion, and five in both therapy and promotion; the four remaining do not have experience in the field. **EDUCATIONAL SECTOR:** two experts are exclusively in the educational sector, three educational and research, one educational, social service and socio-cultural, one sports guidance, health related exercise

and educational, one sports management and guidance, as well as research, one failed to give this information (XQ10, 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	1 Ministry of Sport (or equivalent)	2 NGO specialising in the delivery of recreational or competitive physical activity for older people	3 Ministry of Health or Ministry (or department) with particular responsibility for older people	4 NGO specialising in the delivery of health-related exercise for older people or sickness funds or health insurance or NGO addressing age-related issues	5 Department specialising in the training of those who deliver recreational, competitive or health-related physical activity for older people	6 NGO specialising in the training of those who deliver recreational, competitive or health-related physical activity for older people
						7 Professional association for those specialising in old age healthcare or social care
City or local neighbourhood	8 Municipal department for sport, recreation and leisure services	9 Sport or dance organisation with special interest in older people or Other organisation providing physical activity opportunities for older people	10 Municipal department responsible for healthcare services for older people or Municipal department responsible for social care services for older people	11 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		

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
Primary matrix field	10	8	11	7	5	1	9	6	2	3	4

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	
Medicine					1	1						2
Other Health Profession												0
Exercise/ Sport Science			1	1	1	1	1	1	1			7
Other	1	1										2
Missing data												
Total	1	1	1	1	2	2	1	1	1			11

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

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

supervision/guidance											
Education	x	x	x	x		x	x	x	x		
Research		x		x		x		x			
Social services, social care or social welfare	x										
Socio-cultural organisation	x										

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

▪ NATIONAL QUALIFICATIONS IN THE SUPERVISION/GUIDANCE OF PHYSICAL ACTIVITY

○ Methods

The questionnaire completed by the 11 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

According to four experts a base level title for PA teaching is required, while the other five believe this is not required (XQ11, Table 5). The name of the basic level qualification is: diploma I.S.E.F. (Istituto Superiore di Educazione Fisica) and degree in Exercise and Sport Science (XQ12). Four state the requirement is enforced, while the others either state it is not, or are not informed about this issue (XQ13, Table 5). According to two experts, 75% of the instructors have a base qualification, 50% according to another expert, while the others are not informed or quote the question as inapplicable (XQ21, Table 7).

▪ Higher level qualification

According to eight experts, no specific higher level qualification in supervising or guiding physical activity or exercise by older adults is required, while one expert does not know (XQ14, Table 6). Five state the requirement ought to be respected, one is against, one does not know and two quote the question as inapplicable. (XQ17). According to one expert, 75% of the instructors have a higher level qualification, 25% according to another expert, while the others are not informed or quote the question as inapplicable (XQ22, Table 7).

▪ Assessment, validation and revalidation

One expert only states that an external validation method of the qualification exists (XQ18, Table 6). This comprises a summative assessment of knowledge, practical teaching competence assessed with older participants (XQ19, Table 8) that is confirmed by verification of current cardiopulmonary resuscitation (CPR) certification and a practical

ability test (XQ20, Table 9). The other experts either give negative responses, or quote the questions inapplicable, else believe not to have enough information.

- **Professional register**

PA Experts' responses concerning the existence in Italy of a professional register of PA instructors: only one expert stated that such register exists in Italy, with requirement of a basic level entry qualification. The other seven state that no register exists or they are not informed and therefore they cannot answer question (XQ23, XQ25, Table 10). None answered XQ26 concerning 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). To our knowledge, no register exists and the faculties of exercise and sports science in Italy are fighting at the national level to obtain new rules about this item.

	Basic level qualification	
	Available	Required
Yes	4	4
No	5	3
Don't know	0	1
Not applicable	0	1
Missing Data	0	0
Total	9	9

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

	Higher level qualification			
	Available	Required	Important	External verification
Yes	0	2	5	1
No	8	3	1	3
Don't know	1	1	1	3
Not applicable	0	3	2	2
Missing Data	0	0	0	0
Total	9	9	9	9

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

	Entry level	Higher level
0%	0	0
25%	0	1
50%	1	1
75%	2	0
100%		
Don't know	5	5
Not applicable	1	2
Missing data	0	0
Total	9	9

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
Yes		1		1	6	2
No	1		1		3	7
Total	1	1	1	1	9	9

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
Yes		1		1	1		8
No	9	8	9	8	8	9	1
Total	9	9	9	9	9	9	9

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**
Yes	1	1	
No	7	1	2
Don't know	1	2	2
Not applicable		5	5
Missing data			
Total	9	9	9

Table 10 (XQ23 & 25-26). PA Experts' responses concerning the existence in Italy 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**

On 18/19 June 2007, each of the 11 Italian Experts was sent a template of an explanatory letter of invitation and electronic and paper copies of the other two questionnaires for distribution, in due course, to the directors of their chosen PA programme and PA promotion strategy. If an invitation was declined, because the programme did not agree to participate or because the programme had already been chosen by another PA Expert, then the PA Expert was to identify another successful PA Programme and send another invitation letter.

The PA Experts were encouraged to give their PA Programme Director on-going support and to ensure that the questionnaire was returned to the WP5 coordinator by 10th August, 2007. By e-mail and telephone, defaulters were reminded in mid-July, mid August, late August, early September and mid September. The last reminder included a warning that if questionnaires were not returned by 30 September, it might not be possible for their data to be included in the final analysis and in the national and cross-national reports.

- **Results**

- **Selection of programmes**

We have appointed eleven Experts, but two of them did not comply and failed to return the questionnaires. They also failed to communicate the names of two directors of programs, as required. Therefore the overall enquiry was limited to nine PA Programme Directors.

- **Return of programme questionnaires**

By 31 July 2007, four PA Programme questionnaires had been returned. By 30 August, other two questionnaires had been returned, while, despite several reminders, the two defaulter had still to return their questionnaires. By mid September, nine questionnaires had been returned.

- **Programme directors' educational backgrounds**

All of the nine PA program directors are trained in the field exercise/sports medicine. One of them has a medical formation and another is engaged in sports activity for older people (ProgQ4, Table 11).

- **Catchment areas of programmes**

Seven programs are limited to city/town environment; two are at the regional level. None is neighbourhood based (ProgQ9, Table 12).

- **Ages of programmes**

One program exists since less than one year; three from 1 to 5 years; two from 6 to 10 years; three since more than 10 years (ProgQ10, Table 13).

- **Components of overall programmes**

The most common (8 programmes out of 9) are Community based senior fitness programmes (group); in three cases Falls Prevention Programmes

e Medical condition-specific programmes are enforced; two programmes include Exercise referral / General Practitioner referral programmes. Community based senior chair-based programmes and Home based exercise programmes exist in one programme out of nine. No Masters (elite competitor) programme exists. Four programmes use a single sub-programme; three use two due sub-programmes; one uses three and one five. Medical condition-specific programmes, exist in three cases, but in two they were not specified, while the third includes cardiac rehabilitation and osteoporosis prevention (ProgQ11, Table 14). Concerning working typologies, the most common are Group activity and Indoor activity (N=9), followed by Land-based (N=8), Outdoor (N=4) and Water-based activities (N=3). One programme only uses Individual activity. As an average, every programme uses three or four different working modalities, with minimum two and maximum six (ProgQ12, Table 15). The most common structure utilised is the sport/physical recreation facility (N=7), followed by the community centre (N=6), the day resources centre (N=2) and the sheltered housing, assisted living facility, care home or nursing home (one programme only). No programme utilises the participant's private dwelling. In addition, we find: private swimming pool, club houses for older and retired people and open-door spaces. As an average, each programme utilises two different structures, with minimum one and maximum four (ProgQ13, Table 16).

▪ **Characteristics of programmes' clients**

The minimal age of the participants is 45 in one case, 60 in three cases and 55 in the remaining five. The top age is 80 in four programmes, 100 in two, and 70, 75, 90 in the other three (ProgQ14, Fig. 1). The commonest mean age of the participants is 65 (N=4), followed by 70 (N=2), 45, 55 e 75 programme(N=1 each) (ProgQ15, Fig 1). Six programmes are for community-dwelling older adults, one for institution-dwelling older adults and two for both categories, but in separate groups. No program includes shared activities for the two categories of participants (ProgQ16, Table 17). About functional mobility related to the program structure, all programmes require walking outdoors with no walking aids and no assistance or supervision by another person; five programs include people who frequently walk vigorously or run; three programmes deal with older persons who walk outdoors with a walking aid but no assistance or supervision by another person; one programme is for older people who walk outdoors only with assistance or supervision by another person. No program is for people “who never walk outdoors”. As an average, each programme is for two categories of older people, with a minimum of one and a maximum of four (ProgQ17, Table 18).

About the gender of participants, in eight programmes the percentage of females is 75% and one programme is for women only (ProgQ18, Table 19).

▪ **Characteristics of programmes' classes**

The most frequent number of participants per class is 21-25 (N=6), followed by 11-15 or 16-20 (N=3). Classes of 1, 6-10 e 26-50 participants characterise one programme each. No programme deals with classes of 2-5, or over 50 participants. Overall, 7 programmes work with fixed number classes, while two programmes select among four different numbers per class, depending on the activity (ProgQ19, Table 20). Eight programmes provide one teacher per 11-25 participants and one programme provides one teacher per 2-10 participants (ProgQ20, Table 21). Five programmes offer a maximum of 3-4 lessons per week, two programmes 2 lessons per week and the remaining two 5-7 lessons per week (ProgQ21, Table 22). The most frequent weekly attendance is twice (N=4), followed by 3-4 times per week (N=2). Once weekly was specified in one case and one director was not informed about this item (ProgQ22, Table 22). The percentage of participants attaining the activities since at least one year is 75% in six cases, while the other three directors respectively quoted 0%, 50% and 100% (ProgQ23, Table 23).

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

The three most quoted objectives (N=5) are: health promotion, improved physical function and improved self esteem / confidence. Two programme directors pointed to opportunities to socialise, and one to improved mood. No director considered an important objective to pursue improved competitive performance (ProgQ24, Table 24). An evaluation of satisfaction of participants is never attempted for in four programmes; it is performed 1-2 times per year in two cases, while two directors stated they are not informed (ProgQ25, Table 25). In three programmes only are the participants interviewed about their expectations (ProgQ26, Table 26) and in these three cases programmes are adapted to the expectations (ProgQ27, Table 26). Six of nine programmes recorded "objective outcome measures at regular intervals" (ProgQ28, Table 26). The objective measures recorded at regular intervals more frequently are: "sub maximal test of aerobic fitness", "balance" and "joint range of motion" (N=4). Follow measures of "strength or explosive power", "mood/depression" recorded into three programmes. In two cases were recorded measures of "bone density" and in one case "social support". Among other measures, were indicated "reactivity measures" as well as reactive tests and psychiatric measures. Any programme provide measures of "maximum oxygen uptake (directly measured)" and measures of "bone density". Totally, the number of measures recorded

vary between a minimum of one measure to a maximum of seven measures, with an average of approximately four measures (ProgQ29, Table 27).

▪ **Pre-participation assessment**

Seven programmes out of nine require the potential participants to have a health check (ProgQ30, Table 28). Four require assessment by doctor, two completion of a health screening tool and one a self certification by the participants (ProgQ31, Table 29). Three programmes ask for completion of a health screening tool by the potential participants, but in one case only this is an internationally approved questionnaire (Physical Activities Readiness Questionnaire) (ProgQ32, Table 30; ProgQ33, Table 31). Another is a technical validation form of motility fitness; the name of the third one is unknown to the Programme Director (ProgQ34). The two non validated questionnaires have been adapted to the programme, while the internationally approved one has not been changed (ProgQ35, Table 31). This questionnaire includes questions on vertigo, the technical form on vertigo sight and hearing. About the third questionnaire, the Director is unable to answer (ProgQ36, Table 32). If a potential problem is identified by the questionnaires, in the first two cases the applicant need only sign a liability waiver, while in the third case the applicant must obtain “approval” from any healthcare professional (ProgQ37, Table 33).

▪ **Programme content**

All the programmes considered list as objectives improvement of Coordination/Balance and Joint range of motion. Seven programmes aim at improving Strength and Endurance. Three programmes also consider Body composition and Bone density. One programme aims at improving the Explosive power, one at ameliorating psychological features, such as the body image, and one declares the objective of improving psychosocial welfare of participants. Overall, one programme pursues seven of the listed objectives, two programmes six objectives, four programmes pursue four objectives, and two programmes two objectives (ProgQ38, ProgQ40, Table 34).

About PA typology included in the programmes, all are based on movement to exercise; seven include: exercise to music, swimming, outdoor walking groups and back pain prevention; six include: dumbbells/free weights, resistance balls/bands/tubes; five programmes use aqua exercise, physioballs for bands (swiss balls/exercise balls) and chair-based exercise; four: indoor running and walking not on treadmill, cycle; three: dance, Nordic walking, stepper, osteoporosis prevention,

falls prevention, pelvis floor exercise; two: derived from Pilates, derived from yoga, outdoor walking on path/treadmill, circuits cable machines/fixed resistance, cardio and pulmonary rehabilitation. Badminton, boules, rambling or hill walking and treadmill are, respectively, included in a single programme. Overall, the programmes offer an average of twelve different PA activities, with minimum two (N=2) and maximum sixteen (N=2) (ProgQ39, Table 35).

About checking the participants' "progression" (defined as systematic increase in the intensity or resistance, the frequency and/or duration of exercise) six PA Programme Directors stated that this is constantly done, one that this is never done, one that this is done on the first weeks of the programme only. The last Director does not know (ProgQ41, Table 36). About times for warm up, in five programmes it lasts 11- 15 minutes; in three programmes it lasts 6-10 minutes and in one programme 1-5 minutes (ProgQ42, Table 37). About cooling down, the commonest duration is 6-10 minutes (N=4), followed by 11-15 minutes (N=3) and 1-5 minutes (N=2) (ProgQ43, Table 37). Finally, the most frequent duration of workout is 40 minutes (N=5) while four programmes use 30 minutes (ProgQ44, Table 38). For older people with chronic diseases, eight programmes deliver adapted exercise: five include participants in the mainstream older person's group(s); two in frailty-related or disability-related groups, one in disease-related groups. One programme fails to provide adapted exercise (ProgQ45, Table 39).

▪ **Instructors' qualifications and training**

As for the minimum level of qualification required for instructors delivering programmes to older participants, six programmes require a basic (entry level qualification); two programmes an higher level (old age specific) qualification; one programme a higher level for APA; one programme requires an entry level qualification but prefers teachers with a specific qualification (ProgQ46, Table 40). To the question asking whether instructors for this programme have to be a member of a professional register, two PA Programme Directors answered yes, five no, one does not know and one director states that a professional register does not exist in Italy (ProgQ47, Table 42). About the qualification level of the teachers, three programmes declare 100% teachers with higher level qualification; one programme 75% higher level teachers and 25% base level; one programme 25% higher level teachers and 75% base level; three programmes 100% base level teachers (ProgQ48, ProgQ49, Table 41). In-service training of teachers is provided in eight out of nine programmes, while two programmes do not provide any in-service

training (ProgQ50). In detail, one programme provides 3 hours/year, two 10 hours/year, two 15 hours/year, two over thirty, and for one programme the number of hours is flexible, depending on the initial ability of the teachers (ProgQ51, Table 43). One programme only involves volunteers to implement the following activities: “Budding” a participant, administration, refreshment (ProgQ53 and ProgQ54, Table 44).

- **Client safety**

Six out of nine programmes include specific protocols to be followed in emergency situations (ProgQ55, Table 45). In four cases all the staff members are trained in these procedures; in one case they are not and in the remaining case the Director does not know (ProgQ56A, Table 46). For two programmes only we know that the specific training is performed yearly (ProgQ56B, Table 46). Four programmes detail specific protocols for the use, storage and maintenance of equipment (ProgQ57, Table 45) and in two cases training is addressed to all staff members (ProgQ58A, Table 46). One training programme is performed yearly; we don’t know about the other one (ProgQ58B, Table 46).

- **Finance, transport and refreshments**

Question 47 asked about the total cost (per participant per session) of providing programme. In five cases, total cost per session varies between 2 and 5 euro; two programmes cost 0 – 2 euro, per session; one programme costs more than 10 euro per session; finally, in one case, costs are not known. (ProgQ59, Table 47). Among the proportion of cost paid by each participant in the programme, in one case proportion is equal to zero per cento; in one case, proportion is equal to 5%, 10%, 50%, and 100% respectively. Four directors, finally, were not informed about this question (ProgQ60, Table 48).

Two programmes only organise public transportation: in one case it is available for all participants and is completely free; in the other case, it is not for all participants and we are not informed about the costs for the clients (ProgQ61, Table 49; ProgQ62, Table 50). Refreshments are offered in one programme only, available to all participants and free of costs (ProgQ63, Table 49; ProgQ64, Table 50).

- **Publicity, marketing and promotion**

The most used methods to publicise market or promote the programmes were: word of mouth (N=7), followed by neighbourhood leafleting (N=5), advertising through elder-oriented organisation, leafleting in community centres for older people and walk to local group; these

methods were adapted by four programmes. Three programmes used features in local newspaper, sports hall leafleting, health premises leafleting and website. Single programmes respectively used only one of the following: features in elder-oriented magazines, features in local TV, open days, bring a friend and discounts.

The following methods were not adopted by any programme: advertising in national/regional newspaper, advertising in elder-oriented organisations, features in national/regional newspapers, advertising on local radio, on national/regional radio, national/regional TV, features on local radio, on national/regional TV, on national/regional TV and multiple session bookings. No methods different than those listed in the questionnaire were used, as well. Overall, one programme used 12 different publicising methods; two programmes used 8 methods; six, four, three and two methods, respectively, were used by four different programmes, while two programmes did not use any publicising strategy (ProgQ65, Table 51).

Seven out of nine programmes failed to try capitalising 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. One PA director found this approach useless, while the last one does not know whether or not this was useful. The campaigns referred to in this last case are: “Alimenta il tuo benessere” (feed your welfare) in cooperation with national COOP and “Salutando” (saying hello) in cooperation with Modena COOP (ProgQ66, Table 52).

About using national or regional campaigns related to aspects of ageing and health in order to build partnership with local healthcare professionals or organisations, five out of nine programmes found it useful; one programme found it useless, two programmes did not try to use campaigns and for the last programme we don't know whether or not this was found useful. These approaches were used in order to build partnership with general practitioners and sports medicine doctors, with neighbouring communities, with councils for social service and sports, with sports and exercise university faculties (Scienze Motorie) and local healthcare organisations (ProgQ67, Table 52).

	PA Programme Director											Total
	A	B	C	D	E	F	G	H	I	J	K	
Medicine					X							1
Other Health Profession												0
Exercise/ Sport Science	x	x	x	x	x	X	x	x	x			9
Other							x					1
Missing data												
Total												

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

	Number
National	0
Regional	2
Limited to a city/town	7
Limited to a local neighbourhood	0
Missing data	0
Total	9

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

	Number
Less than 1 year	1
1 to 5 years	3
6 to 10 years	2
More than 10 years	3
Missing data	0
Total	9

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

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

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

	Number
Group activity	9
Individual activity	1
Indoors	9
Outdoors	4
Water-based	3
Land-based	8

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

	Number
Sport / physical recreation facility	7
Community centre	6
Day resources centre	2
Participant's private dwelling	0
Sheltered housing, assisted living facility, care home or nursing home	1
Other	3

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

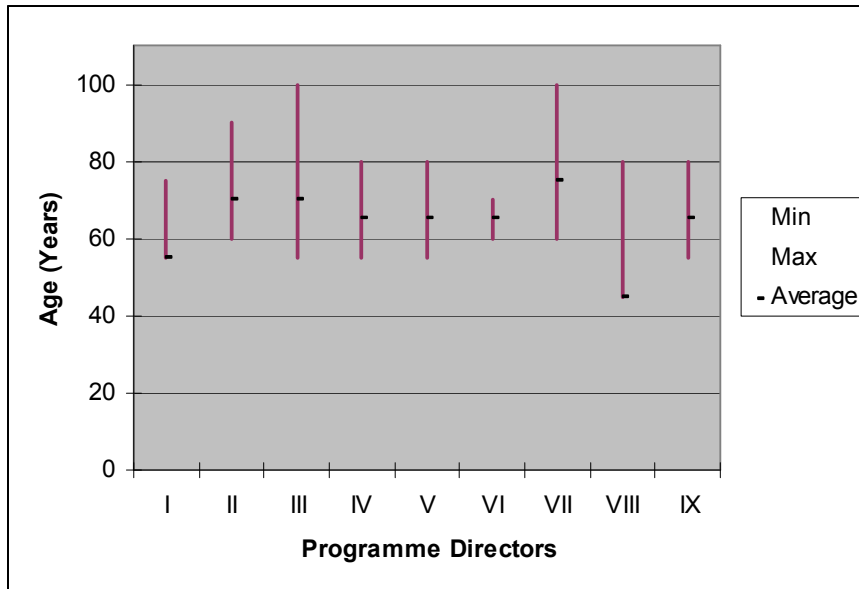


Figure 1 (ProgQ14-15). PA Programme Directors' responses concerning the age groups for whom their overall programme is intended and the average age of participant actually attending a typical session of the programme

	Number
Community- dwelling older adults	6
Institution – dwelling older adults	1
Both, together (in the same group)	0
Both separately (in different groups)	2
Total	9

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

	Number
Frequently walks vigorously or runs	5
Walking outdoors with no walking aids and no assistance or supervision by another person	9
Walks outdoors with a walking aid but no assistance or supervision by another person	3
Walks outdoors only with assistance or supervision by another person	1
Never walks outdoors	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.

	Number
0%	0
25%	0
50%	0
75%	8
100%	1
Don't know	0
Total	9

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

	Number
1	1
2 – 5	0
6 – 10	1
11 – 15	3
16 – 20	3
21 – 25	6
26 – 50	1
51+	0
Don't know	0

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

	Number
1 : 1	0
1 : 2 - 10	1
1 : 11 - 25	8
1 : 26 - 50	0
1 : 51+	0
Don't know	0
Total	0

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

	Maximum	Usual
<1	0	1
1	0	1
2	2	4
3 – 4	5	2
5 – 7	2	0
8+	0	0
Don't know	0	1
Total	9	9

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.

	Number
0%	1
25%	0
50%	1
75%	6
100%	1
Don't know	0
Total	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

	Number
Health promotion	5
Improved competitive performance	0
Disease prevention	0
Improved physical function	5
Improved mood	1
Opportunities to socialise	2
Improved self esteem / confidence	5
Other	0
Don't know	0
Total	18

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.

	Number
Not at all	4
1 – 2	2
3 – 6	0
More than 6	0
Don't know	2
Total	8

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

	survey of aims	prog. adjusted for aims	outcomes measured
Yes	3	0	6
No	4	3	3
Don't know	2	6	0
Total	9	9	9

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

	Number
Strength or explosive power	3
Maximal oxygen uptake (directly measured)	0
Sub maximal test of aerobic fitness	4
Balance	4
Joint range of motion	4
Body composition	2
Bone density	0
Mood / depression	3
Social support	1
Other	2
Not applicable	3

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

	Number
Yes	7
No	2
Don't know	0
Total	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

	Number
Completion of a health screening tool	2
Assessment by a doctor	4
Assessment by a doctor who is a sports medicine specialist or by the programme doctor	0
Assessment by some other healthcare professional	0
Other	1
Total	7

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

	Number
Yes	3
No	6
Don't know	0
Total	9

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.

	Internationally recognised	Adapted for the prog.
Yes	1	2
No	2	0
Not applicable	6	7
Total	9	9

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

	Dizziness	Eyesight	Hearing	Don't know	Not applicable
Yes	2	1	1	0	4
No	7	8	8	9	5
Total	9	9	9	9	9

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	2
Applicant must obtain 'approval' from any healthcare professional	0
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	
Don't know	2
Not applicable	4
Total	9

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
Strength	ProgQ40	7
Explosive power	ProgQ40	1
Endurance	ProgQ38	3
Coordination – Balance	ProgQ38	7
Joint range of motion	ProgQ40	9
Body composition	ProgQ40	3
Bone density	ProgQ40	3
Other	ProgQ40	3

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
Aquatics	
Swimming	7
Aqua exercises	5
Cycling	
On Road/ Paths	0
Off Road/ Track/ Hills	0
Group Sports/ Ball Games	
Badminton	1
Billiard Sports	0
Boules	1
Bowling	0
Golf	0
Minigolf	0
Short tennis	0
Tennis	0
Recreational Movement	
Dance	3
Movement to exercise	9
Exercise to music	7
Derived from Pilates	2
Derived from Tai Chi	0
Derived from Qigong	0
Derived from Yoga	2
Running	
Indoor running (not on treadmill)	4
Outdoor running/ Track	2
Orienteering	0
Skiing	
Cross Country Skiing	0
Downhill (Alpine Skiing)	0
Ski Touring	0
Walking	
Indoor Walking (not on treadmill)	4
Outdoor Walking on path/ track	2
Outdoor Walking groups	7
Rambling or Hill Walking	1
Trekking	0
Nordic Walking	3

TABLE 35 (continued)

Machine based equipment	
Circuits	2
Treadmill	1
Cycle	4
Rowing	0
Stepper	3
Cross – trainer	0
Cable machines/ fixed resistance	2
Dumbbells / Free weights	6
Physioballs (Swiss balls/ exercise balls) for balance	5
Resistance balls/ bands/ tubes	6
Balance disks/ wobbleboards	0
Other	1
Competitive sport	
Adapted exercise	
Back pain prevention	7
Osteoporosis prevention	3
Falls prevention	3
Pelvis Floor exercise	3
Chair-based exercise	5
Cardio rehab	2
Pulmonary rehab	2
Other	0

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

	Number
Never	1
For the first few weeks only	1
For the first few months only	0
Always	6
Don't know	1
Total	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
0 minutes	0	0
1 – 5 minutes	1	2
6 – 10 minutes	3	4
11 – 15 minutes	5	3
16 – 20 minutes	0	0
Don't know	0	0
Total	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
0 minutes	0
10 minutes	0
20 minutes	0
30 minutes	4
40 minutes	5
50 minutes	0
60 minutes	0
More than 60 minutes	0
Don't know	0
Total	9

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

	Number
This is not possible	1
Adapted exercise, with participants in disease-related groups	1
Adapted exercise, with participants in frailty-related or disability-related groups	2
Adapted exercise, with participants included in the mainstream older person's group(s)	5
Don't know	0
Total	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.

	Number
A basic (entry level) qualification	6
A higher level (old age specific) qualification	2
Other	2
Don't know	0

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

	Entry level qualification	Higher level qualification
0%	3	2
25%	1	1
50%	0	1
75%	0	0
100%	5	3
Don't know	0	2
Total	9	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.

	Number
Yes	2
No	6
Don't know	1
Total	9

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

	Number
0	0
1	0
3	1
5	0
10	2
15	2
20	0
30	0
More than 30	2
Don't know	0
Not applicable	2
Total	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

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

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

	Emergency protocols	Equipment protocols
Yes	6	4
No	3	5
Don't know	0	0
Total	9	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

	Emergency protocols	Equipment protocols
3 monthly	0	0
6 monthly	0	0
Annually	2	1
Never	0	0
Don't know	4	5
Not applicable	3	3
Total	9	9

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

	Number
Up to € 2	2
More than € 2, up to € 5	5
More than € 5, up to € 10	0
More than € 10	1
Don't know	1
Total	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)

	Number
0%	1
5%	1
10%	1
25%	0
50%	1
75%	0
100%	1
Don't know	4
Total	9

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

	Transport	Refreshments
Yes, to everyone	1	1
Yes, selectively	1*	0**
No	7	8
Don't know	0	0
Total	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

	Transport	Refreshments
0%	1	1
5%	0	0
10%	0	0
25%	0	0
50%	0	0
75%	0	0
100%	0	0
Don't know	1	0
Total	2	1

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.

	Number	%
Advertising in local newspapers	2	
Advertising in national/ regional newspapers	0	
Advertising in elder-oriented magazines	0	
Advertising through elder-oriented organisations	4	
Features in local newspapers	3	
Features in national/ regional newspapers	0	
Features in elder-oriented magazines	1	
Advertising on local radio	0	
Advertising on national/ regional radio	0	
Advertising on local TV	0	
Advertising on national/ regional TV	0	
Features on local radio	0	
Features on national/ regional TV	0	
Features on local TV	1	
Features on national/ regional TV	0	
Neighbourhood leafleting	5	
Sports hall leafleting	3	
Health premises leafleting	3	
Leafleting in community centres for older people	4	
Talks to local groups	4	
Word of mouth	7	
Websites	3	
Open days	1	
Bring a friend	1	
Discounts	1	
Multiple session bookings	0	
Other	0	

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

	(1)	(2)
Yes	0	5
No	1	1
Have not tried	7	2
Don't know	1	1
Total	9	9

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**

On 18/19 June 2007, each of the 11 Italian Experts was sent a template of an explanatory letter of invitation and electronic and paper copies of the other two questionnaires for distribution, in due course, to the directors of their chosen PA programme and PA promotion strategy. If an invitation was declined, because the programme did not agree to participate or because the programme had already been chosen by another PA Expert, then the PA Expert was to identify another successful PA Promotion Strategy and send another invitation letter.

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The PA Experts were encouraged to give their PA Promotion Strategy Directors on-going support and to ensure that the questionnaire was returned to the WP5 coordinator by 10th August, 2007. By e-mail and telephone, defaulters were reminded in mid-July, mid August, late August, early September and mid September. The last reminder included a warning that if questionnaires were not returned by 30 September, it might not be possible for their data to be included in the final analysis and in the national and cross-national reports.

○ **Results**

▪ **Selection of promotion strategies**

We have appointed eleven Experts, but two of them did not comply and failed to return the questionnaires. They also failed to communicate the names of two directors of promotion strategies, as required. Therefore the overall enquiry was limited to nine PA Promotion Strategy Directors.

▪ **Return of promotion strategy questionnaires**

By 31 July 2007, four PA Programme questionnaires had been returned. By 30 August, other four questionnaires had been returned, while, despite several reminders, the defaulter had still to return his questionnaire. By late September, nine questionnaires had been returned.

▪ **Promotion strategy directors' educational backgrounds**

Educational backgrounds of the Directors of the PA Promotion strategies selected by Italy national Experts: three Directors belong to the medicine field, one to the field of exercise/sports science, one to the legal field, two to the social field and one to the psycho-pedagogical field; the last Director has mixed backgrounds, including health professions, exercise/sport science and psychology (PSQ4, Table 53).

▪ **Prevailing national context**

According to three Directors of the PA Promotion strategies, a law or other regulations for promotion of physical activity exist in Italy; while two Directors state they do not exist and four are not informed. Positive responses are as follows:

1. Ministry for youngsters and sports; balance law 2007;
2. Law 14 dec. 2000 “Disciplina della tutela sanitaria e delle attività sportive della lotta contro il doping” (about health care, sports activities and fight against doping)

Another Director mentions various regional laws, for instance, Regione Liguria, Law 6/2002. The third Director does not remember the name(s) of the law(s) (PSQ8, Table 54). The question about existence of a law or

other regulations on PA promotion specifically for the elderly: Three positive answers, three negatives, and four don't know. Different health care strategies and regional laws are cited as examples (Q9). National level recommendations for promotion of physical activity especially for older people are recognised by five Directors, while the other four are not informed. Cited documents: il Piano sanitario nazionale; il Piano Nazionale Prevenzione: Progetto Guadagniamo Salute; Linee Guida n. 13 del PNLG, del maggio 2007 (PSQ10, Table 54).

▪ **Description of promotion strategies**

The organisations that developed, and delivered, their promotion strategy belong in three cases to the governmental sector (one regional, two national and two local levels), in four cases to non the governmental sector: one commercial, one welfare/ community organisation, one sports promotion, one multinational drug company. In the two remaining cases several organisations were involved that belong both to governmental and non governmental sectors. In one case of multiple organisations, a governmental organisation, at the regional and local levels, cooperated with a non governmental research organisation; in the other case a governmental organisation, at the regional and local levels cooperated with a non governmental research organization and a volunteers association (PSQ11, Table 55).

Promotion strategies were realised: two by governmental organisations (one regional, one local levels), five by non governmental organisations (one commercial, two welfare/ community organisation, one sports promotion, one multinational drug company) and in the remaining cases they were realised by multiple organisations. In detail, a governmental organisation, at the regional and local levels, cooperated with a non governmental research organisation; in the other case a governmental organisation, at the regional and local levels cooperated with a non governmental research organization and a volunteers association (PSQ12, Table 55).

About the nine promotion strategies presented, one is limited only to the regional level, four are limited only to the city/local level, one strategy aimed both to the national and regional level, and the last strategy aimed to regional, city/local level and local neighbourhood level (PSQ14, Table 56).

About the settings in which the promotion strategies encourage physical activity, the more frequently mentioned are centre based (N=7) and outdoors (N=7); only in one case is presented an invitation to make physical activity at home. In the aggregate, two strategies consider as

possible contexts only the centres based and other two strategies only outdoors; four strategies consider both centres based and outdoors and last strategy consider centres based, outdoors and home as setting for physical activity (PSQ15, Table 57). Concerning to the kind of physical activity promoted, the tipology cited with more frequency is represented by group exercises (N=6), followed by independent exercise (N=2). In the whole, five strategies promote solely group exercise, one promote only independent exercise, one both group exercise and independent, while two strategies does not explain the tipology of activity (PSQ15, Table 57).

Social institutions are the settings/organisations that more frequently taking part in the promotion strategies (N=6), followed by Community centres (N=5), by primary health care (N=4) and by welfare organisation (N=1). Other setting/organisations cited by PA Promotion Strategy Directors are: university institutions, social centres, ULSS, ASL, communal swimming-pool, voluntary associations and general practitioners. On the average, are presents two different setting/organisations (minimum one and maximum four) (PSQ16, Table 58).

In relation to the theoretical models, three PA Promotion Strategy Directors have not recourse to any model, three are not inform and the other three answered positively (PSQ17, Table 59). In a case, it was used the Theory of Reasoned Action; in the other two cases, were used different tools with respect to the models presented into the questionnaire, and with precision: “Guidelines of Heidelberg for promotion of physical activity for elderly” and “Physical activity program organisation in the elderly” (Sчена, Luzi and Crivellino) in one case; “Previous studies on diabetics population and on physical activity promotion”, in the other case (PSQ18, Table 59).

With concerning the duration of strategies, four strategies have run by 1-5 years, two by less than 1 year and two by more than 10 years. In one case, the duration of strategy is not known (PSQ19, Table 60). Six of nine strategies run periodically, two run continually and one was applied once only (PSQ20, Table 61).

With the aim to reach the intended population were used: medical practitioner (N=7), exercise/dance instructor (N=5), community/social workers (N=4), volunteers (N=2) e only once respectively nurses, physiotherapists, occupational therapists, physiotherapy/OT Assistants, other allied health care professionals. In two cases, were used intermediaries not present in the questionnaire. In particular, in one case, experts in naturalistic itineraries and swimming instructors ; in the other case, were used elderly participants. Finally, one strategy has not used any intermediaries. On the average, were used two or three

intermediaries, with a minimum of zero and a max of seven different intermediaries (PSQ26, Table 62).

Characteristics of strategies' target populations

Promotion strategies is intended for 45, 50, 55, 60 years as minimum age, respectively in two cases and for 65 years in one case. With regard to maximum age, this is 80 years (N=3), 100 years (N=2), 75 years and 90 years (N=1). Finally, two strategies don't determine age limits (PSQ21, Figure 2). Four strategies aim all older adults, three aim general population (including older adults), two aim community-dwelling older adults and two other strategies aim to different category respect to those presented into the questionnaire. In particular: diabetics type 2 and all over 55 years. Generally, strategies aim once only category; only two strategies aim contemporaneously to two different categories (PSQ22, Table 63).

Relatively the question that asked if the strategy of promotion considered the possible distinctions of kind cultural, linguistic, of income and other, three directors give affirmative answers, five negative answers and one director were not informed about the question (PSQ23, Table 64). About affirmative answers, one strategy consider differences related to education and income levels, one differences related to cultural perceptions, one consider and one consider differences related to psycho-physical situation and motivation of single individual (PSQ24, Table 64).

With respect to the "category" of individual by level of functional mobility, the category more frequently included is persons that "walks outdoors with no walking aids and no assistance or supervision by another person" (N=6), followed by persons that "walks outdoors with a walking aid but no assistance or supervision by another person" (N=3) and category of whose that "frequently walks vigorously or runs" (N=2) and "walks outdoors only with the assistance or supervision by another person" (N=2). Ultimately, none of strategies presented address to persons that "never walks outdoors". Most part of cases (N=5), strategy address to two different categories, while in the remaining cases strategies address to only once category (PSQ25, Table 65).

▪ Design of promotion strategies

Considering approaches used in the strategies to encourage behaviour change in relation to physical activity, all the strategies involve "improved knowledge" (N=9), followed by "improved motivation" (N=7), followed by "improved access and reduction in misconceptions about ageing" (N=6), "fear reduction" (N=5), "improved skill" (N=4)

and, at last, “improved safety” and “improved time management skills” respectively point out by three directors. On the average, strategies consider four, five approaches, with a minimum of two and a maximum of eight different approaches (PSQ28, Table 66). At the question concerning whether the target population was screened for their readiness for behaviour change prior to implementing the promotion strategy, there are three affirmative answers and six negative (PSQ29, Table 67). At the question concerning whether promotion strategies was designed to surmount barriers to physical activity, there are eight affirmative answers, while one director was not informed about the question (PSQ30, Table 68). In particular, barriers identify most frequently are “lack of time” and “lack of energy/motivation”, respectively considered by six strategies; follow “environmental barriers” and “misconceptions about ageing” (N=5), “symptoms associated with chronic conditions” (N=4), “lack of skill” (N=3), “perceived poor health” (N=2) and “fear of injury” (N=1). None of presented strategies involve “acute exacerbation of chronic conditions” or barriers different from those presented in the questionnaire. As a whole, five strategies involve four different barriers, while the remaining three strategies involve respectively two, three and seven barriers (PSQ31, Table 69).

Among the **information approaches** used in the promotion strategies, “community wide campaigns” (N=6) is the most used, followed by “mass media campaigns” (N=4), “group-based health education focused on information provision” (N=3) and “point of decision prompts”, used by only one strategy. At last, among the approaches not included into the questionnaire, one strategy used “pass the word”. Concerning **behavioural and social approaches**, the approach most frequently used is “health professionals social support” (N=7), followed by “individually-adapted behaviour change” (N=4), “non-family support” (N=2) and “family-based social support” (N=1). None of the strategies used “education with TV/video/DVD”, nor approaches alternative to those included into the questionnaire. Among the **environmental and policy approaches**, most frequently is “enhanced access to physical activity” (N=5), followed by “transportation policy” (N=2) and two alternative approaches: “institutional supported for health policy” and “identification for physical activities pathways”. As a whole, concerning information approaches, two strategies used three different tools, four strategies used two different tools and one strategy used any tools. As a whole, concerning behavioural and social approaches, two strategies used three different tools, three strategies used two different tools, two strategies used only one tools and two strategies used any tools. At last, concerning environmental and policy approaches, as a whole, three strategies used

three different tools, three strategies used only one tool and three strategies used any tools.

Totally, two strategies used seven different tools, one strategy use six tools, two strategies used four tools, two used three tools and two used two tools (PSQ32, Table 70).

Concerning the nature of the message(s) used in the promotion strategies, most used is “specific advise” (N=7), followed by “general message”, “specific warning” (respectively, N=3), followed by “general warning” (N=2) and “general advice” used respectively by only one strategy. Concerning other messages, not presented by questionnaire, in one case was used the “results about changing in physical efficiency after a training of ten weeks”. In another case, message represented a specification of objective of course. At last, message was address to motivate to test the enjoy of physical activity in the water (PSQ34, Table 71).

Concerning the ways used for conveying the messages to the target population, most used is “intermediates, healthcare professionals” (N=5), followed by “media” (N=4), “post” (N=3), “events” (e.g. Falls Awareness Day) (N=3); “internet /e-mail” (N=1). None strategy used “models/opinion”; among other tools, there are: “leafleting”, “delivery of issues informative and educative for general medical doctor patient’s” and “communication person by person” As a whole, two strategies used three different tools, six used two tools and one strategy used only one tool to conveying messages (PSQ35, Table 72).

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

In relation to the share of the population reached by the strategy, four directors indicated a share of 25%, one director record a share of 50% and one of 75%, while the remaining three directors were not informed by this date (PSQ27, Table 73). Relatively the approaches used by promotion strategy, among **information approaches** those considered more frequently incisive are “community wide campaigns” (N=4) and “group-based health education focused on information provision” (N=4), followed by “point of decision prompts” (N=2) and “mass media campaigns” (N=1). Among alternative approaches, there are “pass the word” (N=1) and “information about the itinerary” (N=1). In relation to the **behavioural and social approaches**, the tool considered most incisive is “health professionals social support” (N=7), followed by “individually-adapted behaviour change” (N=3) and “non-family

support” (N=3) and finally “family-based social support” (N=1). Any strategy used “education with TV/video/DVD” and so there are not opinions relatively its efficacy. About **environmental and policy approaches**, the tool considered most incisive is “enhanced access to physical activity” (N=4), followed by “transportation policy” (N=2), “infrastructures changes to promote non-motorised transit” (N=1) and one alternative tool, that is “institutional supported for health policy” (N=1). Totally, six, five, three and two approaches were considered as incisive respectively by two strategies, while only one strategy considered valid an unique approaches (PSQ33, Table 74).

Five promotion strategies had been evaluated since their were implemented, while the other four strategies had been not evaluated (PSQ36, Table 75). The aspect that had been evaluated more frequently is “population reached” (N=3), followed by “behaviour change” (N=2) and “cost effectiveness (e.g. total costs)” (N=2). In one case the aspect evaluated was number of participants. Totally, for evaluating strategies, three strategies considered only one aspect, one strategy considered two and another strategy considered three different aspects. (PSQ37, Table 76). About the question concerning whether promotion strategy included a specific plan or device to maintain the behaviour change achieved, four directors given affirmative answers, four given negative answers and one director was not informed about the question (PSQ38, Table 77).

Among the tools used in promotion strategy to maintain behaviour changes, most used are “buddy groups”, “opportunities to socialise” and “promotion days” communicated by three directors; follows “social support” communicated by two directors and “positive reinforcement/feedback rewards” and “financial incentives” indicated respectively by one director. As a whole, in one case were used five different tools, in two cases three different tools and, finally, in one case two different tools (PSQ39, Table 78).

▪ **Finance**

Question 40 asked information about total costs (per year) of developing and running promotion strategies. Six director of none were not informed about this question. In the other three cases, the average cost per year amount to 30.000 euro, with a minimum cost of 10.000 euro and a maximum amount of 50.000 euro. Concerning the source of founding to run promotion strategies, at national/regional government level, in two cases were “health budget” and in one case “social care budget”. There were no founds specific for “leisure/sport”. In one case, furthermore, founds come from by regional founding. At city/local government level, one funding was an “health budget”, one “social care budget” and one

“leisure/sport budget”. Among other source of founding indicated at this level were: council founding and one local government. Among other sources, founding were come from: a bank foundation, a firm, marketing section of a sport venue, an health service company, one education centre and a volunteer association (PSQ41, Table 80).

	PA Promotion Strategy Directors											Total
	A	B	C	D	E	F	G	H	I	J	K	
Medicine			x					x	x			3
Other Health Profession							x					1
Exercise/ Sport Science				x			X					2
Other	x	x		x	x	x	x					6
Missing data												0
Total	1	1	1	2	1	1	3	1	1			12

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

	(1)	(2)	(3)
Yes	3	3	5
No	2	2	0
Don't know	4	4	4
Total	9	9	9

Table 54 (PSQ 7-9). PA Promotion Strategy Directors' responses concerning whether (1) there is a law or other regulations, in Italy, for promotion of physical activity, (2) there is a law or other regulations, in Italy, for the promotion of physical activity especially for older people, and (3) there are any national level recommendations, in Italy, for promotion of physical activity especially for older people

	Developed	Delivered
Government	5	4
National	0	0
Regional	3	3
Local	4	3
Non Governmental	6	7
Commercial	1	1
Welfare/community organisation	1	2
Research organisation	2	2
Other	3	3

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

	Number
National	1
Regional	4
Limited to a city/ town	6
Limited to a local neighbourhood	2

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

	Number
Centre based	7
Home based	1
Outdoors	7
Other	1
Group exercise	6
Independent exercise	2
Other	0

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

	Number
Social institutions	6
Primary health care	4
Community centres	5
Welfare organisations	1
Work place	0
Other	5
Don't know	0

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

	Number
None	3
Health Belief Model	0
Protection Motivation Theory	0
Theory of Reasoned Action	1
Theory of Planned Behaviour	0
ASE* – Model	0
Transtheoretical Model	0
Other	2
Don't know	3

* 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.

	Number
Less than 1 year	2
1 to 5 years	4
6 to 10 years	0
More than 10 years	2
Don't know	1
Total	9

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

	Number
Once only	1
Periodically	6
Continually	2
Other	0
Don't know	0
Total	9

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

	Number
Medical Practitioners	7
Nurses	1
Physiotherapists	1
Occupational therapists	1
Physiotherapy/ OT Assistants	1
Other Allied Health Care Professionals	1
Exercise/ dance instructors	5
Sports coaches	0
Community/Social Workers	4
Volunteers	2
Other	2
None	1
Don't know	0

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

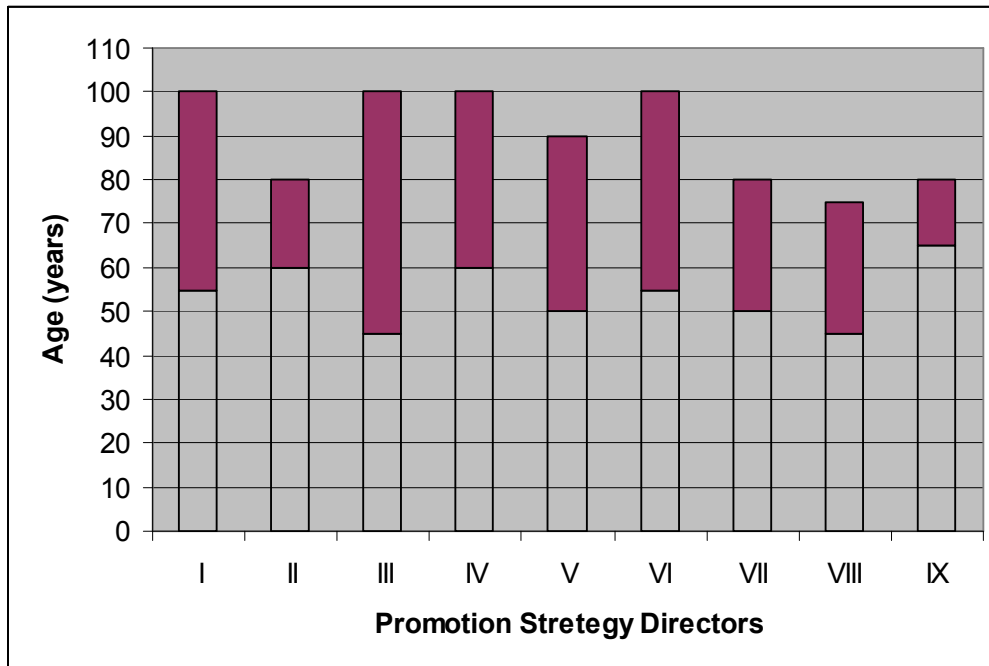


Figure 2 (PSQ21). PA Promotion Strategy Directors' estimates of the upper and lower age limits of those for whom their strategy is intended

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

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

	Number
None	5
Different language	0
Different cultural perceptions	1
Different education levels	2
Different income levels	2
Other	1
Don't know	1

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

	Number
Frequently walks vigorously or runs	2
Walks outdoors with no walking aids and no assistance or supervision by another person	6
Walks outdoors with a walking aid but no assistance or supervision by another person	3
Walks outdoors only with assistance or supervision by another person	2
Never walks outdoors	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.

	Number
Improved knowledge	9
Improved access	6
improved safety	3
improved time management skills	3
Improved motivation	7
Fear reduction	5
Improved skill	4
Reduction in misconceptions about ageing	6
Don't know	0

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

	Number
Yes	3
No	6
Don't know	0
Total	9

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

	Number
Yes	8
No	0
Don't know	1
Total	9

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

	Number
Perceived poor health	2
Symptoms associated with chronic conditions	4
Fear of injury	1
Acute exacerbation of chronic conditions	0
Lack of skill	3
Lack of time	6
Lack of energy / motivation	6
Environmental barriers	5
Misconceptions about ageing	5
Other	0
Don't know	0
Not applicable	0
Total	32

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

	Number
INFORMATION APPROACHES	
Community wide campaigns	6
Group-based health education focused on information provision	3
Mass media campaigns	4
Point of decision prompts	1
Other	1
BEHAVIOURAL AND SOCIAL APPROACHES	
Individually-adapted behaviour change	4
Education with TV/video/DVD	0
Family-based social support	1
Health professionals social support	7
Non-family social support	2
Other	0
ENVIRONMENTAL AND POLICY APPROACHES	
Enhanced access to physical activity	5
Outreach activities	0
Transportation policy	2
Infrastructure changes to promote non-motorised transit	0
Urban planning approaches	0
Other	2
Don't know	0

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

	Number
General message	3
General advice	1
General warning	2
Specific advice	7
Specific warning	3
Other	3
Don’t know	0
Total	19

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

	Number
Media	4
Post	3
Internet / e-mail	1
Intermediates, healthcare professionals	5
Models / opinion	0
Events (e.g. Falls Awareness Day)	3
Other	3
Don’t know	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.

	Number
0%	0
25%	4
50%	1
75%	1
100%	0
Don't know	3
Total	9

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 .

	Number
INFORMATION APPROACHES	
Community wide campaigns	4
Group-based health education focused on information provision	4
Mass media campaigns	1
Point of decision prompts	2
Other	2
BEHAVIOURAL AND SOCIAL APPROACHES	
Individually-adapted behaviour change	3
Education with TV/video/DVD	0
Family-based social support	1
Health professional social support	5
Non-family social support	3
Other	0
ENVIRONMENTAL AND POLICY APPROACHES	
Enhanced access to physical activity	4
Outreach activities	0
Transportation policy	2
Infrastructure changes to promote non-motorised transit	1
Urban planning approaches	0
Other	1
Don't know	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.

	Number
Yes	5
No	4
Don't know	0
Total	9

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

	Number
Behaviour change	2
Population reached	3
Cost effectiveness (e.g. total costs)	2
Other	1
Don't know	0
Not applicable	4

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

	Number
Yes	4
No	4
Don't know	1
Total	9

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
Printed material posted	0
Telephone	0
Positive reinforcement / feedback rewards	1
Financial incentives	1
Social support	2
Buddy groups	3
Opportunities to socialise	3
Promotion days	3
Other	0
Don't know	0
Not applicable	5

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

Median	30000
Least	10000
Most	50000
N	3

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
NATIONAL / REGIONAL GOVERNMENT	
Health budget	2
Social care budget	1
Leisure / sport budget	0
Other	1
CITY / LOCAL GOVERNMENT	
Health budget	1
Social care budget	1
Leisure / sport budget	1
Other	2
OTHER SOURCES	
Lottery	0
Charity	0
Other	6

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

▪ **SYSTEMATIC SEARCH FOR EVIDENCE BASED GUIDELINES**

○ **Objective**

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

The guidelines identified by the search are to be used to create a readily accessible inventory of existing evidence based guidelines. This resource is to be included in the cross-national and national reports on WP5. It will permit a critical comparison of the successful PA programmes and PA promotion strategies (identified by the WP5 Experts) with current evidence-based guidelines.

○ **Methods**

Definitions

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

PA promotion strategy – An intervention, device or plan which it is intended will increase the PA of a community.

e.g. Improved street lighting or an educational TV advertising campaign.

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

Criteria for inclusion in inventory of guidelines

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

- composed by a process involving a consensus of experts, and
- published under the auspices of government departments, international health organisations, age-related NGOs, or learned societies, and

- with sufficient information about the evidence on which they are based to allow the individual recommendations to be graded according to the strength of that evidence (see ‘Key to evidence statements and grades of recommendation’, as published in the most recent SIGN guideline, viz. SIGN Guideline No. 98, July 2007), and
- published from 1990 onwards, and
- addresses the delivery and/or promotion of physical activity for the older person (including old age specific sub-sections of guidelines for the role of physical activity for adults of all ages in health and/or disease).

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

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

We searched the following electronic databases:

Ovid Medline (1950 to June Wk 4 2007)
 CINHL (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
 NHS Scotland elibrary

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).

(1) **Please note:** The number of guidelines included may yet increase slightly as we receive publications. We will inform you if this happens.

▪ CONCORDANCE OF PROGRAMMES WITH GUIDELINES

○ **Discussion**

Qualifications in the supervision/guidance of physical activity.

Nine experts were asked about the availability of national qualifications in the supervision or guidance of physical activity for adults in general and for older adults in particular. According to four experts a base level title for physical activity teaching is required, while the other five believe

this is not required. The name of the basic level qualification is: diploma ISEF (Istituto Superiore di Educazione Fisica) and degree in Exercise and Sport Science. According to eight experts, no specific higher level qualification in supervising or guiding physical activity or exercise by older adults is required, while one expert does not know. This is not in accordance with recommendations about professional competencies and responsibilities, that suggests that instructors delivering supervised exercise will hold appropriate qualifications and insurance and will follow standards of practice (1).

Only one expert stated that such register exists in Italy, with requirement of a basic level entry qualifications. The other experts state that no register exists or they are not informed about. To our knowledge, no register exists in Italy, and the faculties of exercise and sports science are fighting at the national level to obtain new rules about this item.

Objective, outcomes, monitoring and feedback.

The three most quoted objectives are: health promotion, improved physical functioning and improved self esteem/ confidence. Two programme directors pointed to opportunities to socialise, and one to improved mood. To promote and maintain good health, older adults should maintain a physically active lifestyle. This is the first statement of ACSM recommendations (2), and this point is recognized as important objective by all the Italian programmes. Moreover, as recommended by ACSM (3), improved self esteem, self confidence, opportunities to socialise are included among that behavioural factors associated with initiating and maintaining physical activity.

An evaluation of satisfaction of participants is attempted only in two programmes, and it is performed 1 -2 times per years. Only three programmes, participants are interviewed about their expectations and, in these cases, programmes are adapted to the expectations.

As recommended by ACSM (3), tailoring the exercise program to the needs and interest of participant has successfully motivated older adults to initiate and maintain a routine of regular physical activity. The fact that satisfactions and expectations of participants were monitored in few programmes does not appear in accordance with this recommendation.

The situation is better about recording objective outcome measures for participants at regular intervals. In this case, six of nine programmes do it. The more frequently objective measures recorded are: sub maximal test of aerobic fitness, balance, and joint range of motion. This is important, because a regular performance feedback can assist older adults in developing realistic expectations of their own progress, as recommended by ACSM (3).

Pre-participation assessment

Seven programmes out of nine require the potential participants to have health check. Four require assessment by doctor, two completion of a health screening tool and one a self certification by the participants. Only in one case the health screening tools were internationally recognised. If a potential problem is identified by the questionnaire, in two case the applicant need only sign a liability waiver, while in the third case the applicant must obtain “approval” from any healthcare professional.

Programme content

All the considered programmes list as objective improvement of coordination/balance and joint range of motion. Seven programmes aim at improving strength and endurance. This is in accordance with ACSM recommendations (3), that suggest that a multi-dimensional activity program including endurance, strength, balance and flexibility training is optimal for health and functional benefits.

About the typology, all the programmes are based on movement to exercise, and seven programmes included exercise to music, swimming, outdoor walking groups and back pain preventions. In all, it seems that there is a good variability about the modalities of physical activity are offered in the programmes. This appears in accordance with growing evidence that shows that providing choices concerning exercise program characteristics contribute to greater adherence (3).

About checking the participants progression - defined as systematic increase in the intensity or resistance, the frequency and/or duration of exercise – six PA Programme Directors stated that this is constantly done, and one only on the first weeks of the programme. This appears in accordance with statement about the importance of a gradually increase of activity, especially for older adults (3).

About time for warm up and cooling down, the commonest durations are 6-10 minutes and 11-15 minutes. The duration for workout varies between 30 and 40 minutes. The most frequent weekly attendance is twice, followed by 3-4 times per weekly in two programmes. This frequency is suitable for strength, flexibility and balance exercise programme, but is not suitable for resistance training. In fact, guidelines for aerobic physical activities suggest a frequency on most days of the week.

Eight of nine programmes deliver adapted exercise for older people with chronic diseases, mainly including participants in the mainstream older person's group(s).

Instructors' qualifications and training

As for the minimum level of qualification required for instructors delivering programmes to older participants, six programmes require a basic or entry level qualification, and two programmes an higher level, old age specific. In-service training of teacher is provided in eight out of nine programmes, and there is great variability between the programmes among the amount of hours provided each year. This situation is enough in accordance with statements about professional competencies of instructors delivering supervised exercise and about the necessity of continuing professional development (1).

Client safety

Six out of nine programmes include specific protocols to be followed in emergency situations, but only in four cases all the staff members are trained in these procedures. Besides, for two programmes only we know that the specific training is performed yearly. Four programmes detail specific protocols for the use, storage and maintenance of equipment. This situation appears not in accordance with guidelines on emergency policies and procedures, that suggest emergency drills should be practiced once every three months by each staff members (4).

Finance, transport and refreshment

In seven out of nine programmes, total cost per session varies between zero to five euro. Only two programmes organise public transportation: in one case it is available for all participants and it is completely free; in the other case, it is not for all participants and costs are not note. Finally, only one programme offered refreshment, available to all participants and free of costs.

Accessibility is one of the main barrier to physical activity for older adults (5). **Indeed in Italy, distances between places are never very wide, but a greater care of this aspect could be useful.**

▪ CONCORDANCE OF PROMOTION STRATEGIES WITH GUIDELINES

○ Discussion

Description of promotion strategies

Totally, nine strategies are being described in Italy. Only three Directors of PA Promotion Strategies asserted that in Italy exist laws or regulations for promotion of physical activity in generally and specifically for elderly. Two Directors of PA Promotion Strategies asserted they do not exist laws or regulations, and in the remaining four cases, Directors were not informed about the question. From these data the situation appears rather vague. Actually, in Italy exists a guideline for promotion of physical activity, but the publication of this document by ministry of health was delivered just before the interviews is given (6).

The organisation that developed and delivered promotion strategies belong in three cases to the governmental sector and in four cases to the non governmental sector. In the two remaining cases, several organisations were involved that belong to governmental and not governmental sectors, at the same time at regional and local levels. This is in agreement with recommendations of WHO that suggests the realization of partnerships between different sectors at different levels (5). As recommended by ACSM (3), growing evidence shows that providing choices concerning exercise programme characteristics, as group based vs. individual activity programs and choice of exercise location, contribute to greater adherence. About the setting in which the promotion strategies encourage physical activity, four strategies consider only one possible setting, four strategies consider both centres based and outdoors, and one strategy consider centres based, outdoors and home as setting for physical activity.

About the kind of physical activity promoted, the more common typology is group exercise. As recognized by ACSM, group-based physical activity provide several advantages, as social support from companions and instructors, qualified supervision, and opportunities for instruction in proper technique(3). However, as recommended by ACSM (3), tailoring the exercise program to the need and interest of participants has successfully motivated older adults to initiate and maintain a routine of regular physical activity. In this sense, only one strategy promote both group exercise and independent exercise.

Social institutions are the settings/organisations that more frequently taking part in the promotion strategies, followed by community centres, primary health care and welfare organisations. Other settings are university institutions, social centres, voluntary associations and general practitioners. On the average, are presents two different setting/organisations, with a minimum of one and a maximum of four. This is in harmony with the statement of WHO report, which emphasises the partnerships with community agencies, voluntary organisations, religious organizations, and sport clubs etc. to promote active living for

older people (5). From this point of view, in Italy the situation seems fairly fruitful.

Characteristics of strategies' target populations.

About strategies' target population, minimum age varies from 45 to 65 years, while maximum age varies from 80 to 100. Indeed, it seems that does not exist a maximum age limit. Mainly strategies aim all older adults, general population (including older adults) and community-dwelling older adults. Only three strategies considered other criteria, in addition to age, for tailoring interventions. Criteria considered are: education, income levels, cultural perceptions, psycho-physical situation and motivation of single individual.

Design of promotion strategies

Considering approaches used in the strategies to encourage behaviour change in relation to physical activity, all the strategies aim to improve knowledge. Other aims were to improve motivation, access, skill, time management skill, safety and to decrease fear and misconceptions about ageing.

Only in three promotion strategies target population was screened for their readiness for behaviour change, prior to implementing the promotion strategy.

About barriers to physical activity, six strategies aim to surmount lack of time and lack of energy; five strategies aim to surmount environmental barriers and misconception about ageing; other barriers, such as perceived poor health or fear of injury were considered by only two or one strategies.

About theoretical basis of promotion strategies, only one strategy used a theoretical model, in particular the "Theory of Reasoned Action". It seems necessary a major attention regarding theoretical aspects of promotion strategies in the physical activity field.

The information approaches mainly used were community wide campaigns, followed by mass media campaigns, and group-based health education focused on information provision. Only one strategy used point of decision prompts.

About behavioural and social approaches, the mainly used was health professionals social support, followed by individually-adapted behaviour change. Only one strategy used family-based social support, and none strategy used education with TV/video/DVD.

About environmental and policy approaches, the mainly used was enhanced access to physical activity. Two strategies used transportation policy, while other approaches were used by none strategy.

Concerning the nature of the messages used in the promotion strategies, the most common was specific advice, followed by general message, specific warning, general warning and general advice. The mean of information common used were intermediates, healthcare professionals, followed by media, post, and events.

Evaluation and sustainability of effect of promotion strategies.

Four promotion strategies has been reached the 25% of the target population; one the 50% and another one the 75%, while the remaining three directors are not informed about this question. This results should drive to a wide reflection.

Concerning the approaches considered effective in achieving the aims of the promotion strategy, the most effective was health professional social support, community wide campaigns, group-based health education focused on information provision and enhanced access to physical activity.

Five strategies had been evaluated since it was implemented. Three strategies had been evaluated population reached, two strategies behaviour change and two cost effectiveness. The tools used to maintain behaviour change were buddy groups, opportunities to socialise and promotion days, used in three strategies. Two strategies used social support and in one case was used positive reinforcement/feedback rewards and financial incentives.

Finance

Concerning the source of the funding to run promotion strategies, one strategy was funded exclusively by national/regional government; one exclusively by city/local government; three, exclusively, by other sources. In the other cases, were used several sources of funding.

▪ CONCLUSIONS & RECOMMENDATIONS

From different points of view, the Italian situation seems to agree with suggestions spring from the most authoritative international sources. In particular, Italian programmes and promotion strategies for physical activity appear in agreement with international recommendations with regard to many aspects.

Concerning programmes of physical activity, these are the points sufficiently in according with international recommendations: qualifications of instructors; selections of objectives for programmes of physical activity; recording objective outcome measures for participants at regular intervals; providing choices concerning exercise program

characteristics; checking the participants progression, defined as systematic increase in the intensity or resistance, the frequency and/or duration of exercise; in-service training of teachers; supporting participants with courses at reasonable costs.

Concerning physical activity promotion strategies, these points appear as positive: the realization of partnerships between different sectors and at different levels; providing choices concerning exercise programme characteristics; providing group-based physical activity programs; the presence of many settings/organisations that taking part in the promotion strategies.

On the other hand, there are also many aspects that are not in according with international recommendations. First of all, in Italy does not exists a register of qualified instructor but, as said before, the faculties of exercise and sports sciences are fighting at national level to obtain new rules about this item.

Concerning programmes of physical activity, these points appear as critical: evaluation of satisfaction and expectation of participants is lacking, while should be useful for tailoring the exercise program to the need and the interest of participants; none of programmes provide a frequency of lessons suitable for resistance training (most days on week); concerning client safety, not all the programmes have a specific protocols for emergency situations, and not all the staff members are trained in emergency procedures and drills are not practiced with the right frequency; concerning accessibility, only two programmes organise a public transportation, but actually in Italy distances are not too long.

Concerning physical activity promotion strategies, the critical points are: most of PA Promotion Strategies Directors stated that in Italy does not exist laws or regulations for promotion of physical activity or were not informed about the question. As said before, this regulation exists but it was delivered just before interviews were given. So, it is comprehensible that many directors were not informed about this fact; about strategies' target population, only three strategies considered other criteria in addition to age; about theoretical basis of promotion strategies, only one strategy used a theoretical model. It is plain that a greater engagement on this aspect is necessary.

In summary, in the recent past, the Italian situation has been long penalized by the lack of a central organization an normative framework. On the other hand, the abundance and quality of local initiatives has compensated for institutional defects. Presently, the situation seems to changing in a promising direction, thanks to the publication of the national initiative "Guadagnare in Salute" for promoting health, and therefore, for increasing the amount of physical activity in every age of the life.

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▪ ACKNOWLEDGMENTS

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1 Programma di attività motoria in un gruppo di anziani di un centro sociale in periferia di Milano

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3 Una città in salute – Attività motorie per la terza età / A healthy city – Motor activity for old people

Ufficio Attività creativa Terza Età – servizi sociali – comune di Padova www.padovanet.it

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4 Interventi per il miglioramento della qualità della vita nel comune di Badia Calavena. Programma di attività motoria per età adulta e terza età.

“La DEFAV” Associazione diplomati educazione fisica, associate Verona. www.ladefav.it

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6 GinnasticAncora - Attività motoria di gruppo per la terza età / Still in movement - Group movement activity for the elderly

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2 Schiena leggera in acqua / Soft back on the water

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▪ **APPENDIX FOUR – CITATION DETAILS OF EVIDENCE BASED GUIDELINES**

- **Sub headings**
 - **Sub sub headings**
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